

*Rec'd 5/20/15*

GALLAGHER  
EVELIUS & JONES LLP  
ATTORNEYS AT LAW

ELLA R. AIKEN  
eaiken@gejlaw.com  
direct dial: 410 951 1420  
fax: 410 468 2786

May 18, 2015

Ms. Ruby Potter  
[ruby.potter@maryland.gov](mailto:ruby.potter@maryland.gov)  
Health Facilities Coordination Officer  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

**VIA EMAIL and  
HAND DELIVERY**

Re: Certificate of Need Application—Intermediate Care Facilities  
Recovery Centers of America – Upper Malboro  
4620 Melwood Road OPCO, LLC  
Matter No. 15-16-2364

Dear Ms. Potter:

Enclosed are ten copies of the Modified Application with respect to the above-referenced CON application. Also enclosed are two CDs containing searchable PDF files of the responses and exhibits, a WORD version of the responses, and native Excel spreadsheets of the tables and projections.

Because Applicant has modified its application, Applicant is not submitting formal responses to the Requests for Additional Information Questions Dated April 29, 2015. However, for the convenience of those reviewing the Modified Application, Applicant is supplying the information below.

- 1. Provide a brief description of each of the corporations – and their functions in this project -- shown on the organizational chart (Exhibit 2).**

Please see Exhibit 3 to the Modified Application.

- 2. Question 11.C asks applicant to provide a copy of the option to purchase; it was not included.**

Please see Exhibit 7 to the Modified Application.

- 3. The Project Description references a main building and one ancillary building, and describes a plan to raze the main building due to functional obsolescence for the proposed program while retaining an ancillary building to be used for a fitness center. What was the prior use for these structures?**

Please see pages 6-7 of the Modified Application.

#528002  
013522-0001

Ms. Ruby Potter  
Page 2  
May 18, 2015

- 4. Paragraph A(2) states that “The Commission will approve a CON application for a new ICF if the facility will have no more than 40 adolescent or 50 adult ICF beds, or a total of 90 beds, if the applicant is applying to serve both age groups.” Please confirm the classification levels (under the American Society of Addiction Medicine (ASAM) Patient Placement Criteria) of the proposed 125 beds, with a description of the type of care that goes with each classification. Are there anticipated to be any beds that would be licensed as III.7, Medically-Monitored Intensive Inpatient Treatment?**

Please see pages 5-6 of the Modified Application.

- 5. Describe the source used by ESRI Geographic Information Systems to construct demographic projections.**

Please see page 20 of the Modified Application, and Exhibit 9.

- 6. Describe in prose, step-by-step, the calculations in Tables 6 and 8.**

Please see pages 27-36 of the Modified Application.

- 7. List each adjustment to the prescribed need formula, the rationale and justification for each adjustment, and the direction and the general magnitude of each adjustment on projected need.**

Please see pages 27-36 of the Modified Application.

- 8. Provide a map of the projected catchment area with enough detail to delineate the major cities and towns included.**

Please see pages 34-35 of the Modified Application.

- 9. Provide a larger, more legible set of tables included in this section of the application, specifically, tables 4, 6, 7, 8, and 9.**

Please see Exhibit 10 to the Modified Application.

- 10. Referencing Table 4, the application states: “Applicant assumes that existing providers use 20% of their licensed beds as ‘true’ detox beds and the remaining 80% as inpatient beds. The Applicant concluded the 20% assumption from internal discussions with RCA’s clinical and operations team who have extensive experience**

Ms. Ruby Potter  
Page 3  
May 18, 2015

**in the field.” Please confirm and document your assumptions with research into the actual configuration of these facilities.**

Please see pages 31-32 of the Modified Application.

- 11. RCA proposes establishing two ICF facilities within 21 miles of each other in Southern Maryland seeking a total of 291 beds (25 detox and 100 residential in Upper Marlboro, and 21 detox and 145 residential in Waldorf). Please provide evidence that supports the need for two new chemical dependency programs located in adjacent jurisdictions.**

Please see Tables 7, 8 and 10 in the Modified Application.

- 12. The *Sliding Fee Scale* submitted is much more simplistic than most the MHCC is used to seeing. Do you anticipate looking into other factors regarding an individual’s ability to pay, e.g., total gross household income, equity in a primary residence, a person’s net worth, etc.? If so, then please provide a copy of the sliding fee scale that you expect to present to patients and their families or the person responsible for a person’s health or financial issues.**

The sliding fee scale attached to both the original and modified application is the scale that Applicant plans to utilize for the facility. Applicant believes that the scale will work well as drafted and does not wish complicate the scale with numerous factors for staff to apply and consider.

