CORRECTED MODIFIED

CERTIFICATE OF NEED APPLICATION

INTERMEDIATE CARE FACILITY

314 Grove Neck Road
Earleville, Maryland

RECOVERY CENTERS OF AMERICA

Applicant: 314 Grove Neck Road OPCO, LLC

Prior Application Versions
Original Application: March 27, 2015
Modified Application: May 18, 2015
Letter Modification: Nov. 30, 2015

Corrected Modified Application: December 21, 2015

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MARYLAND HEALTH CARE COMMISSION

For internal staff use

_____

MATTER/DOCKET NO.

_____

DATE DOCKETED

APPLICATION FOR CERTIFICATE OF NEED

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: Recovery Centers of America Grove Neck Road Facility

Address:

314 Grove Neck Road	Earleville	21919	Cecil County
Street	City	Zip	County

2. Name of Owner The Owner will be 314 Grove Neck Road LLC. Please see **Exhibit 3** for an organizational chart.

If Owner is a Corporation, Partnership, or Limited Liability Company, attach a description of the ownership structure identifying all individuals that have or will have at least a 5% ownership share in the applicant and any related parent entities. Attach a chart that completely delineates this ownership structure.

3. APPLICANT. ***If the application has a co-applicant, provide the following information in an attachment.***

Legal Name of Project Applicant (Licensee or Proposed Licensee): 314 Grove Neck Road OPCO LLC

Address:

314 Grove Neck Road	Earleville	21919	Cecil County	MD
Street	**City**	**Zip**	**County**	**State**

Telephone: 610-205-1562

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from the applicant:

Applicant will be the Licensee.

5. LEGAL STRUCTURE OF APPLICANT (and LICENSEE, if different from applicant).

Check ☑ or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☐	
	(2) For-profit	☑	
	(3) Close	☐	State & Date of Incorporation: DE, 8/7/2014
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited Liability Partnership	☐	
	Limited Liability Limited Partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☑	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	☑	

6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Name and Title: JP Christen, Chief Operating Officer

Company Name: Recovery Centers of America LLC

Mailing Address:

2701 Renaissance Boulevard, 4th Fl	King of Prussia	19406	PA
Street	City	Zip	State

Telephone: 610-205-1562

E-mail Address (required): jpchristen@recoverycoa.com

Fax: 410-468-2786

If company name is different than applicant briefly describe the relationship Recovery Centers of America LLC is an affiliated company of the Applicant.

B. Additional or alternate contacts:

Name and Title: Kevin McClure, Chief Financial Officer

Company Name: Recovery Centers of America LLC

Mailing Address:

2701 Renaissance Boulevard, 4th Fl	King of Prussia	19406	PA
Street	City	Zip	State

Telephone: 610-205-1562

E-mail Address (required): kmcclure@recoverycoa.com

Fax: 410-468-2786

If company name is different than applicant briefly describe the relationship Recovery Centers of America LLC is an affiliated company of the Applicant.

Name and Title: Thomas C. Dame, Esq

Company Name: Gallagher Evelius & Jones LLP

218 N. Charles St. Ste. 400	Baltimore	21201	MD
Street	City	Zip	State

Telephone: 410-347-1331

E-mail Address (required): tdame@gejlaw.com

Fax: 410-468-2786

If company name is different than applicant briefly describe the relationship Legal Counsel

Name and Title: Ella R. Aiken, Esq.

Company Name: Gallagher Evelius & Jones LLP

Mailing Address:

218 N. Charles St. Ste. 400	Baltimore	21201	MD
Street	City	Zip	State

Telephone: 410-951-1420

E-mail Address (required): eaiken@gejlaw.com

Fax: 410-468-2786

If company name is different than applicant briefly describe the relationship Legal Counsel

Name and Title: Andrew L. Solberg

Company Name: A.L.S Healthcare Consultant Services

Mailing Address:

5612 Thicket Lane	Columbia	21044	MD
Street	City	Zip	State

Telephone: 410-730-2664

E-mail Address (required): asolberg@earthlink.net

Fax: 410-730-6775

If company name is different than applicant briefly describe the relationship Consultant

7. TYPE OF PROJECT

The following list includes all project categories that require a CON pursuant to COMAR 10.24.01.02(A). Please mark all that apply in the list below.

If approved, this CON would result in (check as many as apply):

(1) A new health care facility built, developed, or established ☑

(2) An existing health care facility moved to another site ☐

(3) A change in the bed capacity of a health care facility ☐

(4) A change in the type or scope of any health care service offered by a health care facility ☐

(5) A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf ☐

8. PROJECT DESCRIPTION

A. Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is, why you need to do it, and what it will cost. A one-page response will suffice. Please include:

(1) Brief Description of the project – what the applicant proposes to do
(2) Rationale for the project – the need and/or business case for the proposed project
(3) Cost – the total cost of implementing the proposed project

Applicant Response:

314 Grove Neck Road OPCO, LLC proposes to establish an alcohol and drug abuse intermediate care facility in Cecil County, Maryland. The proposed facility will include 21 Detox / Assessment beds subject to a Certificate of Need review pursuant to COMAR § 10.24.14. Applicant expects to license these beds as American Society of Addiction Medicine (ASAM) level III.7D – Medically Monitored Inpatient Detoxification.[1] Patients in the detoxification program will undergo a comprehensive medical and psychosocial evaluation and will receive detoxification services including medications to ensure a medically safe withdrawal. Patients will be closely monitored 24 hours a day by medical and nursing staff.

The proposed facility will also include ~~28~~87 residential beds that Applicant expects to license as ASAM level III.5 – Clinically Managed High-Intensity Residential Treatment.[2] Patients in the residential program will receive intensive, structured, multi-disciplinary treatment 24 hours a day provided by clinical, nursing and medical staff.

[1] COMAR § 10.47.02.09 defines a level III.7.D program as "[a] medically monitored intensive inpatient treatment program" that shall: (1) [o]ffer a planned regimen of 24-hour professionally directed evaluation, care, and treatment in an inpatient setting; (2) [a]ct as an Intermediate Care Facility Type C/D; and (3) [m]eet the certification requirements for detoxification services as described in COMAR 10.47.02.10E." *Id.* at .09(A). Patients appropriate for this level of care "(1) Meet the current edition of the American Society of Addiction Medicine Patient Placement Criteria for Level III.7, or its equivalent as approved by the Administration; and (2) [r]equire 24-hour monitoring and care for subacute biomedical and emotional or behavioral conditions severe enough to warrant inpatient treatment." *Id.* at .09(B). ASAM defines Level III.7 Services as "Medically Monitored High-Intensity Inpatient Services," and described as "24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. 16 hour/day counsel ability." The ASAM Criteria: Treatment for Addictive, Substance-related, and Co-occurring Conditions, Third ed., Ch. 3, Ed. David Mee-Lee, American Society of Addiction Medicine, 2013. Dimension 1 is defined as "Acute Intoxication and/or Withdrawal Potential;" Dimension 2 is defined as "Biomedical Conditions and Complications"; Dimension 3 is defined as "Emotional, Behavioral or Cognitive Conditions and Complications." *Id.*, Ch. 7.

[2] COMAR § ~~10.47.02.09~~10.47.02.08 defines a level III.5 program as "[a] clinically managed high intensity residential program" that shall "(1) [p]rovide a highly structured environment in combination with moderate to high intensity treatment and ancillary services to support and promote recovery; and (2) [b]e characterized by its reliance on the treatment community as a therapeutic agent." *Id.* at .08(A). Patients appropriate for this level of care "meet the current edition of the American Society of Addiction Medicine Patient Placement Criteria for Level III.5, or its equivalent as approved by the Administration." The ASAM Criteria, Ch. 3. ASAM defines Level III.5 Services as "Clinically Managed High Intensity Residential Services," described as "24 hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community." *Id.*, Ch. 7.

Thousands of Maryland residents who are suffering from addiction need treatment today. Relying on data from Maryland Department of Health and Mental Hygiene (DHMH), the Washington Post reported that "Heroin-related deaths in Maryland spiked 88 percent from 2011 to 2013 . . . and intoxication overdoses of all types now outnumber homicides in the state." *See* **Exhibit 4**. Dr. Joshua Sharfstein, former DHMH Secretary, has remarked "Overdose is a public-health crisis in Maryland, as it is in many states…and we are bringing everything we can to bear against this challenge." *Id.*

Maryland's existing portfolio of treatment facilities cannot begin to solve this problem. The most recently approved CON for bed expansion at Father Martin's Ashley, dated September 19, 2013, noted need for 107 to 152 Private ICF/CD beds for the Central Maryland Region alone~~.~~ for the target year 2018. Additionally, Applicant's calculations indicate a need for new treatment beds in Maryland by 2019 in the range of ~~450~~307 to ~~598, using 2014~~419 for the population ~~data, and 471 to 624 using projected 2019 population data~~RCA anticipates serving. The Eastern Shore Maryland Region has a net bed need of ~~33 to 87 using 2014 population data, and 34 to 90 using 2019 projected~~10 to 51 for the same population.

Applicant, together with its investors, is prepared to devote significant financial and clinical resources to not only developing the facility and treatment regimens, but to providing education and support to its surrounding communities. The total project cost is $~~17,370,227, $7,444,384~~30,832,335, $7,368,855 of which is attributable to the detox/assessment portion of the project that is subject to Certificate of Need review. Because Applicant will fund the project entirely through private channels, rather than seek state or local, or charitable funding, this cost represents a significant gain to the State and its efforts to combat the current addiction crises.

B. Comprehensive Project Description: The description should include details regarding:

(1) Construction, renovation, and demolition plans
(2) Changes in square footage of departments and units
(3) Physical plant or location changes
(4) Changes to affected services following completion of the project
(5) Outline the project schedule.

Applicant Response:

I. THE RECOVERY CENTERS OF AMERICA GROVE NECK ROAD FACILITY

A. The Grove Neck Road Facility

Located in rural Cecil County, the Grove Neck Road facility will offer exclusively inpatient services. The facility will be located in a manor house on approximately 530 acres fronting Grove Neck Road in rural Cecil County, Maryland. The site has more than a mile of water frontage. The Manor house was constructed in 1991 and was expanded to 47,000 square feet in the late 1990s. The home is a masterpiece of colonial architecture designed in the classical tradition. Because the ~~building~~Manor House itself is in superb condition, the renovation plans are limited to the integration of administrative, clinical program, and regulatory requirements.

Applicant will need to upgrade the facilities to comply with the requirements that will result from a change in occupancy from "residential" to I-~~-~~1 and I-~~-~~2 institutional group

occupancy. Applicant has met with local code officials to determine ~~the "~~what upgrades~~"~~ to the building and systems ~~that~~ are required by the change in use.

RCA plans to renovate the Manor House to contain 31 residential beds, and to open a residential treatment facility while awaiting CON approval for detox/assessment beds. RCA also plans to add a terrace addition of 8 residential beds to the Manor House once its growth allocation plan is approved by the Critical Area Commission. The Manor house will have a circular sunroom with sweeping views of the property that will be utilized as large group meeting space. The dining area will face the southeastern part of the property and include a gourmet kitchen. Patio space may be used for outdoor dining, group therapy and events. The total terrace addition is 2,654 square feet, bringing the total square footage of the Manor House and addition to 47,082 square feet. RCA anticipates that this renovation and construction will take six months (Phase I).

Once RCA receives CON approval for its detox/ assessment beds, it plans to add a three story addition to the Manor House. The first floor will contain a 21 bed detox unit. Floors two and three will each contain 24-bed residential treatment units, for a total of 48 residential beds. The total three-level addition is 30,270 square feet, bringing the total square footage of the Manor House and additions to 77,352 square feet. Construction on the addition will begin immediately once the CON is approved and all permits are received, and is anticipated to take 8 months (Phase II).

Patients who require detox level care after the completion of Phase I but before CON approval will be cared for at a facility out of state. Even after RCA opens its detox/assessment beds with CON approval, RCA will continue to accept patients into its residential program who utilize detox services at out-of-state locations or at a detox-only facilities, or who require residential only care.

RCA will also renovate structures other than the Manor House to support its residential treatment facility during Phase I. Two Gatehouses at the entrance to the Manor House area will be renovated to house admissions, family programming and meeting space. Two of three freestanding buildings ranging from 6,000-10,000 square feet, the "Car Barns," will also be renovated. One will be renovated to include a gymnasium and fitness center. Another will hold two offices for the Personal Trainer and Recreation/Adventure staff. The bulk of that building will house the new water treatment plant. The total square footage of affected by the proposed project, including both the Manor House and additional structures, is 95,126.

Most systems at this property will serve the new occupancy requirements and are well within their useful lives, however, one ~~area~~system to be addressed is the fire ~~sprinklers~~sprinkler system. Applicant will make improvements to the fire safety systems by expanding the sprinkler system to areas of the buildings that currently do not have coverage. Other project costs are normal and customary for buildings converted to a different purpose, i.e. partitions, finishes, and the reworking of branch lines for MEP (Mechanical, Electrical, and Plumbing).

~~The Applicant plans to renovate a 6,000 square foot free standing structure for Detox treatment, bringing the total square footage to 53,000. Subject to CON approval, construction could begin in mid-summer 2015 and be completed in February 2016.~~

~~The Manor house will have a circular sunroom with sweeping views of the property that will be utilized as large group meeting space. The dining area will face the southeastern part of~~

~~the property and include a gourmet kitchen. Patio space may be used for outdoor dining, group therapy and events.~~

B. Recovery Centers of America

Recovery Centers of America ("RCA") will be the operator of the facility, under an arrangement with Applicant, the proposed licensee. RCA is a privately held company that will provide services for individuals with substance use disorder and their families. The RCA Executive Team represents an average of 22 years of experience managing facilities that treat up to 40,000 individuals daily. The Executive Team's experience is in the following sectors:

- Residential and Outpatient Treatment Facilities
- Acute Care Hospitals
- Behavioral Health Services
- Academic Research
- Governmental Drug Policy Initiatives

RCA has developed a continuum of care model that is tailored to the unique needs of each patient and their families. The proposed project mission is to provide world class treatment with immediate solutions and a commitment to supporting lifelong recovery. RCA will offer clinical excellence to its patients, family, alumni, and the larger community through a continuum of care. RCA's model will include the following services, as the market demands:

- Residential/Inpatient Treatment
- Partial Hospitalization Program (PHP)
- Intensive Outpatient (IOP)
- Traditional Outpatient (OP)
- Family Therapy
- Support Groups (AA/NA/12-Step Groups)
- Community Groups
- Spiritual Services
- Contact Center

RCA plans to utilize a technologically advanced, scientific treatment approach. RCA will treat everyone who walks through the doors of its state-of-the-art facilities with respect and dignity. RCA employees truly care about the recovery of patients and will provide the quality communication, long-term monitoring, and accountability.

II. RCA'S TALENTED WORKFORCE

A. RCA Chief Clinical Officer

RCA's clinical care will be overseen by Deni Carise, Ph.D., Chief Clinical Officer for all RCA facilities. Dr. Carise, a clinical psychologist, will live at each RCA facility for the month prior to and following the facility's opening, and will remain involved in each RCA facility after opening, setting standards for clinical care, measuring effectiveness, and being available to the RCA staff.

Dr. Carise has worked in the field of substance abuse and behavioral healthcare, as a researcher and clinician, for more than 28 years. She has extensive personal knowledge,

know-how, and experience with regard to the types of activities she will be undertaking for RCA. Dr. Carise's areas of expertise include:

- Development, implementation and measurement of treatment tools and evidence-based practices such as computer software, clinical toolkits, program descriptors, assessment, intake and treatment planning instruments and procedures, continuing care, fidelity assessment, relapse prevention, family therapy, 12-step support, decreasing paperwork burden, diagnosing systems, psychodrama;
- Developing systems of care and partnerships such as performance-based contracting, ~~concurrent~~Continuing recovery monitoring, implementation science, developing partnerships in the field, working with State directors, instrument and methods development;
- Tracking trends in alcohol and drug addiction;
- Eliciting positive public opinion and support for treatment.

A list of journal articles and other research and publications authored by Dr. Carise in each of these areas is attached as **Exhibit 5**. Dr. Carise also is an Adjunct Clinical Professor at the University of Pennsylvania School of Medicine. She is a frequent contributor to Huffington Post's Healthy Living blog – a list of her contributions is included in **Exhibit 5**, together with additional news and media contributions or appearances by Dr. Carise. **Exhibit 5** also lists various lectures Dr. Carise has given, and other relevant professional activities.

B. RCA Staff

To implement its services, RCA will employ talented, licensed clinical staff including Clinical Directors, Clinical Supervisors, Primary Therapists, Case Managers, and Recovery Support Staff. These skilled clinicians will receive rigorous training and ongoing monitoring for competencies including Motivational Interviewing, Co-Occurring Disorders, Cognitive Behavioral Therapy, and Dialectical Behavioral Therapy.

RCA will maintain a medical team 24 hours a day, 7 days a week. RCA plans to employ Registered and Licensed Practical Nurses who will work closely with Nurse Practitioners, Psychiatric Nurse Practitioners, Physician Assistants and Psychiatrists.

C. RCA Collaboration

RCA staff collaborates with colleagues from the top research institutions and with the top innovators in the field, including the following.

Research groups: UPENN, Yale, Hopkins, Harvard, Brown, Dartmouth, UMDNJ, Treatment Research Institute.

Top innovators: Tom McLellan, Herbert Kleber, Amelia Arria, Charles O'Brien, Maxine Stitzer, Kathy Carroll, Bill Miller, William White, Kathleen Brady, Rick Rawson, Lisa Marsch.

III. TREATMENT AND PROGRAMMING

A. Approach to Treatment and Recovery

Getting a patient into treatment has historically been difficult and included numerous break-points or times when the patient finds it easier to walk away from treatment than to engage in or continue treatment. Some of these breakpoints include:

- The inability to identify the correct program;
- The inability to find quality treatment close to home;
- Treatment programs that do not answer phones or return calls;
- Difficulty identifying if the treatment provider accepts their health insurance;
- Lack of immediate transportation to the program; and
- Difficulty transitioning from residential to a new outpatient treatment center.

RCA insists on having a full continuum of care at its facilities. The National Institute on Drug Abuse – Principles of Drug Addiction Treatment: A Research Based Guide (Third Edition) ("NIDA Guide"), reports that good outcomes are contingent on adequate treatment length. **Exhibit 6** at p. ~~12.~~14.

One of the most common break-points or times when patients leave treatment occurs when they need to transition from one facility to another, such as from residential to intensive outpatient or step-down care. If a patient has to develop new treatment relationships and start over in a new system with new peers, they rarely show up for the next, lower level of services. However, it the patient gets that service in the same system, or better yet, the same place, where the patient received residential care, the patient is more to continue in treatment and recovery.

The NIDA Guide remarks:

> Individuals progress through drug addiction treatment at various rates, so there is no predetermined length of treatment. However, research has shown unequivocally that good outcomes are contingent on adequate treatment length. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited effectiveness, and treatment lasting significantly longer is recommended for maintaining positive outcomes. For methadone maintenance, 12 months is considered the minimum, and some opioid-addicted individuals continue to benefit from methadone maintenance for many years.
>
> Treatment dropout is one of the major problems encountered by treatment programs; therefore, motivational techniques that can keep patients engaged will also improve outcomes. By viewing addiction as a chronic disease and offering continuing care and monitoring, programs can succeed, but this will often require multiple episodes of treatment and readily readmitting patients that have relapsed.

Exhibit 6 at p. ~~12.~~14.

RCA will give patients the highest likelihood of making the 90-day mark and increasing positive long-term outcomes. In an effort to create a program where patients will have better

treatment outcomes and better enable patients to have a meaningful, continued recovery, RCA will:

- Eliminate breakpoints for getting patients into treatment;
- Have a full continuum of care to extend gains made in all levels of treatment;
- Deliver services by highly trained, educated staff;
- Utilize evidence-based / best practices;
- Involve the family and other support systems;
- Provide individualized, tailored treatment including treatment plans, services, etc.; and
- Measure success rates.

In addition, RCA will participate in the NIDA Clinical Trials Network (CTN). In the CTN, the National Institute on Drug Abuse, treatment researchers, and community-based service providers cooperatively develop, validate, refine, and deliver new treatment options to patients in treatment. Members of RCA's leadership have long-standing involvement in the NIDA Clinical Trials Network.

B. Clinical Programming

RCA Clinical Programming will include common elements for all patients, but will also allow each patient to develop special services that are unique to his or her needs and interests. Examples of planned programming within the Clinical Services are:

- Individual Therapy
- Lectures/Workshops
- Small Groups (Primary Group Therapy, Gender groups, LGBT)
- Psychodrama
- Creative Art Therapies (Art, Dance, Music)
- Recreation Therapies (Challenge/Ropes Course)
- Stress Management
- Body/Central Nervous System Management (Meditation, Yoga, Progressive relaxation)

Clinical programming at RCA will be comprised of scientifically proven effective practices, known as Evidence-Based Practices (EBPs). EBPs examine reasons why specific procedures, treatments and medicine are given in an effort to meet two important goals: providing the most effective treatments and ensuring patient safety. RCA's clinical programming will consist of EBPs registered by the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP), including:

- Motivational Interviewing (Wm. Miller/MINT model)
- Relapse Prevention (TRI Toolkit and Matrix Models)
- 12-Step Facilitation (Project Match, TRI Toolkit)
- Dialectical Behavior Therapy (University of Washington Model)
- Cognitive Behavioral Therapies
- Behavioral Couples Therapy (Harvard University Model)
- The Matrix Model (selected sites)
- Trauma-Support Therapies (Boston, HWR & Seeking Safety)
- Supportive-Expressive Psychotherapy (University of Pennsylvania Model)

- Social Skills Training (Texas Christian University Model)

C. Patient Treatment Path

RCA will provide the following support and services to patients as they engage on their path to treatment and rehabilitation.

1. Contact Center

RCA will operate 24/7, 365 day a year Contact Center through which individuals can access services by calls, texts, web chat, or emails. The Contact Center will be available to all Marylanders without limitation. Based on inquiries and medical necessity, every inbound contact will be assessed and referred within a close proximity to assure accessibility. RCA is in the process of obtaining referral agreements in the state of Maryland within a 30 mile radius that include but are not limited to residential, both inpatient and outpatient, sober living, half way houses, and other support groups related to addiction services. The Contact Center will be an asset to individuals and entities that will be available 24/7 with access to professionals trained and knowledgeable in regard to its callers and access to neighborhood resources. It will also offer insurance advocacy, and will be dedicated and committed to helping anyone who suffers from the disease of addiction.

The Contact Center will be staffed with RCA Care Advocates – clinically trained counselors who will specialize in assisting individuals navigate through the barriers to treatment. Care Advocates will act as a liaison for the patient, patient's family, and loved ones. Care Advocates will also verify insurance benefits and obtain authorization and case manage all inbound contacts regardless of their ability to pay. Care Advocates will dispatch Interventionists and transportation to an RCA facility if appropriate, and refer patients to appropriate levels of care based on medical necessity. Referrals will include, but will not be limited to, RCA facilities, RCA partners and any other resources available to meet the caller's needs. RCA will place patients into meaningful recovery in their own neighborhoods, regardless of insurance or economic barriers.

The Contact Center will have full integration of all RCA systems, including its ~~CRM~~Customer Relationship Manager (Salesforce), telephonic system and EMR (electronic medical record system). The integration of RCA systems is mission critical and will allow RCA Care Advocates to see real time facility data, the location of the individual who is calling in, and any history of the caller if they have called RCA before. This will allow for seamless transition of patient information when the patient is admitted into an RCA treatment program. RCA will have a robust database with a variety of treatment options, support groups, and educational information to meet our customers' every need.

2. Intervention

RCA's team of trained Interventionists will conduct an intervention on-site or in a patient's home when needed. The Interventionist will facilitate the intervention from start to finish. They will arrange the intervention, prepare the family and friends, and lead the discussions during the intervention. The Interventionist will then prepare a clinical assessment, address payment options, accompany the patient to the treatment program, provide transportation via black car service if needed, and provide family counseling to begin the healing process for the patient and their loved ones.

3. Detoxification

Upon admission, all patients will undergo a comprehensive medical evaluation. When medically indicated, patients will receive detoxification services, including medications to ensure

a medically safe withdrawal and help ease the pain associated with withdraw symptoms. Patients are closely monitored 24 hours a day by physicians and other medical staff. The second goal of Detoxification is to ensure transition into the next level of care – residential or some form of outpatient. Detoxification alone is never considered a full course of treatment.

4. **Inpatient/Residential Treatment**

Intensive, structured residential care will be available. A patient's care will begin with a series of medical and clinical assessments, the results of which will be used to determine the patient's schedule, services and length of stay. Patients will be actively engaged in clinical services from 7:30 AM to 9:30 PM every day. Patient services include: daily group therapy and education seminars; individual therapy sessions one or two times per week; family program along with family and couples counseling; multiple choices for patient to select types of additional services such as art therapy, music therapy, relapse prevention. Some of these programs will be required, and some will be elective.

