Tyeaesis Johnson
Seasons Residential Treatment Program
Matter 14-16-2357

Mr. Kevin McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland, 21215-2299

Re: Seasons Residential Treatment Program
Establishment of an 80-bed RTC
Matter No. 14-16-2357

Dear Mr. McDonald,

The purpose of this letter is to support the above referenced application filed on behalf of Seasons Residential Treatment Program, LLC ("Seasons RTP", "Seasons" or "the Applicant") in accordance with the policies outlined in Code of Maryland Regulations, ***COMAR 10.24.01*****,** Certificate of Need ("CON") process.

In response to questions filed by the Maryland Health Care Commission (MHCC), in the "Completeness Document," please see the attached application and answers below regarding intent to establish a residential treatment center ("RTC") in Prince George's County, Maryland. Answers to questions from the Commission are indicated below and referenced in the attached application for your review and consideration.

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

Regarding the identification of the Project Applicant please provide the following additional information and clarifications:

A. Identify all individuals that have at least a 5% ownership share in Seasons Residential Treatment Program, LLC ("Seasons") and specify each individual's ownership share.
   At the time of the CON application filing, Tyeaesis Johnson is the sole owner and shareholder of Seasons Residential Treatment Program, LLC

B. Given the statement on page 67 that Strategic Behavioral Health, LLC ("Strategic") will acquire Seasons if the CON is approved and Seasons RTP is licensed, provide any signed MOU or other agreement between Seasons and Strategic concerning the proposed project.

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See attached MOU between Seasons and Strategic Behavioral Health, LLC.

C. Explain why Strategic is not the applicant for this CON or a co-applicant.

SBH is not the applicant or co-applicant because the assets of Seasons have not been acquired at the time of the filing of the CON application. An agreement in principle regarding acquisition has been reached between Seasons and SBH.

D. Identify all individuals that have at least a 5% ownership share in Strategic and specify each individual's ownership share.

Tyeaesis Johnson is the sole owner of Seasons and has 100% of the outstanding ownership shared.

2. Regarding the response to question 11, please provide the following clarifications and additional information:

A. A copy of the option to purchase the property from NVA Property, LLC

Please see the new Purchase and Sale Agreement attached in Exhibit 1A of the CON application.

B. The response to part C(2)(ii) of this questions suggests that Seasons will purchase the property, if the CON is approved. If this is the case and the purchase will occur prior to commencement of operations or within the first few years of operation, the cost of such purchase should be included in the Project Budget (Part II of the application). Please specify the expected time frame and cost of purchasing the site and revise the project budget, if necessary.

Please see the new Purchase and Sale Agreement reflecting the new site and closing conditions therein. Adjustments to Project Budget (Part II of the application) have been made to reflect the change in site location, budget, etc.. Please note: The executed version of this document will be forwarded to the Commission as soon it is made available by the seller. An agreement in principle has been made between the parties regarding sale, details and conditions are specific to remaining due diligence.

C. What will be the disposition of this property when Strategic acquires Seasons

Strategic will purchase all assets owned by Seasons at the time of acquisition.

3. Regarding the project description (question 16), please expand on the following:

A. Reconcile the statement of general assumptions 1d on page 1 of Exhibit 3 stating that "we have only included the renovation of one (1) cottage building" with the statement on page 2 that follows Building B: Residential Cottages (A-D): Renovation of four(4) existing residential cottages. No longer applicable.

B. With respect to the exclusions identified by the construction contractor in Exhibit 3, page one under #2, please address each one indicating whether the excluded items will be needed and undertaken by the seller or the Applicant. If any of the costs will be incurred by the Applicant, specify where the cost is included in the project budget on page 20 and 21.

No longer applicable; answer to this question is detailed in the revised project budget.

C. Given the statement in the last paragraph of Application page 15 that you are requesting approval of 80 beds when the project plans call for 72 beds, identify the proposed location of the additional 8 beds.
We have revised our request and are seeking approval for 72 beds in the new location.

