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October 17, 2016

VIA EMAIL AND/OR OVERNIGHT DELIVERY

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

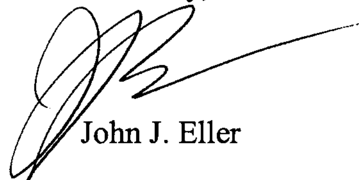
Re: Comments of Ashley, Inc., D/B/A Ashley Addiction Treatment (F/K/A Father Martin's Ashley) on the Modification in Response to September 20, 2016 Project Status Conference
Matter No.: 15-07-2363

Dear Mr. McDonald:

On behalf of Ashley, Inc. d/b/a Ashley Addiction Treatment (F/K/A Father Martin's Ashley, Inc.), I am submitting comments in the above-referenced matter, for review and consideration by the Maryland Health Care Commission. Six copies are attached for your convenience. We will also provide electronic and Word copies as appropriate.

Please let us know if any additional information is needed.

Sincerely,



John J. Eller

JJE/tjr
Enclosures
cc: Stephanie Garrity, M.S.,
Cecil County Health Officer
Suellen Wideman, Esquire
Maryland Health Care Commission
Ms. Ruby Potter
Maryland Health Care Commission
Steven M. Kendrick, MBA, Sr. VP and COO
Father Martin's Ashley

3141165

cc: Tom Dame, Esquire
Gallagher Evelius & Jones LLP
Richard J. Coughlan, Director
DHG Healthcare

IN THE MATTER OF	*	BEFORE THE
RECOVERY CENTERS OF AMERICA –EARLEVILLE	*	MARYLAND HEALTH
	*	CARE COMMISSION
	*	Matter No. 15-07-2363

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COMMENTS OF ASHLEY, INC., D/B/A ASHLEY ADDICTION TREATMENT (F/K/A FATHER MARTIN'S ASHLEY) ON THE MODIFICATION IN RESPONSE TO SEPTEMBER 20, 2016 PROJECT STATUS CONFERENCE

Introduction

On behalf of Ashley, Inc., d/b/a Ashley Addiction Treatment (f/k/a Father Martin's Ashley) ("Ashley"), we are filing these comments ("Comments") in response to the October 7, 2016, filing of project modifications (the "Modifications") by Recovery Centers of America – Earleville ("RCA-E") (Exhibit 1, TABLEs F., G., H., J., K.,) in the above-captioned matter.

At the outset, we reiterate the position Ashley has stated in prior filings in this matter: Ashley is not opposed to the entry of new providers of substance abuse treatment services in Maryland. Rather, Ashley seeks to assure that there is a level playing field, and that any such new providers may only receive CON approval to institute new services if they meet all requirements of the State Health Plan chapter on Alcoholism & Drug Abuse Intermediate Care Facility Treatment Services – COMAR 10.24.14 (the "SHP"), as Ashley was required to do when it received CON approval to expand its facility on September 19, 2013 (Docket No. 13-12-2340, the "Ashley CON Approval") The Modifications submitted by RCA-E do not remedy the deficiencies previously identified and explained by Ashley in earlier filings. Ashley continues to stand by those earlier filings which demonstrate that RCA-E has not yet met all SHP requirements to obtain CON approval. In these Comments, Ashley will provide further

explanation regarding RCA-E's non-compliance with the SHP requirements regarding care to indigent and gray area patients (also sometimes referred to herein for convenience as "charity care") at § .05D(1)(c) (the "Standard") which states that an applicant must "Commit that it will provide 15% or more of its proposed annual adult intermediate care facility bed days to indigent or gray area patients."

A. Under the SHP, the entire RCA-E facility is considered to be an intermediate care facility, not just the portion in which detoxification services are provided.

RCA-E's non-compliance with the 15% Standard is based upon a misinterpretation of what constitutes an intermediate care facility ("ICF") under the Chapter. The SHP contains a number of definitions pertinent to a full understanding of an appropriate interpretation of the charity care Standard. First, the Commission has defined the term "intermediate care facility" for CON approval purposes as follows:

> Intermediate care facility means a facility designed to facilitate the sub-acute detoxification AND REHABILITATION of alcohol and drug abusers by placing them in an organized therapeutic environment in which they receive medical services, diagnostic services, individual and group therapy and counseling, vocational rehabilitation, and work therapy while benefiting from the support that a residential setting can provide. Emphasis added. SHP, Pages 32-33.

Key terms of the ICF definition are further defined as follows:

> Detoxification means the systematic medically-supervised reduction of the effects of alcohol or drugs and the effects of alcohol or drug withdrawal in the body, which commonly occurs in one of four settings: acute general hospitals (acute detoxification only); alcoholism rehabilitation units and intermediate care facilities (sub-acute detoxification only); non-hospital detoxification (sub-acute only); or non-health care settings (self-induced withdrawal). SHP, Pages 31-32.
>
> * * *
>
> Sub-acute detoxification means short-term treatment for the intoxicated or overdosed individual who may be appropriately treated outside an acute care hospital. SHP, Page 34.

Under these definitions, an ICF is a facility that not only provides sub-acute detoxification, but ALSO provides rehabilitation, all within "a residential setting." The SHP does not state that the beds in an ICF are limited to providing detoxification services, but rather that an ICF is a facility that provides BOTH sub-acute detoxification AND rehabilitation in the same residential setting. The SHP makes no distinction between types of beds and levels of care in ICF facilities; it is anticipated that an ICF providing substance abuse treatment services will provide the full course of treatment needed for patients, which encompasses both the detoxification phase of treatment, and the post-detoxification rehabilitation services, all in the same residential facility. The Standard requires that an applicant provide at least 15% "of its proposed annual adult intermediate care facility bed days" for charity care cases. Given that the SHP defines intermediate care facility to include both sub-acute detoxification as well as the post-detoxification rehabilitation of patients, rather than defining an ICF solely in terms of detoxification as RCA-E has done, it is evident that the SHP requires that the Standard be applied to the entire 30 day ALOS of RCA-E patients irrespective of the bed designation within the facility, or whether CON review is required for some or all of the beds providing the full range of ICF detoxification and rehabilitation services.

B. The fundamental basis for RCA-E's non-compliance is a misinterpretation of the requirements of the SHP, and viewing the charity care requirements in the Standard as being applicable only to patient days associated with detoxification occurring in that portion of its ICF containing beds for which CON approval is required, rather than being applicable to patient days encompassing the entirety of the average length of stay ("ALOS") representing the full period in which both detoxification and rehabilitation substance abuse treatment services are provided in an ICF setting.

RCA-E has recognized that once patients have completed detoxification, they should not and will not be discharged to other settings outside of the RCA-E facilities. But an artificial distinction is made between the detoxification portion of the ALOS, and the subsequent

rehabilitation portion of the ALOS (which RCA-E labels as "residential"). That distinction is not supported by the context and definitions provided in the SHP. RCA-E's projections are shown separately for patients in the detoxification phase of recovery, and the post-detoxification phase in the same facility. The ALOS for detoxification is projected to be 14 days, and for subsequent rehabilitation is 16 days, for a total of 30 days of ALOS. The two sets of projections are made for the very same patients, in the very same RCA-E facility, showing an ALOS of 30 days for the entire continuous course of treatment to be provided to those patients. RCA-E calculates its charity care requirement only in terms of the detoxification portion of the ALOS, notwithstanding its commitment to provide charity care for the remainder of any patient stay. This has the effect of inflating the charity care contribution with respect to the 14 day ALOS, so as to appear to meet the SHP standard, but actually falls far short of the 15% requirement when viewed in terms of the total 30 day ALOS for a patient. The charity care commitment appears to meet the SHP standard, but only when calculated with respect to the detoxification patient days only, which represent less than half of the average length of stay for each patient. When the charity care commitment is viewed in terms of the total ALOS for any patient, it is seriously deficient with respect to the SHP 15% Standard. That Standard should apply to the RCA-E facility as a whole which, as defined in the SHP, is an ICF that provides both "sub-acute detoxification and rehabilitation" services.

C. There is apparently some RCA-E confusion in how to determine compliance with the SHP charity care Standard because of an apparent inconsistency in SHP requirements and the request for project modifications in the September 20, 2016 summary of the project status conference (the "PSC Summary").

The PSC Summary states that:

> Each applicant must make a charity care commitment equivalent to 15% of the net revenue associated with total detox patient days (i.e., for the Level 3.7-D patient beds for which CON approval is sought). While the 2015 modified

> applications' proposed charity care figures for RCA-Earleville and RCA-Waldorf appear to meet the standard, the amount of funds proposed by RCA-Upper Marlboro for charity care to such patients does not appear to be equivalent to the 15% of the net revenue for its detox bed days. As I noted, the applicants should determine whether new cost estimates and tables necessitate the need for changes from the 2015 modified applications.