5. **Recovery Support Services**

RCA will offer Recovery Support Services (RSS) that are designed and delivered by people who have experienced both substance use disorder and recovery. RSS will help people become and stay engaged in the recovery process, reduce the likelihood of relapse, and focus on strength and resilience. The four major types of RSS are: (1) peer mentoring or coaching, (2) recovery resource connecting, (3) facilitating and leading recovery groups, and (4) building community. Examples of RSS include but are not limited to: peer-led support groups, parenting classes, Job Readiness training, assistance accessing community health and social services, alcohol- and drug-free social events and opportunities.

6. ~~Concurrent~~Continuing **Recovery Monitoring**

~~Concurrent~~Continuing Recovery Monitoring (CRM) will provide patients monthly support for one year post-discharge from a RCA residential treatment program. Based on chronic disease medical models, CRM will provide clinically-relevant evaluation and recovery support for the patient. The monthly evaluation will include a standardized assessment of physical and behavioral health, societal/familial function, reduction in substance use and cravings. Based on the patient's assessment response, the counselor will:

- Provide recommendations for continuing care, such as outpatient treatment.
- Connect patient to support groups in the local area
- Provide accountability and recovery support

7. **Post-Treatment Alumni Services**

RCA's Alumni Program is built on the foundation that offering continued support for those in recovery is a necessary service. The program will provide patients with the necessary support and resources to maintain sobriety close to home. The services will offer patients and their families a safe environment where they can come to talk, build relationships, attend Recovery Support Meetings, receive continued education, participate in fun events and activities, and more. RCA Alumni Program Activities will include Sober Events, 12-Step Meetings, cookouts, group activities such as hiking trips, family activities, and fundraising events.

D. Elective Patient and Community Programming

RCA will provide educational, spiritual, and community support programming to its patients, some of which will be available to the surrounding community.

1. Self-Help Groups

Also known as mutual help, mutual aid, or support groups, these groups will be comprised of people who share a common problem or addiction and provide mutual support to help each other to cope with and heal or recover from, their problems. RCA will provide space on the grounds of its programs for numerous self-help groups to meet on a regular basis. Patients can attend these meetings before, during, and after their treatment to help develop their support network and provide the highest likelihood of maintaining recovery. Examples of Mutual or Self-Help Groups include: Alcoholics Anonymous, Cocaine Anonymous, Narcotics Anonymous, Secular Organization for Sobriety, SMART Recovery, Adult Children of Alcoholics, Al-Anon, Alateen, Debtors Anonymous, Gamblers Anonymous, Emotions Anonymous, and Overeaters Anonymous.

2. Spiritual Services

All RCA Treatment Programs will have spiritual staff dedicated to helping others find recovery. These staff may be from any one of a number of various religious affiliations, with the common their belief that any spiritual basis can be of help in the maintenance and continuation of a rewarding life in recovery. Part of their job will be to provide services for RCA patients, family, staff, alumni, and anyone the community who may be attracted to our particular blend of spiritual services that include exceptional discussions and musical performances amid prayer and meditation.

3. Speaker Series

The RCA Speaker Series serves will provide information and opportunity for dialogue to the local community, families of patients, alumni and professionals. Speakers will include RCA employees, researchers and other experts in the field. Topics may include but are not limited to:

- What To Do If You Suspect A Loved One Is Abusing Drugs
- Does Treatment For Substance Use Disorder Work? Compared To What?
- The Impact of Affordable Care Act & Healthcare Reform on Substance Abuse Treatment
- Why Say No to Marijuana Legalization?
- How to Talk to Your Kids About Drugs and Alcohol
- Reconsidering Addiction Treatment
- The Science of Addiction
- Is Alcohol a Drug?
- How to Find the Right Treatment Program – Ten Questions to Ask

IV. CONCLUSION

There is no greater problem facing Maryland today than the scourge of drug and alcohol addiction, and the deplorable shortage of facilities needed to help thousands of individuals and families return to healthy, productive lives. Applicant believes that 314 Grove Neck Road is the

ideal location for a top-quality, state of the art facility to help those in need and reduce the state's deficit in care.

9. Complete Table A of the CON Table Package.

See **Exhibit 35.**

10. Identify any community based services that are or will be offered at the facility and explain how each one will be affected by the project.

Applicant will provide space on the facility grounds for various self-help groups, and will provide information and an opportunity for dialogue to the local community through its Speakers Series. These programs are described more fully in the Project Description, pp. 5-~~13.~~14.

11. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: _approximately 530__ acres

B. Have all necessary State and local land use and environmental approvals, including zoning and site plan, for the project as proposed been obtained? YES_____ NO _____ (If NO, describe below the current status and timetable for receiving each of the necessary approvals.)

This property is located in an area of Cecil County zoned Southern Agricultur Residential ("SAR"). In November 2014 the Cecil County Board of Appeals granted RCA special exception to operate a hospital in the SAR zone.

Final site plans have yet to be approved. The previous owners received approvals fo a site plan and a Growth Allocation for redevelopment of the site. The previously approve Growth Allocation is not limited to a specific use and can be utilized for the proposed projec However, because this property lies within the Chesapeake Bay Watershed, RCA must file revised site plan along with a revised Growth Allocation Application. Part of the Growt Allocation Application is a modification of the buffer plan relating to the portion of the proper that has riparian rights on McGill Creek and Back Creek.

RCA staff met with Cecil County officials and solicited proposals from the vendors tha developed the previously approved plans and Growth Allocation applications. All partie agree that this process is routine and will take from five to six months to complete.

C. Form of Site Control (Respond to the one that applies. If more than one, explain.):

(1) Owned by: RREF BB-MD SGRP, LLC

(2) Options to purchase held by: Recovery Centers of America LLC – *see* **Exhibit 7**.
Please provide a copy of the purchase option as an attachment.

(3) Land Lease held by: _____
Please provide a copy of the land lease as an attachment.

(4) Option to lease held by: _____
Please provide a copy of the option to lease as an attachment.

(5) Other: _____
Explain and provide legal documents as an attachment.

12. PROJECT SCHEDULE

(INSTRUCTION: IN COMPLETING THE APPLICABLE OF ITEMS 10, 11 or 12, PLEASE CONSULT THE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

For new construction or renovation projects.
Project Implementation Target Dates
A. Obligation of Capital Expenditure ___~~2~~1____ ~~months~~month from approval date.
B. Beginning Construction _____~~3~~2_____ months from capital obligation.
C. Pre-Licensure/First Use _____~~14~~10_____ months from capital obligation.
D. Full Utilization _____4_____ months from first use.

For projects not involving construction or renovations.
Project Implementation Target Dates
A. Obligation or expenditure of 51% of Capital Expenditure _____ months from CON approval date.
B. Pre-Licensure/First Use _____ months from capital obligation.
C. Full Utilization _____ months from first use.

For projects not involving capital expenditures.
Project Implementation Target Dates
A. Obligation or expenditure of 51% Project Budget _____ months from CON approval date.
B. Pre-Licensure/First Use _____ months from CON approval.
C. Full Utilization _____ months from first use.

13. PROJECT DRAWINGS

Projects involving new construction and/or renovations should include scalable schematic drawings of the facility at least a 1/16" scale. Drawings should be completely legible and include dates.

These drawings should include the following before (existing) and after (proposed), as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, number of beds, location of bath rooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as "shell space".
B. For projects involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.
C. Specify dimensions and square footage of patient rooms.

Applicant Response

See **Exhibit ~~8.~~34.**

14. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete the Construction and Renovation Square Footage worksheet in the CON Table Package (Table B)

B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project and identify the provider of each utility. Specify the steps that will be necessary to obtain utilities.

The property is served by well and septic. Water supplied by the wells meets the projected needs. Cecil County has approved septic expansion to accommodate the facilities daily design flows. The applicant will design and install a Best Available Technology septic system prior to occupancy. Electricity is supplied by Choptank Electric Cooperative. There is no natural gas service to this site.

PART II - PROJECT BUDGET

Complete the Project Budget worksheet in the CON Table Package (Table C).

Note: Applicant should include a list of all assumptions and specify what is included in each budget line, as well as the source of cost estimates and the manner in which all cost estimates are derived. Explain how the budgeted amount for contingencies was determined and why the amount budgeted is adequate for the project given the nature of the project and the current stage of design (i.e., schematic, working drawings, etc.).

Applicant Response

Please see **Exhibit** ~~1,~~**35**, Corrected Table E for the Project Budget and statement of assumptions.

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

1. List names and addresses of all owners and individuals responsible for the proposed project and its implementation.

   314 Grove Neck Road OPCO, LLC
   2701 Renaissance Blvd. 4th Fl.
   King of Prussia PA 19406

   Recovery Centers of America, LLC
   2701 Renaissance Blvd. 4th Fl.
   King of Prussia PA 19406

   Please see **Exhibit 3** for a statement of the role each named entity will have.

2. Are the applicant, owners, or the responsible persons listed in response to Part 1, questions 2, 3, 4, 7, and 9 above now involved, or have they ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of these facilities, including facility name, address, and dates of involvement.

   314 Grove Neck Road OPCO, LLC: No.

   Recovery Centers of America, LLC ("RCA"): RCA does not own, operate, or manage any health care facilities.

   RCA is developing a detox and rehabilitation facility at 75 Lindall Street, Danvers, MA. RCA began exploring the development of the Danvers facility in July, 2014, and a CON has been granted for this facility.

   In addition, RCA will be involved in the management of the three applications for the development of Intermediate Care Facilities that are currently pending before this Commission, if Certificates of Need are granted. RCA is also exploring a number of other sites for the potential development of facilities offering detox and/or rehabilitation services.

3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to Question 2, above, been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owners or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

   No.

4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which

any applicant has in the past been involved (listed in response to Question 2, above) received inquiries in last from 10 years from any federal or state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with any state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

No.

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5. Have the applicant, owners or responsible individuals listed in response to Part 1, questions 2, 3, 4, 7, and 9, above, ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

   No.

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the proposed or existing facility.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information and belief.

5/18/2015
Date

Signature of Owner or Board-designated Official

Authorized agent Applicant
Position/Title

John Paul Christen
Printed Name

5/18/2015
Date

Signature of Owner or Board-designated Official

Chief Operating Officer of Recovery Centers of America, LLC
Position/Title

John Paul Christen

Printed Name

PART IV - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

INSTRUCTION: Each applicant must respond to all criteria included in COMAR 0.24.01.08G(3), listed below.

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards and other review criteria.

If a particular standard or criteria is covered in the response to a previous standard or criteria, the applicant may cite the specific location of those discussions in order to avoid duplication. When doing so, the applicant should ensure that the previous material directly pertains to the requirement and to the directions included in this application form. Incomplete responses to any requirement will result in an information request from Commission Staff to ensure adequacy of the response, which will prolong the application's review period.

10.24.01.08G(3)(a). THE STATE HEALTH PLAN.

Every applicant must address each applicable standard in the chapter of the State Health Plan for Facilities and Services[3]. Commission staff can help guide applicants to the chapter(s) that applies to a particular proposal.

Please provide a direct, concise response explaining the project's consistency with each standard. Some standards require specific documentation (e.g., policies, certifications) which should be included within the application as an exhibit.
THE STATE HEALTH PLAN FOR FACILITIES AND SERVICES: ALCOHOLISM AND DRUG ABUSE INTERMEDIATE CARE FACILITY TREATMENT SERVICES.

10.24.14.05 Certificate of Need Approval Rules and Review Standards for New Substance Abuse Treatment Facilities and for Expansions of Existing Facilities

.05A. Approval Rules Related To Facility Size.

Unless the applicant demonstrates why a relevant standard should not apply, the following standards apply to applicants seeking to establish or to expand either a Track One or a Track Two intermediate care facility.

(1) The Commission will approve a Certificate of Need application for an intermediate care facility having less than 15 beds only if the applicant dedicates a special population as defined in Regulation .08.

(2) The Commission will approve a Certificate of Need application for a new intermediate care facility only if the facility will have no more than 40 adolescent or 50 adult intermediate care facility beds, or a total of 90 beds, if the applicant is applying to serve both age groups.

[3] ~~[1]~~ Copies of all applicable State Health Plan chapters are available from the Commission and are available on the Commission's web site here:http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/hcfs_shp.

(3) The Commission will not approve a Certificate of Need application for expansion of an existing alcohol and drug abuse intermediate care facility if its approval would result in the facility exceeding a total of 40 adolescent or 100 adult intermediate care facility beds, or a total of 140 beds, if the applicant is applying to serve both age groups.

Applicant Response

Not applicable. Applicant is applying for no more than 50 adult ICF treatment beds.

.05B. Identification of Intermediate Care Facility Alcohol and Drug Abuse Bed Need.

(1) An applicant seeking Certificate of Need approval to establish or expand an intermediate care facility for substance abuse treatment services must apply under one of the two categories of bed need under this Chapter:

(a) For Track One, the Commission projects maximum need for alcohol and drug abuse intermediate care beds in a region using the need projection methodology in Regulation .07 of this Chapter and updates published in the Maryland Register.

(b) For Track Two, as defined at Regulation .08, an applicant who proposes to provide 50 percent or more of its patient days annually to indigent and gray area patients may apply for:

(i) Publicly-funded beds, as defined in Regulation .08 of this Chapter, consistent with the level of funding provided by the Maryland Medical Assistance Programs (MMAP), Alcohol and Drug Abuse Administration, or a local jurisdiction or jurisdictions; and

(ii) A number of beds to be used for private-pay patients in accordance with Regulation .08, in addition to the number of beds projected to be needed in Regulation .07 of this Chapter.

(2) To establish or to expand a Track Two intermediate care facility, an applicant must:

(a) Document the need for the number and types of beds being applied for;

(b) Agree to co-mingle publicly-funded and private-pay patients within the facility;

(c) Assure that indigents, including court-referrals, will receive preference for admission, and

(d) Agree that, if either the Alcohol and Drug Abuse Administration, or a local jurisdiction terminates the contractual agreement and funding for the facility's clients, the facility will notify the Commission and the Office of Health Care Quality within 15 days that that the facility is relinquishing its certification to operate, and will not use either its publicly- or privately-funded intermediate care facility beds for private-pay patients without obtaining a new Certificate of Need.

Applicant Response

I. Drug and Alcohol Addiction as a National Problem

The need for additional beds is supported by the 2013 National Survey on Drug Use and Health (NSDUH), an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency within the United States Department of Health and Human Services.[4] The survey is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the civilian, noninstitutionalized population of the United States aged 12 years old or older. The following are key results of the survey:

A. Illicit Drug Use

- In 2013, an estimated 24.6 million Americans aged 12 or older were current (past month) illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview. This estimate represents 9.4 percent of the population aged 12 or older. Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics (pain relievers, tranquilizers, stimulants, and sedatives) used nonmedically.
- The rate of current illicit drug use among persons aged 12 or older in 2013 (9.4 percent) was similar to the rates in 2010 (8.9 percent) and 2012 (9.2 percent), but it was higher than the rates in 2002 to 2009 and in 2011 (ranging from 7.9 to 8.7 percent), showing significant increase in use over the past several years.
- Marijuana was the most commonly used illicit drug in 2013. There were 19.8 million current (past month) users in 2013 (7.5 percent of those aged 12 or older), which was similar to the number and rate in 2012 (18.9 million or 7.3 percent). The 2013 rate was higher than the rates in 2002 to 2011 (ranging from 5.8 to 7.0 percent). Marijuana was used by 80.6 percent of current illicit drug users in 2013.
- Daily or almost daily use of marijuana (used on 20 or more days in the past month) increased from 5.1 million persons in 2005 to 2007 to 8.1 million persons in 2013.
- In 2013, there were 1.5 million current cocaine users aged 12 or older, or 0.6 percent of the population. These estimates were similar to the numbers and rates in 2009 to 2012 (ranging from 1.4 million to 1.7 million or from 0.5 to 0.7 percent), but they were lower than those in 2002 to 2007 (ranging from 2.0 million to 2.4 million or from 0.8 to 1.0 percent).
- The number of past year heroin users in 2013 (681,000) was similar to the numbers in 2009 to 2012 (ranging from 582,000 to 669,000) and was higher than the numbers in 2002 to 2005, 2007, and 2008 (ranging from 314,000 to 455,000).
- An estimated 1.3 million persons aged 12 or older in 2013 (0.5 percent) used hallucinogens in the past month. The number of users in 2013 was similar to that in 2012 (1.1 million), but it was higher than in 2011 (1.0 million).
- The percentage of persons aged 12 or older who used prescription-type psychotherapeutic drugs nonmedically in the past month in 2013 (2.5 percent) was similar to the percentages in 2010 to 2012 (ranging from 2.4 to 2.7 percent).
- The number and percentage of past month methamphetamine users in 2013 (595,000 or 0.2 percent) were similar to those in 2012 (440,000 or 0.2 percent) and 2011 (439,000 or 0.2 percent), but they were higher than the estimates in 2010 (353,000 or 0.1 percent).

[4] The survey is available at http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf (last accessed 3/5/2015).

- Among youths aged 12 to 17, the rate of current illicit drug use was lower in 2013 (8.8 percent) than in 2002 to 2007 (ranging from 9.6 to 11.6 percent) and in 2009 to 2012 (ranging from 9.5 to 10.1 percent).
- The rate of current marijuana use among youths aged 12 to 17 in 2013 (7.1 percent) was similar to the 2012 rate (7.2 percent) and the rates in 2004 to 2010 (ranging from 6.7 to 7.6 percent); however, it was lower than the rates in 2002, 2003, and 2011 (ranging from 7.9 to 8.2 percent).
- Among youths aged 12 to 17, the rate of current nonmedical use of prescription-type drugs declined from 4.0 percent in 2002 and 2003 to 2.2 percent in 2013. The rate of nonmedical pain reliever use among youths also declined from 3.2 percent in 2002 and 2003 to 1.7 percent in 2013.
- The rate of current use of illicit drugs among young adults aged 18 to 25 in 2013 (21.5 percent) was similar to the rates in 2009 to 2012 (ranging from 21.3 to 21.6 percent), which was consistent with the steady rate of current marijuana use in this age group during this time (19.1 percent in 2013 and ranging from 18.2 to 19.0 percent in 2009 to 2012).
- Among young adults aged 18 to 25, the rate of current nonmedical use of prescription-type drugs in 2013 was 4.8 percent, which was similar to the rates in 2011 (5.0 percent) and 2012 (5.3 percent), but it was lower than the rates in the years from 2002 to 2010 (ranging from 5.5 to 6.5 percent).
- The rate of current cocaine use in 2013 among young adults aged 18 to 25 was 1.1 percent, which was similar to the rates in 2009, 2011, and 2012, but it was lower than the rates from 2002 to 2008 and in 2010.
- Among adults aged 26 or older, the rate of current illicit drug use in 2013 (7.3 percent) was similar to the rate in 2012 (7.0 percent), but it was higher than the rates in 2002 to 2011 (ranging from 5.5 to 6.6 percent). This was driven by rates of current marijuana use, which also remained steady between 2013 and 2012 (5.6 and 5.3 percent, respectively). However, the rate of current marijuana use in 2013 was higher than the rates in 2002 to 2011 (ranging from 3.9 to 4.8 percent).
- Among adults aged 50 to 64, the rate of current illicit drug use increased from 2.7 percent in 2002 to 6.0 percent in 2013. For adults aged 50 to 54, the rate increased from 3.4 percent in 2002 to 7.9 percent in 2013. Among those aged 55 to 59, the rate of current illicit drug use increased from 1.9 percent in 2002 to 5.7 percent in 2013. Among those aged 60 to 64, the rate of current illicit drug use increased from 1.1 percent in 2003 and 2004 to 3.9 percent in 2013.
- Among unemployed adults aged 18 or older in 2013, 18.2 percent were current illicit drug users, which was higher than the rates of 9.1 percent for those who were employed full time and 13.7 percent for those who were employed part time. However, most illicit drug users were employed. Of the 22.4 million current illicit drug users aged 18 or older in 2013, 15.4 million (68.9 percent) were employed either full or part time.
- In 2013, 9.9 million persons (3.8 percent of those aged 12 or older) reported driving under the influence of illicit drugs during the past year, which was similar to the rate in 2012 (3.9 percent). In 2013, the rate was highest among young adults aged 18 to 25 (10.6 percent), although this rate was lower than the rate in 2012 for this age group (11.9 percent).
- Among persons aged 12 or older in 2012-2013 who used pain relievers nonmedically in the past 12 months, 53.0 percent got the drug they used most recently from a friend or relative for free, and 10.6 percent bought the drug from a friend or relative. Another 21.2 percent reported that they got the drug through a

prescription from one doctor. An annual average of 4.3 percent got pain relievers from a drug dealer or other stranger, and 0.1 percent bought them on the Internet.

B. Alcohol Use

- Slightly more than half (52.2 percent) of Americans aged 12 or older reported being current drinkers of alcohol in the 2013 survey, which was similar to the rate in 2012 (52.1 percent). This translates to an estimated 136.9 million current drinkers in 2013.
- In 2013, nearly one quarter (22.9 percent) of persons aged 12 or older were binge alcohol users in the past 30 days. This translates to about 60.1 million people. The rate in 2013 was similar to the estimate in 2012 (23.0 percent). Binge drinking is defined as having five or more drinks on the same occasion on at least 1 day in the 30 days prior to the survey.
- In 2013, heavy drinking was reported by 6.3 percent of the population aged 12 or older, or 16.5 million people. This rate was similar to the rate of heavy drinking in 2012 (6.5 percent). Heavy drinking is defined as binge drinking on at least 5 days in the past 30 days.
- Among young adults aged 18 to 25 in 2013, the rate of binge drinking was 37.9 percent, and the rate of heavy drinking was 11.3 percent. These rates were lower than the corresponding rates in 2012 (39.5 and 12.7 percent, respectively).
- The rate of current alcohol use among youths aged 12 to 17 was 11.6 percent in 2013. Youth binge and heavy drinking rates in 2013 were 6.2 and 1.2 percent, respectively. The rates for current and binge alcohol use were lower than those reported in 2012 (12.9 and 7.2 percent, respectively).
- In 2013, an estimated 10.9 percent of persons aged 12 or older drove under the influence of alcohol at least once in the past year. This percentage was lower than in 2002 (14.2 percent), but it was similar to the rate in 2012 (11.2 percent). The rate was highest among persons aged 21 to 25 and persons aged 26 to 29 (19.7 and 20.7 percent, respectively). Among persons aged 12 to 20 and those aged 21 to 25, the rates of driving under the influence of alcohol were lower in 2013 (4.7 and 19.7 percent, respectively) than in 2012 (5.7 and 21.9 percent, respectively).
- An estimated 8.7 million underage persons (aged 12 to 20) were current drinkers in 2013, including 5.4 million binge drinkers and 1.4 million heavy drinkers. Corresponding percentages of underage persons in 2013 were 22.7 percent for current alcohol use, 14.2 percent for binge alcohol use, and 3.7 percent for heavy use. All of these percentages were lower than those in 2012. 4
- Past month, binge, and heavy drinking rates among underage persons declined between 2002 and 2013. Past month alcohol use declined from 28.8 to 22.7 percent, binge drinking declined from 19.3 to 14.2 percent, and heavy drinking declined from 6.2 to 3.7 percent.
- In 2013, 52.2 percent of current underage drinkers reported that their last use of alcohol occurred in someone else's home, and 34.2 percent reported that it had occurred in their own home. Most current drinkers aged 12 to 20 (77.6 percent) were with two or more other people the last time they drank alcohol. The rate of drinking alone the last time that underage persons drank alcohol was highest among youths aged 12 to 14 (14.5 percent).
- Among current underage drinkers, 28.7 percent paid for the alcohol the last time they drank, including 7.8 percent who purchased the alcohol themselves and 20.5 percent who gave money to someone else to purchase it. Among those who did not pay for the alcohol they last drank, 36.6 percent got it from an unrelated person

aged 21 or older; 24.5 percent got it from a parent, guardian, or other adult family member; and 16.4 percent got it from another person younger than 21 years old.

- In 2013, underage current drinkers were more likely than current alcohol users aged 21 or older to use illicit drugs within 2 hours of alcohol use on their last reported drinking occasion (19.9 vs. 5.7 percent, respectively). The most commonly reported illicit drug used by underage drinkers in combination with alcohol was marijuana.

II. Maryland Bed Need

Thousands of Maryland residents who are suffering from addiction need treatment today. Relying on data from Maryland Department of Health and Mental Hygiene (DHMH), the Washington Post reported that "Heroin-related deaths in Maryland spiked 88 percent from 2011 to 2013 . . . and intoxication overdoses of all types now outnumber homicides in the state." *See* **Exhibit 4**. Dr. Joshua Sharfstein, former DHMH Secretary, has remarked "Overdose is a public-health crisis in Maryland, as it is in many states…and we are bringing everything we can to bear against this challenge." *Id.*

Maryland's existing portfolio of treatment facilities cannot begin to solve this problem. The most recently approved CON for bed expansion at Father Martin's Ashley dated September 19, 2013 noted need for Private ICF/CD beds 107 to 152 for the Central Maryland Region alone. Additionally, Applicant's calculations indicate a need for new treatment beds in Maryland by 2019 in the range of ~~450~~307 to ~~598, using 2014~~419 for the population ~~data, and 471 to 624 using projected 2019 population data~~RCA anticipates serving. The Eastern Shore Maryland Region has a net bed need of ~~33 to 87 using 2014 population data, and 34 to 90 using 2019 projected~~10 to 51 for the same population.