D. Will the floor plans of each of the cottages be the same as that provided in Exhibit 3? If not, provide floor plans for the other cottages.
No longer applicable.

PART II - PROJECT BUDGET

4. The sum of the renovation costs (lines Alb(l) through (4) equals $2,056,148 not the $2,056,098 reported on page 20. This discrepancy is carried through the budget. Please correct this error and make sure that, if the total uses of funds change, the sources of funds are also changed.
No longer applicable, please see revised budget with costs for new construction.

5. Explain how the $92,000 in contingencies (line lc(3)) was estimated and demonstrate that it is reasonable given the nature of the project and the current level of design.
Contingency is historically based on 5% of the total capital costs and based on previous SBH development and new market entry.

6. Identify what is included in the Working Capital Startup Costs and explain how it was estimated to be $1,143,662.
Working capital start-up budget are estimates for the first five (5) months of operations. All programs must have required clinical staff, general employees, fixtures, furnishings and other variable and fixed costs in place prior to petitioning the state for a license to operate. These associated costs will be incurred prior to our first admission and will be carried prior to projected cash flow. We estimate the following program expenses:
   - Administration costs: $33,750
   - Facilities and Equipment: $208,500
   - Personnel: includes Recruiting and On-boarding costs, Payroll, Payroll costs and Benefits to include Workers Comp: $867,412
   - Marketing and Customer Relations: $11,500
   - Student Welfare Costs (toiletries, parent and family travel, activities, food): $22,500

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PART Ill – **CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3)**

Response to State Health Plan Chapter for Psychiatric Services: Interim Residential Treatment Center Capacity at COMAR 10.24.07G

COMAR Standard 10.24.07 G (1)(a-c): Core Principles

Programming need is outlined below, please note we were advised during the pre-application submission process to disregard the requirements outlined in COMAR Standard 10.24.07 G (1)(a)-(c) and COMAR Standard 10.24.07 G (2)(a)-(e). The Need standard is to be measured against the Core Principles outlined in COMAR Standard 10.24.07 G (1)(a)-(c).

(3) **Commission will use the following standards to review applications to provide residential treatment center care**

(a) Need. Each applicant shall document the need for residential treatment center care in the community it intends to serve consistent with G(a)-(e)

Please see detailed response to this question in the attached application.

7. What is the Community that the project is intended to serve?

Population project intended to serve is also Included in the Needs standard. This standard has been revised from original submission.

Seasons Residential Treatment Program intends to serve the needs of male and female youth between the ages of 13 to 21 who have been previously diagnosed with mental illness with or without a co-occurring disorder. We will petition to license as a Residential Treatment Center, (RTC) in the State of Maryland and will certify as a Psychiatric Residential Treatment Facility, (PRTF) and will meet the federal standards of care for a PRTF license.

If approved, our program will deliver evidence based, quantifiable treatment in an intensive clinical model. We will meet the needs of individuals who require safe and structured 24-hour care and a more comprehensive psychiatric evaluation and treatment than can reasonably be provided in a traditional outpatient setting or less intensive residential program. Our program will be ideal for youth with refractory behaviors and those qualified by stakeholders as "tough to treat."

Our admissions criteria will exclude youth without an Axis I Psychiatric Disorders diagnosis and those with a full scale IQ lower than 70. We will also exclude youth with a history of fire setting and those who have demonstrated sexually aggressive behaviors as their primary reason for treatment and placement in a residential program.

We will give admission priority to youth from the State of Maryland; however, as a

certified PRTF, we will likely attract admissions from around the region and the country. Admission consideration will be extended to appropriate placements from private placements, parents, social service agencies and related referral sources.

Our long-term strategic plan includes registering with federal agencies including the Department of Homeland Security and Department of Defense to provide specific services to dependents of active duty and retired military and international youth who meet our admissions criteria.