- 13. Please provide a detailed policy outlining the sliding fee scale.**

Please see Exhibit 12 to the Modified Application.

- 14. Application states (p.34) that many states have expanded Medicaid to cover adults with incomes up to 133% of the Federal poverty level, and that the benefits must include mental health and substance abuse services, changes that “are a major catalyst for transformation of substance abuse service coverage and delivery in Medicaid.” Does this statement imply that RCA – Upper Marlboro intends to serve patients covered by Medicaid?**

Please see page 43 of the Modified Application.

- 15. The standard requires an applicant to commit that it will provide 15 percent or more of its proposed annual adult intermediate care facility bed days to indigent or**

Ms. Ruby Potter  
Page 4  
May 18, 2015

**gray area patients. Applicant has stated that this standard is outdated given the changes occurring in the health insurance landscape since the standard was adopted, and has proposed a commitment of 5% on the rationale that the implementation of the Affordable care Act means that many more people are insured for these services. Please provide documentation from the literature and/or insurance sources that bolster this point of view.**

Please see Exhibit 13 to the Modified Application.

- 16. Applicant also cites a previous MHCC decision in the review of an application from Father Martin's Ashley (FMA) that accepted a lower commitment to provision of services to indigent and gray area patients (6.3% of patient-days was the accepted commitment). However, the main driver of the Commission's decision on this aspect of FMA's application was the fact that higher levels of charity care would lead to unsustainable losses. The projections shown by RCA tell a much different story, with profits expected to be approximately 30% of total operating budget in the second and third year.**
- a) Please explain why – if indeed these projections materialize – a 15% charity care commitment is not achievable.**
  - b) Please resubmit Tables G and H with a 15% charity care commitment.**

Please see pages 42-43 of the Modified Application, and Exhibit 2.

- 17. Provide a list of services and prices.**

Please see Exhibit 15 to the Modified Application.

- 18. The application states that this application is for 25 adult ICF treatment beds and 100 other residential beds. Staff could infer that the residential beds will also be limited to adults, but would like confirmation of that.**

Please see page 44 of the Modified Application.

- 19. Will RCA seek state licensure for the detox and residential programs from the Department of Health and Mental Hygiene as required by subsection (2) of this standard?**

Please see Applicant's response to Standard .05H, page 45 of the Modified Application.

Ms. Ruby Potter  
Page 5  
May 18, 2015

- 20. Staff did not find specific reference in the policies provided that would govern length of stay, as required by the standard. Although the application states a commitment to include at least one year of aftercare (p.37), it is also not clear that any policy or procedure meets the requirement that “each patient’s treatment plan includes, or will include, at least one year of aftercare following discharge from the facility.”**

Please see Applicant’s response to Standard .05I, pages 46-47 of the Modified Application.

- 21. Please provide an executed transfer and referral agreement with each of the organizations and entities listed in your response to this standard.**

Please see Applicant’s response to Standard .05J, pages 47-48 of the Modified Application, and Exhibit 17.

- 22. The application did not list potential referral sources. Please do so, and for the immediate purposes of this review, assume that 15% of the facility’s annual patient days required by Regulation .08 of this Chapter will be incurred by the indigent or gray area populations, including days paid under a contract with the Behavioral Health Administration (formerly the Alcohol and Drug Abuse Administration), or a jurisdictional alcohol or drug abuse authority, or the Medical Assistance program, as the standard specifies.**

Please see Applicant’s response to Standard .05K, page 48 of the Modified Application, and Exhibit 18

- 23. Questions regarding Table E, Project Budget:**

- a. **Despite a sizable mortgage, Table E does not reflect any interest cost during construction; please confirm that is the case..**
- b. **The costs for demolishing the existing building and the Site Preparation Costs reported in Table D do not seem to be reflected anywhere in the Project Budget, unless they are subsumed in another line item; please explain.**

Please see the notes to Exhibit 1, Table E of the Modified Application.

Ms. Ruby Potter  
Page 6  
May 18, 2015

**24. Please describe the needs covered by the *working capital start-up costs* line item.**

Please see the notes to Exhibit 1, Table E of the Modified Application.