A. Methodology

Applicant projected need based on the method of calculation for private beds outlined in the State Health Plan, COMAR 10.24.14.07B(7) (the "ICF State Health Plan Methodology").

.07(B)(7)(a): Identify by geographic region the non-indigent Maryland population for the 12-17 years and 18 years and above age groups by subtracting the number of Medical Assistance recipients from the projected Maryland population for the target year.

Applicant identified the geographic region for the facility as the Eastern Shore, as defined in the .07B.(3), Geographic Regions.

.07(B)(7)(b): Estimate the adolescent and adult populations at risk of alcohol and drug abuse by multiplying the non-indigent population in Maryland by a prevalence rate of 0.15 for the adolescent population and a prevalence rate 0.0864 for the adult population.

Adult Population Data

Applicant first defined the total adult (18+) population in Maryland for years 2010, 2014 and 2019. Applicant did not estimate the adolescent population because its facility will treat adults only.

To define the adult population in Maryland, Applicant selected population data for the years 2010 and 2014, and projected population for 2019. The 2010 data is from Maryland's Department of Planning database and Data Analysis, which was sourced by the 2010 US Census. The 2014 population and 2019 projected population data were sourced by ~~metho~~ Geographic Information Systems (GIS) software. ESRI's Updated Demographics data is built on Census 2010 data and 2010 geography, and contains current-year estimates and five-year projections for categories such as population, households, income, and housing. The source is described in more detail in the document attached as **Exhibit 9**.

Using these sources, Applicant defined the total adult (18+) population in Maryland for years 2010, 2014 and 2019 as demonstrated in Table 1 below. A full page rendering of Table 1 appears in **Exhibit** ~~10.~~ **37.**

Table 1
2010 and projected 2014, 2019 Population
Eastern Shore Region

Cecil County, MD

	2014	2019
18-19	2,676	2,620
20-24	6,406	5,668
25-34	12,638	13,766
35-44	13,062	13,145
45-54	16,151	15,060
55-64	14,101	15,381
65-74	8,751	10,598
75-84	3,769	4,440
85+	1,433	1,555
Total 18+	***78,987***	***82,233***

Caroline County, MD

	2014	2019
18-19	799	808
20-24	1,922	1,555
25-34	4,184	4,096
35-44	4,054	4,256
45-54	4,795	4,296
55-64	4,483	4,617
65-74	2,883	3,300
75-84	1,395	1,529
85+	583	586
Total 18+	***25,098***	***25,043***

Somerset County, MD

	2014	2019
18-19	973	967
20-24	3,276	3,091
25-34	3,515	3,574
35-44	3,006	3,077
45-54	3,416	3,061
55-64	3,317	3,326
65-74	2,382	2,722
75-84	1,187	1,333
85+	493	513
Total 18+	***21,565***	***21,664***

Kent County, MD

	2014	2019
18-19	580	1,092
20-24	1,640	1,470
25-34	2,030	1,981
35-44	1,851	1,927
45-54	2,667	2,293
55-64	3,070	3,134
65-74	2,673	2,832
75-84	1,411	1,629
85+	759	783
Total 18+	***16,681***	***17,141***

Dorchester County, MD

	2014	2019
18-19	733	748
20-24	1,891	1,651
25-34	3,846	3,917
35-44	3,628	3,740
45-54	4,807	4,262
55-64	5,006	5,258
65-74	3,695	4,210
75-84	1,949	2,236
85+	824	864
Total 18+	***26,379***	***26,886***

RCA Calculated E. Shore Region Population (18+)

	2010
Cecil	75,753
Kent	16,649
Queen Anne's	36,424
Talbot	30,407
Caroline	24,719
Dorchester	25,550
Wicomico	76,638
Worcester	42,031
Somerset	22,005
Total	***350,176***

Queen Anne's County, MD

	2014	2019
18-19	2,134	1,999
20-24	4,002	4,422
25-34	7,800	9,014
35-44	10,918	9,807
45-54	13,999	13,849
55-64	12,142	13,353
65-74	9,159	10,707
75-84	4,951	5,549
85+	1,989	2,261
Total 18+	***67,094***	***70,961***

Wicomico County, MD

	2014	2019
18-19	3,458	3,473
20-24	8,874	7,889
25-34	13,620	14,304
35-44	11,139	11,670
45-54	13,016	11,881
55-64	12,518	12,974
65-74	8,290	9,687
75-84	4,211	4,915
85+	1,953	2,068
Total 18+	***77,079***	***78,861***

RCA Calculated E. Shore Region Population (18+)

	2014	2019
Cecil	78987	82233.4
Kent	16681	17141.24
Queen Anne's	67094	70961.2
Talbot	31378.8	32098.8
Caroline	25097.8	25042.6
Dorchester	26378.8	26886
Wicomico	77079.4	78861.2
Worcester	63643	63958.2
Somerset	21565.2	21664.2
Total	***407,905***	***418,847***

Talbot County, MD

	2014	2019
18-19	775	813
20-24	1,872	1,642
25-34	3,796	3,968
35-44	3,767	3,751
45-54	5,321	4,809
55-64	5,891	6,216
65-74	5,448	5,806
75-84	3,113	3,617
85+	1,396	1,477
Total 18+	***31,379***	***32,099***

Worcester County, MD

	2014	2019
18-19	1,966	1,917
20-24	5,701	5,153
25-34	8,493	8,597
35-44	8,122	8,127
45-54	10,785	9,640
55-64	11,593	11,934
65-74	9,841	10,813
75-84	5,235	5,764
85+	1,907	2,013
Total 18+	***63,643***	***63,958***

Estimated Number of Privately Insured People

After defining the adult population, Applicant determined the commercially-insured population rather than the non-indigent population referred to in the standard above. Applicant believes that calculating the number of privately insured Maryland residents is the most representative of the population who will seek treatment at Applicant's facility. To determine the amount of residents in the region who are privately insured, Applicant applied a 64.2% figure to the population total. The 64.2% figure is the national average for the privately insured population, based on the 2013 National Health Interview Survey, available on the website of the CDC, http://www.cdc.gov/nchs/fastats/health-insurance.htm.

Estimated Number of Substance Abusers

After determining the population of Maryland residents with private insurance, Applicant estimated the number of substance abusers in that population by applying prevalence rate of 0.0864, as provided in standard .07(B)(7)(b).

.07(B)(7)(c): Estimate the non-indigent adolescent and adult target population by multiplying the at-risk adolescent population by 0.20 and the at-risk adult population by 0.25. Estimate the non-indigent adolescent and adult populations requiring some form of treatment by multiplying the adolescent and adult target populations by 0.95.

Applicant estimated the target population by multiplying the at-risk privately insured adult population with commercial insurance by .25.

As noted previously, Applicant is focused on the privately insured population rather than the non-indigent population, and did not project need for the adolescent population.

.07(B)(7)(d): Estimate the non-indigent adolescent and adult target treatment populations requiring care in an intermediate care facility by multiplying the adolescent target treatment population and the adult target treatment population by 0.15.

Applicant estimated the privately insured adult target treatment population requiring care in an intermediate care facility by multiplying the adult target treatment population by .15 and .~~30,~~30 based on the assumption set forth in the ICF State Health Plan, COMAR §~~10.24.14.04(e).~~ 10.24.14.07B(4)(e) ("For the Eastern Shore it is assumed that 15 to 30 percent of the adult target treatment population are assumed to require care in an intermediate care facility.")

As noted previously, Applicant focused on the privately insured population rather than the non-indigent population, and did not project need for the adolescent population.

.07(B)(7)(e): Estimate the intermediate care treatment populations requiring readmission in the target year by multiplying the adolescent intermediate care treatment population by 0.20 and the adult intermediate care treatment population by 0.10.

Applicant estimated the intermediate care treatment populations requiring readmission in the target year by multiplying the adult intermediate care treatment population by 0.10.

As noted previously, Applicant did not project need for the adolescent population.

.07(B)(7) (f) Calculate the total number of persons requiring intermediate care by adding the intermediate care treatment population, readmissions, and the number of out-of-state discharges from intermediate care facilities in the base year.

Applicant calculated the total number of privately insured adults requiring intermediate care by adding the intermediate care treatment population and readmissions.

Applicant did not calculate the number of out-of-state discharges from intermediate care facilities in the base year. Instead, Applicant projected need solely for the population in the facility's geographic region. Applicant later determined its catchment area and determined what

percentage of its beds it expects to use to serve patients in the geographic region, as discussed below.

.07(B)(7) (g) Calculate the gross number of adolescent and adult intermediate care beds required by multiplying the total number of persons requiring intermediate care by a 22-day average length of stay for adolescents and a 14-day average length of stay for adults, and dividing by the product of 365 and 0.85.

Applicant calculated the gross number adult intermediate care beds required by multiplying the total number of privately insured adults requiring intermediate care by a 14-day average length of stay for adults, and dividing by the product of 365 and 0.85.[5]

As noted previously, Applicant focused on the privately insured population rather than the non-indigent population, and did not project need for the adolescent population.

.07(B)(7)(h) Calculate the adjusted inventory of intermediate care beds by subtracting the number of intermediate care beds in facilities recognized by the Commission as serving at least 30 to 50 percent publicly-budgeted indigent patients from the total number of licensed and certified beds that are identified by the Commission as providing intermediate care, including beds that may be licensed for psychiatric care that are included in the inventory.

Identifying Existing Non-Funded Facilities

Because the ICF State Health Plan Methodology was last updated in 2005, Applicant did not rely on its representation of existing track one facilities. Instead, Applicant determined which of the existing facilities in the geographic region that offer care at level III.7 and/or III.7D are not identified as "funded" by Department of Health and Mental Hygiene, Behavioral Health Administration Maryland Certified Treatment Locator.[6]

Determining Number of Detox Beds

~~Applicant determined, based on calls to the facilities and using a website that aggregates drug and alcohol inpatient treatment facility information, all beds within each facility.[7] The facilities appear to use beds flexibly for detox and residential treatment. Applicant took the total number of beds and discounted them by 80% to find the 'true' number of beds that serve patients in detox at any given time.~~

~~Source of 20% Assumption~~

~~Applicant used 20% as an estimate for 'true' detox beds for each facility based on the RCA management team's experience in the field and the 2013 The National Survey of Substance Abuse Treatment Services, attached as Exhibit 11. The N-SSATS (National Survey of Substance Abuse Treatment Services) is an annual survey conducted by the Substance~~

[5] This 14 day length of stay is used as the basis for Applicant's modified revenue, expense, and statistical projections. Upon review of its clinical programming and in connection with modifying this application, Applicant determined that a 14 day length of stay is appropriate. Many patients will require a 14 day stay in Applicant's detox program due to co-occurring mental disorders, complicated medical issues or longer benzodiazepine tapers.

[6] http://bha.dhmh.maryland.gov

~~[7] http://addictionresourceguide.com/name.html~~

Abuse and Mental Health Services Administration (SAMHSA). This is data from 94.2% (349 facilities) of Maryland's substance abuse treatment centers on one day (March 31, 2011).

There are two ways to consider the data provided in the Type of Care section (pg. 2).

(1) The Residential (Non-Hospital) section, which is equivalent to what the Earleville location will provide, shows 21.6% of patients in treatment facilities were in treatment for detoxification.

Table 2
Maryland Residential Treatment
Patients in Treatment on March 31, 2011 by Care Level

	# Patients in level of care	% of ALL levels of care	% of Residential
Residential (non-hospital)	74	21.2	
- Short Term	28	8.0%	37.8%
- Long Term	68	19.5%	91.9%
- Detoxification	16	4.6%	21.6%

(2) The Total Data from All Treatment (Outpatient, Residential (non-hospital), and Hospital Inpatient), shows totals to 24.4% patients in residential treatment facilities were in treatment for detoxification.

Table 3
Maryland Outpatient, Residential and Hospital Inpatient Treatment
Patients in Treatment on March 31, 2011 by Care Level

	# Patients in level of care	% of Residential
Outpatient	289	82.8%
- Regular	262	75.1%
- Intensive	150	43.0%
- Day treatment/partial hospitalization	15	4.3%
- Detoxification	53	15.2%
- Methadone Maintenance	62	17.8%
Residential (non-hospital)	74	21.2%
- Short Term	28	8.0%
- Long Term	68	19.5%
- Detox	16	4.6%
Hospital Inpatient	16	4.6%
- Treatment	13	3.7%
- Detoxification	16	4.6%
Total	349	
Detox Only Totals	85	24.4%

As explained in RCA's August 31, 2015 response to the July 17, 2015 Completeness Questions, Question 8, and Exhibit 32, data are not readily available concerning the percentage of beds that existing facilities are able to devote to ICF care on average. Applicant assumed that 41% of beds at facilities that provide both ICF and other services were devoted to ICF care based on its own projected detox / assessment bed to total bed ratio, as of August 31, 2015, except for I'm Still Standing By Grace, which identified its number of detox beds. *See* August 31, 2015 Response to Completeness Questions, Mod. Appl. Exhibit 32.

Although the number of residential beds that Applicant will build has increased, Applicant has not revised this 41% figure, as Applicant anticipates that many of these additional beds will be utilized by patients who receive detox services at out-of-state locations or at a detox-only facilities, or who require residential only care.

Calculation of Adjusted Inventory

After determining the number of intermediate care funded and non-funded beds for the region, Applicant subtracted the number of intermediate care beds in funded facilities.

Corrected Modified Table 4[7]
Existing Detox Beds
~~Southern~~
Applying RCA 41% average
Eastern Shore Region, Maryland

Not Funded	**All Beds** (2)	**Detox Beds (41%)**
Hudson Center	33	14
Warwick Manor	42	17
Total	*75*	*31*

Funded (1)	**All Beds**	**Detox Beds (41%)**
Whitsitt Rehab Center	20	8
Total	*20*	*8*

Total Existing ICF Bed Inventory	**39**
Total Existing Not-Funded ICF Bed Inventory	***~~31~~ 8***

(1) As identified by Department of Health and Mental Hygiene, Behavioral Health Administration Maryland Certified Treatment Locator
(2) Based on phone calls to the facilities, ~~http://addictionresourceguide.com/~~http://addictionresourceguide.com/, or the SAMHSA treatment locator

[7] Modified in August 31, 2015 Response to Completeness Questions, **Exhibit 32**, to change assumption of ICF beds from 15% to 41%, corrected December 21, 2015 to update Total Existing Non-Funded ICF Bed Inventory, which was previously incorrectly calculated as 31. Corrections were also made to facility names.

(3) Based on the 2013 The National Survey of Substance Abuse Treatment Services, attached as Exhibit11.

.07(B)(7)(i) Calculate the total net number of adolescent and adult intermediate are beds needed by subtracting the adjusted inventory from the gross number of intermediate care beds needed.

Applicant calculated the total net number of intermediate beds for privately insured adults by subtracting the adjusted inventory from the gross number of intermediate care beds needed.

Additional Step One: Total Adult ICF Bed Need

Because Applicant first projected the need only for the population its beds will primarily serve – privately insured patients, Applicant added a step to demonstrate the total adult bed need in the State. To do this, Applicant multiplied the total number of beds needed for privately insured adults by 1+35.8% (1.358), based on the 35.8% of the population that is not covered by private insurance. Exhibit 9.

After calculating regional and statewide bed need, applicant projected the number of beds sought in this application that will be used for treatment of Maryland residents, and how many will be used for out-of-state residents in the facility's catchment area.**Additional Step Two:** Distributing Applicant Beds among in-state and out-of state patients

In order to project how many of Applicant's beds will be used to serve Maryland patients, Applicant determined the number of in-state and out of state residents in its catchment area.

To define the primary catchment area of the facility, Applicant first procured a 30, 60 and 90 mile radius around the proposed location. As a result of the large regional market strategy that Applicant intends to deploy in the mid-Atlantic market, and the lack of like providers in the marketplace, Applicant included clusters of large populations that bordered the 90 mile catchment area, roughly extending the catchment area in some cases 110 miles from the facility. This selection of large population clusters was done using the population density function of the ESRI software (heatmap). To include these areas of high population in the primary catchment area, Applicant inserted a polygon around the Applicant's selected area. This resulted in the catchment area, demonstrated by the black line in Figure 1 below.

Figure 1
Facility Catchment Area

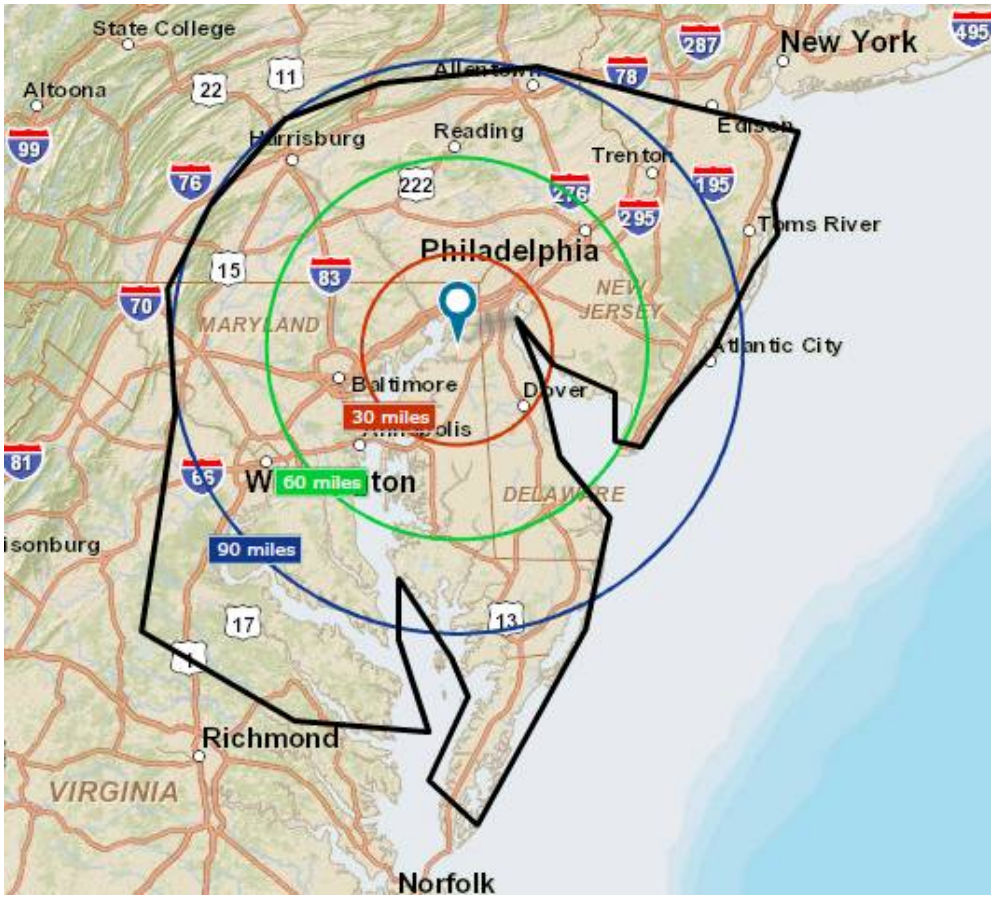
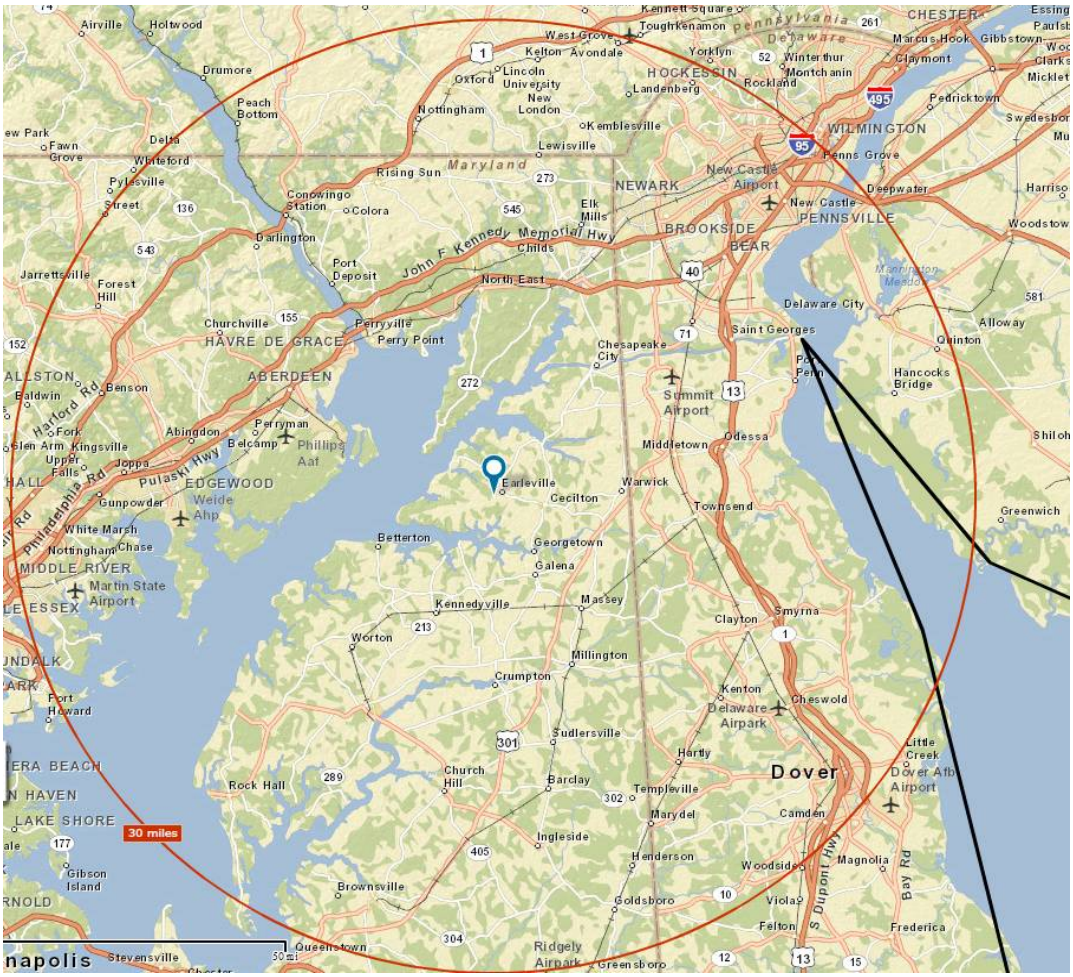


Figure 2, below, identifies towns and cities within the 30 miles of the facility. A full page image of Figure 2 is included in **Exhibit** ~~10.~~**37.**

Figure 2
Major Cities and Towns within 30 Miles of Facility



Once the catchment area was defined, Applicant used the ESRI software to determine what the population within the catchment area was from Maryland, and the out-of state population in the catchment area.

Table 5
Earleville Catchment Area, 2014

	2014 Estimate	MD 2014 Population	Not MD Calc	RCA MD Catchment
Total Market Area	**20,523,245**		**258,632**	
18-24	1,409,636		24,292	
25-34	2,773,014		32,548	
35-44	2,323,322		32,093	
45-54	2,954,304		37,398	
55-64	2,643,504		34,485	
65-74	1,666,964		24,501	
75-84	866,986		13,605	
85+	416,572		6,260	
Total Population over 18	15,054,302	4,612,691	205,182	**4,407,509**

Table 6
Earleville Catchment Area, 2019

	2019 Estimate	MD 2019 Population	Not MD Calc	RCA MD Catchment
Total Market Area	**21,233,164**		**262,485**	
18-24	1,828,473		22,717	
25-34	2,867,537		33,759	
35-44	2,744,461		31,696	
45-54	2,770,481		34,654	
55-64	2,828,370		36,280	
65-74	1,989,971		28,327	
75-84	997,857		15,477	
85+	443,257		6,534	
Total Population over 18	16,470,407	4,793,500	209,444	**4,584,056**

~~A full~~Full size ~~rendering~~renderings of Tables 5 and 6 appear in **Exhibit** ~~10.~~**37**.

Applicant then applied the ratio of Marylanders within the catchment area to total population within the catchment area~~'~~ to the total number of detox beds sought, to show how many of the requested detox beds would likely serve Maryland residents, and how many would likely serve out-of-state residents.

Additional Step ~~Three~~Two: Projecting Maryland Statewide Need

Using the same methodology described above, Applicant projected need for the entire State of Maryland.

B. Application

The methodology above resulted in the following project bed need for the Eastern Shore Region. A full page table is included in **Exhibit** ~~10.~~**37**.