First, the PSC Summary indicates that the 2015 modified applications' proposed charity care figures for the RCA-Earleville and RCA-Waldorf projects "appear" to meet the Standard, but quite appropriately does not indicate that the Reviewer has reached a final conclusion in this regard, leaving it to RCA-E to prove its claim of compliance. These Comments will demonstrate why the proposed RCA-E project still does not meet the 15% Standard.

Further, there is some confusion as to why charity care commitments are being discussed in terms of 15% of the net revenue associated with total detoxification patient days, rather than in terms of intermediate care facility bed days as defined and specified in the SHP. The SHP Standard provides no requirement that an applicant must make a charity care commitment equivalent to 15% of the net revenue associated with patient days provided for Level 3.7-D patient beds. In fact, the SHP makes no distinction between which levels of care provided in an ICF, or the number of beds that an applicant may designate in its proposed ICF for a particular level of care that would be subject to CON review. More importantly, the SHP requires that all patient bed days located in an ICF such as the proposed RCA-Earleville facility are subject to the 15% Standard. No exceptions are provided in the Standard related to particular levels of care, or that that the Standard is met by an equivalent net revenue commitment. We would request that the Reviewer specifically request that RCA-E state the number of projected patient days it intends to provide to indigent and charity care patients to meet the 15% Standard.

D. RCA-E has not provided a complete response to the either the Reviewer's request, or the SHP standard.

The Modifications (Exhibit 1) submitted into the record do not indicate the number of proposed annual adult ICF bed days the proposed RCA-E facility will provide to charity care patients. As shown on TABLE F., the applicant has projected that it will provide 34,292 bed days of care in its proposed ICF in Calendar Year 2018. To demonstrate consistency with the SHP 15% Standard at that level of total projected patient days, RCA-E is required to commit to providing 5,144 of those bed days to indigent and gray area patients. This number of projected bed days does not appear in the Modifications[1]. Thus, there is no way to determine if the 15% charity care requirement is met consistent with the updated projections requested by the Reviewer. The proposed explanation of how RCA-E has determined that it will provide charity care equivalent to 15% of its net revenue does not appear to include revenue associated with providing 5,144 bed days in the proposed ICF.

RCA-E states:

> As demonstrated in Exhibit 39, Tables F through K, Applicant has complied with this recommendation. Applicant is committed to providing charity care in an amount equal to 15% of the net revenue associated with its detox bed days. As reflected in Exhibit 39, Tables G, H, J, and K, charity care for each calendar year is equal to 15% of (Gross Detox Revenue less [Detox Allowance for Bad Debt and Detox Contractual Allowance]). The resulting dollar amount of charity care is distributed across detox and residential services such that patients receiving care under RCA's charity care policy would receive both detox and residential treatment at the facility.

TABLES F through K demonstrate that the projected revenue of the proposed RCA-E intermediate care facility will be sufficient to finance the requisite level of 5,144 bed days to meet the 15% charity care Standard for charity care patients in the SHP. As pointed out in our

[1] In a prior submission of modifications submitted on December 21, 2015, RCA-E estimated that it would provide approximately 1,755 patient days for the care of indigent and charity care patients in 2017, and meet a 6.15% standard. (See Exhibit 2, p. 42). An updated estimate of charity care patient days has not yet been provided to be consistent with the projections of revenues and expenses shown on Exhibit 1. We have estimated that to meet its self-selected charity care commitment of 6.15% charity care days, rather than the required 15%, it would need to provide 2,110 charity care days in 2018.

previous comments, RCA-E projected generating operating income of over $3 Million while providing 15% of its patient days to indigent and gray area patients. See Exhibit 7--- Comments of Father Martins Ashley on the Modified CON Application of Recovery Centers of America--Earleville, February 3, 2016, p. 4.

E. RCA-E has still not shown why it should be granted an exception to the 15% standard. The expanded coverage achieved since the implementation of the Affordable Care Act has not reached the level expected to reduce the need for charity care at RCA-E.

Under the SHP, all of the patient days projected to be provided in the entire RCA-E facility are considered to be subject to the 15% standard. RCA-E has asserted that only 6.15% of the projected patient days are necessary to meet the standard, because the number of uninsured Marylanders is expected to decrease by 59% as a result of expansion of Medicaid coverage and private insurance under the Affordable Care Act. For this reason, RCA-E projected that it would provide approximately 1,755 patient days in 2017, and committed $1,509,228 in charity care. (See Exhibit 2, pp. 41-43), well below what the Standard requires.

The source of the 59% reduction cited by RCA-E estimate is a "Fact Sheet" published by The Henry J. Kaiser Family Foundation, "How Will the Uninsured in Maryland Fare Under the Affordable Care Act?," January, 2014. (See Exhibit 3). Kaiser anticipated that the Affordable Care Act had the potential to extend coverage to 756,000 Marylanders. Most of this additional coverage would be provided through either Medicaid or the Marketplaces. Despite the expansion of health coverage, the number of uninsured Marylanders has decreased since 2013, but not by 59%.

A review of the statistics published by the United States Census Bureau show that the number of Marylanders without health insurance has declined since 2013 from 593,000 to 389,000 in 2015, a reduction of 204,000 Marylanders. (See Exhibit 4) This is far less than the

59% reduction in uninsured Marylanders anticipated by Kaiser in 2014, and adopted by RCA-E as a reasonable basis for reducing the amount of charity care it should provide to the indigent and gray area population from 15% to 6.15% in 2018. (See Exhibit 2, p. 41). Despite the reduction in the number of uninsured Marylanders between 2013 and 2015, there remain hundreds of thousands who still lack health coverage after the implementation of the ACA, many of whom are indigent adults who could benefit from the services to be provided by the proposed RCA-E facility, but lack the insurance coverage or private means to pay for these services. It would be pure speculation to assume that by 2018, the reduction in uninsured Marylanders will reach the Kaiser target, and that indigent and gray area Marylanders will be able to obtain the services proposed by RCA-E at other ICF facilities. So far, the trend between 2013 and 2015, while positive, has not been sufficient to warrant the requested exception to the Standard.

To its credit, RCA-E has recognized that once the indigent and gray area patients admitted for care have completed detoxification, they should not and will not be discharged to other settings outside of the RCA-E facilities. Nevertheless, the Standard requires that an applicant provide at least 15% "of its proposed annual adult intermediate care facility bed days" for charity care cases. Until such time that it is known that indigent and gray area Marylanders have the health coverage necessary to obtain the services RCA-E intends to provide at the level RCA-E anticipates, the 59% hoped-for reduction in the number of uninsured Marylanders should not be accepted as a reason to reduce RCA-E's commitment below 15% of its projected 34,292 total patient days, or the 5,143 charity care days for the indigent and gray area patients that the State Health Plan requires.

RCA-E has projected annual net income of over $6 Million in CY 2018 (Inflated) (See Exhibit 1., TABLE H). It remains incumbent upon RCA-E to show why some portion of this

projected income is insufficient to provide the projected charity care patient days consistent with the State Health Plan standard of 15%, and still generate an operating income to demonstrate financial feasibility. RCA-E has budgeted far too little in charity care to meet the needs of indigent and charity care patients who need its services, and can afford to allocate more charity care days and still produce sufficient income to be financially viable.

F. Comparative Analysis of RCA-E and Ashley

In contrast to RCA-E, the Ashley CON Approval and its requirements for providing charity care were calculated based on its ability to finance both charity care days to indigent and gray area populations, as well as non-indigent patients, and provide sufficient operating income for a "break-even" operation. Further, Ashley's CON approval and requirements for providing charity care were calculated based on its total ALOS covering both sub-acute detoxification and rehabilitation in the same facility, as clearly required by the SHP, rather than the minority of patient days attributable to detoxification, which at Ashley is 4.24 days rather than the 14 projected at RCA-E. (See Exhibit 8---Comments of Father Martin's Ashley on the Modified CON Application of Recovery Center of America (Earleville, Maryland), November 16, 2015, p. 12). As shown on Exhibit 5, which contains excerpts from the Ashley CON Approval, Ashley projected providing 34,660 patient days of care, very close to the 34,292 patient days projected by RCA-E. Of those total patient days, 2,190 charity care days were projected for indigent and gray area patients, and 1,825 charity care days were projected for non-indigent patients, for a total of 4,015 charity care patient days, or 11.6% of total patient days. In equivalent dollars, Ashley projected providing $3,584,821 of charity care, of which $1,955,357 was for charity care days for indigent and gray area patients, and $1,629,464 was for charity care days for non-indigent patients.