8. Regarding the figures cited in the response to this standard on pages 22 through 29 provide the following clarifications.
This section has been revised from original submission. Please see changes in attached application and note the section has been completed revised and includes new FY '14 data in Exhibit(s) 6 and 7 of the attached application.

   a. Are the figures found in Exhibit 12? If no, where are these figures?
   B. Please identify the source of the information in each figure in Exhibit 12. If the presentation of the information in the figure is different than the source, identify the entity that analyzed the data and prepared the figure.
   C. On page 24, it states that on January 31, 2013 750 children funded by Maryland placing agencies were in RTCs. Explain this statement given that Figure 4 reports that the 750 were placed in community based residential child care programs by the Department of Human Resources ("DHR") and figure 5 reports that a total of 729 were in RTCs on that date. Figure 3 reports a total of 748 (DHR-168, Dept. of Juvenile Services ("DJS") – 179, and Mental Hygiene Administration ("MHA") – 401).
   D. Reconcile the Non-Community Based Placements number in figure 3 with the numbers in figure 4 for January 31, 2013.
   E. Where is the source of the statement on page 24 that 66% of Maryland youth in out of home placement are between 12 and 21? If it is figure 5, where does it state that figure 5 represents only out-of-home placements? More importantly, what is the relationship between the total number of out-of home placements and the need for non-community based placements in RTCs?

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F. Regarding Figure 8, what is considered to be an out of state community based residential placement and what is considered to be an out of state non-community based residential placement?

G. How many DHR clients were in out-of state residential treatment centers on January 31, 2013?

H. Why is the proposed project being located in Prince George's County when on page 26 it states that of the youth placed in RTC/PRTF by MHA 23.2% werefrom Baltimore City, 21.9% from Baltimore County, and 14.5% from Montgomery County and on page 25 it states that for DJS the highest percentage was also from Baltimore City (19.8%)?
See revised application under Need standard for answer to (H)

9. On page 24 it states that 750 children funded by Maryland were in RTC's. Please provide more detailed information on where these adolescents are placed both in state and out of state (preferably the number by facility), and the average lengths of stays.
Please see data for out of home placements in the State of Maryland in Exhibit 6: *The FY 2014 Out of Home Placement and Resource Guide*. Although the data includes where State of Maryland youth are placed out of state, the data does not include average length of stay for each placement. These data can be found in Exhibit 6, and is referenced most prominently, under the Need standard in the application.

As a former admissions director and marketing director tasked with supporting 15 programs in 11 states, I have first-hand account of how difficult it is for agencies to place youth with refractory behaviors and serious treatment needs in in-state programs. Therefore, it is not uncommon for these youth to languish in out of state placements for the following reasons:

- Difficult to find appropriate discharge/reintegration options – home discharge is often not recommended as an immediate "step down'"
- Poor family/parent/case management/agency involvement in youth treatment plan because of distance of program – "out of Site, out of mind."
- There are so few therapeutically focused programs to treat these youth, they are often placed in more punitive programs and behaviors tend to escalate in these environments

10. Specify the location (County and zip code) and the number of RTC beds in each facility on page 29 that serve the same population as the population proposed to be served.Where are the 150 Maryland certified PRTF-level beds cited on page 58? Provide a breakdown by facility and location (county and zip code)
This section revised, please see application.

11. Given that the details from page 24 through 28 and Exhibit 12 indicates that

number youth in out of state RTCs on January 31, 2013 were not especially high with 26 DJS clients out of a total of 179 in RTCs and 8 MHA clients out of a total of 401 in RTCs,submit a clear complete analysis of how all the data provided on pages 22 through 29 and Exhibit 12 demonstrates a need for the 72 beds proposed for the initial opening. How many will come from MD? How many from DC? How manyfrom VA? How many from WV?

This information is covered in the Need section in the following ways:

- Number of youth placed in out of state programs by all MD agencies
- MD DJS "Service Gap Analysis" as outlined in Exhibit 6
- PRTF/RTC's serve a broader community and is different from in-patient hospital beds in this regard
- Program would give priority to Maryland youth, but, would support appropriate placements and admissions from the region and around the country
- Program growth is organic and would not reach 72 beds within first 24 months of launch
- Census breakdown by state is included in Need standard

12. Explain why a location in Washington, DC would not be better given the high volume of DC youth placed in RTCs far away from DC and the likelihood of a high volume of DC youth in the proposed facility.