Corrected Modified Table 7[8]
Regional ICF Bed Need Projection
Eastern Shore, Maryland

			MD 2010 Population[(2)]	RCA 2014 Population[(3)]	RCA 2019 Proj. Pop.[(3)]
	Projected Population for 18 Years and older		350,176	407,905	418,847
a	**Estimated # of privately insured[(1)]**	*64.20%*	224,813	261,875	268,900
b	**Estimated # of Substance Abuse Users**	*8.64%*	19,424	22,626	23,233
c1	**Estimated Annual Target Population**	*25.00%*	4,856	5,657	5,808
c2	**Estimated # requiring Treatment**	*95.00%*	4,613	5,374	5,518
d	**Estimated Population requiring ICF (15-30%)**				
d1	Min %	*15.00%*	692	806	828
d2	Max %	*30.00%*	1,384	1,612	1,655
e	**Estimated Range requiring Readmission**				
e1	Min %	*10.00%*	69	81	83
e2	Max %	*10.00%*	138	161	166
f	**Range of Adults requiring ICF Care**				
	Min = (d1+e1)		761	887	910
	Max = (d2+e2)		1,522	1,773	1,821
g	**Gross # of Adult ICF Bed Needed**				
g1	Min = ((f*14 ALOS))/365)/0.85		34	40	41
g2	Max = ((f*14 ALOS))/365)/0.85		69	80	82
h	**Existing Non-Funded Inventory ICF beds**		31	31	31
i	**Net Private ICF Bed Needed**				
	Min = (g1-h)		3	9	10
	Max = (g2-h)		38	49	51
~~j~~	~~**Net All ICF Bed Needed**[(5)]~~				
	~~Min = (iMin x(1 + pop .% w/out priv. ins.))~~	~~*35.80%*~~	16	23	25
	~~Max = (iMax x (1 + pop. % w/out priv. ins.))~~	~~*35.80%*~~	62	78	81

Highlighted were cells removed from 12/21/15 Corrected Modified Application. [This text appears in redline only]

(1) 2013 National Health Interview Survey – CDC
(2) Maryland's Department of Planning database and Data Analysis
(3) Numbers based off ESRI data
(4) Number of existing beds modified to reflect 41% detox assumption. See Corrected Modified Table 4, *supra*.

[8] RCA modified Table 7 in its August 31, 2015 Response to Completeness Questions, **Exhibit 32** by updating the existing non-funded inventory based on the change in assumption of the percentage of licensed beds being utilized for detox /assessment from 15% to 41%. RCA corrected Modified Table 7 in connection with its December 21, 2015 submission to remove the final three rows, "Net All ICF Bed Need," which is not relevant to RCA's application. RCA also made non substantive formatting changes and corrections, which can be seen in the redline version of its submission.

This application seeks 21 detox/assessment beds. The number of beds that Applicant projects will serve Maryland residents is illustrated in Table 8, below.

Table 8
RCA ICF Beds Requested
Eastern Shore, Maryland
Distributed among Maryland and out-of-State Patients

RCA Requested Detox / Assessment Beds	Total
Earleville, MD	21
Total Detox / Assesment Beds	**21**

2014	
Individuals 18 + in facility catcment area	*15,054,302*
Individuals 18 + in MD in facility catchment area	*4,528,933*
% of patients from MD in catchment area	*30.1%*
Detox / Assement Beds for MD Residents	*7*
2019	
Individuals 18 + in facility catcment area	*16,470,407*
Individuals 18 + in MD in facility catchment area	*4,584,056*
% of patients from MD in catchment area	*27.8%*
Detox / Assement Beds for MD Residents	*6*

RCA Requested Detox / Assesment Beds to serve MD population	2014	2019
Earleville, MD	7	6
Total Detox / Assesment Beds	**7**	**6**

Following the same methodology, Applicant calculated the number of existing non-funded beds (Corrected Modified Table 9, below), and projected private adult bed need for the entire state of Maryland (Corrected Modified Table 10, below – *see also* **Exhibit** ~~10~~**37**). [9]

[9] RCA understands that although Pathways is listed as "funded" on the DHMH treatment locator site, it is presently a Track I facility. RCA provided an updated existing provider analysis in connection with its December 1, 2015 Response to Interested Party Comments. Because that Response, and the additional analysis therein, was provided after the modification deadline, RCA will not be modifying Table 9, or the analysis that follows, to reflect Pathways' present status as a Track I facility. However, RCA notes that the inclusion of Pathways' ICF beds in the analysis presented in this application would not significantly reduce the extreme need for ICF beds in Maryland, nor would it render the maximum need in the target year (2019) below the number of beds RCA seeks.

Corrected Modified Table 9[10]
Existing Detox Beds
Maryland State

Not Funded (1)	All Beds (2)	Detox Beds (41%)
Anchor @ Walden-Sierra	20	8
Father Martin's Ashley	100	41
Hudson Center	33	14
I'm Still Standing By Grace (3)	42	12
Warwick Manor	42	17
Total	~~286~~ *237*	*92*

Funded (1)	All Beds	Detox Beds (41%)
Arc House	16	7
Avery Treatment Center	32	13
Carroll Addiction Rehab Center	20	8
Finan Center, Jackson Unit		0
Massie Unit	25	10
Jackson Unit	0	0
Hope House	18	7
Mountain Manor, Baltimore City (4)	46	19
Pathways	20	8
Shoemaker Women's Program	19	8
Tuerk House	63	26
Whitsitt Rehab Center	20	8
Gaudenzia at Park Heights (5)	-	-
Hope House, Anne Arundel (5)	-	-
Hope House, Laurel (5)	-	-
Mountain Manor, Emmitsville	-	-
Total	*186*	*114+*

Total Existing ICF Bed Inventory	**206+**
Total Existing Not-Funded ICF Bed Inventory	***92***

~~(1) As identified by Department of Health and Mental Hygiene, Behavioral Health Administration Maryland Certified Treatment Locator~~

[10] RCA modified Table 9 in its August 31, 2015 Response to Completeness Questions, Exhibit 32 by updating the existing non-funded inventory based on the change in assumption of the percentage of licensed beds being utilized for detox /assessment from 15% to 41%. RCA corrected Modified Table 9 in connection with its December 21, 2015 submission by updating the total for all beds, which was previously incorrectly calculated as 287. Corrections were also made to facility names.

~~(2) Based on phone calls to the facilities, http://addictionresourceguide.com/, or the SAMHSA treatment locator~~
~~(3) Based on the 2013 The National Survey of Substance Abuse Treatment Services, attached as Exhibit11.~~
~~(4) Facility self-identified number of residential and detox beds by phone~~
~~(5) BHA lists three buildings for the Baltimore City location. Two of the three are listed as funded.~~
~~(6) Applicant was not able to determine the number of beds.~~

(1) As identified by Department of Health and Mental Hygiene, Behavioral Health Administration Maryland Certified Treatment Locator
(2) Based on phone calls to the facilities and/or http://addictionresourceguide.com/
(3) Facility self-identified number of residential and detox beds by phone
(4) BHA lists three buildings for the Baltimore City location. Two of the three are listed as funded.
(5) Applicant was not able to determine the number of beds.

Corrected Modified Table 10[11]
ICF Bed Need Projection
Maryland State

			MD 2010 Population[2]	MD 2014 Population[3]	MD 2019 Projected Population[3]
	MD Population for 18 Years and older		4,420,588	4,612,691	4,793,500
	E. Shore Region Population for 18 Years and older		350,176	407,905	418,847
	MD Population 18 and older excluding E. Shore Region		4,070,412	4,204,786	4,374,653
a	**Estimated # of privately insured** [1]	*64.2%*	2,613,205	2,699,472	2,808,527
b	**Estimated # of Substance Abuse Users**	*8.64%*	225,781	233,234	242,657
c1	**Estimated Annual Target Population**	*25.00%*	56,445	58,309	60,664
c2	**Estimated # requiring Treatment**	*95.00%*	53,623	55,393	57,631
d	**Estimated Population requiring ICF (12.5-15%)**				
d1	Min % - All Regions excluding E. Shore	*12.50%*	6,703	6,924	7,204
d2	Max % - All Regions excluding E.Shore	*15.00%*	8,043	8,309	8,645
d3	Min % - E. Shore Region	*15.00%*	692	806	828
d4	Max % - E. Shore Region	*30.00%*	1,384	1,612	1,655
e	**Estimated Range requiring Readmission**				
e1	Min %	*10.00%*	739	773	803
e2	Max %	*10.00%*	943	992	1,030
f	**Range of Adults requiring ICF/CD Care**				
	Min = (d1+d3+e1)		8,134	8,503	8,835
	Max = (d2+d4+e2)		10,370	10,913	11,330
g	**Gross # of Adult ICF Bed Needed**				
g1	Min = ((f*14 ALOS))/365)/0.85		367	384	399
g2	Max = ((f*14 ALOS))/365)/0.85		468	492	511
h	**Existing Non-Funded Inventory ICF/CD beds** [4]		92	92	92
i	**Net Private ICF/CD Bed Needed**				
	Min = (g1-h)		275	292	307
	Max = (g2-h)		376	400	419
j	**Net <u>All</u> ICF Bed Needed** [5]				
	Min = (gMin x 1.358 (pop w/out priv. ins.))- (hExisting b	*35.8%*	406	429	449
	Max= (gMax x 1.358 (pop w/out priv. ins.))- (hExisting b	*35.8%*	543	577	602

Highlighted were cells removed from 12/21/15 Corrected Modified Application. [This text appears in redline only]

(1) 2013 National Health Interview Survey – CDC
(2) Maryland's Department of Planning database and Data Analysis
(3) Numbers based off ESRI data

[11] RCA modified Table 10 in its August 31, 2015 Response to Completeness Questions, **Exhibit 32** by updating the existing non-funded inventory based on the change in assumption of the percentage of licensed beds being utilized for detox /assessment from 15% to 41%. RCA corrected Modified Table 7 in connection with its December 21, 2015 submission to remove the final three rows, "Net All ICF Bed Need," which is not relevant to RCA's application.

(4) Number of existing beds modified to reflect 41% detox assumption. See Modified Table 9, *supra*.

As demonstrated, there is significant need for ICF care in both the region and state, and Applicant is seeking to fill only a small portion of that need.

.05C. Sliding Fee Scale.

An applicant must establish a sliding fee scale for gray area patients consistent with the client's ability to pay.

Applicant Response

The facility will utilize a sliding fee scale for gray area patients consistent with the patient's ability to pay. The fee schedule is summarized as follows, and represents discount percentages from the standard billing rate charged to insurance carriers for each service:

<100% of Federal Poverty Level	75%
<150% but >100% of Federal Poverty Level	50%
<200% but >150% of Federal Poverty Level	25%

A policy outlining the sliding scale fee is attached as **Exhibit 12**.

.05D. Provision of Service to Indigent and Gray Area Patients.

(1) Unless an applicant demonstrates why one or more of the following standards should not apply or should be modified, an applicant seeking to establish or to expand a Track One intermediate care facility must:

(a) Establish a sliding fee scale for gray area patients consistent with a client's ability to pay;

(b) Commit that it will provide 30 percent or more of its proposed annual adolescent intermediate care facility bed days to indigent and gray area patients; and

(c) Commit that it will provide 15 percent of more of its proposed annual adult intermediate care facility bed days to indigent or gray area patients.

(2) A existing Track One intermediate care facility may propose an alternative to the standards in Regulation D(1) that would increase the availability of alcoholism and drug abuse treatment to indigent or gray area patients in its health planning region.

(3) In evaluating an existing Track One intermediate care facility's proposal to provide a lower required minimum percentage of bed days committed to indigent or gray area patients in Regulation D(1) or an alternative proposal under Regulation D(2), the Commission shall consider:

(a) The needs of the population in the health planning region; and

(b) The financial feasibility of the applicant's meeting the requirements of Regulation D(1).

(4) An existing Track One intermediate care facility that seeks to increase beds shall provide information regarding the percentage of its annual patient days in the preceding 12 months that were generated by charity care, indigent, or gray area patients, including publicly-funded patients.

Applicant Response

Applicant requests a modification of subsection (1)(c) as the healthcare insurance landscape has changed dramatically since this standard was promulgated.

A. Increased Medicaid and Private Insurance Coverage Under the Affordable Care Act.

As discussed in the Henry J. Kaiser Family Foundation report dated January 6, 2014, attached as **Exhibit 13**, the 2010 Affordable Care Act (ACA) has the potential to extend coverage to many of the 47 million nonelderly uninsured people nationwide, including 756,000 uninsured Marylanders. The ACA establishes coverage provisions across the income spectrum, with the expansion of Medicaid eligibility for adults serving as the vehicle for covering low-income individuals and premium tax credits to help people purchase insurance directly through new Health Insurance Marketplaces serving as the vehicle for covering people with moderate incomes. The 2012 ruling of the United States Supreme Court in *Nat'l Federation of Independent Business v. Sebelius*, 567 U.S. ___ (2012), made the Medicaid expansion optional for states. Maryland implemented the expansion in 2014. As a result, almost all nonelderly uninsured, most of whom are adults, are now eligible for coverage expansions.

With Maryland deciding to implement the Medicaid expansion, nearly six in ten (59%) uninsured nonelderly people in the state are eligible for financial assistance to gain coverage through either Medicaid or the marketplaces. Given the income distribution of the uninsured in the state, the main pathway for coverage is Medicaid, with four in ten (40%) uninsured Marylanders eligible for either Medicaid or CHIP as of 2014. While some of these people (such as eligible children) are eligible under pathways in place before the ACA, most adults are newly-eligible through the ACA expansion. One in five (20%) uninsured people in Maryland are eligible for premium tax credits to help them purchase coverage in the marketplace.

Other uninsured Marylanders may gain coverage under the ACA but will not receive direct financial assistance. These people include the 23% with incomes above the limit for premium tax subsidies or who have an affordable offer of coverage through their employer. Some of these people are still able to purchase unsubsidized coverage in the Marketplace, which may be more affordable or more comprehensive than coverage they could obtain on their own through the individual market. Lastly, the approximately 17% of uninsured people in Maryland who are undocumented immigrants are ineligible for financial assistance under the ACA and barred from purchasing coverage through the marketplaces. This group is likely to remain uninsured, though they will still have a need for health care services.

The ACA will help many currently uninsured Marylanders gain health coverage by providing coverage options across the income spectrum for low and moderate-income people. While almost all of the uninsured in Maryland are eligible for some type of coverage under the ACA, the impact of the ACA will depend on take-up of coverage among the eligible uninsured, and outreach and enrollment efforts will be an important factor in decreasing the uninsured rate. The ACA includes a requirement that most individuals obtain health coverage, but some people (such as the lowest income or those without an affordable option) are exempt and others may still remain uninsured.

Medicaid's role in purchasing and delivering substance abuse services is changing dramatically. Prior to the implementation of the ACA, most state Medicaid programs did not

cover childless adults and covered only a limited number of parents. Moreover, coverage of substance abuse services has traditionally been an optional Medicaid benefit and, as a result, many states have provided only limited substance abuse service coverage. Twenty-five states plus Washington, DC, are expanding Medicaid in 2014 and will collectively cover as many as 5 million adults with incomes up to 133 percent of the federal poverty level (FPL). Benefits extended to these newly covered adults must include mental health and substance abuse services that meet the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). Taken together, these changes are a major catalyst for transformation of substance abuse service coverage and delivery in Medicaid.

While Applicant's facility will not serve patients covered by Medicaid, the expansion in Medicaid coverage means that treatment services are now available to more Maryland residents at other facilities that are already in existence. According to the Substance Abuse and Mental Health Services Administration, there are already over 20 substance abuse treatment facilities in the state of Maryland that accept Medicaid. Because of the ACA, 59% of the previously uninsured nonelderly people in the state will now have access to seek Medicaid coverage and be eligible for treatment at these facilities.

B. The Applicant's Commitment to Provide Care for Indigent and Gray Area Patients.

Notwithstanding the greater availability of coverage for Marylanders, the Applicant is committed to providing care to indigent and gray area patients. However, the level of commitment set forth in Standard .05D(1)(c) (*i.e.*, 15 percent or more of bed days) is not reasonable in light of the increased number of covered patients. In fact, prior to the expansive effect of the ACA, the Commission staff had already expressed concern that the level of care called for in Standard .05D(1)(c) is too high. See September 19, 2013 Transcript of Proceedings before the Commission on Father Martin's Ashley CON Application for Bed Expansion, **Exhibit 14** at 7.

Given that the Affordable Care Act has expanded Medicaid and private insurance coverage for an estimated 59% of previously uninsured Marylanders, Applicant believes it would be reasonable to reduce the amount of indigent care required by this standard decision, which preceded the effect of the ACA act, by 59%. Applying this figure, it would be reasonable to provide 6.15% of patient days for indigent and gray area patients. (15% x 41% = 6.15%).

Applicants revenue and expense projection tables, **Exhibit** ~~1,~~**35.** Tables G, H, J and K, reflect this commitment of 6.15%~~. However, at~~, calculated as a percentage of net revenue rather than patient days. At the request of the Commission staff, Applicant has produced alternative financial tables that reflect the 15% figure referenced in this standard. See **Exhibit** ~~2,~~**36.** Tables G, H, J and K. For purposes of calculating charity care, RCA values each day of detox / assessment level care at $860, and each day of residential level care at $724.

RCA believes it is clinically inappropriate to provide charity care for eligible patients' only for detox services. Thus, the Applicant has committed to provide charity care for the entire course of detox and residential treatment, although there is no requirement that RCA provide charity care for residential treatment at ASAM level III.5. In fact, if the total charity care that RCA has committed to provide was applied to detox services only, RCA's commitment would amount to almost 25% of patient days, exceeding the requirement set forth in Standard .04D(1)(c). Using the financial projections for 2017 as an example, RCA's commitment of $1,509,228 in charity care is equivalent to approximately 1,755 patient days (1,509,228 ÷ 860 =

1,754.91), which is 24.6% of the total projected patient days for detox services in that year (see Table F, line 2(i)).

Applicant is prepared to invest substantial resources into the construction and operation of this detox and residential treatment facility, and will bear the financial risk of this venture. This facility will be a positive step towards addressing the significant need for Intermediate Care Facilities in Maryland.

.05E. Information Regarding Charges.

An applicant must agree to post information concerning charges for services, and the range and types of services provided, in a conspicuous place, and must document that this information is available to the public upon request.

Applicant Response

The Applicant will post charges for services, and the range and types of services provided in a conspicuous place. This information will be available to the public. A list of services and prices is attached as **Exhibit 15**.

.05F. Location.

An applicant seeking to establish a new intermediate care facility must propose a location within a 30-minute one-way travel time by automobile to an acute care hospital.

Applicant Response

The facility is within 30 minutes driving time from Union Hospital, 106 Bow Street, Elkton, MD 21921 (26 minutes without traffic/28 minutes with traffic, according to Google Maps).

.05G. Age Groups.

(1) An applicant must identify the number of adolescent and adult beds for which it is applying, and document age-specific treatment protocols for adolescents ages 12-17 and adults ages 18 and older.
(2) If the applicant is proposing both adolescent and adult beds, it must document that it will provide a separate physical, therapeutic, and educational environment consistent with the treatment needs of each age group including, for adolescents, providing for continuation of formal education.
(3) A facility proposing to convert existing adolescent intermediate care substance abuse treatment beds to adult beds, or to convert existing adult beds to adolescent beds, must obtain a Certificate of Need.

Applicant Response

The Applicant is applying for 21 adult ICF treatment beds. The project will include ~~28~~87 other adult residential beds.

.05H. Quality Assurance.

(1) An applicant must seek accreditation by an appropriate entity, either the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), in accordance with CFR, Title 42, Part 440, Section 160, the CARF…The Rehabilitation Accreditation Commission, or any other accrediting body approved by the Department of Health and Mental Hygiene. The appropriate accreditation must be obtained before a Certificate of Need-approved ICF begins operation, and must be maintained as a condition of continuing authority to operate an ICF for substance abuse treatment in Maryland.

(a) An applicant seeking to expand an existing ICF must document that its accreditation continues in good standing, and an applicant seeking to establish an ICF must agree to apply for, and obtain, accreditation prior to the first use review required under COMAR 10.24.01.18; and

(b) An ICF that loses its accreditation must notify the Commission and the Office of Health Care Quality in writing within fifteen days after it receives notice that its accreditation has been revoked or suspended.

(c) An ICF that loses its accreditation may be permitted to continue operation on a provisional basis, pending remediation of any deficiency that caused its accreditation to be revoked, if the Office of Health Care Quality advises the Commission that its continued operation is in the public interest.

(2) A Certificate of Need-approved ICF must be certified by the Office of Health Care Quality before it begins operation, and must maintain that certification as a condition of continuing authority to operate an ICF for substance abuse treatment in Maryland.

(a) An applicant seeking to expand an existing ICF must document that its certification continues in good standing, and an applicant seeking to establish an ICF must agree to apply for certification by the time it requests that Commission staff perform the first use review required under COMAR 10.24.01.18.

(b) An ICF that loses its State certification must notify the Commission in writing within fifteen days after it receives notice that its accreditation has been revoked or suspended, and must cease operation until the Office of Health Care Quality notifies the Commission that deficiencies have been corrected.

(c) Effective on the date that the Office of Health Care Quality revokes State certification from an ICF, the regulations at COMAR 10.24.01.03C governing temporary delicensure of a health care facility apply to the affected ICF bed capacity.

Applicant Response

The Applicant will apply for accreditation from the Joint Commission ~~on Accreditation of Rehabilitation Facilities (CARF)~~ once the facility is licensed and operational. RCA has

requested the Early Survey Option from the Joint Commission. If granted, this survey will occur one month before opening and will grant preliminary accreditation status before opening.

Applicant will also seek licensure from the Department of Health and Mental Hygiene for its detox and residential programs, as will the other applicants affiliated with Recovery Centers of America.

.05I. Utilization Review and Control Programs.

(1) An applicant must document the commitment to participate in utilization review and control programs, and have treatment protocols, including written policies governing admission, length of stay, discharge planning, and referral.
(2) An applicant must document that each patient's treatment plan includes, or will include, at least one year of aftercare following discharge from the facility.

Applicant Response

(1) The Applicant commits to patient care provided by competent staff in a safe environment, as determined in part by admission and continued stay criteria. Objective monitoring and evaluation processes will assure that resources are utilized sufficiently to provide quality patient care and efficiency of financial and personal resources. The utilization management plan applies to all patients, regardless of payment source, and encompasses all departments and services providing direct patient care. Applicant commits to participating in utilization review, which includes the following standard minimum components:

- Evaluation of the utilization of services provided, as related to over/under-utilization of services.
- Periodic evaluation of documentation.
- Ongoing review of clinical appropriateness for Admission, Continued Stay and Discharge, in accordance with RCA Policy and Procedures Manual.

(2) The Applicant commits to include at least one year of aftercare following treatment in each patient's treatment plan. Patient Aftercare Planning begins at the time of admission. In adherence to RCA Policy No. 3000.007 (Discharge Procedure), discharge planning includes:

- Clinical Issues to be addressed in Continuing Care
- A description of the services to be provided which will assist the patient in maintaining long-term sobriety
- A specific point of contact to facilitate the patient in obtaining the needed services
- Dates, times and address of continuing care appointments
- Re-entry criteria

RCA's Continuing Recovery Monitoring (CRM) will be an optional program that will provide patients monthly support for one year post-discharge from a RCA residential treatment program. Based off of chronic disease medical models, CRM provides clinically-relevant evaluation and recovery support for the patient. The monthly evaluation includes:

- Standardized assessment of physical and behavioral health, societal/familial function, reduction in substance use and cravings.
- Based on the patient's assessment response, counselor will:
  - Provide recommendations for continuing care, such as outpatient treatment. Recommendations include locations and frequency of appointments.
  - Connect patient to support groups in the local area.
  - Provide accountability and recovery support.

Aftercare planning includes the following standard minimum components:

- Enrollment in ~~Concurrent~~Continuing Recovery Monitoring (CRM), which is a 12-month program designed to provide clinically –relevant evaluation and recovery support for the patient. CRM includes a monthly standardized assessment of the patient's physical and behavioral health, societal/familial function, reduction in substance use and cravings. Based on the patient's assessment response, a Continuing Care counselor will:
  - Provide recommendations for continuing care, such as outpatient treatment.
  - Connect patient to support groups in the local area
  - Provide accountability and recovery support

Applicant has attached in **Exhibit 16** draft policy and procedures for:

- Admissions & Exclusion Criteria
- Discharge Procedures
- Initial Patient Care
- Utilization Reviews and Continued Stay (***revised since Original Application***)
- Continued Stay ~~Criteria~~Procedure

.05J. Transfer and Referral Agreements.

(1) An applicant must have written transfer and referral agreements with facilities capable of managing cases which exceed, extend, or complement its own capabilities, including facilities which provide inpatient, intensive and general outpatient programs, halfway house placement, long-term care, aftercare, and other types of appropriate follow-up treatment.
(2) The applicant must provide documentation of its transfer and referral agreements, in the form of letters of agreement or acknowledgement from the following types of facilities:
(a) Acute care hospitals;

(b) Halfway houses, therapeutic communities, long-term care facilities, and local alcohol and drug abuse intensive and other outpatient programs;
(c) Local community mental health center or center(s);
(d) The jurisdiction's mental health and alcohol and drug abuse authorities;
(e) The Alcohol and Drug Abuse Administration and the Mental Hygiene Administration;
(f) The jurisdiction's agencies that provide prevention, education, driving-while-intoxicated programs, family counseling, and other services; and,
(g) The Department of Juvenile Justice and local juvenile justice authorities, if applying for beds to serve adolescents.