In contrast, RCA-E has proposed providing $1,035,664 in charity care dollars (See Exhibit 1, TABLE H., p. 12) for indigent and gray area patients in CY 2018, a decrease from the $1,509,228 amount proposed for 2017, for the approximate 1,755 patient days. (See Exhibit 2, p. 42). To make the updated 2018 proposed charity care commitment equivalent to the previously submitted 2017 projection, we have estimated that RCA-E would need to provide approximately 2,110 charity care patient days to in 2018 in order to meet its proposed target of 6.15% of its 34,292 total projected patient days to indigent and gray area patients. This is 80 fewer charity care patient days projected and CON-approved for Ashley, and does not include any charity care patient days to be provided to non-indigent patients. At this level of commitment, which represents less than half of the required 15% level, RCA-E has projected generating over $6M in operating income. (See Exhibit 6). And it is extremely important to reiterate, as noted earlier in these Comments, that even at the 15% level, RCA-E would still have projected operating income of over $3M.

Summary and Conclusion

The proposed RCA-E ICF and the Ashley ICF are comparable in terms of the nature and scope of substance abuse treatment services, and will likely serve essentially the same populations: adults with serious addictions who require multiple levels of inpatient care. As such, there should be a level playing field in evaluating the RCA-E project, so that it receives the same scrutiny, and is held to the same standards, as Ashley. Under the SHP, like Ashley, RCA-E in its entirety is an intermediate care facility, and as such, all of its bed days must be taken into account in determining whether it meets the 15% charity care commitment required by the SHP. Yet RCA-E seeks to characterize itself as a bifurcated facility such that only a portion of its facility is subject to the charity care standard, or viewed as comparable to Ashley. To accept

RCA-E's position would be inconsistent with the SHP requirements, a disservice to the community by failing to assure optimal access to needed services by gray area and indigent patients, and unfair to Ashley that has made a genuine and substantial ongoing commitment to increasing its charity care days as required by the SHP and incorporated by the Commission in its Ashley CON Approval in 2013.

When one considers the similarities of RCA-E and Ashley, the contrasts between their charity care commitments to their patients are striking. RCA-E proposes to have a total of 108 ICF beds, with 34,292 projected bed days in CY 2018, and an ALOS of 30 days for the full course of treatment. Ashley has 100 ICF beds, and projected 34,660 bed days for those beds, with an ALOS of 28 days. Notwithstanding this comparability, RCA-E has projected only 1,755 charity care days, actual charity care costs of only $1,509,228, and profitability in excess of $6M annually. Its projections are based on a commitment of 6.1%, representing a 59% reduction from the SHP requirement of 15%, based on pure speculation of what might occur in the future with respect to improved health insurance coverage, rather than demonstrated trends in access to substance abuse treatment services, which do not support such a reduction. If RCA-E were to provide charity care at the 15% level, it has acknowledged that it could do so, and still have profits in excess of $3M annually.

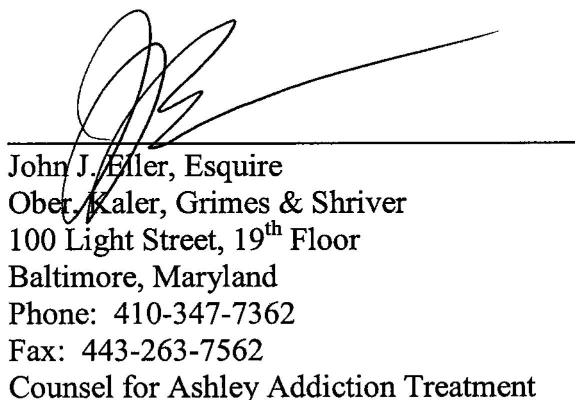
By contrast, Ashley projected 4,015 charity care days, and charity care costs of $3,584,821, representing a commitment at a 6.3% level which results in operating income at essentially a break-even level.

In short, notwithstanding the obvious comparability of the facilities, RCA-E seeks to be viewed under an artificial distinction among its beds and levels of care that is not supported by a plain reading of the SHP, with the result that RCA-E would be required to provide far less

charity care to Maryland residents than what the SHP requires, and far less than half of Ashley's commitment, while still realizing enormous profits.

If the Commission believes there is some valid basis for allowing RCA-E to meet the charity care Standard at some level lower than 15% of total bed days, that basis must be well-substantiated by RCA-E. But that basis has not yet been demonstrated. And since the Commission acts in the public interest, consistent with SHP definitions and requirements in which increasing treatment access by indigent and gray area Marylanders is a specific public policy objective incorporated in State law and regulations, it should not accept the misguided interpretation of the SHP suggested by RCA-E if the Commission is to assure effective and equitable patient access to the needed treatment services RCA-E proposes to provide the public.

Respectfully submitted,



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Fax: 443-263-7562
Counsel for Ashley Addiction Treatment

CERTIFICATE OF SERVICE

I HEREBY CERTIFY THAT, on this 17th of October, 2016, a copy of the foregoing Comments of Ashley, Inc., d/b/a Ashley Addiction Treatment (f/k/a Father Martin's Ashley) On The Modification In Response To September 20, 2016 Project Status Conference submitted by Recovery Centers Of America - Earleville was sent via e-mail and overnight delivery to:

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Counsel for Ashley Addiction Treatment

EXHIBITS

1. Excerpts from Modifications filed by RCA-E on October 7, 2016
2. Excerpts from Corrected Modified Certificate of Need Application, December 21, 2015
3. Article: How Will the Uninsured in Maryland Fare Under the Affordable Care Act? Published January, 2014 by the Henry J. Kaiser Family Foundation
4. Census Bureau Statistics: Population Without Health Insurance Coverage by State: 2013 to 2015
5. Excerpts from Ashley CON Approval, September 19, 2013
6. Comparison Between Projections of RCA-E and the CON-Approved Projections of Ashley
7. Excerpts from Comments of Father Martin's Ashley on the Modified CON Application of Recovery Center of America-Earleville, February 3, 2016
8. Excerpts from Comments of Father Martin's Ashley on the Modified CON Application of Recovery Center of America (Earleville, Maryland), November 16, 2015
9. Affirmations

EXHIBIT 1

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY - as of October 7, 2016

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. 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) Include additional years, if needed in order to be consistent with Tables G and H.						
Calendar Year	N/A	N/A	2015	2016	2017	2018				
1. DISCHARGES										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	0	0	0	0	0	0	0	0	0	0
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute	0	0	0	0	0	0	0	0	0	0
f. Rehabilitation										
g. Comprehensive Care										
h. Residential(1)	N/A	N/A	N/A	396	1,590	1,688				
i. Detox	N/A	N/A	N/A	0	509	520				
TOTAL DISCHARGES	0	0	0	396	1,590	1,688	0	0	0	0
2. PATIENT DAYS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	0	0	0	0	0	0	0	0	0	0
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute	0	0	0	0	0	0	0	0	0	0
f. Rehabilitation										
g. Comprehensive Care										
h. Residential(1)	N/A	N/A	N/A	6,336	25,436	27,010				
i. Detox	N/A	N/A	N/A	0	7,122	7,282				
TOTAL PATIENT DAYS	0	0	0	6,336	32,558	34,292	0	0	0	0

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY - as of October 7, 2016

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. 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) Include additional years, if needed in order to be consistent with Tables G and H.						
Calendar Year	N/A	N/A	2015	2016	2017	2018				
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Residential	N/A	N/A	N/A	16.0	16.0	16.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
i. Detox	N/A	N/A	N/A	N/A	14.0	14.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	#DIV/0!	#DIV/0!	#DIV/0!	16.0	30.0	30.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	0	0	0	0	0	0	0	0	0	0
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute	0	0	0	0	0	0	0	0	0	0
f. Rehabilitation										
g. Comprehensive Care										
h. Residential	N/A	N/A	N/A	39	87	87				
i. Detox	N/A	N/A	N/A	0	21	21				
TOTAL LICENSED BEDS	0	0	0	39	108	108	0	0	0	0

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY - as of October 7, 2016

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. 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) Include additional years, if needed in order to be consistent with Tables G and H.						
Calendar Year	N/A	N/A	2015	2016	2017	2018				
5. OCCUPANCY PERCENTAGE *IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Residential(1)	N/A	N/A	N/A	66.3%	80.1%	85.1%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
i. Detox	N/A	N/A	N/A	N/A	92.9%	95.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	#DIV/0!	#DIV/0!	#DIV/0!	66.3%	82.6%	87.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
6. OUTPATIENT VISITS										
a. Emergency Department										
b. Same-day Surgery										
c. Laboratory										
d. Imaging										
h. Residential	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
i. Detox	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
TOTAL OUTPATIENT VISITS	0	0	0	0	0	0	0	0	0	0
7. OBSERVATIONS**										
a. Number of Patients	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
b. Hours	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

* Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a medical practitioner; may or may not be provided in a distinct area of the hospital.