**25. Please describe the nature of the Property Due Diligence, Transaction, Acquisition, and Due Diligence costs, which total a little over \$1.1 million or approximately 5.3% of Project Costs.**

Please see the notes to Exhibit 1, Table E of the Modified Application.

**Please reconcile the significant discrepancy between the sources of funding reported on your Project Budget in Table E (\$7.3 million equity and \$13.7 million debt) and what is stated under the Viability criteria p. 48 (\$9.9 million equity and \$11.3 million debt).**

These items have been reconciled in the Modified Application.

**26. Please identify and document the source of the equity funding.**

Please see page 57 of the Modified Application.

**27. The projections in Table F show that the number of residential care discharges to be about 50% of total discharges, with detox making up the rest.**

- a) **Is there overlap between the counts (i.e., a patient starts in detox and transitions to residential), or are they totally discrete? Another way of asking the question is, for 2016, are there 1,052 discrete individuals (and 2,476 in 2017, and 2,482 in '18) or some other number of discrete individuals?**
- b) **Given the discharges projected, it seems clear that many patients will be admitted for detox and residential care; what is the typical expected treatment protocol for those individuals?**
- c) **Explain the TOTAL AVERAGE LENGTH OF STAY computation in relation to a) and b) above.**
- d) **Please complete Table I for the detox portion of the program.**

Please see the statement of assumptions provided with Exhibit 1, Table F to the Modified Application, and Exhibit 1, Table I. Please also see footnote 5 in the Modified Application.

Ms. Ruby Potter  
Page 7  
May 18, 2015

**28. Since applicant has simultaneously submitted two other CON applications for facilities elsewhere in Maryland, please explain why the applicant chose a strategy of using several sites around the state rather than selecting one central location with a large number of detox and residential beds which would offer the ability to realize economies of scale.**

Please see page 55 of the Modified Application.

**29. As instructed in the application: *Audited financial statements for the past two years should be provided by all applicant entities and parent companies to demonstrate the financial condition of the entities involved and the availability of the equity contribution. If audited financial statements are not available for the entity or individuals that will provide the equity contribution, submit documentation of the financial condition of the entities and/or individuals providing the funds and the availability of such funds. Acceptable documentation is a letter signed by an independent Certified Public Accountant. Such letter shall detail the financial information considered by the CPA in reaching the conclusion that adequate funds are available.***

Please see page 57 of the Modified Application, and Exhibit 25.

**30. Provide documentation of the commitment of the equity partner, and provide documentation re: the bank that has been selected, and the terms of the loan.**

Please see page 57 of the Modified Application.

**31. As this criteria requires, please provide an analysis that addresses the following areas as stated:**

- a) **On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project;**
- b) **On the payer mix of all other existing health care providers that are likely to experience some impact on payer mix as a result of this project.**
- c) **On access to health care services for the service area population that will be served by the project. (State and support the assumptions used in this analysis of the impact on access);**
- d) **On costs to the health care delivery system.**

Ms. Ruby Potter  
Page 8  
May 18, 2015

- e) **If you assert this project will not have an impact on existing providers, then provide evidence to support your position.**

Please see the Modified Application, pages 60-62.

- 32. Please provide a response to the probable impact of the proposed RCA-Upper Marlboro facility on existing providers such as the Avery Road Treatment Center in Montgomery County, Hope House Treatment Center in Prince George's, Anchor of Walden in St. Mary's County, or either Hope House Treatment Center or Pathways in Annapolis since each provide Level III.7 detox and residential care.**

Data are not readily available regarding the operations of existing ICF providers. However, please see the Modified Application, pages 60-62.

- 33. Table A: Please reconcile the difference in the number of detox beds reported in Table A (25 beds) with Table F (20 beds). Also explain the entries that show a physical capacity for 20 beds in 9 rooms, yet a total number of 25 beds; i.e., how does one fit 25 beds into a physical capacity of 20? Finally, please supply the planned configuration of bed accommodations for both the detox and residential programs, i.e., number of single-occupancy, double-occupancy, triple-occupancy, etc.**

Please see Exhibit 1, Table A to the Modified Application.

- 34. Regarding Table C, please respond to the following:**

- a) **Address the Class of Construction and the Type of Construction for the proposed facility.**
- b) **Reconcile and clarify the discrepancy in Total Square Footage for New Construction - Detox reported in Table B (8,925 sq.ft.) with Table C (8,623 sq.ft.).**
- c) **Provide a response for the sprinklers and HVAC system for the proposed project.**

Please see Exhibit 1, Tables B and C to the Modified Application.