Applicant Response

On Applicant's behalf, RCA has requested written transfer and referral agreements from facilities capable of managing cases which exceed, extend, or complement its own capabilities, including facilities which provide inpatient, intensive and general outpatient programs, halfway house placement, long-term care, aftercare, and other types of appropriate follow-up treatment.

The Applicant has contacted and has transmitted transfer and referral agreements to the following:

(a) Acute Care hospitals: University of Maryland Harford Memorial Hospital in Havre De Grace, Union Hospital in Elkton, and Eastern Shore Hospital Center in Cambridge.

(b) Halfway houses, therapeutic communities, long-term care facilities, and local alcohol and drug abuse intensive and other outpatient programs: VA Maryland Healthcare System in Perry Point, Haven House Inc. in Elkton, Homecoming Project Inc. in Bel Air, Mann House Inc. in Bel Air, Serenity Place in Cover DE, and Limen House in Wilmington DE.

(c) The local community health center: Upper Shore Community Health in Chestertown.

(d) Cecil County Mental Health Core Service Agency in Elkton

(e) Maryland Department of Health and Mental Hygiene in Annapolis

(f) Cecil County Health Department in Elkton, MD

(g) Maryland Department of Juvenile Justice

To date, Applicant has executed agreements with four of the facilities listed, **Exhibit 17**. Applicant will continue to follow up with the additional facilities.

.05K. Sources of Referral.

(1) An applicant proposing to establish a new Track Two facility must document to demonstrate that 50 percent of the facility's annual patient days, consistent with Regulation .08 of this Chapter, will be generated by the indigent or gray area

population, including days paid under a contract with the Alcohol and Drug Abuse Administration or a jurisdictional alcohol or drug abuse authority.

(2) An applicant proposing to establish a new Track One facility must document referral agreements to demonstrate that 15 percent 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 Alcohol or Drug Abuse Administration or a jurisdictional alcohol or drug abuse authority, or the Medical Assistance program.

Applicant Response

For the reasons described in response to Standard .05D, Applicant seeks a modification of subsection (2) as the indigent and/or gray area patient population has changed dramatically since the standard was established.

Applicant fully expects to engage in relationships with organizations that will refer patients in need of charity care. Applicant has identified several potential referral sources, identified in **Exhibit 18**. Applicant will reach out to at least some of these organizations to secure referral agreements as the CON process moves forward.

.05L. In-Service Education.

An applicant must document that it will institute or, if an existing facility, maintain a standardized in-service orientation and continuing education program for all categories of direct service personnel, whether paid or volunteer.

Applicant Response

It is the policy of Recovery Centers of America to ensure that the mission of the organization and each affiliated facility is met by providing appropriately qualified staff to deliver services to patients and by ensuring that ongoing education and training needs are identified and provided.

The RCA Human Resources Department oversees the Onboarding Orientation. Orientation curriculum includes but is not limited to:

A. RCA Mission and Philosophy
B. Patient Rights
C. Confidentiality
D. Patient or Employee Accident/Injury
E. Employee Personal Safety
F. Ethics
G. HIPAA
H. Diversity/Cultural Awareness
I. Incident Reporting
J. Customer Service
K. Medication Management
L. Fire Safety & Prevention

M. Emergency Evacuation Procedures
N. Suicide Precautions
O. Use of Hazardous Chemicals
P. Infection Control, Communicable Diseases, Blood borne Pathogens

The RCA Training Institute oversees the Clinical Core Trainings for clinical supervisors, primary therapists, case managers, and recovery support staff. Clinical core curriculum includes but is not limited to:

A. Co-Occurring Disorders
B. Motivational Interviewing
C. Relapse Prevention
D. Cognitive Behavioral Therapy
E. Trauma Support Therapy
F. Social Skills Training
G. Group Facilitation Skills
H. Effective Documentation on EMR

Additional Staff Training and educational opportunities are offered throughout the year, as well as ongoing supervision, support and social gatherings.

The Human Resources Department is responsible for tracking attendance at in-service education sessions and ensuring that continuing education units are awarded when possible.

In **Exhibit 19**, Applicant has attached drafts of RCA's Addiction Severity Index Training Agenda, Motivational Interviewing Training Agenda, and Training on Evidence Based Practices.

.05M. Sub-Acute Detoxification.

An applicant must demonstrate its capacity to admit and treat alcohol or drug abusers requiring sub-acute detoxification by documenting appropriate admission standards, treatment protocols, staffing standards, and physical plant configuration.

Applicant Response

RCA has developed an Admissions Criteria policy and procedure and Detoxification Treatment Protocols for the evaluation, treatment and detoxification for patients in the Applicant's care. The Admissions Criteria Policy and Detoxification Treatment Protocols are attached as **Exhibit 20**. The Detoxification unit will be a separate unit staffed 24 hours a day, 7 days a week by nursing personnel. A physician or physician assistant will assess each patient on the detoxification unit within 24 hours of admission. A physician or physician assistant will also provide on-site monitoring and evaluation of patients in the detoxification unit on a daily basis, if medically necessary. All patients in the detoxification program will be provided treatment for coexisting medical, emotional, or behavioral problems. The Detoxification unit is labeled on ~~our~~the site plans ~~in~~. **Exhibit ~~8.~~34.**

.05N. Voluntary Counseling, Testing, and Treatment Protocols for Human Immunodeficiency Virus (HIV).

An applicant must demonstrate that it has procedures to train staff in appropriate methods of infection control and specialized counseling for HIV-positive persons and active AIDS patients.

Applicant Response

The facility will be staffed through RCA, through an arrangement with Applicant, the proposed licensee. RCA's Safety and Infection Control Committee will ensure that all staff receives training in infection control. RCA staff will be trained on RCA's Infection Control policy upon hire and annually thereafter. In addition, RCA will offer HIV testing and counseling with patient consent per RCA's policy on HIV Testing and Counseling. RCA's draft HIV Testing and Counseling, and Infection Control policies are attached as **Exhibit 21**.

.05O. Outpatient Alcohol & Drug Abuse Programs.

(1) An applicant must develop and document an outpatient program to provide, at a minimum: individual needs assessment and evaluation; individual, family, and group counseling; aftercare; and information and referral for at least one year after each patient's discharge from the intermediate care facility.
(2) An applicant must document continuity of care and appropriate staffing at off-site outpatient programs.
(3) Outpatient programs must identify special populations as defined in Regulation. 08, in their service areas and provide outreach and outpatient services to meet their needs.
(4) Outpatient programs must demonstrate the ability to provide services in the evening and on weekends.
(5) An applicant may demonstrate that outpatient programs are available to its patients, or proposed patient population, through written referral agreements that meet the requirements of (1) through (4) of this standard with existing outpatient programs.

Applicant Response

Applicant is committed to a continuum of care. Every patient that receives treatment at the Earleville location will be referred to outpatient treatment. Aftercare planning begins at the time of admission, and each patient will receive an individualized aftercare plan upon discharge. RCA will operate eight outpatient facilities within the catchment area: two in Blackwood NJ, two in Waldorf MD, and two in Paoli PA. In addition to the other RCA facilities, RCA also has a referral agreement with the Homecoming Project that provides outpatient services in Bel Air, MD. See **Exhibit 17**.

The outpatient services available at the other, nearby RCA facilities will include Partial Hospitalization, Intensive Outpatient and Outpatient Programs. RCA's Partial Hospitalization program will provide treatment five days a week for four hours each day and will be offered Monday through Friday. This five day a week program will provide education, group therapy, and individual therapy to patients. The Intensive Outpatient Program will offer group therapy

three days a week for three hours each session. The Outpatient Program will offer group therapy two times per week for two hours each session. Both the Intensive Outpatient Program and the Outpatient Program will be offered during the day, evening hours, and on weekends. In addition all patients in the outpatient programs will receive assessment upon admission, participate in a psychosocial evaluation process, and receive an individualized treatment plan from their primary therapist. Individual and family sessions will also be provided to all patients as clinically indicated. RCA's draft Outpatient Services policy is attached as **Exhibit 22**.

.05P. Program Reporting.

Applicants must agree to report, on a monthly basis, utilization data and other required information to the Alcohol and Drug Abuse Administration's Substance Abuse Management Information System (SAMIS) program, and participate in any comparable data collection program specified by the Department of Health and Mental Hygiene.

Applicant Response

Applicant will report utilization data and required information to the Alcohol and Drug Abuse Administration's Substance Abuse Management Information System (SAMIS) program on a monthly basis. Applicant will also participate in the comparable data collection program specified by the Department of Health and Mental Hygiene.

10.24.01.08G(3)(b). Need.

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.

INSTRUCTIONS: 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. If the relevant chapter of the State Health Plan includes a need standard or need projection methodology, please reference/address it in your response. For applications proposing to address the need of special population groups, please specifically identify those populations that are underserved and describe how this Project will address their needs.

If the project involves modernization of an existing facility through renovation and/or expansion, provide a detailed explanation of why such modernization is needed by the service area population. Identify and discuss relevant building or life safety code issues, age of physical plant issues, or standard of care issues that support the need for the proposed modernization.

Please assure that all sources of information used in the need analysis are identified. List all assumptions made in the need analysis regarding demand for services, utilization rate(s), and the relevant population, and provide information supporting the validity of the assumptions.

Complete the Statistical Projection (Tables D and E, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Table D must be completed if the applicant is an existing facility. Table E must be completed if the application is for a new facility or service or if it is requested by MHCC staff.

Applicant Response

Please see Applicant's response to standard .05B, *supra*.

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the project. It should also identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including the alternative of the services being provided by existing facilities.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development cost to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective goal and objective achievement or the most effective solution to the identified problem(s) for the level of cost required to implement the project, when compared to the effectiveness and cost of alternatives including the alternative of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Applicant Response

The proposed project subject to CON approval involves ~~renovating~~adding a three level addition to an existing structure to create an efficient and modern Intermediate Care Facility for Alcohol and Drug Abuse treatment. As discussed in the project description. RCA has selected the proposed site based on the shortage of quality provider beds in the State of Maryland (and across the country). Many Maryland residents are suffering from addiction and need treatment today. *See* **Exhibit 23**.

At a State House news conference, Maryland Governor Larry Hogan described how pervasive he found the problem as he traveled around the state last year. "'This used to be considered an urban problem, but it's not anymore,' he said. All over the state, he said, local officials told him heroin had become their No. 1 problem." *See* **Exhibit 23**. Applicant's bed need calculations demonstrate that existing providers do not have enough capacity to meet the growing need and RCA brings a solution to a massive problem.

Acquisition of existing providers does not address the need for incremental new beds and produces no net benefit to residents of the State of Maryland. Additionally, limiting sites of service and increasing bed size does not provide the necessary breadth of coverage residents of Maryland require to address the growing population suffering from addiction

Accordingly, RCA determined to build new treatment facilities of a scope that could begin to address the dire need in the State of Maryland. It looked at existing properties in the $1M to $20M price range across the State, and targeted locations with dense populations and

commensurate bed need. To the extent possible, RCA looked to repurpose existing structures in order to minimize environmental impacts. The charts below demonstrate RCA's demographic analysis that contributed to its site selection and subsequent CON applications.

Site Selection

The Applicant selected the property at 314 Grove Neck Road, Earleville, MD as a future location for the company's Inpatient Substance Abuse program. The Applicant reviewed many different sites across the state of Maryland, considering many factors. Such factors included, but were not limited to zoning parameters by right and special exception, site size, points of access to major roadways, and interchanges, among others.

Of the factors reviewed that have not been previously discussed in the application is the time the Applicant spent observing the demographics of the site. The Applicant used a 90 mile catchment area to determine if the site was viable on the basis of being able to capture a patient who is able to afford Applicant services. The Applicant concluded the site was viable. Below is a summary of the site's demographic.

Table 11
Summary of Site's Demographic Catchment Area
90 Mile Radius

	Census 2010	Growth	2014	Growth	2019
Population	20,078,328	2.2%	20,523,245	3.5%	21,233,164
Households	7,579,243	2.4%	7,758,761	3.5%	8,031,322

Household Incomes	2014	% of Households	2019	% of Households	Growth
$75,000 - $99,999	988,980	12.7%	1,145,349	14.3%	15.8%
$100,000 - $149,000	1,386,410	17.9%	1,499,172	18.7%	8.1%
$150,000 - $199,000	635,348	8.2%	838,577	10.4%	32.0%
$200,000 +	618,160	8.0%	832,755	10.4%	34.7%
Average Houshold Income	**$92,933**		**$108,389**		**16.6%**

	Census 2010	%	2014	%	2019	%
18-19	559,143	2.8%	532,367	2.6%	535,655	2.5%
20-24	1,353,057	6.7%	1,409,636	6.9%	1,292,818	6.1%
25-34	2,663,098	13.3%	2,773,014	13.5%	2,867,537	13.5%
Target Population	*4,575,298*	22.8%	*4,715,017*	23.0%	*4,696,010*	22.1%
35-44	2,747,299	13.7%	2,623,322	12.8%	2,744,461	12.9%
45-54	3,080,305	15.3%	2,954,304	14.4%	2,770,481	13.0%
55-64	2,393,469	11.9%	2,643,504	12.9%	2,828,370	13.3%
65-74	1,366,202	6.8%	1,666,964	8.1%	1,989,971	9.4%
75-84	844,425	4.2%	866,986	4.2%	997,857	4.7%
85+	377,044	1.9%	416,572	2.0%	443,257	2.1%

Source – ESRI

Selection of Multiple Sites

Applicant has selected two additional sites to develop a detox and residential treatment facility, which are the subjects of other CON applications. Although Applicant recognizes that it may be possible to gain some financial efficiency by operating one larger facility, this approach would not be consistent with Applicant's model of care. By having three sites strategically located across the state of Maryland, Applicant will be able to provide treatment that is readily available to patients near where patients live and work. This improves patients' access to treatment because, in most cases, they can reach their chosen facilities within 60 miles of their home or workplace.

A single large facility in the center of the state would hinder patients' access to care. Many patients would have to travel more than 90 miles to access a centralized facility. In the field of substance abuse treatment, if treatment is difficult to access and not readily available, then the likelihood increases that a patient may continue in their current addiction or relapse into addiction. *See, e.g.,* **Exhibit 24**. Many people with the disease of addiction are uncertain about entering into treatment, so taking advantage of available services that are close to them the moment they are ready for treatment is crucial for their success. The earlier treatment is offered in the disease process, the greater likelihood of positive outcomes. Thus, while having one large facility centrally located would allow RCA to take advantage of large economies of scale, it would hinder access to treatment greatly.

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

The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

- Complete applicable Revenue & Expense Tables and the Workforce and Bedside Care Staffing worksheets in the CON Table Package, as required. Attach additional pages as necessary detailing assumptions with respect to each revenue and expense line item. Instructions are provided in the cover sheet of the CON package and on each worksheet. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable. If the projections are based on Medicare percentages above the median for the jurisdiction in which the nursing home exists or is proposed, explain why the projected Medicare percentages are reasonable.
- 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.
- If debt financing is required and/or grants or fund raising is proposed, detail the experience of the entities and/or individuals involved in obtaining such financing and grants and in raising funds for similar projects. If grant funding is proposed, identify the grant that has been or will be pursued and document the eligibility of the proposed project for the grant.
- Describe and document relevant community support for the proposed project.
- Identify the performance requirements applicable to the proposed project (see question 12, “Project Schedule”) and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, obtaining State and local land use, environmental, and design approvals, contracting and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame(s).

Applicant Response

Project Financing

The funding plan for the project is summarized as follows:

Equity	$ ~~6,079,679~~4,238,526
Senior bank debt	~~11,290,648~~$ 26,593,809
Total project cost	$~~17,370,227~~ 30,832,335

RCA has raised all equity required for the project. Deerfield Management Company is providing senior debt for the entire transaction. Deerfield will provide debt financing for this proposed project as well as two other projects RCA is proposing in Upper Marlboro, Maryland (Melwood) and Waldorf, Maryland (Billingsley). Attached as **Exhibit 38** is a letter from Deerfield confirming its commitment of more than $67 million in financing for RCA's three Maryland projects. The financing will be allocated as follows:

	Earleville	**Melwood**	**Billingsley**	**Combined**
Financing	$26,593,809	$18,129,890	$22,889,406	**$67,613,105**

Of the total project cost, ~~43~~24% is attributable to the detoxification treatment component requiring CON approval.

~~RCA has engaged Stifel Nicolaus and Company, an investment banking firm, to facilitate the capital raise for all RCA projects. It has received a term sheet and has executed an engagement letter with an equity partner to fund the equity portion of the project. Due diligence is underway and is anticipated to conclude by the end of March 2015, with funding concurrent with the closing of the senior bank debt.~~

~~RCA is in negotiations with multiple banks and other financing institutions to place the senior bank debt. This debt will be structured either as mortgage debt or a senior term loan, depending upon the institution selected for funding.~~

~~This financing plan was put in place based on the advice of our outside consultants and RCA's internal expertise in raising capital. The RCA executive management team has significant experience in both types of financing, with total financing obtained and placed for their respective businesses in the billions of dollars. Under current market conditions in the industry, as well as in the overall financing marketplace, both management and the investment banking team are extremely confident that the projects will be funded within the expected timelines.~~

~~RCA will advise the Commission of its progress in financing the project.~~

Documentation of Financial Condition of Investor

Deerfield Management Company is providing the ~~equity and~~ senior debt for the entire transaction. The terms of equity contribution and the debt are not able to be made publicly available as doing so would compromise RCA by disclosing such terms to competitors and

other outside parties, and the Company is under a non-disclose agreement with the investor/lender.

Attached as **Exhibit 25** is the ADV form on file with the SEC for Deerfield. The relevant part of the financial information for the RCA funding is the current gross asset value of the "Private Design III" fund from which the transaction will be funded. On **page 38** of the ADV form it shows a fund valuation of $1,667,124,016.

Project Design

Recognizing the critical need for timely and effective conversion of significant capital resources into facilities that support the clinical program, RCA recruited senior real estate team members with significant and complementary experience. RCA's team excels in two critical areas in developing real estate for a specialized application such as this. First, RCA recognizes that the real estate team must understand the requirements, programs, adjacencies, and appropriate staffing levels of the facility's clinical program. To that extent, RCA created a prototype facility designed to optimally support the patient as s/he migrates through the continuum of care. Second, RCA recognized the importance of working with local officials and local vendors to develop and execute on an efficient timeline for navigating the permitting approval processes. RCA met with local officials and local vendors to identify activities and timeframes required to achieve municipal approvals for the project. RCA's real estate team has consistently executed programs and projects with previous employers and has developed a plan to successfully execute Applicants project and programs.

The Manor house was constructed in 1991 and was expanded to 31,000 square feet in the late 1990's. The home is a masterpiece of colonial architecture constructed in the classical tradition. Because the building is in superb condition, RCA's renovation plans are limited to the integration of administrative, clinical program, and regulatory requirements~~. RCA plans to renovate a 6,000 square foot free standing structure for Detox treatment, bringing the total square feet after such renovation to 37,000.~~, and additions to accommodate the size of RCA's project.

Revenue & Expense, and Workforce Projections

Please see **Exhibit** ~~1. The statements of assumptions for those projections, included within Exhibit 1, outlines the assumptions utilized to prepare the tables that exist as part of the application.~~ **35**. These tables included in **Exhibit** ~~1~~**35** demonstrate the ability for RCA to create a sustainable project. The use of projected staffing was based on research on market comparable positions and salary levels as well as demographics of individuals in the area.

Community Support

Applicant is in the process of seeking letters of support from various organizations and community members in 314 Grove Neck Road's service area, and expects to receive letters of support throughout the CON application process. Applicant will keep the Commission informed of its progress. A letter of support from Clifford I. Houston, Zoning Administrator for the Cecil County Department of Planning and Zoning is attached in **Exhibit 26**.

Applicable Performance Requirements

Pursuant to COMAR § 10.24.01.12, once the Commission grants a Certificate of Need, Applicant will have 18 months to obligate not less than 51 percent of the approved capital expenditure, as documented by a binding construction contract or equipment purchase order. Applicant will have four months from the effective date of the construction contract to break ground, and must complete the project 18 months thereafter. COMAR § 10.24.01.12.B(1),(2), C(1)(c).

Applicant will meet the Performance Requirements of COMAR § 0.24.01.12. Applicant expects to obligate not less than 51% of the approved capital expenditure ~~within two months~~for construction of the three-level addition that will contain detox portion of its project within one month of CON approval.[12] Applicant expects to break ground within ~~three~~two months thereafter, and to complete construction within ~~11~~ten months after breaking ground.

[12] Applicant is currently engaged in site work pursuant to the August 3, 2015 Determination of Coverage, and expects to construct 38 of its 87 residential beds while this CON is pending, as described in its November 30, 2015 request to modify the August 3, 2015 Determination of Coverage.

10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.

An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

INSTRUCTIONS: List all of the Maryland Certificates of Need that have been issued to the project applicant, its parent, or its affiliates or subsidiaries over the prior 15 years, including their terms and conditions, and any changes to approved Certificates that needed to be obtained. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

Applicant Response

Not applicable.

10.24.01.08G(3)(f). Impact on Existing Providers and the Health Care Delivery System.

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project. Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, payer mix, access to service and cost to the health care delivery system including relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions. Provide an analysis of the following impacts:

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. If an applicant for a new nursing home claims no impact on payer mix, the applicant must identify the likely source of any expected increase in patients by payer.
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.

If the applicant is an existing facility or program, provide a summary description of the impact of the proposed project on the applicant's costs and charges, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

Applicant Response

Data are not readily available regarding the operations of existing ICF providers. However, it is clear the project will not have a materially adverse impact on existing providers. The Applicant proposes to add only 21 ICF beds (and ~~28~~87 residential beds). Based on projected admissions in the proposed facility's service area, only six of the 21 beds will be used for Maryland residents by year 2019 (*see* Table 8). With an expected length of stay of fourteen days, the six beds for Maryland admissions will serve only approximately 133 Maryland adult patients per year ([(.85 occupancy rate x 6 beds) x 365 days] / 14 day LOS = 133).

Using the need methodology set forth in the State Health Plan, as many as 1,821 adult Marylanders residing in the Eastern Shore Region will require ICF care in 2019. Presently, the Eastern Shore Region has only two Track One facilities: Hudson Health Services in Salisbury and Warwick Manor Behavioral Health in East New Market. Thus, the demand for beds exceeds the current supply, and the addition of six beds for Maryland admissions will not significantly adversely impact other providers.

This project is primarily aimed at improving access of care for residents of Maryland and secondarily on increasing access for individuals in need of treatment from across the country. Officials across Maryland, including Governor Hogan, have made it clear that the State of Maryland has an inadequate substance use disorder treatment system to serve the rising numbers of Maryland residents who suffer from the disease of addiction. The current system of substance abuse treatment in the nation is failing – 89% of Americans who meet DSM 5 criteria for substance abuse or dependence do not get treatment.

This problem needs all providers to work together in reducing these startling statistics. If only 11% of cancer victims received treatment, the country would be in an uproar. The applicant plans on attacking the disease head-on through a multi-pronged approach that consistently educates the community and minimizes the barriers that stand in the way of receiving treatment. Applicant's efforts will also focus on reducing stigma and celebrating recovery.

Applicant's efforts combat this disease will come from many avenues including:

- Providing a local continuum of care to extend gains made in all levels of treatment
- Treatment that is close to the patients home and/or workplace
- Utilizing evidence-based / best practices
- Providing individualized, tailored treatment
- Delivering Patient-Centered Care as defined by the Institute of Medicine
- Providing on and off-site educational seminars, workshops and other activities
- Providing a family program and intervention services
- Having on the ground care advocates who will establish relationships with community resources (physicians, hospitals, schools, etc.)
- A 24/7 contact center that will serve as a resource for anyone seeking treatment for themselves of a loved one on, any person who does not meet our clinical criteria to a highly qualified referral
- A 24/7 transportation service
- Employing science identified by the National Institute of Drug Abuse following NIDA's Principles of Effective Treatment
- Collaborating with colleagues from the top research institutions and with the top innovators in the field
- A targeted regional marketing campaign spend comprised of both digital and traditional media that not only promotes brand awareness but aims at educating and reducing the stigma associated with the disease

The proposed project will increase access to urgently needed alcohol and drug abuse treatment services in the Eastern Shore Region and throughout the projected service area. The Applicant has committed to provide 6.15% of patient days for indigent and gray area patients, and to make additional resources available to the entire community. Thus, patients with limited financial resources will have greater access to care after implementation of the project.