Note (1): The additional patients admitted for residential not supported by the detox beds will be admitted after detox at a facility outside of Maryland or at detox only facility, or will be admitted for residential only care.

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - as of October 7, 2016

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	$ 103,816,000				
b. Outpatient Services										
Gross Patient Service Revenues	$ -	$ -	$ -	$ 18,374,400	$ 98,690,250	$ 103,816,000	$ -	$ -	$ -	$ -
c. Allowance For Bad Debt			$ -	$ 509,696	$1,989,754	$2,093,332				
d. Contractual Allowance			$ -	$ 13,277,440	$ 72,160,199	$ 75,904,908				
e. Charity Care			$ -	$ -	$ 918,738	$ 939,378				
Net Patient Services Revenue	$ -	$ -	$ -	$ 4,587,264	$ 23,621,559	$ 24,878,382	$ -	$ -	$ -	$ -
f. Other Operating Revenues (Specify/add rows if needed)										
NET OPERATING REVENUE	$ -	$ -	$ -	$ 4,587,264	$ 23,621,559	$ 24,878,382	$ -	$ -	$ -	$ -
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				
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	$ -	$ -	$ -	$ -

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - as of October 7, 2016

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				
3. INCOME										
a. Income From Operation	$ -	$ -	$ -	$ (1,362,350)	$ 4,382,346	$ 4,749,513	$ -	$ -	$ -	$ -
b. Non-Operating Income										
SUBTOTAL	$ -	$ -	$ -	$ (1,362,350)	$ 4,382,346	$ 4,749,513	$ -	$ -	$ -	$ -
c. Income Taxes										
NET INCOME (LOSS)	$ -	$ -	$ -	$ (1,362,350)	$ 4,382,346	$ 4,749,513	$ -	$ -	$ -	$ -
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%				
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										
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 - as of October 7, 2016

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	$ 114,457,140				
b. Outpatient Services										
Gross Patient Service Revenues	$ -	$ -	$ -	$ 18,374,400	$ 103,624,762	$ 114,457,140	$ -	$ -	$ -	$ -
c. Allowance For Bad Debt			$ -	$ 509,696	$ 2,089,241	$ 2,307,898				
d. Contractual Allowance			$ -	$ 13,277,440	$ 75,768,209	$ 83,685,161				
e. Charity Care			$ -	$ -	$ 964,675	$ 1,035,664				
Net Patient Services Revenue	$ -	$ -	$ -	$ 4,587,264	$ 24,802,637	$ 27,428,417	$ -	$ -	$ -	$ -
f. Other Operating Revenues (Specify/add rows if needed)			$ -	$ -	$ -	$ -				
NET OPERATING REVENUE	$ -	$ -	$ -	$ 4,587,264	$ 24,802,637	$ 27,428,417	$ -	$ -	$ -	$ -
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				
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	$ -	$ -	$ -	$ -
3. INCOME										
a. Income From Operation	$ -	$ -	$ -	$ (1,362,350)	$ 5,122,788	$ 6,195,948	$ -	$ -	$ -	$ -
b. Non-Operating Income										

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - as of October 7, 2016

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				
SUBTOTAL	$ -	$ -	$ -	$ (1,362,350)	$ 5,122,788	$ 6,195,948	$ -	$ -	$ -	$ -
c. Income Taxes										
NET INCOME (LOSS)	$ -	$ -	$ -	$ (1,362,350)	$ 5,122,788	$ 6,195,948	$ -	$ -	$ -	$ -
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%				
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 I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE - as of October 7, 2016

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. 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) Include additional years, if needed in order to be consistent with Tables G and H.						
Calendar Year	N/A	N/A	2015	2016	2017	2018				
1. DISCHARGES										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	0	0	0	0	0	0	0	0	0	0
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute	0	0	0	0	0	0	0	0	0	0
f. Rehabilitation										
g. Comprehensive Care										
h. Residential										
i. Detox	N/A	N/A	N/A	N/A	509	520				
TOTAL DISCHARGES	0	0	0	N/A	509	520	0	0	0	0
2. PATIENT DAYS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	0	0	0	0	0	0	0	0	0	0
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute	0	0	0	0	0	0	0	0	0	0
f. Rehabilitation										
g. Comprehensive Care										
h. Residential										
i. Detox	N/A	N/A	N/A	N/A	7,122	7,282				
TOTAL PATIENT DAYS	0	0	0	0	7,122	7,282	0	0	0	0
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE - as of October 7, 2016

INSTRUCTION : Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. 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) Include additional years, if needed in order to be consistent with Tables G and H.						
Calendar Year	N/A	N/A	2015	2016	2017	2018				
Total Acute	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Residential	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
i. Detox	N/A	N/A	N/A	N/A	14.0	14.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	0	0	0	0	0	0	0	0	0	0
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
f. Rehabilitation										
g. Comprehensive Care										
h. Residential										
i. Detox	N/A	N/A	N/A	N/A	21	21				
TOTAL LICENSED BEDS	*0*	*0*	*0*	*0*	*21*	*21*	*0*	*0*	*0*	*0*

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE - as of October 7, 2016

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. 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) Include additional years, if needed in order to be consistent with Tables G and H.						
Calendar Year	N/A	N/A	2015	2016	2017	2018				
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** *Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Residential	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
i. Detox	N/A	N/A	N/A	N/A	92.9%	95.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	92.9%	95.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
6. OUTPATIENT VISITS										
a. Emergency Department										
b. Same-day Surgery										
c. Laboratory										
d. Imaging										
h. Residential	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
i. Detox	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
TOTAL OUTPATIENT VISITS	0	0	0	0	0	0	0	0	0	0
7. OBSERVATIONS**										
a. Number of Patients	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
b. Hours	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

* Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a medical practitioner; may or may not be provided in a distinct area of the hospital.

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE - DETOX - as of October 7, 2016

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	$ 25,487,000			
b. Outpatient Services							
Gross Patient Service Revenues	***$ -***	***$ -***	***$ 24,927,000***	***$ 25,487,000***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ -	$ -	496,615.00	$ 507,771			
d. Contractual Allowance			18,305,465	$ 18,716,708			
e. Charity Care	$ -	$ -	468,236	$ 478,755			
Net Patient Services Revenue	***$ -***	***$ -***	***$ 5,656,684***	***$ 5,783,766***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify)							
NET OPERATING REVENUE	***$ -***	***$ -***	***$ 5,656,684***	***$ 5,783,766***	***$ -***	***$ -***	***$ -***
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			

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE - DETOX - as of October 7, 2016

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			
TOTAL OPERATING EXPENSES	$ -	$ -	$ 3,725,722	$ 3,891,910	$ -	$ -	$ -
3. INCOME - DETOX							
a. Income From Operation	$ -	$ -	$ 1,930,962	$ 1,891,856	$ -	$ -	$ -
b. Non-Operating Income							
SUBTOTAL	$ -	$ -	$ 1,930,962	$ 1,891,856	$ -	$ -	$ -
c. Income Taxes							
NET INCOME (LOSS)	$ -	$ -	$ 1,930,962	$ 1,891,856	$ -	$ -	$ -
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%	0.0%	19.5%	19.5%			
5) Self-pay	0.0%	0.0%	80.5%	80.5%			
6) Other	0.0%	0.0%	0.0%	0.0%			
TOTAL	0.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE - DETOX - as of October 7, 2016

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**			
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%	0.0%	25.00%	25.00%			
5) Self-pay	0.0%	0.0%	68.85%	68.85%			
6) Other	0.0%	0.0%	6.15%	6.15%			
TOTAL	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE - DETOX - as of October 7, 2016

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	$ 28,099,418			
b. Outpatient Services							
Gross Patient Service Revenues	***$ -***	***$ -***	***$ 26,173,350***	***$ 28,099,418***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ -	$ -	$ 521,446	$ 559,819			
d. Contractual Allowance			$ 19,220,738	$ 20,635,171			
e. Charity Care	$ -	$ -	$ 491,648	$ 527,828			
Net Patient Services Revenue	***$ -***	***$ -***	***$ 5,939,518***	***$ 6,376,600***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)							
NET OPERATING REVENUE	***$ -***	***$ -***	***$ 5,939,518***	***$ 6,376,600***	***$ -***	***$ -***	***$ -***
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			

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE - DETOX - as of October 7, 2016