The following information is included in the revised application, in summary:

Developing a program in the District of Columbia is indeed a good idea given the lack of PRTF's/RTC and the percentage of youth who are placed in this level of care. However, as you can imagine, the cost of developing and operating the type of program we have outlined is significant and the associated fixed and variable costs would increase tremendously in more dense areas where the cost of land and new construction is considerably higher. This is the primary reason why the current PRTF/RTC programs in the State of Maryland are all in more rural areas of their respective counties, or, in more rural counties within the state (Frederick and Dorchester). This is pretty consistent in most states where there is a large urban area – PRTF/RTC's tend to be in more rural areas. It is also easier to support youth and community safety and security in a less densely populated area.

The per diem would likely be much higher if the program was located in the District of Columbia. The land and construction costs would have a tremendous impact on our budget and raise associated expenses. This additional cost would likely be passed on to our stakeholders, including youth placed by the State of Maryland. Our strategic location will allow us to serve an unmet need in southern Maryland and realize more organic growth (safer for our staff and youth) with slightly lower fixed costs.

Much like an inpatient hospital, we will seek to serve the primary needs of the local

community and the entire state of Maryland. Our first priority will be to close the service gap and decrease local resources (and youth) from leaving the State. However, at this level of care and particularly for programs with federal PRTF certification, the need for evidenced-based, quality care is a national. Many referral sources will place youth across many miles in search of appropriate care for refractory clients (see answer to 8H) – we can serve this need and bring and keep much-needed revenue in the State.

We also plan to employ qualified staff from the local county, where the unemployment rate is above the national average and the need for careers and professional development is great. We will develop staff at all levels and have an aggressive training plan that will allow staff to increase learning opportunities and advancement within the organization. We have met with Prince George's County Economic Development and they are excited about our plan to bring jobs and opportunities to the county

Regarding admissions and census mix, we will work with stakeholders and agencies in the District of Columbia, Virginia and West Virginia and around the country to attract youth who meet our admissions criteria. Our overall mission is to decrease recidivism rates, partner closely to support effective community and family reintegration and return youth to their families and communities with sustainable tools as quickly as possible. We believe a program would greatly benefit Maryland youth, as they will be given the first priority in our admissions protocol.

We estimate the census mix to be as follows:

- 45-47% Maryland youth
- 25% District of Columbia placed youth
- 10% Virginia placed youth
- 5% West Virginia placed youth
- 10% other states out side the mid-Atlantic region
- 3% internationally placed youth meeting our admissions criteria

(b) <u>Sex Specific Programs</u>

13. Given that the diagnostic and assessment unit will be a male only unit, where will females go for such services?

In the new site, the diagnostic unit will serve both male and female residents

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(h) Staff Training

14. Subpart (ii) of this standard requires each applicant to document the curriculum trainingfor each category of direct care service personnel and show how the training will help staff meet the clinical needs of the population to be served. The response includes the 40hours of orientation required of all levels of staff but not curriculum specific to each category of direct service staff. In addition, the response does not show how the trainingwill help staff meet the clinical needs of the population to be served. Please provide a complete response to this subpart of the standard.
Please see the training curriculum in Exhibit 13, revised from the original submission

(i) Staffing

15. Regarding the staffing are there any state or national standards or guidelines that address the types and staffing ratios for RTCs/ PRTFs? If yes, please provide documentary evidence of such standards or guidelines and address the consistency of Seasons RTC with them.
There are no national standards relative to staff to resident ratios for PRTF/RTC programs. However, programs that are certified or licensed to provide a higher level of care as a Psychiatric Residential Treatment Facility (PRTF), have specific standards as to the type of staff they must employ and the quality and quantity of care the resident must receive in order to maintain federal standards for this level of care **(see Exhibit 10)**

Staffing requirements are generally mandated by the licensing agency in each state and there does not seem to be any real protocol for how the ratio is set. Based on my experience, the requirements range from a staff to resident ratio of 1:3 (example: North Carolina) to no stated requirement or regulation. There are currently no regulations related to staffing requirements and staff to resident ratios for the State of Maryland.