In addition, Applicant asks that the Commission note the lack of providers that will directly compete with Applicant's locations. Table 12 below demonstrates the low amount of direct competition in the Mid-Atlantic Region, and provides a better understanding of Applicant's 'neighborhood' model. Applicant's 'neighborhood' model is defined as 90 miles reach from the

facility, or roughly an hour and half drive. A full page rendering of Table 12 appears in **Exhibit ~~10.~~37.**

Modified Table 12[13]
Neighboring Providers

	Name of Facility	City	Total Beds	Detox Offered	Detox Beds	Private Pay Daily Rate	Distance from Facility (mi)
1	Williamsville Wellness	Hanover, VA	16	No	0	$833	*182*
2	Sagebrush	Great Falls, VA	N/Av	N/Av	N/Av	$1,167	*113*
3	Warwick Manor [1]	East New Market, MD	42	Yes	17	N/Av	*71*
4	Father Martin's Ashley [1]	Havre De Grace, MD	100	Yes	41	$857	*32*
5	Mountain Manor [1]	Emmitsburg, MD	46	Yes	19	$245	*120*
6	Hudson Health Services 1	Salisbury, MD	33	Yes	14	$575	*88*
7	Anchor of Walden [1]	Charlotte Hall, MD	20	Yes	8	N/Av	*124*
8	I'm Still Standing By Grace [2]	Baltimore, MD	42	Yes	12	N/ Av	*72*
9	Clarity Way	Hanover, PA	23	Yes	7	$1,000	*89*
10	Caron Treatment Centers Adult P.C. Serv.	Wernersville, PA	257	Yes	10	$1,167	
11	Retreat: Lancaster	Lancaster, PA	150	Yes	40	$1,000	*76*
12	Malvern Institute (two locations)	Malvern & Willow Grove, PA	172	Yes	42	$680	*64*
13	Mirmount	Media, PA	115	Yes	33	$625	*61*
14	Meadowwood	New Castle, DE	58	Yes	N/Av	$800	*59*
	Total / Average		**1074**		**243**		*30*

Source: Applicant phone calls to facilities and SAMHSA Treatment Locator
(1) Applicant assumed that Maryland ICF facilities use ~~20~~41% of their licensed beds for detox~~, as discussed in response to standard .05B, supra~~
(2) Facility identified number of beds used for detox via phone

Applicant is confident that it's multi-prong attack on this disease along with the efforts of other providers, county and state official's, tasks forces and other alliances, will be successful in empowering more individuals to seek treatment for their disease. Applicant believes that this reduction will provide a net benefit to existing providers.

[13] RCA modified Table 12 in its August 31, 2015 Response to Completeness Questions, **Exhibit 32** by updating, where noted, certain existing non-funded inventory based on the change in assumption of the percentage of licensed beds being utilized for detox /assessment from 15% to 41%.

Recovery Centers of America—Earleville
314 Grove Neck Road OPCO, LLC
Establishment of Alcohol and Drug Abuse
Intermediate Care Facility in Cecil County, Maryland
Matter No. 15-07-2363

Responses to Additional Information Questions Dated July 17, 2015

Part I- Project Identification and General Information

1. **Identify all individuals that have, or will have, at least five percent ownership share in the applicant and any related parent entities.**

Applicant Response

No natural person directly owns more than 5% of 314 Grove Neck Rd OPCO LLC ("Applicant") or its parent, TRC-OC LLC. A limited liability company, Deerfield Private Design Fund III, L.P. (a fund sponsored by Deerfield Management Company), family trusts, and others own the holding company Recovery Centers of America Holdings LLC. Please see the Modified Application, **Exhibit 3**, for a chart depicting the ownership structure.

Applicant is not privy to the investment structure of the entities that own Recovery Centers of America Holdings LLC. However, with the exception of J. Brian O'Neill, no individual will have the ability to make operational or clinical decisions for the proposed project as a result of having an ownership interest in any parent entity on the organizational chart attached as **Exhibit 3** to the Modified Application.

Applicant acknowledges that COMAR § 10.24.01.07 requires Applicant to "submit a formal application for Certificate of Need, in the form and manner prescribed by the Executive Director." However, Applicant respectfully requests that the Commission limit this question and Question 2 in the Application to the Applicant and Owner. Ownership in a parent entity is not a legal equivalent to ownership in a subsidiary. Furthermore, a requirement that an applicant submit the requested information could not be enforced uniformly for all applicants. For example, the Commission has approved CON applications for subsidiaries of Genesis Healthcare, a publicly traded company (NYSE:GEN) with a number of long term care facilities in Maryland. As worded, the question would require any subsidiary of Genesis Healthcare to identify not only any person and/or entity with a 5% ownership interest in Genesis Healthcare ("Shareholders"), but also any person that holds a 5% interest in those Shareholders – information that Genesis Healthcare may not know, and that could change daily.

Applicant is not aware of any statute that would authorize the Commission to impose greater disclosure requirements on non-publicly traded companies, or to condition docketing of a CON application on information that is not required by the regulatory standards or review criteria. Accordingly, Applicant respectfully requests that the Commission accept the above disclosure, and that contained in **Exhibit 3** to the Modified Application, as a complete response to this question.

Part III – Consistency with General Review Criteria at COMAR 10.24.01.08G(3)

A) State Health Plan: COMAR 10.24.14 STATE HEALTH PLAN FOR FACILITIES AND SERVICES: ALCOHOL AND DRUG ABUSE TREATMENT SERVICES STANDARDS

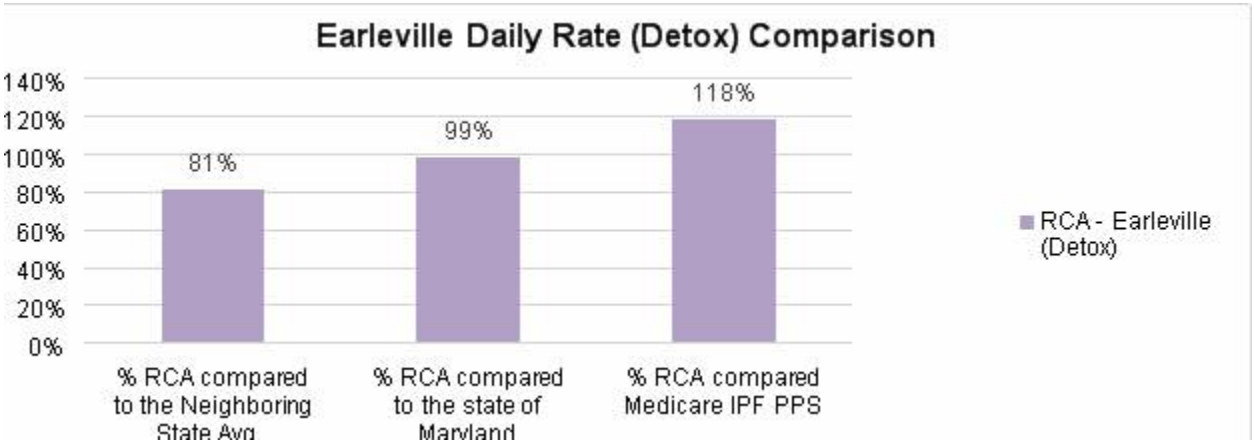
Information Regarding Charges

2. Limited staff research reveals that the proposed charges for Inpatient Detoxification and Inpatient Rehabilitation are significantly higher than those charged by other facilities. Provide information that shows the viability of the proposed charges that you have relied upon in developing those daily charges; have they been "tested" with insurance carriers?

Applicant Response

RCA's Detoxification and Inpatient Rehabilitation reimbursement is not significantly higher than those of other facilities. RCA conducted extensive research based on various external resources in determining its standard billing rates. The rates discussed in the Modified Application are standard rates from insurance carriers. The following analysis displays three data points: The applicant's average detox rate compared against neighboring states, the State of Maryland, and Medicare.

Table 13
RCA – ~~Earleville Daily~~Detox Rate Comparison
Maryland Facilities



Source: Medicare IPF PPS data gathered from CMS and TruVen Health Analytics

Table 14
~~RCA - Earleville~~ a
Daily Reimbursement Rate ~~Comparison~~
RCA, Maryland, and Neighboring ~~States~~State Providers

Rhode Island (2013)	$1,326
Massachusetts (2013)	$1,128
New Jersey (2013)	$1,001
Pennsylvania (2013)	$956
Maryland (2013)	$872
Neighboring State Avg (2013)	$1,057
RCA – I/P Residential	$724
~~RCA - Melwood & Billingsley (Detox Rate)~~	~~$860~~
RCA ~~- Earleville (~~– Detox / ICF Rate~~)~~	$860
~~Source: TruVen Health Analytics~~	
RCA - Blended Rate	$787

Source: TruVen Health Analytics

RCA daily ICF reimbursement rate of $860 for Earleville compares favorably to the Neighboring State Average of $1,057. As shown in ~~Exhibit 27,~~Table 13 above and Table 14b, below, the RCA ~~Model Average daily~~model ICF rate for Earleville is 99% of rates observed in the State of Maryland. RCA expects to obtain detox rates 118% higher than Medicare rates. As ~~this table~~these tables displays, these rates are not uncommon in the health care market.

Modified Table 14b[14]
Daily Reimbursement Rate Comparison
RCA to Maryland and Neighboring State Providers

	RCA Model Daily Rate	RCA to Neighboring State Avg.	RCA to Maryland	RCA to Medicare IPF PPS
RCA - I/P	$724	68%	83%	100%
RCA - Detox	$860	81%	99%	118%

[14] The information presented in Table 14b was previously included in Exhibit 27. RCA Modified the table presented in that Exhibit to be consistent with the November 30, 2015 Modification.

RCA - Earleville (Blended)	$787	75%	90%	108%

Medivance Billing Service specializes in offering comprehensive substance abuse billing, collections and revenue cycle management services to substance abuse rehab facilities. Medivance calculated a residential average daily payment – that includes over 50+ insurance providers – of $1,135. Comparatively, RCA will charge $724 for residential ~~serices~~services, which is 36.2% lower than the Medivance average. ~~(Modified Application, Statement of Assumptions for Financial projections, page 2)~~

Identification of Intermediate Care Facility Alcohol and Drug Abuse Bed Need

3. **Describe the source used by ESRI Geographic Information Systems to construct demographic projections. The application attempted to answer this question with Exhibit 9; the exhibit was not legible/intelligible so please respond in your own words.**

Applicant Response

Exhibit 9 to the Modified Application is a news release available on the ESRI website that reports a study ranked ESRI US Demographic data as the most accurate among surveyed data sources. It also describes how the study was conducted, and discusses the ESRI team and accuracy of its data. The release is available at ESRI's website.[1]

ESRI is a business analytics online software package offering an array of data sources for defined geographical areas. In connection with this Application, RCA relied upon the demographics data provided by the software. The ESRI software provides both current year demographic data for defined geographical areas, and also forecasts a 5-year projection utilizing complex algorithms that ESRI constantly refines to provide the most accurate data. ESRI states that it utilizes data provided by the most recent US Census (2010) and the American Community Survey (ACS). An ESRI White Paper on the American Community Survey found ESRI US Demographic Data Most Accurate.[1]

1. ESRI. "Study Ranks ESRI US Demographic Data Most Accurate." <http://www.esri.com/news/arcnews/summer12articles/study-ranks- esri-us-demographic-data-most-accurate.html> (last visited August 14, 2015).

Provision of Service to Indigent and Gray Area Patients

4. **Application states (p.43) 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." If people covered by Medicaid will indeed have coverage for substance abuse services, why does this proposed project exclude that population?**

Applicant Response

Applicant acknowledges the concern of this question. RCA would like to serve Medicaid beneficiaries. However, the low level of Medicaid reimbursement precludes RCA from serving this population at this time.

Moreover, Medicaid does not currently cover the services that RCA seeks to provide to facilities with more than 16 beds. The federal Institutions for Mental Disease (IMD) Exclusion prohibits Medicaid reimbursement for adults between the ages of 21 and 64 who are receiving services provided in "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and treatment of individuals with mental diseases."[1] Due to this rule, Medicaid will not be reimbursing services as RCA's total beds exceed 16 beds in each location.

Although RCA's facilities will not accept Medicaid reimbursement, RCA will offer other services that will benefit this population. RCA will raise addiction awareness and implement a referral program as executed through 24/7 call center and awareness efforts. Through these programs, RCA will also increase referrals to existing Maryland providers that accept Medicaid patients.

1. The Department of Mental Hygiene. Maryland Medicaid Seeks IMD Exclusion Waiver (July 28 2015). Web.http://dhmh.maryland.gov/newsroom1/Pages/Maryland-Medicaid-seeks-IMD-Exclusion-waiver.aspx

5. **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 gray area patients. In proposing a lower percentage, the applicant 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; Exhibit 2, which models financial performance at that higher percentage of indigent or gray area patients, shows a healthy profit margin, with a profit of $3.4M on total expenses of $10.9M in year 2, and profits of $3.39M on expenses of $10.9M in year 3. In light of those numbers, why should MHCC consider deviating from the guidance of this standard?**

Applicant Response

The Tables in this response, Tables 15 through 18 below, have been modified to reflect changes made in connection with the November 30, 2015 Modification, and the correction of the tables submitted in connection with the December 21, 2015 Corrected Modified Application.

In connection with the Commission's 2013 approval of the expansion of the Father Martin's Ashley facility, the Commission staff stated that "it's possible that the State Health Plan requirement [for Gray Area care] is somewhat high." Transcript of September 19, 2013 Proceedings of the Commission at 7 (**Exhibit 14** to Modified Application). In suggesting an alternative measure, Joel Riklin, then the Commission's Acting Chief of CON, suggested that one possible comparison (although "not strictly apples-to-apples") would be to look to the charity care provided by Maryland hospitals, which he described as having a median of 3.5% ratio of charity care to operating expenses in FY 2012. Id. On that basis, RCA's proposal is much more generous than the charity care provided by Maryland hospitals. As a percentage of operating expenses, RCA's projected charity care commitment will be approximately 25% (for 2017 and 2018). See Table G (Charity Care divided by Total Operating Expenses).

Also, when considering RCA's ability to provide service to Gray Area patients, it is important to consider RCA's status as a for-profit health care entity. RCA's financial model for the three Maryland facilities would be unsustainable if charity care were expanded from 6.15% to 15% of bed days. Although the Applicant's financial projections appear to show a higher margin than other Track 1 facilities, these projections do not include federal income tax or state taxes. By including estimated taxes in the financial analysis, the Applicant's total estimated expenses would increase by more than $1.6M. This reflects a new projected total margin for the Applicant of 13.7% in 2018. In addition, the applicant is projecting $139,323 in property taxes in 2018, and various projected State taxes of $307,029. With these considerations, RCA's Maryland facilities will incur an estimated combined total of $10,081,984 additional expenses in total estimated taxes in 2018, which reduces RCA's combined profit margin from 27.6% to 15.6%.

If RCA were to provide 15% of its annual adult intermediate care facility bed days to Indigent or Gray Area patients at Earleville, the total profit margin would decrease to 4.1%. The decrease in total margin for Earleville is far below other Track 1 facilities, which are afforded the provision to accept an amount lower than 15% of its proposed annual intermediate care facility bed days to Indigent or Gray Area patients.

Modified Table 15
Total Margin – RCA & Selected Track I Facilities
RCA Modeled at 15% Charity Care

Source: ~~*Data~~RCA data gathered from RCA Certificate of Need application~~*~~ Track 1 ~~Facilities~~Facility data gathered from Hudson House and Father Martin's Ashley IRS 990 Forms[1,2]

Modified Table 16
Financial Analysis 6.15% Charity Care

	Financial Analysis - 6.15% Charity Care		Track 1 Facilities	
	RCA Earleville (2018)	RCA - Combined (2018)	Father Martin's Ashley (2013)	Hudson House (2013)
Net Revenue	$ 24,539,091	$ 92,806,533	$ 24,206,028	$ 3,457,205
Total Expenses	22,047,316	79,388,156	22,137,496	3,037,489
Net Operating Income	$ 2,491,775	$ 13,418,377	$ 2,068,532	$ 419,716
Estimated Tax Expense	$ 1,918,447	$ 10,330,962	$ -	$ -
Total Margin	10.2%	14.5%	8.5%	12.1%

Source: ~~*Data~~RCA data gathered from RCA Certificate of Need application~~*~~. Track 1 ~~Facilities~~Facility data gathered from Hudson House and Father Martin's Ashley IRS 990 Forms[1,2]

Modified Table 17
Financial Analysis 15% Charity Care

	Financial Analysis - 15% Charity Care		Track 1 Facilities	
	RCA Earleville (2018)	RCA - Combined (2018)	Father Martin's Ashley (2013)	Hudson House (2013)
Net Revenue	$ 22,225,069	$ 84,639,187	$ 24,206,028	$ 3,457,205
Total Expenses	21,040,716	75,835,361	22,137,496	3,037,489
Net Operating Income	$ 1,184,353	$ 8,803,826	$ 2,068,532	$ 419,716
Estimated Tax Expense	$ 911,847	$ 6,778,167	$ -	$ -
Total Margin	5.3%	10.4%	8.5%	12.1%

Source: ~~*Data~~RCA data gathered from RCA Certificate of Need application~~*~~. Track 1 ~~Facilities~~Facility data gathered from Hudson House and Father Martin's Ashley IRS 990 Forms[1,2]

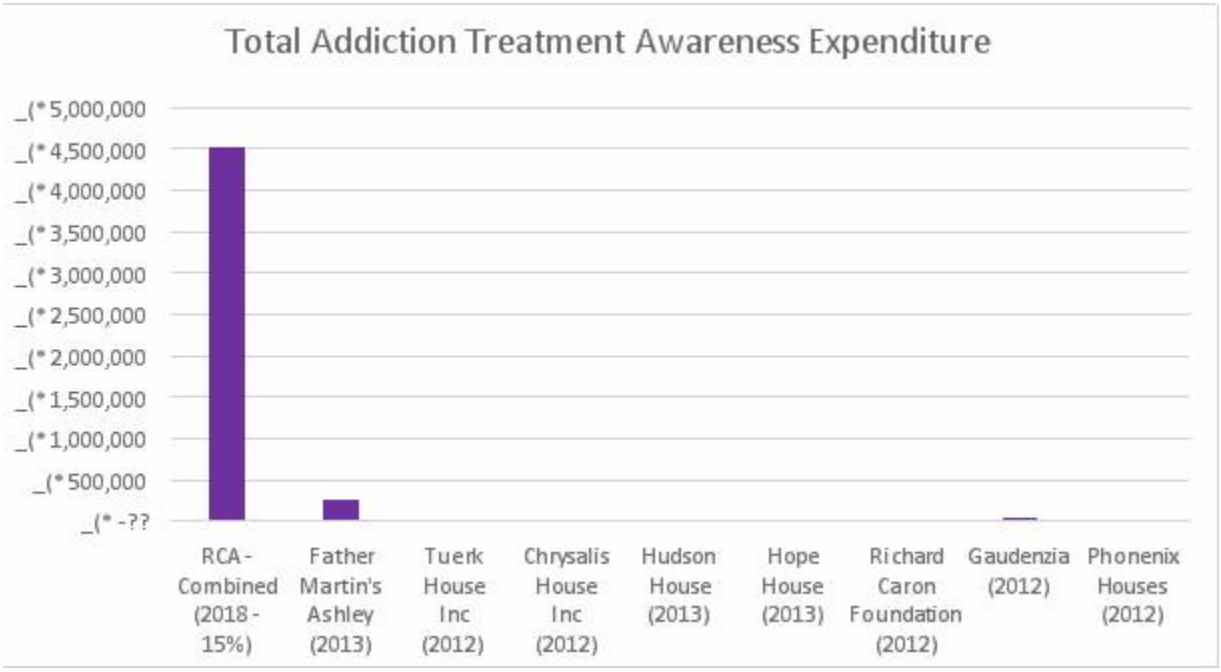
Since the original 15% Gray Area Population standard was developed and instituted, the landscape of health care has changed. The Patient Protection and Affordable Care Act of 2010 dramatically changed the health care landscape with respect to individuals who did not have health insurance. Since the passage of the Patient Protection and Affordable Care Act large segments of this uninsured population now has health insurance. RCA has estimated that 6.15% of its patient days are from the Gray Area Population. This percentage is derived from the statistic provided by the Kaiser Family Foundation that 41% of adults in the state of Maryland were not eligible for insurance coverage[3] (41% of 15% provides the value of 6.15%). These statistics are meant to demonstrate the increasing volume of insured adults, and RCA's subsequent calculation of the proportional need to provide care for this patient population. "Father Martin's Ashley shall provide a minimum of 6.3% of patient days of care to indigent and gray area patients, as defined in the State Health Plan, commencing with the first full year of operation following completion of the approved project."[4]

RCA will have the largest addiction treatment awareness budget within the State of Maryland. The projections state that RCA will spend more than $~~4M~~9.8 million (for all three proposed facilities) over the next three years in awareness throughout the State of Maryland, specifically $~~506,024~~ 2,195,121for the Earleville location alone. See **Exhibit ~~1,~~35.** Table G,

Line 2.m, Modified CON Application. This effort will increase awareness, promote treatment, and inform the entire State outreach efforts. With RCA's allocated awareness budget, RCA will outspend other detox centers which are not spending nearly as much, if any amount at all, on their respective awareness campaigns. After an analysis of other Maryland not-for-profit detox centers, RCA will spend 90% more than all the not-for-profits combined on addiction treatment awareness.

Beyond RCA's plan to serve Maryland's Gray Area Population in its Maryland facilities, RCA is planning a 24/7 coverage call center that will receive calls through its increased awareness efforts for patient seeking care. The call center will refer patients to both RCA facilities and other substance abuse treatment programs as appropriate.

Modified Table 18



Source: *Data gathered from RCA Certificate of Need application

*Other facility data gathered from IRS 990 Forms

1. Hudson Health Services Inc. (2014) Form 990 Return of Organization Exempt From Income Tax. DLN: 93493024006015. Web. <www.guidestar.org>
2. Father Martin's Ashley. (2014) Form 990 Return of Organization Exempt From Income Tax. DLN: 93493047011375. Web.<www.guidestar.org>
3. The Henry J. Kaiser Family Foundation. (2014). How Will the Uninsured in Maryland Fare Under the Affordable Care Act? Retrieved July 24, 2015. <http://kff.org/health-reform/fact-sheet/state-profiles-uninsured-under-aca-maryland/>
4. Steffen, Ben. Tanio, Craig. Maryland Health Care Commission. "Commissioners Docket No. 13-12-2340" November 20 2014. Web. <http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents /2014_decisions/con_father_martin_decision_20141120.pdf>

Transfer and Referral Agreements

6. **Please provide an executed transfer and referral agreement with each of the organizations and entities listed in your response to this standard. (Note: the replacement application included one executed agreement; please forward the remaining if/when received.)**

Applicant Response

Applicant included various executed referral agreements in **Exhibit 17** to the Modified Application. In addition, **Exhibit 28** is an agreement for the exchange of information and patients as clinically needed between Hope House and the Maryland RCA facilities. RCA is continuing to discuss referral agreements with other providers.

Applicant will forward any additional agreements and letters of support as received to the Commission.

Sources of Referral

7. **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.**

Applicant Response

RCA has begun its referral network relationship on behalf of Applicant. To date, RCA has a signed agreements with Hope House, Community and Behavioral Health, Homecoming Project, Inc., Union Hospital, and UM Harford Memorial Hospital. See **Exhibits 17 and 28**.

Beyond these formal referral agreements, RCA has established contact with local Maryland community mental health centers and acute care facilities. In an attempt to further expand referral agreements, RCA has compiled a list of hospitals in the 30 mile radius in which it will contact in order to develop referral agreements among the healthcare facilities.

In addition, RCA will have a dedicated call center which will act as a point of service for individuals and families with contact information for facilities to provide recovery treatment. If an uninsured patient contacts RCA's call center and private financial resources are not available to cover the cost of care, applicable State-funded programs will be located by using the Substance Abuse and Mental Health Services Administration's (SAMHSA) treatment locator website and these patients will be provided a listing and contact information for these programs. RCA will also refer uninsured Maryland residents to the respective jurisdiction's county substance abuse/addiction program.

Statistical Projections

8. **The original set of three CON applications filed by RCA each showed a distinctly different mix and ratio of detox and residential patients, as shown in the table immediately below (value is the average # of annual discharges taken from the respective Tables F of the original applications). To summarize, Grove Neck had a far higher ratio of detox; Billingsley had a higher ratio of residential; while at Melwood the ratios were identical (see table below).**

Facility	Discharges			
	Residential	Detox	Total	Ratio of Detox to Residential
314 Grove Neck Rd	363	965	1328	2.66 - 1
4620 Melwood Rd	1002	1002	2004	1 - 1
11100 Billingsley Rd	1534	1111	2645	0.72 - 1

The replacement applications showed a different picture, with all facilities showing an equal number of detox and residential.

a. **Please explain the differing ratios in the initial application.**

Applicant Response

Part A and B will be answered together below.

b. **Why did the projections change in the replacement application? How did you determine that congruity between detox and residential client volume is the best assumption to make for all these facilities? How did you reach this conclusion, and what evidence did you review and rely on?**

Applicant Response

To better support an explanation of this ratio, RCA researched national and state wide discharge data for detox and residential beds. SAMHSA published discharge data for both detox and residential beds for the State of Maryland. These data concluded a detox to residential discharge ratio of 1 – 2.55.[1] RCA's methodology is based upon a combination of Maryland discharge data and the differing physical characteristics of each site.

Detox is more complicated because many patients are using multiple drugs, among them alcohol and benzos, already a longer detox. RCA's Utilization Management Team also will pursue the Acute Inpatient Rehabilitation (IR) level of care with MCOs to address patients who are actively receiving treatment that RCA is managing for both addictions and acute medical illness.

Scientific literature shows that 90 days of treatment provides the best chance for a patient to achieve long term sobriety.[1] However, length of treatment and length of stay will vary for each individual. Considering this, RCA used information from Cigna which provided a range of 13-30 days for the average length of stay for chemical dependency residential treatment. [3] The RCA value of 16 days falls on the Cigna range.