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**		
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	$ -	$ -	$ 2,128,853	$ 2,271,975	$ -	$ -	$ -
b. Non-Operating Income						
SUBTOTAL	$ -	$ -	$ 2,128,853	$ 2,271,975	$ -	$ -	$ -
c. Income Taxes						
NET INCOME (LOSS)	$ -	$ -	$ 2,128,853	$ 2,271,975	$ -	$ -	$ -
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%	0.0%	19.5%	19.5%		
5) Self-pay	0.0%	0.0%	80.5%	80.5%		
6) Other	0.0%	0.0%	0.0%	0.0%		
TOTAL	*0.0%*	*0.0%*	*100.0%*	*100.0%*	*0.0%*	*0.0%*	*0.0%*

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE - DETOX - as of October 7, 2016

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**			
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%	0.0%	25.00%	25.00%			
5) Self-pay	0.0%	0.0%	68.85%	68.85%			
6) Other	0.0%	0.0%	6.15%	6.15%			
TOTAL	*0.0%*	*0.0%*	*100.0%*	*100.0%*	*0.0%*	*0.0%*	*0.0%*

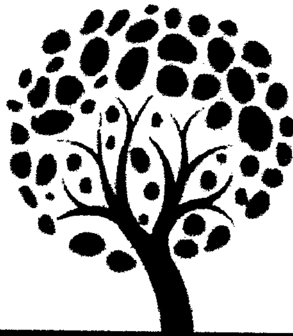
EXHIBIT 2

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

.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 35**, Tables G, H, J and K, reflect this commitment of 6.15%, 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 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)).

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 35**, Tables G, H, J and K, reflect this commitment of 6.15%, 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 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 87 other adult residential beds.

EXHIBIT 3

THE HENRY J. KAISER FAMILY FOUNDATION
Filling the need for trusted information on health issues...

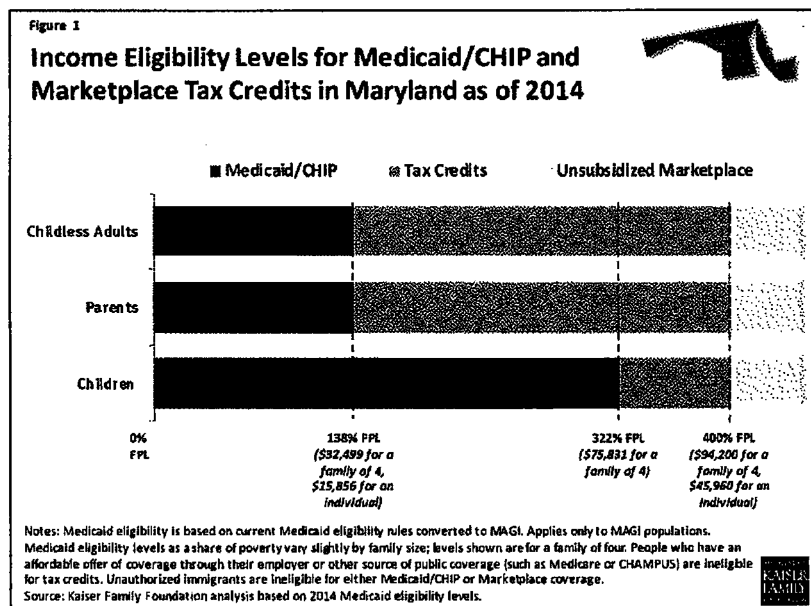
January 2014 | Fact Sheet

How Will the Uninsured in Maryland Fare Under the Affordable Care Act?

The 2010 Affordable Care Act (ACA) has the potential to extend coverage to many of the 47 million nonelderly uninsured people nationwide, including the 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 June 2012 Supreme Court ruling made the Medicaid expansion optional for states, and as of December 2013, Maryland was planning to implement the expansion in 2014. As a result, the ACA will be fully implemented in Maryland, and almost all nonelderly uninsured, most of whom are adults, are eligible for coverage expansions. As the ACA coverage expansions are implemented and coverage changes are assessed, it is important to understand the potential scope of the law in the state.

HOW DOES THE ACA EXPAND HEALTH INSURANCE COVERAGE IN MARYLAND?

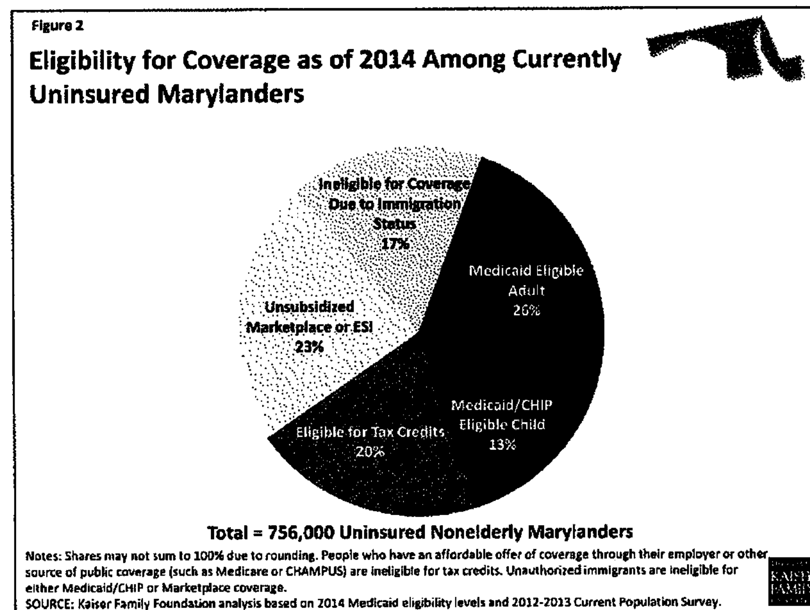
Historically, Medicaid had gaps in coverage for adults because eligibility was restricted to specific categories of low-income individuals, such as children, their parents, pregnant women, the elderly, or individuals with disabilities. In most states, adults without dependent children were ineligible for Medicaid, regardless of their income, and income limits for parents were very low—often below half the poverty level.[1] The ACA aimed to fill in these gaps by extending Medicaid to nearly all nonelderly adults with incomes at or below 138% of poverty (about $32,500 for a family of four in 2013). Thus, as of January 2014, Medicaid eligibility in Maryland covers almost all nonelderly adults up to 138% of poverty, as shown by the dark blue shading in Figure 1. All states previously expanded eligibility for children to higher levels than adults through Medicaid and the Children's Health Insurance Program (CHIP), and in Maryland, children with family incomes up to 322% of poverty (about $75,800 for a family of four) are eligible for Medicaid or CHIP. As was the case before the ACA, undocumented immigrants remain ineligible to enroll in Medicaid, and recent lawfully residing immigrants are subject to certain Medicaid eligibility restrictions.[2]



Under the ACA, people with incomes between 100% and 400% of poverty may be eligible for premium tax credits when they purchase coverage in a Marketplace. The amount of the tax credit is based on income and the cost of insurance, and tax credits are only available to people who are not eligible for other coverage, such as Medicaid/CHIP, Medicare, or employer coverage, and who are citizens or lawfully-present immigrants. Thus, the effective lower income limit for tax credits in Maryland is 322% of poverty for children and 138% of poverty for adults, as indicated by the bright blue shading in Figure 1. Citizens and lawfully-present immigrants with incomes above 400% of poverty can purchase unsubsidized coverage through the Marketplace.

HOW MANY UNINSURED MARYLANDERS ARE ELIGIBLE FOR ASSISTANCE UNDER THE ACA?

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 (Figure 2). 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 percent 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 be 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 percent 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.

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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. There is no deadline for enrolling in Medicaid coverage under the ACA, and open enrollment in the Marketplaces continues through March 2014. Continued attention to who gains coverage as the ACA is fully implemented and who is excluded from its reach—as well as whether and how their health needs are being met—can help inform decisions about the future of health coverage in Maryland.

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[1] Some states had expanded coverage to parents at higher income levels or provided coverage to adults without children. See http://www.kff.org/medicaid/fact-sheet/medicaid-eligibility-for-adults-as-of-january-1-2014/ for more detail on pre- and post-ACA Medicaid eligibility for adults.

[2] For more detail on Medicaid coverage for immigrants, see: http://www.kff.org/disparities-policy/fact-sheet/key-facts-on-health-coverage-for-low/.

EXHIBIT 4

Table A-1.