Seasons is pretty consistent with local PRTF/RTC providers relative to our highest staff to resident ratio is 1:6 (third shift) and slightly "above average" ratio of 1:5 on our assessment unit and during 1st and 2nd shifts.

16. Subpart (ii) of this standard requires each applicant to document how the level of staffing will provide active treatment and fulfill the goals of its proposed treatment programs and meet the needs of the patients. The response does directly

respond to this part of the standard. Please provide a complete response to this subpart of the standard.

17. Please specify the experience of the principles of Seasons and Strategic in developing and managing similar type facilities and services.

At the time of the MHCC CON application filing, Seasons Residential Treatment Program, LLC, a Maryland Corporation, is negotiating terms of an agreement to become a wholly owned subsidiary of Strategic Behavioral Health (SBH). Strategic Behavioral Health is a Memphis-based operator and developer of inpatient mental health facilities. At the end of 2014, SBH operated nine Joint Commission approved facilities in four states and has more than 700 in-patient beds.

The company has experienced exponential growth since its launch without sacrificing high quality care to clients. Part of the company's investment and development approach in new markets is to embrace new construction over property acquisition to ensure the facility meets the specific needs of the community and the goals of the mental health population it proposes to serve. Careful and meticulous consideration is given to all aspects of care within the scope of sound fiscal management.

With more than 100 years of training and experience as an inpatient mental health provider, the senior management team of Strategic Behavioral Health will significantly decrease our "learning curve" and allow the local program to seamlessly "hit the ground running." The de-centralized organization will provide oversight, management, staff training and functional area expertise to the Seasons staff; however, the local management team will work closely with the parent organization to ensure issues specific to the community are included in the care we provide.

Seasons believes the acquisition will allow the proposed residential program to provide an exhaustive list of resources to Maryland residents and youth and families from around the country suffering with mental health challenges. The (relatively) small size the company, commitment to patient and stakeholder communication, accountability of their programs and proficiency of the management team, will make a tremendous and immediate impact on the care we deliver.

The current owner of Seasons has more than 30 years of marketing, sales and public relations experience, including more than 12 years in health care. She has worked with neuroscience and mental health care providers, served in local chapters of mental health advocacy organizations and supported youth and family outreach programs as both a volunteer and paid staff.

Prior to managing all aspects of the start-up efforts for Seasons Residential Treatment, she worked for a large non-profit, in-patient mental health provider.

Her previous employer managed more than 2,000 beds in Joint-Commission approved Residential Treatment Centers (RTC's) and Psychiatric Residential Treatment Facilities (PRTF's). The organization also delivered community-based programs for a variety of consumers including adults, adolescents and children.

In this role, she served on the senior management team as director of business development and created, leveraged and managed new and existing business relationships and negotiated in-patient per diems and provider contracts for federal, state and local payers from around the country. She worked with agencies around the country, including with social service agencies in the State of Maryland.

In addition to working with agencies from around the country to admit appropriate youth, her leadership and efforts resulted in approval from the Department of Homeland Security to allow developmentally delayed and children with mental health challenges from other countries (administered by the Student and Visitor Exchange Program (SEVP)) to receive care unavailable in their native countries. She also provided direct management, oversight and budgetary responsibility for the marketing and admissions team for the program where she was headquartered. She holds a Masters in Business Administration in Management from Emory University and earned an undergraduate degree in Public Relations from the School of Journalism, at the University of North Carolina at Chapel Hill.

If the program is approved, she will continue to serve as Chief Executive Officer.

Miscellaneous Questions

18. Where did #4 #5 and #6 on pages 58 and 59 come from?
Questions have been deleted. I am not sure if it was a "cut and paste" from another CON application (hospitals?) and somehow was folded in.