1. Substance Abuse and Mental Health Services Administration, *Treatment Episode Data Set (TEDS): 2011. Discharges from Substance Abuse Treatment Services.* BHSIS Series S-70, HHS Publication No. (SMA) 14-4846. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014
2. Principles of Drug Addiction Treatment: A Research Based Guide (Third Edition). National Institute of Drug Abuse. "How long does drug addiction treatment usually last?" (December 2012). Web. Retrieved August 16, 2015. http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/how-long-does-drug-addiction-treatment
3. Clarifying the difference between Inpatient and Residential Chemical Dependency Treatment.(2010).RetrievedAugust28,2015. <http://www.cignabehavioral.com/web/basicsite/provider/newsAndLearning/newsletter/newsletter2011Quarter3/pages/inpatientVsResidential.html>

c. **Would it not be prudent to assume some drop-out rate between detox and residential? Conversely, do you anticipate enrolling anyone in residential treatment who either did not require detox or has been through that phase at another facility?**

Applicant Response

There will be some patients who do drop-out between detox and residential treatment, but RCA will attempt to limit the amount of drop-out through the services model listed on pages 9-10 of the Modified Application. RCA's research shows a large need for the planned services at the facilities and due to the large need for recovery services, RCA believes the impact of drop-outs will be negligible.

To the extent that patients do drop out of treatment, RCA expects to be able to fill any empty beds with patients seeking residential treatment only. The description of the referral agreement with Hope House in the Earleville response indicates there will be some transfer of residents following detox as defined by ASAM criteria.

Viability of the Proposal

9. The application asks an applicant to provide:

*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.*

An SEC form ADV – not financial statements -- was provided for Deerfield Management Company (listed in Exhibit 3 as an investor with no role in operations), but nothing was submitted for the other 3 parent companies or for the applicant. Please remedy this oversight.

Applicant Response

Financial statements are not available for the Mary Margaret Trust and Recovery LLC. Furthermore, the financial condition of such investors is not relevant to the application as all funds to be invested by these entities have been received and expended at this time. All future equity investment and debt proceeds will be received from the Deerfield Private Design Fund III, L.P., a fund affiliated with Deerfield Management Company ("Deerfield"). The financial condition of the fund providing the financing has been provided in the SEC form ADV in **Exhibit 25** on the Modified Earleville Application.

10. 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. The citation in your cover letter refers us to p. 58, but provides no evidence that any commitments have been received.

Applicant Response

~~The total financing for the projects has been committed by Deerfield. The loan documents associated with such financing are confidential documents. However, attached as~~

~~Exhibit 29 is a letter prepared and executed by the executive management of~~ RCA has raised all equity required for the project. Deerfield Management Company~~, which reflects that financing is committed~~ is providing senior debt for the entire transaction. Deerfield will provide debt financing for this proposed project as well as two other projects RCA is proposing in Upper Marlboro, Maryland (Melwood) and Waldorf, Maryland (Billingsley). Attached as **Exhibit 39** is a letter from Deerfield confirming its commitment of more than $67 million in financing for ~~the~~RCA's three Maryland projects. The financing will be allocated as follows:

	Earleville	Melwood	Billingsley	Combined
Financing	**$26,593,809**	$18,129,890	$22,889,406	**$67,613,105**

Impact on Existing Providers

11. Please explain how the applicant's proposed establishment of three ICF-CDs not enrolled in the Medicaid program will not have an adverse financial impact on existing residential treatment centers who participate and serve the Medicaid enrolled population and who provide charity care commitments that exceed the 6.15% offered by RCA.

Applicant Response

RCA projects no adverse impact on the existing residential treatment centers due to the demand for beds in Maryland described in the bed need analysis Modified Application, Modified Tables 9-10. The State's Bed Need Projection Methodology in COMAR 10.24.14, available public discourse, and RCA's analysis demonstrate that there is a clear rise in substance abuse related deaths and a subsequent need for addiction treatment options. Due to the need for beds in Maryland, the potential impact of establishing these three recovery centers would be positive by providing care for the individuals in need and contributing to the stated goals of Maryland and Governor Hogan of reducing the heroin and opioid epidemic.

Governor Hogan has tasked the Lt. Governor Boyd K. Rutherford to "bring together all of the stakeholders in order to come up with a plan to tackle this emergency." The following observations regarding the need for additional services and capacity were provided in Lt. Governor Boyd K. Rutherford's "Maryland Emergency Task Force on Heroin and Opioid – Interim Report":

- A strong recurring theme in the testimony delivered at the summits was the lack of sufficient resources to address the heroin and opioid epidemic and the serious issues Marylanders face as they try to access care
- Stakeholders across the State reported a critical shortage of qualified treatment professionals and insufficient capacity at both inpatient and outpatient treatment facilities
- The need to realign and secure additional funding and launch efforts to expand the capacity and collaboration of the treatment system
- Overwhelming inability to access treatment immediately
- Lack of appropriate levels of care in their respective county or region
- Health department and other county officials reported a shortage of long-term residential treatment options
- Data provided by the Department of Health and Mental Hygiene indicates that serious deficiencies exist in the treatment system that prevent an individual from accessing the full range of care settings and levels of care

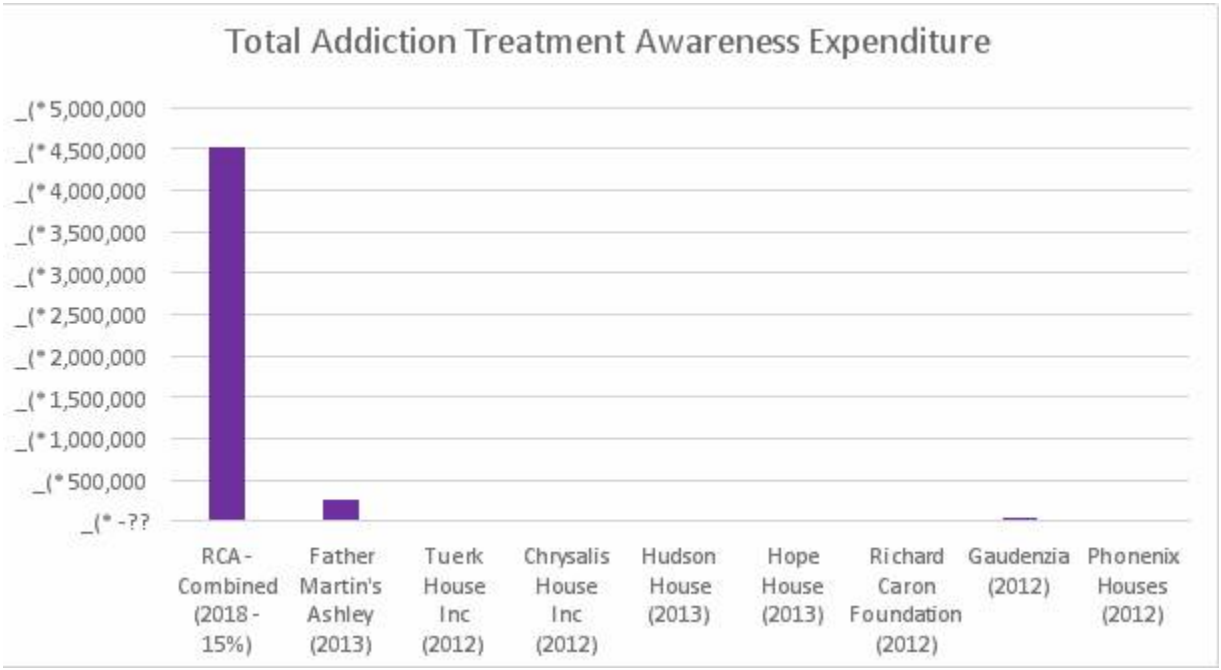
- The admission data for fiscal year 2014 by level of care indicates inconsistent use and lack of availability of the full continuum of care in each part of the State
- With the exception of Baltimore City, every county has significant gaps in services
- Counties located in Western Maryland and on the Eastern Shore provide the majority of their services in outpatient settings, possess very limited access to residential services, and lack other services across the continuum of care
- Queen Anne's County, heroin is the driving force behind car thefts, thefts from autos, and burglaries

A copy of the Interim Report of the Governor's Heroin and Opioid Emergency Task Force is attached as **Exhibit 30**.

In addition, please see the compilation of news articles and other materials in **Exhibit 31**, which demonstrate the magnitude of the substance abuse epidemic.

Based on the RCA bed need analysis, there will be excess capacity of beds after taking RCA's requested volume into consideration; therefore, RCA will not harm other substance abuse treatment providers. It is clear that current addiction treatment awareness programs are not meeting the increasing demand for treatment for individuals in need. RCA is willing to invest in the State of Maryland to provide this needed service.

Modified Table 20[15]



Source: *Data gathered from RCA Certificate of Need application

*Other facility data gathered from IRS 990 Forms

Furthermore, as discussed in response to the question concerning the Gray Area Population, RCA's commitment for spending on addiction treatment awareness and the Call Center that RCA will launch will provide a service to both the individuals in need as well as the

[15] Table 20 has been modified to reflect changes made in connection with the November 30, 2015 Modification, and the correction of the tables submitted in connection with the December 21, 2015 Corrected Modified Application.

Maryland Track 2 providers. RCA's call center service will include a referral program to provide patients in need with information and access to other recovery centers in the surrounding area, increasing overall access to recovery statewide. Also, RCA will be a tax paying entity contributing to the State of Maryland. Additionally, RCA will be an active participant within Substance Abuse Management Information Systems (SAMIS) data collection for the State of Maryland. RCA's inclusion in this data submission program will help to improve quality and treatment of persons with substance abuse problems in the State of Maryland.

For the State of Maryland, there is a calculated need of ~~449~~307 to ~~602~~419 detox beds by ~~2019.~~2019 for the population that RCA anticipates serving. See Table 21, below, and the Corrected Modified Application, Table 7. RCA requests 21 detox beds for the Eastern Shore Maryland marketplace, while the calculated need for that region is 25 to 66 detox beds by 2019. These 21 detox beds will service the local regional areas as well as the State of Maryland's growing need for available beds. Based on the experience of other providers, RCA expects that only available 7 of these 21 beds will be used to treat Maryland residents, while the remaining 14 beds will be used by out of state patients. Corrected Modified Application, Table 8.

The need for these beds is further evidenced by Governor Hogan's Heroin and Opioid Emergency Taskforce. The Taskforce has noted that "Heroin and opioid drug dependency has more than doubled in Maryland over the last decade. The number of deaths in Maryland related to heroin and opioid drug dependency has increased by more than 100 percent in the last five years."[1]

Table 21
Summary of Bed Need Analysis (2019)

Location	~~All~~ ICF Bed Need for RCA Target Population	Projected Population (18+)	RCA Requested (Total / # for MD Residents)	Remaining Capacity after RCA Beds for MD Residents
Eastern Shore	~~25~~10-~~81~~51	418,847	21 / 6	~~19~~4-~~75~~46
Maryland	~~449~~307-~~602~~419	4,793,500	140 / 61	~~388~~246-~~541~~358

Source: RCA calculation using 2019 estimated ESRI population data. See ~~Exhibit 32;~~Dec. 21, 2015 Corrected Modified Application, Modified Tables 6 and 8; ~~Modified Applications~~and August 31, 2015 Responses to Completeness Questions for Upper Marlboro and Waldorf, Modified Tables 6 and 8.

Lastly, as mentioned in response to Question 4, Medicaid does not currently cover the services that RCA seeks to provide to with non-hospital facilities with more than 16 beds. The federal Institutions for Mental Disease (IMD) Exclusion prohibits Medicaid reimbursement for adults between the ages of 21 and 64 who are receiving services provided in "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and treatment of individuals with mental diseases."[2] Due to this rule, Medicaid will not be reimbursing the ICF stays as RCA's detox beds count exceeds 16 beds in each location.

1. Office of Lt. Governor Boyd Rutherford. Maryland.gov. “Maryland’s Heroin and Opioid Emergency Task Force.” (2015). Web. Retrieved August 16, 2015. <http://governor.maryland.gov/ltgovernor/home/heroin-and-opioid-emergency-task-force/heroin-facts/>
2. The Department of Mental Hygiene. Maryland Medicaid Seeks IMD Exclusion Waiver (July 28 2015). Web. http://dhmh.maryland.gov/newsroom1/Pages/Maryland-Medicaid-seeks-IMD-Exclusion-waiver.aspx

Recovery Centers of America—Earleville
314 Grove Neck Road OPCO, LLC
Establishment of Alcohol and Drug Abuse
Intermediate Care Facility in Cecil County, Maryland
Docket No. 15-07-2363

Responses to Additional Information Questions Dated September 29, 2015

Information Regarding Charges

1. **Your response cited "extensive research (of) ... various external resources" used to determine RCA's standard billing rates and stated that the rates "are standard rates from insurance carriers," and presented Table 13 that compared proposed rates against those in neighboring states, Maryland payers, and Medicare. Please document the sources for each of the data points shown, i.e.:**

   a. **List the rates quoted by each insurance carrier in the listed states that were researched.**

   b. **List the insurance carriers in Maryland, and their respective rates.**

Applicant Response

The information presented in **Table 13** is paid claims data from Truven Health Analytics' Marketscan Research database for commercial payors. (See **Exhibit 33**). Recovery Centers of America ("RCA") understands that specific rate information by carrier and provider is proprietary and is tightly controlled by both payors and treatment facilities. As such, RCA cannot provide rates quoted by each specific carrier in Maryland or other states.

Statistical Projections

2. **Question 8 asked for an explanation as to why the ratios of detox to residential patients varied so widely among the three initial applications (while in the modified versions the ratio was 1:1). The response simply spoke to the current proposals and did not answer the question posed.**

Applicant Response

RCA's initial submission located detox beds based on the unique characteristics of each site. RCA reviewed its bed complement as its planning progressed. Although RCA was able to determine an average Maryland detox to residential bed ratio of 1 – 2.55 through data published by SAMHSA based on actual discharge data, SAMSHA and NIDA do not publish guidelines on an ~~idea~~ideal ratio. RCA's staff have significant experience leading treatment centers similar to the RCA programs. In the collective experience of RCA's staff, the range of percentage of detox to total beds runs from 20% to 50%. RCA determined that fitting within this range would be better for patient flow and would better enable RCA to have detox beds available at all times for emergent patients. Overall, RCA's current plans include 87 residential beds, for a total of 108 beds at this site. While this resulted in an average detox to total bed percentage of just under 20%, this is not inconsistent with RCA's intention to stay within the 20%-50% range, as RCA expects that a significant number of its 87 residential beds at Earleville will service patients who receive detox services at out-of-state locations or at a detox-only facilities, or who require residential only care.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 21st day of December, 2015, a copy of the Corrected Modified Certificate Of Need Application of 314 Grove Neck Road OPCO, LLC was served by email and first-class mail on:

Marta D. Harting, Esq.
Venable LLP
750 E. Pratt St #900
Baltimore, MD 21202
mdharting@venable.com

John J. Eller, Esq.
Ober, Kaler, Grimes & Shriver
120 East Baltimore Street
Baltimore MD 21202
jjeller@ober.com

Suellen Wideman
Assistant Attorney General
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore MD 21215
suellen.wideman@maryland.gov

Stephanie Garrity, MS
Health Officer
Cecil County
401 Bow Street
Elkton MD 21921
stephanie.garrity@maryland.gov

Ella R. Aiken

AFFIRMATIONS

Document comparison by Workshare Compare on Tuesday, December 22, 2015 2:44:04 PM

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Document 1 ID	PowerDocs://DOCS/547829/1
Description	DOCS-#547829-v1-Corrected_Mod_CON_Appl_-_Earlevill e_-_USE_FOR_REDLINE_ONLY
Document 2 ID	PowerDocs://DOCS/547829/2
Description	DOCS-#547829-v2-Corrected_Mod_CON_Appl_-_Earlevill e_-_USE_FOR_REDLINE_ONLY
Rendering set	Standard

Legend:	
Insertion	
~~Deletion~~	
~~Moved from~~	
Moved to	
Style change	
Format change	
~~Moved deletion~~	
Inserted cell	
Deleted cell	
Moved cell	
Split/Merged cell	
Padding cell	

Statistics:	
	Count
Insertions	380
Deletions	283
Moved from	1
Moved to	1
Style change	0
Format changed	0
Total changes	665

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT - ~~Nov~~Dec. ~~30~~,21, ~~2015 Update~~

INSTRUCTION : Add or delete rows if necessary. See additional instruction in the column to the right of the table.

DEPARTMENT/FUNCTIONAL AREA	~~EARLEVILLE - DEPARTMENTAL GROSS SQUARE FEET~~								~~Additional Instructi~~
	Current	To be Added Thru New Construction Detox	To Be Renovated Detox	To Remain As Is Detox	To be Added Thru New Construction Residential	To Be Renovated Residential	To Remain As Is Residential	Total (Shared) After Project Completion~~1~~	~~Total After Project Completion should equal square feet to be added, renovated, and remain as is~~
Gnd Floor Counseling		~~0~~	~~0~~		~~0~~	~~0~~		0	
Gnd Floor Nursing		~~0~~	~~0~~		~~0~~	~~0~~		0	
Gnd Floor Admissions		~~0~~	~~0~~		~~0~~	~~0~~		0	
Gnd Floor Medical & Psychiatric		~~0~~	~~0~~		~~0~~	~~0~~		0	
Gnd Floor Adjunctive/Ancillary (Yoga, Fitness, etc.)		~~0~~	~~815~~		~~0~~	~~3,374~~4,189		4,189	
Gnd Floor Administrative		~~0~~	~~351~~		~~0~~	~~1,456~~1,807		1,807	
Inpatient Rooms w/ bathrooms		~~0~~	~~0~~		~~0~~	~~0~~		0	
Common Areas		~~0~~	~~235~~		~~0~~	~~973~~1,208		1,208	
Circulation		~~0~~	~~601~~		~~0~~	~~2,492~~3,093		3,093	
Building Mechanical/Electrical		~~0~~	~~468~~		~~0~~	~~1,939~~2,407		2,407	
Int & Ext. Wall Thicknesses		~~0~~	~~449~~		~~0~~	~~1,862~~2,311		2,311	
Gnd Floor Kitchen/Dining		~~0~~	~~0~~		~~0~~	~~0~~		0	
1st Floor Counseling		~~208~~848	~~1,002~~		~~683~~223	~~4,149~~5,151		~~6,042~~6,222	
1st Floor Nursing		~~221~~899	~~83~~		~~724~~236	~~343~~426		~~1,371~~1,561	
1st Floor Admissions		~~0~~	~~668~~		~~0~~	~~2,765~~3,433		3,433	
1st Floor Medical & Psychiatric		~~107~~437	~~90~~		~~352~~115	~~371~~461		~~920~~1,013	
1st Floor Adjunctive/Ancillary (Yoga, Fitness, etc.)		~~0~~	~~1,721~~		~~0~~	~~7,131~~8,852		8,852	
1st Floor Administrative		~~0~~	~~369~~		~~0~~	~~1,530~~1,899		1,899	
Inpatient Rooms w/ bathrooms		4,032			1,061	1,680		~~5,712~~6,773	
Common Areas		~~221~~899	~~215~~		~~724~~236	~~889~~1,104		~~2,049~~2,239	
Circulation		~~731~~2,976	~~972~~		~~2,397~~783	~~4,027~~4,999		~~8,127~~8,758	
Building Mechanical/Electrical		~~0~~	~~1,264~~		~~0~~	~~5,237~~6,501		6,501	
Int & Ext. Wall Thicknesses		~~0~~	~~512~~		~~0~~	~~2,119~~2,631		2,631	
1st Floor Kitchen/Dining		~~0~~	~~432~~		~~0~~	~~1,792~~2,224		2,224	
2nd Floor Counseling		~~165~~	~~0~~		~~863~~848	~~0~~		~~1,028~~848	
2nd Floor Nursing		~~175~~	~~39~~		~~914~~899	~~160~~199		~~1,288~~1,098	
2nd Floor Admissions		~~0~~	~~0~~		~~0~~	~~0~~		0	
2nd Floor Medical & Psychiatric		~~85~~	~~0~~		~~445~~437	~~0~~		~~530~~437	
2nd Floor Adjunctive/Ancillary (Yoga, Fitness, etc.)		~~0~~	~~0~~		~~0~~	~~0~~		0	
2nd Floor Administrative		~~0~~	~~0~~		~~0~~	~~0~~		0	
Inpatient Rooms w/ bathrooms					~~5,093~~4,032	3,076		~~8,169~~7,108	
Common Areas		~~175~~	~~17~~		~~914~~899	~~68~~85		~~1,174~~984	

Circulation		579	213		3,0282,976	8821,095		4,7024,071	
Building Mechanical/Electrical		0	0		0	0		0	
Int & Ext. Wall Thicknesses		0	185		0	766951		951	
2nd Floor Kitchen/Dining		0	0		0	0		0	
3rd Floor Counseling		165	0		683848	0		848	
3rd Floor Nursing		175	0		724899	0		899	
3rd Floor Admissions		0	0		0	0		0	
3rd Floor Medical & Psychiatric		85	0		352437	0		437	
3rd Floor Adjunctive/Ancillary (Yoga, Fitness, etc.)		0	0		0	0		0	
3rd Floor Administrative		0	0		0	0		0	
Inpatient Rooms w/ bathrooms					4,032	960		4,992	
Common Areas		175	22		724899	91113		1,012	
Circulation		579	204		2,3972,976	8471,051		4,027	
Building Mechanical/Electrical		0	0		0	0		0	
3rd Floor Kitchen/Dining		0	0		0	0		0	
Existing Wall Construction		0	58		0	238296		296	
Total		7,878 10,090	10,9850		25,0 4622 ,834	51,21 762, 202	0	95,126	Calculate sum of all rows

Note (1): Zeroes across a row indicate no space devoted to that function on identified floor.

TABLE C. CONSTRUCTION CHARACTERISTICS ~~- EARLEVILLE - Nov. 30,~~Dec. 21, 2015 ~~Update~~

INSTRUCTION : If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table C for each structure.

	DETOX NEW CONSTRUCTION	RESIDENTIAL NEW CONSTRUCTION	DETOX RENOVATION	RESIDENTIAL RENOVATION
BASE BUILDING CHARACTERISTICS	**Check if applicable**			
Class of Construction (for renovations the class of the building being renovated)*				
Class A Class B Class C Class D				
Type of Construction/Renovation*				
Low Average Good Excellent				
Number of Stories				

*As defined by Marshall Valuation Service

*As defined by Marshall Valuation Service

PROJECT SPACE	List Number of Feet, if applicable				
Total Square Footage	**Total Square Feet**				
Basement			2,919	12,096	95,126
First Floor	5,520	4,879	7,328	32,033	
Second Floor	1,179	11,256	454	4,952	
Third Floor	1,179	8,911	284	2,136	
Fourth Floor					*Calculate average square feet of all floors*
Average Square Feet	**2,626**	**8,349**	**2,746**	**12,804**	
Perimeter in Linear Feet	**Linear Feet**				
Basement			918.67	918.67	
First Floor	555	229	1,542.83	1,542.83	
Second Floor		555	984.17	984.17	
Third Floor		555	324.50	324.50	
Fourth Floor					
Total Linear Feet	**555**	**1,339**	**3,770.17**	**3,770.17**	
Average Linear Feet	**555**	**446**	**942.54**	**942.54**	
Wall Height (floor to eaves)	**Feet**				
Basement				10	
First Floor	10	10		12	
Second Floor		12		10.50	
Third Floor		12	9	9	
Fourth Floor					
Average Wall Height	**10**	**11**	**9.00**	**10.38**	
OTHER COMPONENTS					
Elevators	**List Number**				
Passenger		1 elevator		1 elevator	
Freight					
Sprinklers	**Square Feet Covered**				
Wet System	7,878	25,046	10,985	33,507	
Dry System					
Other	**Describe Type**				
Type of HVAC System for proposed project	Water source heat pumps with central hydronic loop and some split systems.				
Type of Exterior Walls for proposed project	Wood frame, interior plaster finish, exterior brick veneer.				

~~3000~~

~~Calculate total linear feet of all floors~~
~~Calculate average linear feet of all floors~~

~~Calculate average wall height of all floors~~

PROJECT SPACE	List Number of Feet, if applicable			
Total Square Footage	**Total Square Feet**			
Basement			0	15,015
First Floor	10,090	2,654	0	39,361
Second Floor	0	10,090	0	5,406
Third Floor	0	10,090	0	2,420
Fourth Floor				
Average Square Feet	**3,363**	**7,611**	**0**	**15,551**
Perimeter in Linear Feet	**Linear Feet**			
Basement				1,837
First Floor	555	229		3,086
Second Floor		555		1,968
Third Floor		555		649
Fourth Floor				
Total Linear Feet	**555**	**1,339**	**0**	**7,540**
Average Linear Feet	**555**	**446**	**#DIV/0!**	**1,885**
Wall Height (floor to eaves)	**Feet**			
Basement				10
First Floor	10	10		12
Second Floor				10.50
Third Floor				9
Fourth Floor				
Average Wall Height	**10**	**10**	**#DIV/0!**	**10.38**
OTHER COMPONENTS				
Elevators	**List Number**			
Passenger	1 elevator	1 elevator		1 elevator
Freight				
Sprinklers	**Square Feet Covered**			
Wet System	10,090	22,834	0	62,202
Dry System				

Other	Describe Type
Type of HVAC System for proposed project	Water source heat pumps with central hydronic loop and some split systems.
Type of Exterior Walls for proposed project	Wood frame, interior plaster finish, exterior brick veneer.