Population Without Health Insurance Coverage by State: 2013 to 2015

(Numbers in thousands. Civilian noninstitutionalized population. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see *www2.census.gov/programs-surveys/acs/tech_docs/accuracy/ACS_Accuracy_of_Data_2015.pdf*)

State	Medicaid Expansion State? Yes (Y) or No (N)[1]	2013 Uninsured				2014 Uninsured				2015 Uninsured				Difference in Uninsured (2015 less 2014)				Difference in Uninsured (2015 less 2013)			
		Number	Margin of Error[2] (±)	Percent	Margin of Error[2] (±)	Number	Margin of Error[2] (±)	Percent	Margin of Error[2] (±)	Number	Margin of Error[2] (±)	Percent	Margin of Error[2] (±)	Number	Margin of Error[2] (±)	Percent	Margin of Error[2] (±)	Number	Margin of Error[2] (±)	Percent	Margin of Error[2] (±)
United States		45,181	200	14.5	0.1	36,670	190	11.7	0.1	29,758	179	9.4	0.1	*-6,913	261	*-2.3	0.1	*-15,423	269	*-5.1	0.1
Alabama	N	645	17	13.6	0.4	579	17	12.1	0.4	484	16	10.1	0.3	*-95	23	*-2.0	0.5	*-161	23	*-3.4	0.5
Alaska	N	132	7	18.5	1.0	122	6	17.2	0.9	106	5	14.9	0.7	*-16	8	*-2.3	1.1	*-26	9	*-3.7	1.2
Arizona	Y	1,118	24	17.1	0.4	903	18	13.6	0.3	728	21	10.8	0.3	*-175	28	*-2.8	0.4	*-390	32	*-6.3	0.5
Arkansas	Y	465	14	16.0	0.5	343	13	11.8	0.4	278	12	9.5	0.4	*-66	18	*-2.3	0.6	*-187	18	*-6.5	0.6
California	Y	6,500	57	17.2	0.2	4,767	47	12.4	0.1	3,317	34	8.6	0.1	*-1,449	58	*-3.9	0.2	*-3,183	66	*-8.6	0.2
Colorado	Y	729	18	14.1	0.3	543	16	10.3	0.3	433	15	8.1	0.3	*-110	22	*-2.2	0.4	*-297	23	*-6.0	0.4
Connecticut	Y	333	14	9.4	0.4	245	11	6.9	0.3	211	13	6.0	0.4	*-35	17	*-1.0	0.5	*-122	20	*-3.4	0.6
Delaware	Y	83	6	9.1	0.7	72	6	7.8	0.7	54	6	5.9	0.6	*-17	8	*-1.9	0.9	*-29	8	*-3.3	0.9
District of Columbia	Y	42	4	6.7	0.6	34	4	5.3	0.7	25	4	3.8	0.6	*-9	6	*-1.5	0.9	*-17	5	*-2.9	0.8
Florida	N	3,853	43	20.0	0.2	3,245	43	16.6	0.2	2,662	40	13.3	0.2	*-584	59	*-3.2	0.3	*-1,191	59	*-6.7	0.3
Georgia	N	1,846	30	18.8	0.3	1,568	28	15.8	0.3	1,388	26	13.9	0.3	*-180	38	*-2.0	0.4	*-458	39	*-5.0	0.4
Hawaii	Y	91	6	6.7	0.4	72	5	5.3	0.4	55	4	4.0	0.3	*-18	7	*-1.3	0.5	*-36	7	*-2.8	0.5
Idaho	N	257	12	16.2	0.8	219	11	13.6	0.7	180	10	11.0	0.6	*-38	15	*-2.5	0.9	*-77	16	*-5.1	1.0
Illinois	Y	1,618	27	12.7	0.2	1,238	22	9.7	0.2	900	22	7.1	0.2	*-338	31	*-2.6	0.2	*-718	35	*-5.6	0.3
Indiana	N	903	19	14.0	0.3	776	22	11.9	0.3	628	17	9.6	0.3	*-148	28	*-2.3	0.4	*-275	26	*-4.3	0.4
Iowa	Y	248	9	8.1	0.3	189	8	6.2	0.3	155	8	5.0	0.3	*-34	12	*-1.1	0.4	*-93	12	*-3.1	0.4
Kansas	N	348	12	12.3	0.4	291	11	10.2	0.4	261	12	9.1	0.4	*-31	16	*-1.1	0.6	*-88	17	*-3.1	0.6
Kentucky	Y	616	14	14.3	0.3	366	11	8.5	0.3	261	11	6.0	0.2	*-105	15	*-2.4	0.4	*-355	18	*-8.3	0.4
Louisiana	N	751	17	16.6	0.4	672	16	14.8	0.3	546	17	11.9	0.4	*-126	23	*-2.8	0.5	*-206	24	*-4.7	0.5
Maine	N	147	7	11.2	0.5	134	8	10.1	0.6	111	7	8.4	0.5	*-23	11	*-1.7	0.8	*-37	10	*-2.8	0.8
Maryland	Y	593	17	10.2	0.3	463	16	7.9	0.3	389	11	6.6	0.2	*-74	19	*-1.3	0.3	*-204	20	*-3.6	0.3
Massachusetts	Y	247	10	3.7	0.2	219	8	3.3	0.1	189	9	2.8	0.1	*-29	12	*-0.5	0.2	*-57	14	*-0.9	0.2
Michigan	+Y	1,072	19	11.0	0.2	837	18	8.5	0.2	597	14	6.1	0.1	*-240	23	*-2.5	0.2	*-475	24	*-4.9	0.2
Minnesota	Y	440	14	8.2	0.3	317	12	5.9	0.2	245	11	4.5	0.2	*-72	16	*-1.4	0.3	*-195	18	*-3.7	0.3
Mississippi	N	500	16	17.1	0.5	424	14	14.5	0.5	372	12	12.7	0.4	*-53	18	*-1.8	0.6	*-128	20	*-4.4	0.7
Missouri	N	773	18	13.0	0.3	694	19	11.7	0.3	583	15	9.8	0.3	*-111	24	*-1.9	0.4	*-190	24	*-3.3	0.4
Montana	N	165	8	16.5	0.8	143	6	14.2	0.6	119	7	11.6	0.7	*-25	9	*-2.6	0.9	*-46	10	*-4.8	1.0
Nebraska	N	209	9	11.3	0.5	179	7	9.7	0.4	154	9	8.2	0.5	*-25	11	*-1.4	0.6	*-55	13	*-3.1	0.7
Nevada	Y	570	17	20.7	0.6	427	15	15.2	0.5	351	12	12.3	0.4	*-76	19	*-2.9	0.7	*-219	21	*-8.4	0.7
New Hampshire	+Y	140	7	10.7	0.5	120	7	9.2	0.5	83	6	6.3	0.4	*-37	9	*-2.8	0.7	*-57	9	*-4.4	0.7
New Jersey	Y	1,160	22	13.2	0.2	965	19	10.9	0.2	771	22	8.7	0.2	*-194	29	*-2.2	0.3	*-389	31	*-4.5	0.3
New Mexico	Y	382	13	18.6	0.6	298	10	14.5	0.5	224	9	10.9	0.5	*-74	14	*-3.6	0.7	*-158	16	*-7.7	0.8
New York	Y	2,070	30	10.7	0.2	1,697	28	8.7	0.1	1,381	25	7.1	0.1	*-316	37	*-1.6	0.2	*-689	39	*-3.6	0.2
North Carolina	N	1,509	26	15.6	0.3	1,276	25	13.1	0.3	1,103	23	11.2	0.2	*-173	34	*-1.9	0.3	*-406	35	*-4.5	0.4
North Dakota	Y	73	6	10.4	0.8	57	5	7.9	0.7	57	5	7.8	0.7	1	7	-0.1	0.9	*-16	7	*-2.6	1.0
Ohio	Y	1,258	21	11.0	0.2	955	20	8.4	0.2	746	19	6.5	0.2	*-209	27	*-1.8	0.2	*-511	28	*-4.5	0.2
Oklahoma	N	666	13	17.7	0.3	584	11	15.4	0.3	533	12	13.9	0.3	*-51	16	*-1.5	0.4	*-133	17	*-3.8	0.5
Oregon	Y	571	15	14.7	0.4	383	13	9.7	0.3	280	12	7.0	0.3	*-102	18	*-2.7	0.4	*-291	20	*-7.6	0.5
Pennsylvania	+Y	1,222	22	9.7	0.2	1,065	21	8.5	0.2	802	17	6.4	0.1	*-263	27	*-2.1	0.2	*-420	28	*-3.4	0.2
Rhode Island	Y	120	7	11.6	0.7	77	6	7.4	0.6	59	6	5.7	0.6	*-18	8	*-1.7	0.8	*-61	9	*-5.9	0.9
South Carolina	N	739	18	15.8	0.4	642	17	13.6	0.4	523	14	10.9	0.3	*-118	22	*-2.7	0.5	*-216	23	*-4.9	0.5
South Dakota	N	93	5	11.3	0.7	82	4	9.8	0.5	86	5	10.2	0.6	4	7	0.4	0.8	-7	8	*-1.1	0.9
Tennessee	N	887	20	13.9	0.3	776	19	12.0	0.3	667	19	10.3	0.3	*-109	27	*-1.8	0.4	*-219	28	*-3.6	0.4
Texas	N	5,748	55	22.1	0.2	5,047	43	19.1	0.2	4,615	55	17.1	0.2	*-432	69	*-2.0	0.3	*-1,133	77	*-5.0	0.3
Utah	N	402	13	14.0	0.5	366	13	12.5	0.5	311	14	10.5	0.5	*-54	19	*-2.1	0.6	*-91	19	*-3.5	0.6
Vermont	Y	45	4	7.2	0.6	31	3	5.0	0.4	24	2	3.8	0.4	*-7	4	*-1.1	0.6	*-21	5	*-3.4	0.7
Virginia	N	991	22	12.3	0.3	884	22	10.9	0.3	746	23	9.1	0.3	*-137	32	*-1.7	0.4	*-244	32	*-3.2	0.4
Washington	Y	960	22	14.0	0.3	643	17	9.2	0.2	468	13	6.6	0.2	*-175	21	*-2.6	0.3	*-492	25	*-7.4	0.4
West Virginia	Y	255	10	14.0	0.5	156	8	8.6	0.4	108	6	6.0	0.4	*-48	10	*-2.6	0.6	*-147	12	*-8.0	0.6
Wisconsin	N	518	14	9.1	0.2	418	12	7.3	0.2	323	10	5.7	0.2	*-95	15	*-1.7	0.3	*-195	17	*-3.5	0.3
Wyoming	N	77	5	13.4	0.9	69	5	12.0	0.8	66	6	11.5	1.0	-2	7	-0.4	1.3	*-11	7	*-1.9	1.3