Responses to Other Criterion

Need Criterion, 10.24.01.08G(3)(b)

19. There is no response to the "Need" criterion which states
Please see Need standard above

For purposes of evaluating an application under this subsection, the Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

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The application form instructs applicants to:

Please discuss the need of the population served or to be served by the Project.

Responses should include a quantitative analysis that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. For applications proposing to address the need of special population groups identified in this criterion, please specifically identify those populations that are underserved and describe how this Project will address their needs.

Please respond to this criterion by providing the information requested or by directing MHCC staff to other parts of the application that provide the requested information.

20. Regarding Table 2 on pages 63 through 64, please provide the following clarifications:
    A. Submit projections of the number of school days for the day students so that MHCC can calculate the revenue and expense per day.
    Please see data for this section in the revised application
    B. Explain how the average length of stay (line 3d) is calculated given that it is usually patient days (line 2d) divided by admission (line Id).
    Reviewed and satisfied on call – not a hospital calculation.
    C. Given that the project plans only provide for 72 beds as specified on page 15, the facility will only be licensed for 72 beds when it opens. Therefore the number of licensed beds reported on line 5d should only be 72 beds until such time as the capacity for an additional 8 beds is completed and licensed. Please revise accordingly and revise the calculated occupancy rates.
    No longer an issue in the new proposal.

Availability of More Cost-Effective Alternatives

21. With respect to the "Availability of More Cost-Effective Alternatives" criterion, please provide the following additional information and clarifications:
    A. Submit data and literature supporting the statement on page 65, 2"d paragraph of the response, that "the population that we wish to serve has a history of multiple placements and "failures" in local residential programs, community-based programs and "high fidelity" wrap around services."
    These data is supported in description of type of youth we will serve (Level III) as defined by the *2013 MD DJS Residential and Community-Based Gap Analysis* (Exhibit 7) and *2014 FY Out of Home Placement and Resource Guide* (Exhibit 8*)*
    B. Submit data and literature supporting the statement on page 65, 2"d paragraph

the response, that "overall, the costs associated with inappropriate residential placement, missed/masked mental health diagnoses and late onset of adequate clinical resources can be staggering to all stakeholders." Quantify the staggering costs.

Deleted. Costs for all markets could not be quantified.

C. Submit data and literature supporting the statement on page 65, 5th paragraph of the response, that "Data suggests youth placed far from local resources are at risk for poor family and community reintegration, unsuccessful discharge planning and have a higher rate of recidivism than those placed in the appropriate level of care closer to home." Please provide the data and sources that support this statement especially the part of the statement regarding a higher rate of recidivism.
No longer applicable – no local data; national data available.

D. Submit data supporting the statement on page 65, 6th paragraph of the response that one of the reasons many of the youth were placed out of state was due to the lack of programs to treat older youth (ages 18 to 21).
The demographic data from Exhibit 7 supports the large percentage of youth over the age of 18 to 21 in need of service. There are only 3 programs that serve both male and female youth over the age of 18 in the State of Maryland.

E. Address the program effectiveness of housing the target adolescent population in rooms with from three to six beds. Submit available literature on the subject.
No longer applicable in new construction model.

F. How does Strategic measure the effectiveness of its residential treatment programs in serving its client population? What basic and verifiable evidence can Strategic provide to demonstrate that the outcomes for patients completing its treatment program are cost-effective when compared to other programs treating the population 12 to 21 to be served by the proposed program?
Seasons would be the only program in the State of Maryland conducting prospective analysis of youth in residential treatment programs (Exhibit 4). This is an initiative supported by the Governor's Office for Children and will be very useful in the future. There is no way to compare the cost saving compared to Maryland programs because other programs are not measuring/tracking youth post discharge. The State of Maryland is also not quantifying/tracking recidivism rates for out of home and out of state placements; however, it is mentioned as a statement of how admissions and cost data can be skewed in agency data (see Exhibit 7).

The applicant can provide national data if requested – we discussed a state level comparison on the follow up call to this completeness letter.