TABLE E. PROJECT BUDGET - ~~EARLEVILLE - Nov. 30, 2015 Update~~Earleville

INSTRUCTION : Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application. See additional instruction in the column to the right of the table.

NOTE : Inflation should only be included in the Inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.a as a use of funds and on line B.8 as a source of funds

~~*NOTE : Inflation should only be included in the Inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.a as a use of funds and on line B.8 as a source of funds*~~

			DETOX	RESIDENTIAL	Total
A.	USE ~~OF~~OF FUNDS				
~~1~~1.	CAPITAL COSTS	~~CAPITAL COSTS~~			
a.	Land Purchase	~~a. Land Purchase~~	$3,257,143	$4,342,857	**$7,600,000**
		~~b. New Construction~~			
b.	New Construction				
(1)	Building	~~(1) Building~~	$1,353,150	$4,129,777	$5,482,927
(2)	Fixed Equipment	~~(2) Fixed Equipment~~			$0
(3)	Site and Infrastructure	~~(3) Site and Infrastructure~~	$516,912	$2,113,424	$2,630,336
(4)	Architect/Engineering Fees	~~(4) Architect/Engineering Fees~~	$17,465	[illegible]	$[illegible]
(5)	Permits (Building, Utilities, Etc.)	~~(5) Permits (Building, Utilities, Etc.)~~	$12,305	[illegible]	$[illegible]
	SUBTOTAL		~~$1,870,062~~ $1,899,832	~~$6,243,201~~ $6,334,055	~~$8,113,263~~ $8,233,887
		~~c. Renovations~~			
c.	Renovations				
(1)	Building	~~(1) Building~~	~~$0~~	$5,685,213	$5,685,213
(2)	Fixed Equipment (not included in construction)	~~(2) Fixed Equipment (not included in construction)~~			$0
(3)	Architect/Engineering Fees	~~(3) Architect/Engineering Fees~~	~~$61,776~~	~~$[illegible]~~	~~$[illegible]~~
(4)	Permits (Building, Utilities, Etc.)	~~(4) Permits (Building, Utilities, Etc.)~~	~~$43,523~~	~~$[illegible]~~	~~$[illegible]~~

		SUBTOTAL	~~$105,2990~~	~~$5,825,64~~ ~~25,810,28~~ 7	~~$5,930,91~~ ~~45,810,28~~ 7
		~~d. Other Capital Costs~~			
d.	Other Capital Costs				
(1)	Movable Equipment	~~(1) Movable Equipment~~	$184,800	$2,010,638	$2,195,438
(2)	Contingency Allowance	~~(2) Contingency Allowance~~	$167,798	$587,159	$754,957
(3)	Gross interest during construction period	~~(3) Gross interest during construction period~~	$0	$0	$0
(4)	Legal Fees	~~(4) Legal Fees~~	$107,143	$142,857	$250,000
(5)	Property Due Diligence	~~(5) Property Due Diligence~~	$21,429	$28,571	$50,000
		SUBTOTAL	*$481,170*	*$2,769,225*	$3,250,395
		TOTAL CURRENT CAPITAL COSTS	~~*$5,713,674*~~ *5,638,145*	~~*$19,180,895*~~ *19,256,424*	$24,894,569
e.	Inflation Allowance	~~e. Inflation Allowance~~			$0
		TOTAL CAPITAL COSTS	~~$5,713,67~~ 45,638,145	~~$19,180,89~~ 519,256,424	$24,894,569
~~2~~ 2.	Financing Cost and Other Cash Requirements	~~Financing Cost and Other Cash Requirements~~			
a.	Loan Placement Fees	~~a. Loan Placement Fees~~			$0
b.	Bond Discount	~~b. Bond Discount~~			$0
c.	Legal Fees	~~c. Legal Fees~~			$0
d.	Non-Legal Consultant Fees	~~d. Non-Legal Consultant Fees~~			$0
e.	Liquidation of Existing Debt	~~e. Liquidation of Existing Debt~~			$0
f.	Debt Service Reserve Fund	~~f. Debt Service Reserve Fund~~			$0
g.	Transaction Costs	~~g. Transaction Costs~~	**$754,424**	**$2,210,204**	$2,964,628
h.	Acquisition Costs	~~h. Acquisition Costs~~	**$162,857**	**$217,143**	$380,000
i	Due Diligence Costs	~~i Due Diligence Costs~~	**$64,286**	**$85,714**	$150,000
		SUBTOTAL	*$981,567*	*$2,513,061*	$3,494,628
3.	~~3.~~Working Capital Startup Costs	~~Working Capital Startup Costs~~	$749,143	$1,693,995	$2,443,138
		TOTAL USES OF FUNDS	~~*$7,444,384*~~ *7,368,855*	~~*$23,387,951*~~ *23,463,480*	*$30,832,335*
B.	~~Sourc~~ ~~e~~Sources of Funds				
1.	~~1.~~Cash	~~Ca~~ ~~sh~~			$0
2.	~~2.~~Philanthropy (to date and expected)	~~Philanthropy (to date and expected)~~			$0
3.	~~3.~~Authorized Bonds	~~Authorized Bonds~~			$0
4.	~~4.~~Interest Income from bond proceeds listed in #3	~~Interest Income from bond proceeds listed in #3~~			$0

5.	5.Mortgage	Mortgage	$6,421,003	$20,172,806 620,237,952	$26,593,809
6.	6.Working Capital Loans	Working Capital Loans			$0
7.	Grants or Appropriations	Grants or Appropriations			
a.	Federal	a. Federal			$0
b.	State	b. State			$0
c.	Local	c. Local			$0
8.	8.Equity funding	Equity funding	$1,022,381,125	$3,215,453 225,528	$4,238,526
	TOTAL SOURCES OF FUNDS		*$7,444,384 7,368,855*	*$23,387,951 23,463,480*	$30,832,335
Annual Lease Costs (if applicable)					
1.	1.Land	Land			$0
2.	2.Building	Building			$0
3.	3.Major Movable Equipment	Major Movable Equipment			$0
4.	4.Minor Movable Equipment	Minor Movable Equipment			$0
5.	5.Other *(Specify/add rows if needed)*	Other *(Specify/add rows if needed)*			$0

Describe the terms of the lease(s) below, including information on the fair market value of the item(s), and the number of years, annual cost, and the interest rate for the lease.

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY -

INSTRUCTION : Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non- operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	**N/A**	**N/A**	**2015**	**2016**	**2017**	**2018**				
1. **REVENUE**										
a. Inpatient Services			$ -	$ 18,374,400	$ 98,690,250	$ 105,156,500				
b. Outpatient Services										
Gross Patient Service Revenues	***$ -***	***$ -***	***$ -***	***$ 18,374,400***	***$ 98,690,250***	***$ 105,156,500***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt			$ -	$ 509,696	$~~2,027,617~~ 1,989,754	$2,120,038				
d. Contractual Allowance			$ -	$ 13,277,440	$ ~~71,655,356~~72 ,160,199	$ 76,889,322				
e. Charity Care			$ -	$ 282,117	$ ~~1,537,948~~1,5 09,228	$ 1,608,049				
Net Patient Services Revenue	***$ -***	***$ -***	***$ -***	***$ 4,305,147***	***$ ~~23,469,329~~23 ,031,069***	***$ 24,539,091***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)										
NET OPERATING REVENUE	***$ -***	***$ -***	***$ -***	***$ 4,305,147***	***$ ~~23,469,329~~23 ,031,069***	***$ 24,539,091***	***$ -***	***$ -***	***$ -***	***$ -***
2. **EXPENSES**										
a. Salaries & Wages (including benefits)			$ -	$ 2,966,587	$8,109,670	$8,458,548				
b. Contractual Services			$ -	$ 254,509	$ 588,576	$ 627,044				
c. Interest on Current Debt			$ -	$ -	$ -	$ -				
d. Interest on Project Debt			$ -	$ -	$ -	$ -				
e. Current Depreciation			$ -	$ -	$ -	$ -				
f. Project Depreciation			$ -	$ -	$ -	$ -				
g. Current Amortization			$ -	$ -	$ -	$ -				
h. Project Amortization			$ -	$ -	$ -	$ -				
i. Supplies			$ -	$ 9,897	$ 32,319	$ 34,432				
j. Administrative/office expenses			$ -	$ 1,081,078	$ 3,519,962	$ 3,821,863				

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY -

k. Facilities expenses (repairs & maintenance, rent, real estate taxes, utilities			$ -	$ 1,088,423	$ 4,187,390	$ 4,202,601				
l. Food			$ -	$ 321,109	$ 1,659,063	$ 1,767,494				
m. Marketing expense			$ -	$ 178,141	$ 920,396	$ 980,551				
n. Liability insurance			$ -	$ 32,620	$ 132,712	$ 141,386				
o. Other Expenses: Licensing & legal expenses			$ -	$ 17,250	$ 89,125	$ 94,950				
TOTAL OPERATING EXPENSES	$ -	$ -	$ -	$ 5,949,614	$19,239,213	$ 20,128,869	$ -	$ -	$ -	$ -

INSTRUCTION : Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non- operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	N/A N/A	~~N/A~~	2015	2016	2017	2018	~~2017~~	~~2018~~		
3. **INCOME**										
a. **Income From Operation**	$ -	$ -	$ -	$ (1,644,467)	$ ~~4,230,116~~3,791,856	$ 4,410,222	$ -	$ -	$ -	$ -
b. Non-Operating Income										
SUBTOTAL	$ -	$ -	$ -	$ (1,644,467)	$ ~~4,230,116~~3,791,856	$ 4,410,222	$ -	$ -	$ -	$ -
c. Income Taxes										
NET INCOME (LOSS)	$ -	$ -	$ -	$ (1,644,467)	$ ~~4,230,116~~3,791,856	$ 4,410,222	$ -	$ -	$ -	$ -
4. **PATIENT MIX**										
a. **Percent of Total Revenue**										
1) Medicare			0.0%	0.0%	0.0%	0.0%				
2) Medicaid			0.0%	0.0%	0.0%	0.0%				
3) Blue Cross			0.0%	0.0%	0.0%	0.0%				
4) Commercial Insurance			0.0%	19.5%	19.5%	19.5%				
5) Self-pay			0.0%	80.5%	80.5%	80.5%				
6) Other			0.0%	0.0%	0.0%	0.0%				

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY -

b.	**Percent of Equivalent Inpatient Days**										
1)	Medicare			0.0%	0.0%	0.0%	0.0%				
2)	Medicaid			0.0%	0.0%	0.0%	0.0%				
3)	Blue Cross			0.0%	0.0%	0.0%	0.0%				
4)	Commercial Insurance			0.0%	25.00 %	25.00 %	25.00 %				
5)	Self-pay			0.0%	68.85 %	68.85 %	68.85 %				
6)	Other			0.0%	6.15%	6.15%	6.15%				
TOTAL		***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0 %***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - ~~EARLEVILLE~~Earleville -

INSTRUCTION : Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	**N/A**	**N/A**	**2015**	**2016**	**2017**	**2018**				
1. REVENUE										
a. Inpatient Services			$ -	$ 18,374,400	$ 103,624,762	$ 115,935,041				
b. Outpatient Services										
Gross Patient Service Revenues	***$ -***	***$ -***	***$ -***	***$ 18,374,400***	***$ 103,624,762***	***$ 115,935,041***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt			$ -	$ 509,696	$ ~~2,128,998~~2,089,241	$ 2,337,342				
d. Contractual Allowance			$ -	$ 13,277,440	$ ~~75,238,123~~ 75,768,209	$ 84,770,477				
e. Charity Care			$ -	$ 282,117	$ ~~1,614,845~~1,584,690	$ 1,772,874				
Net Patient Services Revenue	***$ -***	***$ -***	***$ -***	***$ 4,305,147***	***$ ~~24,642,796~~ 24,182,622***	***$ 27,054,348***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)			$ -	$ -	$ -	$ -				
NET OPERATING REVENUE	***$ -***	***$ -***	***$ -***	***$ 4,305,147***	***$ ~~24,642,796~~ 24,182,622***	***$ 27,054,348***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)			$ -	$ 2,966,587	$ 8,391,622	$ 9,177,524				
b. Contractual Services			$ -	$ 254,509	$ 609,478	$ 680,342				
c. Interest on Current Debt			$ -	$ -	$ -	$ -				
d. Interest on Project Debt			$ -	$ -	$ -	$ -				
e. Current Depreciation			$ -	$ -	$ -	$ -				
f. Project Depreciation			$ -	$ -	$ -	$ -				
g. Current Amortization			$ -	$ -	$ -	$ -				
h. Project Amortization			$ -	$ -	$ -	$ -				
i. Supplies			$ -	$ 9,897	$ 33,467	$ 37,358				
j. Administrative/office expenses			$ -	$ 1,081,078	$ 3,544,207	$ 3,863,670				

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - ~~EARLEVILLE~~Earleville -

k. Facilities expenses (repairs & maintenance, rent, real estate taxes, utilities			$ -	$ 1,088,423	$ 4,200,299	$ 4,235,521				
l. Food			$ -	$ 321,109	$ 1,717,979	$ 1,917,731				
m. Marketing expense			$ -	$ 178,141	$ 953,082	$ 1,063,898				
n. Liability insurance			$ -	$ 32,620	$ 137,425	$ 153,404				
o. Other Expenses: Licensing & legal expenses			$ -	$ 17,250	$ 92,290	$ 103,021				
TOTAL OPERATING EXPENSES	$ -	$ -	$ -	$ 5,949,614	$ 19,679,849	$ 21,232,469	$ -	$ -	$ -	$ -

INSTRUCTION : Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	**N/A**	**N/A**	**2015**	**2016**	**2017**	**2018**				
3. INCOME										
a. Income From Operation	$ -	$ -	$ -	$ (1,644,467)	$ ~~4,962,947~~4,502,773	$ 5,821,879	$ -	$ -	$ -	$ -
b. Non-Operating Income										
SUBTOTAL	$ -	$ -	$ -	$ (1,644,467)	$ ~~4,962,947~~4,502,773	$ 5,821,879	$ -	$ -	$ -	$ -
c. Income Taxes										
NET INCOME (LOSS)	$ -	$ -	$ -	$ (1,644,467)	$ ~~4,962,947~~4,502,773	$ 5,821,879	$ -	$ -	$ -	$ -
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare			0.0%	0.0%	0.0%	0.0%				
2) Medicaid			0.0%	0.0%	0.0%	0.0%				
3) Blue Cross			0.0%	0.0%	0.0%	0.0%				
4) Commercial Insurance			0.0%	19.5%	19.5%	19.5%				
5) Self-pay			0.0%	80.5%	80.5%	80.5%				
6) Other			0.0%	0.0%	0.0%	0.0%				

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - ~~EARLEVILLE~~Earleville -

TOTAL		***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b.	**Percent of Equivalent Inpatient Days**										
Total MSGA											
1)	Medicare			0.0%	0.0%	0.0%	0.0%				
2)	Medicaid			0.0%	0.0%	0.0%	0.0%				
3)	Blue Cross			0.0%	0.0%	0.0%	0.0%				
4)	Commercial Insurance			0.0%	25.00%	25.00%	25.00%				
5)	Self-pay			0.0%	68.85%	68.85%	68.85%				
6)	Other			0.0%	6.15%	6.15%	6.15%				
TOTAL		***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE - DETOX - ~~EARLEVILLE~~ Earleville- ~~Nov~~Dec. ~~30,~~21, ~~2015 Update~~

INSTRUCTION : After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

		Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year		**2015**	**2016**	**2017**	**2018**			
1.	**REVENUE - DETOX**							
a.	Inpatient Services	$ -	$ -	$ 24,927,000	$ 26,827,500			
b.	Outpatient Services							
Gross Patient Service Revenues		***$ -***	***$ -***	***$ 24,927,000***	***$ 26,827,500***	***$ -***	***$ -***	***$ -***
c.	Allowance For Bad Debt	$ -	$ -	~~$~~ ~~534,478~~49 6,615.00	$ 534,478			
d.	Contractual Allowance			~~$ 17,800,622~~ 18,305,465	$ 19,701,122			
e.	Charity Care	$ -	$ -	~~$~~ ~~405,402~~ 376,683	$ 405,402			
Net Patient Services Revenue		***$ -***	***$ -***	***$ ~~6,186,498~~5,748,237***	***$ 6,186,498***	***$ -***	***$ -***	***$ -***
f. (Specify)	Other Operating Revenues							
NET OPERATING REVENUE		***$ -***	***$ -***	***$ ~~6,186,498~~5,748,237***	***$ 6,186,498***	***$ -***	***$ -***	***$ -***
2.	**EXPENSES - DETOX**							
a.	Salaries & Wages (including benefits)	$ -	$ -	$ 1,561,644	$ 1,622,681			
b.	Contractual Services	$ -	$ -	$ 114,445	$ 121,925			
c.	Interest on Current Debt	$ -	$ -	$ -	$ -			
d.	Interest on Project Debt	$ -	$ -	$ -	$ -			
e.	Current Depreciation	$ -	$ -	$ -	$ -			
f.	Project Depreciation	$ -	$ -	$ -	$ -			
g.	Current Amortization	$ -	$ -	$ -	$ -			
h.	Project Amortization	$ -	$ -	$ -	$ -			
i.	Supplies	$ -	$ -	$ 6,284	$ 6,695			
j.	Administrative/office expenses	$ -	$ -	$ 684,437	$ 743,140			
k.	Facilities expenses (repairs & maintenance, rent, real estate taxes, utilities	$ -	$ -	$ 814,215	$ 817,172			
l.	Food	$ -	$ -	$ 322,596	$ 343,679			
m.	Marketing expense	$ -	$ -	$ 178,966	$ 190,663			
n.	Liability insurance	$ -	$ -	$ 25,805	$ 27,492			
o.	Other Expenses: Licensing & legal expenses	$ -	$ -	$ 17,330	$ 18,463			
TOTAL OPERATING EXPENSES		***$ -***	***$ -***	***$ 3,725,722***	***$ 3,891,910***	***$ -***	***$ -***	***$ -***
3.	**INCOME - DETOX**							
a.	**Income From Operation**	$ -	$ -	$ ~~2,460,776~~2,022,515	$ 2,294,588	$ -	$ -	$ -
b.	Non-Operating Income							
SUBTOTAL		***$ -***	***$ -***	***$ ~~2,460,776~~2,022,515***	***$ 2,294,588***	***$ -***	***$ -***	***$ -***
c.	Income Taxes							
NET INCOME (LOSS)		***$ -***	***$ -***	***$ ~~2,460,776~~2,022,515***	***$ 2,294,588***	***$ -***	***$ -***	***$ -***
4.	**PATIENT MIX - DETOX**							
a.	**Percent of Total Revenue**							

1)	Medicare	0.0%	0.0%	0.0%	0.0%			
2)	Medicaid	0.0%	0.0%	0.0%	0.0%			
3)	Blue Cross	0.0%	0.0%	0.0%	0.0%			
4)	Commercial Insurance	0.0%	~~19.5~~ 0.0%	19.5%	19.5%			
5)	Self-pay	0.0%	~~80.5~~ 0.0%	80.5%	80.5%			
6)	Other	0.0%	0.0%	0.0%	0.0%			
TOTAL		***0.0%***	***~~100.~~ ~~0~~0.0 %***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***
b.	**Percent of Equivalent Inpatient Days**							
Total MSGA								
1)	Medicare	0.0%	0.0%	0.0%	0.0%			
2)	Medicaid	0.0%	0.0%	0.0%	0.0%			
3)	Blue Cross	0.0%	0.0%	0.0%	0.0%			
4)	Commercial Insurance	0.0%	~~25.0~~ ~~0~~0.0 %	25.00%	25.00%			
5)	Self-pay	0.0%	~~68.8~~ ~~5~~0.0 %	68.85%	68.85%			
6)	Other	0.0%	~~6.15~~ 0.0%	6.15%	6.15%			
TOTAL		***0.0%***	***~~100.~~ ~~0~~0.0 %***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE - ~~DETOX - EARLEVILLE - Nov. 30,~~Earleville - Detox - Dec. 21, ~~2015 Update~~

INSTRUCTION : After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

		Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year		**2015**	**2016**	**2017**	**2018**			
1.	**REVENUE**							
a.	Inpatient Services	$ -	$ -	$ 26,173,350	$ 29,577,319			
b.	Outpatient Services							
Gross Patient Service Revenues		***$ -***	***$ -***	***$ 26,173,350***	***$ 29,577,319***	***$ -***	***$ -***	***$ -***
c.	Allowance For Bad Debt	$ -	$ -	$ ~~561,202~~ 521,446	$ 589,262			
d.	Contractual Allowance			$ ~~18,690,653~~1 9,220,738	$ 21,720,487			
e.	Charity Care	$ -	$ -	$ ~~425,672~~ 395,517	$ 446,956			
Net Patient Services Revenue		***$ -***	***$ -***	***$ ~~6,495,823~~6,0 35,649***	***$ 6,820,614***	***$ -***	***$ -***	***$ -***
f.	Other Operating Revenues (Specify/add rows of needed)							
NET OPERATING REVENUE		***$ -***	***$ -***	***$ ~~6,495,823~~6,0 35,649***	***$ 6,820,614***	***$ -***	***$ -***	***$ -***
2.	**EXPENSES**							
a.	Salaries & Wages (including benefits)	$ -	$ -	$ 1,615,732	$ 1,760,607			
b.	Contractual Services	$ -	$ -	$ 118,510	$ 132,289			
c.	Interest on Current Debt	$ -	$ -	$ -	$ -			
d.	Interest on Project Debt	$ -	$ -	$ -	$ -			
e.	Current Depreciation	$ -	$ -	$ -	$ -			
f.	Project Depreciation	$ -	$ -	$ -	$ -			
g.	Current Amortization	$ -	$ -	$ -	$ -			
h.	Project Amortization	$ -	$ -	$ -	$ -			
i.	Supplies	$ -	$ -	$ 6,507	$ 7,264			
j.	Administrative/office expenses	$ -	$ -	$ 689,151	$ 751,269			

k.	Facilities expenses (repairs & maintenance, rent, real estate taxes, utilities	$ -	$ -	$ 816,725	$ 823,574			
l.	Food	$ -	$ -	$ 334,051	$ 372,892			
m.	Marketing expense	$ -	$ -	$ 185,322	$ 206,869			
n.	Liability insurance	$ -	$ -	$ 26,722	$ 29,829			
o.	Other Expenses: Licensing & legal expenses	$ -	$ -	$ 17,945	$ 20,032			
TOTAL OPERATING EXPENSES		**$ -**	**$ -**	**$ 3,810,665**	**$ 4,104,625**	**$ -**	**$ -**	**$ -**
3.	**INCOME**							
a.	**Income From Operation**	**$ -**	**$ -**	**$ ~~2,685,158~~2,224,984**	**$ 2,715,989**	**$ -**	**$ -**	**$ -**
b.	Non-Operating Income							
SUBTOTAL		***$ -***	***$ -***	***$ ~~2,685,158~~2,224,984***	***$ 2,715,989***	***$ -***	***$ -***	***$ -***
c.	Income Taxes							
NET INCOME (LOSS)		***$ -***	***$ -***	***$ ~~2,685,158~~2,224,984***	***$ 2,715,989***	***$ -***	***$ -***	***$ -***
4.	**PATIENT MIX**							
a.	**Percent of Total Revenue**							
1)	Medicare	0.0%	0.0%	0.0%	0.0%			
2)	Medicaid	0.0%	0.0%	0.0%	0.0%			
3)	Blue Cross	0.0%	0.0%	0.0%	0.0%			
4)	Commercial Insurance	0.0%	~~19.5~~ 0.0%	19.5%	19.5%			
5)	Self-pay	0.0%	~~80.5~~ 0.0%	80.5%	80.5%			
6)	Other	0.0%	0.0%	0.0%	0.0%			
TOTAL		***0.0%***	***~~100.0~~ 0.0 %***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***
b.	**Percent of Equivalent Inpatient Days**							
1)	Medicare	0.0%	0.0%	0.0%	0.0%			
2)	Medicaid	0.0%	0.0%	0.0%	0.0%			
3)	Blue Cross	0.0%	0.0%	0.0%	0.0%			
4)	Commercial Insurance	0.0%	~~25.00~~ 0.0 %	25.00%	25.00%			
5)	Self-pay	0.0%	~~68.85~~ 0.0 %	68.85%	68.85%			
6)	Other	0.0%	~~6.15~~ 0.0%	6.15%	6.15%			
TOTAL		***0.0%***	***~~100.0~~ 0.0 %***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***

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Description	Exh35 Corrected4
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Legend:	
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Moved to	0
Style change	0
Format changed	0
Total changes	859