*Statistically different from zero at the 90 percent confidence level.
+ Expanded Medicaid eligibility between January 1, 2014, and January 1, 2015.
Z Represents or rounds to zero.

[1]Medicaid expansion status as of January 1, 2015. For more information, see <www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html>.

[2]Data are based on a sample and are subject to sampling variability. A margin of error is a measure of an estimate's variability. The larger the margin of error is in relation to the size of the estimate, the less reliable the estimate. This number, when added to and subtracted from the estimate, forms the 90 percent confidence interval.

Note: Differences are calculated with unrounded numbers, which may produce different results from using the rounded values in the table.

Source: U.S. Census Bureau, 2013, 2014, and 2015 1-Year American Community Surveys.

EXHIBIT 5

IN THE MATTER OF	*	**BEFORE THE**
	*	
ASHLEY, INC., d/b/a	*	**MARYLAND**
	*	
FATHER MARTIN'S ASHLEY	*	**HEALTH CARE**
	*	
Docket No. 13-12-2340	*	**COMMISSION**
	*	

* *

Staff Report and Recommendation

September 19, 2013

indigent and gray area patient days, or "qualifying charity care," under the definitions of the SHP.

Table 6: Three Scenarios Comparing Financial Feasibility Based on Variations in Qualifying Charity Care and Non-Indigent Discounted Care* Provided at FMA

	Proposed Level and Mix of Charity Care/Non-Indigent Discounting	Scenario #1 More Than 15% Total Charity Care/Non-Indigent Discounting	Scenario #2 More than 15% Indigent & Gray Area/Non-Indigent Discounting
	FY 2017	**FY 2017**	**FY 2017**
Total Projected Beds Days	34,660	34,660	34,660
Indigent Bed Days	1,453	2,190	3,285
Gray Area Bed Days	737	1,460	2,190
Total Qualifying Charity Days	2,190	3,650	5,475
Percentage of Total Bed Days Qualifying as Charity	6.3%	10.5%	15.8%
Non-Indigent Discounting Bed Days	1,825	1,825	1,825
Total Qualifying Charity/Non-indigent Discounting Bed Days	4,015	5,475	7,300
Percentage of Total Bed Days Qualifying as Charity/Non-Indigent Discounting	11.6%	15.8%	21.1%
Gross Patient Service Revenue	$31,119,186	$31,119,186	$31,119,186
Allowance for Bad Debt	102,991	98,298	92,432
Contractual Allowance	7,127,366	6,787,806	6,363,356
Qualifying Charity Care/Non-Indigent Discounts	3,584,821	4,888,393	6,517,857
Net Patient Services Revenue	$20,304,008	$19,344,689	$18,145,541
Other Operating Revenues	563,529	563,529	563,529
Net Operating Revenue	$20,867,537	$19,908,218	$18,709,070
Total Operating Expenses	$20,846,324	$20,846,324	$20,846,324
Operating Income (Loss)	**$21,213**	**($938,106)**	**($2,137,254)**

Source: Father Martin's Ashley April 19, 2013 responses to second completeness letter (DI #14, pp. 14-16)
* Non-Indigent are patients with inadequate health insurance who receive FMA services

As shown, FMA projects a small level of income net of operating expenses in FY 2017 under the applicant's proposed levels of qualifying charity care and non-qualifying discounted care to non-indigent persons. Under the other scenarios, it projects operating losses with a projected loss from operations of over $2.1 million if it meets the standard target for qualifying charity care.

EXHIBIT 6

COMPARISON BETWEEN PROJECTIONS OF RCE-E AND THE CON-APPROVED PROJECTIONS OF ASHLEY

	Gross Patient Service Revenues	Net Patient Services Revenue	Charity Care (Indigent and Gray Area)	Net Income	Bed Days	Charity Care Bed Days	Gross Patient Service Revenues/Bed Days	Net Patient Services Revenue/Bed Days	Charity Care/Bed Days	Charity Care/Gross Patient Service Revenue	Charity Care/Net Patient Service Revenue	Net Income/Gross Patient Service Revenues	Net Income/Net Patient Services Revenues	Charity Care Bed Days/Bed Days
TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY: CY 2018	$103,816,000	$24,878,382	$939,378	$4,749,513	34,292	2110*	$3,027.41	$725.49	$27.39	0.9%	3.78%	4.57%	19.09%	#VALUE!
TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY: CY 2018	$114,457,140	$27,428,417	$1,035,664	$6,195,948	34,292	2110*	$3,337.72	$799.85	$30.20	0.9%	3.78%	5.41%	22.59%	#VALUE!
TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE - DETOX: CY 2018	$25,487,000	$5,783,766	$478,755	$1,891,856	7,282	?	$3,500.00	$794.26	$65.74	1.9%	8.28%			
TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE - DETOX: CY 2018	$28,099,418	$6,376,600	$527,828	$2,271,975	7,283	?	$3,858.22	$875.55	$72.47	1.9%	8.28%			
FMA, FY 2017 from TABLE 6, p. 14	$31,119,186	$20,304,008	$1,955,357	$21,213	34,660	2,190	$897.84	$585.81	$56.42	6.3%	9.63%	0.07%	0.10%	6.32%

*Estimated

Source: "Modification in Response to September 20, 2016 Project Status Conference": MHCC Staff Report, Ashley, Inc., Docket No. 13-12-2340, September 19, 2013.

EXHIBIT 7

IN THE MATTER OF	*	BEFORE THE
RECOVERY CENTER OF AMERICA –EARLEVILLE	*	MARYLAND HEALTH
	*	CARE COMMISSION
	*	Docket No. 15-07-2363

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**COMMENTS OF FATHER MARTIN'S ASHLEY
ON THE MODIFIED CON APPLICATION OF
RECOVERY CENTER OF AMERICA (EARLEVILLE, MARYLAND)**

INTRODUCTION

Pursuant to COMAR 10.24.01.08(F)(1) and the notice posted on the Maryland Health Care Commission's website on January 20, 2016: http://mhcc.maryland.gov/mhcc/Pages/hcfs/hcfs_con/hcfs_con_filed_applications.aspx (See Exhibit 1) Ashley, Inc. d/b/a Father Martin's Ashley ("FMA"), an interested party in regard to Docket No. 15-07-2363, hereby submits comments on the MODIFIED application by Recovery Centers of America – Earleville ("RCA-E" or the "Applicant") for a Certificate of Need ("CON") to establish an intermediate care alcohol and drug abuse facility ("ICF").

On November 16, 2015, pursuant to COMAR 10.24.01.08(F)(1) and the notice published at 42 Md. Reg. 1364-1365 (October 16, 2015), counsel to FMA submitted on FMA's behalf Comments on the Modified CON Application by Recovery Center of America (Earleville, Maryland). In those comments, FMA provided documentation qualifying FMA as an Interested Party to the above-referenced CON application, and provided comments to the Commission with respect to the proposed project to establish a new 49-bed inpatient treatment center. Those comments addressed the deficiencies of the proposed project for failing to comply with applicable CON review criteria, and urged that the modified CON application as submitted be denied, unless the deficiencies are remedied and the application is brought into full compliance with State Health Plan Standards.