Viability of the Proposal, 10.24.01.08G(3)(d)

22. Please specify the source of any payments for the option on the property and the anticipated source of funds to purchase the property. Provide documentation of the availability of equity and any other funds that will be used to pay for the renovations, operating start-up, and the acquisition of the property.
Please see attached Audited Financial Statements for Strategic Behavioral Health

23. On page 67 you state that Seasons has received support from local community providers, referral agencies and related service providers and the table of contents indicates that Exhibit 12 contains letters of support. However, Exhibit 12 contains figures 1 through 22 listed on page 6 of the table of contents, and letters of support do not appear any place else in the application. If you have letters of support, please submit them and submit any other evidence of relevant community support for and opposition to the proposed project.
Please see Exhibit 15 for MOU and letters of support.

24. Regarding Table 4 on page 72 and 73, please provide the following clarifications and additional

information:

A. Table 4 should have been completed following the instructions for Table 3, which include that all projected revenues and expenses should be presented in current dollars. It is not clear that the projections are all in current dollars especially the inpatient revenues that are projected to increase at a faster rate than inpatient admissions and patient days. Please explain or correct as needed.
Please see revised Table 4.

B. The instructions also state that the projections need to be accompanied by a statement of the assumptions made in developing the projections. There does not appear to be any such statement of assumptions included the application. Please specify all assumptions including revenues by payer and the basis for the projected expenses by category. Explain why you think the projections are reasonable for each revenue category and each expense category.
Please see revised Table 4.

C. Explain how the contractual allowance is calculated.
Please see revised Table 4

D. For year one the inpatient and outpatient revenues sum to $8,171,000 not the $8,981,000 shown on page 72. This discrepancy is carried down to income from operation (line 3a and beyond). Please correct this apparent discrepancy.
Corrected in revised budget

E. Explain why the expense for contractual services is projected to increase by over 150% from year one to year two and then decrease from year two to year three.
Corrected in revised budget

F. Explain why rent is projected to decrease from $456,000 in year one to $176,000 in year two and $36,000 in years three and four.
Corrected in revised budget

Impact on Existing Providers, 10.24.0l.08G(3)(t)

25. The application does not appear to include a response to the wording of this criterion, which requires that the applicant provide information and analysis with respect to the impact (not necessarily negative) of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy when there is a risk that this will increase costs to the health care delivery system, and on costs and charges of other providers. Please respond to this criterion.
Response included in Need standard, specifically, how PRTF/RTC's differ from hospitals in their coverage area – not a local coverage area. The application also provides information regarding geographic and demographic access to services for youth, families and agencies. The costs to the health care delivery system, specifically for youth going to out of state providers, (see Exhibit 6) will decrease (per diem, travel costs, etc.). The rates for PRTF's and RTC's are set by the State of Maryland/Medicaid (Value Options), third-party insurers and local social service agencies (DOE, juvenile services). The rate is based on the type of facility the youth is placed in, and the level of care required, the basic per diem rate is not set by the provider.

26. Please support the note at the bottom of page 75 with the following information and clarifications:

A. Please submit the source information that led to the assumption that employee benefits will cost 23.5% of payroll based on the average cost of local employers
This cost is based on average cost of local employers because our benefits package will need to be competitive in order to attract the best staff.

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B. Explain how the inclusion of a "variable cost savings" impacted the assumption and quantify the variable cost savings attributable to post-acquisition total payroll and number of employees.

Not clear

D. Explain why the employee benefit costs are based on local employers rather than Strategic given the expectation that Seasons will be acquired by Strategic and Strategic's experience operating similar facilities.

There will be a benefit based on economies of scale in some of our benefits costs, but, overall, this cost is based on average cost of local employers because our benefits package will need to be competitive in this market in order to attract the best staff.

Ms. Ty Johnson, Chief Executive Officer, is authorized to respond to questions regarding the application via phone or email (below). The temporary program mailing address is: 1101 30th Street, NW, 4th Floor, Washington, DC 20007.

Sincerely,

Ty Johnson
Chief Executive Officer
Seasons Residential Treatment Program, LLC
tyjohnson@seasonsdc.com
404 433 5205 (cell)