**On the Revenue and Expense tables (G and H), given that "other expenses" make up almost 50% of total expenses, please itemize the categories listed.**

Ms. Ruby Potter  
Page 9  
May 18, 2015

Please see Exhibit 1, Tables G and H to the Modified Application.

- 35. Please confirm whether the Work Force Information reported in Table L is for the entire facility, or only for either the detox or residential unit? The attachments to that table appear intended to delineate that, but are difficult to decipher. If the Work Force Information reported in Table L is for the entire facility, please an alternate Table L showing the information for just the detox unit.**

The Work Force Information reported in Table L is only for the detox unit.

- 36. Please make sure that the total cost of hiring regular employees and contractual employees reported in Table L agrees with the Salaries & Wages and Contractual Service costs reported in Exhibit G and J for the first full year of operation (CY 2017).**

The total cost of hiring regular employees and contractual employees reported in Table L (\$4,185,908) agrees with the Salaries & Wages and Contractual Service costs reported in Exhibit J, #2a for 2018 which represents the detox unit only. Table L agrees correlates to the costs for 2018, the final year presented in the financial projections.

- 37. The information presented in this section only reports on Mr. Christen. He is listed as COO, but it is not clear if he is listed as an owner or as the person responsible for implementation. Please expand the answers to this section to include all individuals who will own 5% or more of the corporation that holds ultimate control.**

Applicant has modified its response to Part III to identify, as owners and persons responsible for the proposed project, 4620 Melwood Road OPCO LLC and Recovery Centers of America Holdings LLC, on whose behalf Mr. Christen has signed. As explained in Exhibit 3 to the Modified Application, 4620 Melwood Road OPCO LLC ("Applicant") will be the licensee and operator of the facility, providing facility level staff. Recovery Centers of America Holdings LLC ("RCA") will provide corporate administrative staff, policies, and funding for ongoing operations. Applicant will have direct control of operations, and RCA, as an indirect owner, also will have the ability to control decisions at the facility. The other entities identified on Exhibit 3 to the Modified Application provide funding or serve as holding companies, and will not have input in the day-to-day operational decisions of the facilities, or the treatment and care provided.

COMAR § 10.24.01.07 (C) requires an applicant to identify, in its letter of intent, "each person on whose behalf the letter of intent is filed...." COMAR § 10.24.01.07 (C)(ii) provides

GALLAGHER  
EVELIUS & JONES LLP  
ATTORNEYS AT LAW

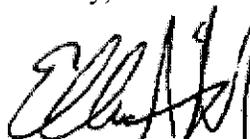
Ms. Ruby Potter  
Page 10  
May 18, 2015

“In the case of a letter of intent filed on behalf of a person that is not a natural person, the date the entity was formed, the business address of the entity, and the identity and percentage of ownership of all persons having an ownership interest of 5 percent or more in the entity.” “Person” within the regulation specifically includes non-natural persons. *Id.* The regulation does not require Applicant to provide information concerning all “individuals” that hold a 5% or more “ultimate” interest in the controlling entities,” it requires only that Applicant name all persons (including non-natural persons), having an ownership interest in the controlling entity. Applicant respectfully maintains that it has complied with this regulation by providing the name of all persons who have a 5% or more ownership interest in the persons on behalf of whom the Letter of Intent was filed, RCA and Applicant.

I hereby certify that a copy of this submission has also been forwarded to the appropriate local health planning agency as noted below.

Please sign and return to our waiting messenger the enclosed acknowledgment of receipt.

Sincerely,



Ella R. Aiken

TCD:blr

Enclosures

cc: Kevin McDonald, Chief, Certificate of Need (w/ CD)  
Paul Parker, Director, Center for Health Care Facilities Planning & Development, MHCC  
Joel Riklin, Health Policy Analyst, HSP&P/CON  
Suellen Wideman, Esq., Assistant Attorney General, MHCC  
Pamela B. Creekmur, Health Officer, Prince George's County (w/ enclosures)  
JP Christen, Chief Operating Officer, Recovery Centers of America  
Edmund J. Campbell, Jr., Esq.  
Andrew L. Solberg, A.L.S. Healthcare Consultant Services  
Thomas C. Dame, Esq.