Subsequently, on November 30, 2015, the Applicant modified its docketed CON application ("Modified RCA-E") and submitted a series of additional documents into the record of this CON review, as shown below:

- Recovery Center of America - Earleville - Redline Modification Request (12/21/15)
- Recovery Center of America - Earleville - Complete Corrected Modification Request (12/21/15)
    - Exhibits to Complete Corrected Modification Request (12/21/15)
- Recovery Center of America - Earleville - Completeness Response (12/21/15)

FMA has reviewed the Modified RCA-E and the additional documents placed in the record by the Applicant, and hereby submits three additional comments for the Commission's consideration.

<u>Comment #1</u>

The modified RCA-E application is not currently approvable because it has failed to demonstrate consistency with COMAR 10.24.14.05D. Provision of Service to Indigent and Gray Area Patients. This standard requires, in pertinent part, the following:

> (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 or more of its proposed annual adult intermediate care facility bed days to indigent or gray area patients.
>
> (2) An 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 requirement of Regulation D(1).

The Applicant has stated the intent to provide/commit 6.15% of its patient days of care to indigent and gray area patients at the proposed RCA-E facility. Nevertheless, the modified RCA-E Application states:

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.

(See Exhibit 2, CORRECTED MODIFIED CON Application, redlined copy, with deleted language indicated above in parentheses, p. 47)

We reviewed the alternative financial tables shown at Exhibit 36, and find that the proposed RCA-E facility is projected to produce pre-tax income in CY 2017 and CY 2018:

	Pre-Tax Net Income	
Entire Facility	**CY 2017**	**CY 2018**
Alternative TABLE G., UNINFLATED, 15% Charity Care	$1,620,039	$2,096,200
Alternative TABLE H., INFLATED, 15% Charity Care	$2,222,366	$3,270,670
New Facility or Service - DETOX		
Alternative TABLE J. DETOX, UNINFLATED, 15% Charity Care	$5,206,182	$5,603,116
Alternative TABLE K. DETOX, INFLATED, 15% Charity Care	$1,655,826	$2,072,810

Source: EXHIBIT 36, MODIFIED CON Application – RCA Earleville

As stated in the FMA Comments submitted on November 16, 2015, RCA – Earleville is projected to produce substantial net income when complying with the State Health Plan requirement that 15% of its projected patient days are provided to charity care patients. The modified application also shows that RCA-E can achieve a profitable operation at the 15% standard, and therefore, the percentage of patient days provided to indigent and charity care patients should not be reduced.

The Applicant offers a spurious and misleading argument to support its proposed level of charity care: that if 6.15% of its patient days for detox services were to be provided to indigent and charity care patient days, the actual percentage would rise to 25%, as detox patient days only comprise a portion of an entire stay:

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 = 471,754.91), which is 24.6% of the total projected patient days for detox services in that year (see Table F, line 2(i)).

(See Exhibit 3, CORRECTED MODIFIED CON Application, redlined copy, p. 47)

RCA-E is not planning to limit the services provided to indigent and charity care patients to the detox portion of care that is needed, but rather to provide the full course of treatment needed by those patients. For that reason, it is inappropriate to consider charity care only within the

context of detox services. RCA-E is attempting to "get credit" where no credit is due by splitting the projected average length of stay into the CON-regulated portion, i.e., detox days, and the non-CON regulated portion, i.e., the rehabilitation days. We would urge the Commission to enforce the plain meaning of the standard: that a minimum of 15% of the projected patient days be provided to gray area and charity care patients at RCA-E unless a reasonable basis for the proposed reduction from 15% to 6.15% has been provided by the applicant. RCA-E recognizes that indigent and charity care patients will not be discharged after detox simply because they cannot pay for continued care, and that it is inappropriate to provide charity care only for the detox portion of a course of treatment, yet suggests it should be considered to meet the State Health Plan standard precisely for that reason.

Comment #2

The modified RCA-E application is not currently approvable because it has failed to justify the number of beds needed to provide subacute detox services. In its comments submitted on November 18, 2015, FMA showed that the 21 detox beds proposed for RCA-E were inconsistent with the State Health Plan Intermediate Care Private Bed Need Average Length of Stay standard found at COMAR 10.24.14.07 B. (7) (g)., and inconsistent with the actual number of subacute detox days of care provide at FMA. A more realistic projection would show a need for 7 such Detox beds, as shown below:

Calendar Year	Projected Admissions		ALOS: Detox	ALOS: Residential	Total Days		Beds Needed (@85% Occupancy)	
	Detox	Residential			Detox	Residential	Detox	Residential
2016		396	4 days	16 days		6,336		21
2017	509	1,590	4 days	16 days	2,036	25,440	7	82
2018	548	1,688	4 days	16 days	2,192	27,008	7	87

Despite these comments, the Applicant has continued to assert the need for 21 detox beds needed based on its own changing and unfounded estimates ranging from 15% to 20% to 41% of the detox bed inventory in existing providers, some of which depend on faulty and inconsistent assumptions concerning FMA's own utilization and bed capacity for providing subacute detox services. For example, in the Original CON Application submitted on March 27,

EXHIBIT 8

IN THE MATTER OF	*	BEFORE THE
RECOVERY CENTER OF AMERICA –EARLEVILLE	*	MARYLAND HEALTH
	*	CARE COMMISSION
	*	Matter No. 15-07-2363

****

COMMENTS OF FATHER MARTIN'S ASHLEY ON THE MODIFIED CON APPLICATION OF <u>RECOVERY CENTER OF AMERICA (EARLEVILLE, MARYLAND)</u>

<u>INTRODUCTION</u>

Pursuant to COMAR 10.24.01.08(F)(1) and the notice published at 42 Md. Reg. 1364-1365 (October 16, 2015), Ashley, Inc., d/b/a Father Martin's Ashley ("FMA"), by undersigned counsel hereby seeks from the Maryland Health Care Commission ("MHCC" or "Commission") interested party status in regard to Docket No. 15-07-2363, the application by Recovery Centers of America – Earleville (the "Applicant", or RCA-E") for a Certificate of Need ("CON") to establish an intermediate care alcohol and drug abuse facility ("ICF").

FMA is an 85-bed licensed ICF, located in Havre de Grace, Maryland, which provides substance abuse treatment services. The facility is private, not-for-profit, and non-denominational. It is licensed by the Department of Health and Mental Hygiene to provide three levels of care: clinically managed high-intensity residential treatment, medically monitored intensive inpatient treatment, and medically monitored intensive inpatient treatment-detoxification.

FMA fully supports the expansion of capacity for the treatment of substance abuse patients in Maryland. However, FMA believes the proposed project fails to comply with applicable CON review criteria, and opposes approval of the CON application in its present

adjustments in FY 2017 in order to continue to provide access to privately insured patients. This is a 23% adjustment to FMA's charges that its patients and health plans are not required to pay.

Despite the statement that "RCA will also offer our patients a package of services at a discounted price and will negotiate volume discounts with payers" (See Attached Pricing Schedule, Exhibit 5), RCA-E did not provide any projections of contractual adjustments (discounts to third-party payers) in its revenue forecasts. Without such projections, one can only assume that all RCA-E patients who are not indigent will pay 100% of charges, consistent with the RCA-E Pricing Schedule. This is an unrealistic assumption, and demonstrates that the financial projections of the Applicant do not support its conclusions that it cannot be financially viable by providing 15% of its patient days to indigent and gray area patients.

RCA-E has not demonstrated a reasonable basis for the proposed reduction from 15% to 6.13%: The applicant should be held to the same standard of financial viability as was the case for FMA, that is, that its projected operating losses would be covered by operating income.

The standard used by the Commission to permit FMA to operate at a lower percentage was that it would achieve a "break-even" operation. The record in this matter shows that RCA-E can achieve better than a "break-even" operation at the 15% standard, and therefore, the percentage of patient days provided to indigent and gray area patients should not be reduced. (See Exhibit 6).

Comment #2 -

The RCA-E application is not currently approvable because it has failed to demonstrate consistency with the need methodology required by COMAR 10.24.14.05 B. (1)(a), which states:

> **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; 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.*

RCA-E has presented numerous plans and projections for determining the need for inpatient substance abuse treatment services in its proposed 49-bed adult intermediate care facility. We have examined the need methodology, supporting information and the resulting projections included in the RCA-E Modified CON Application and make the following comments regarding the demonstrated need for detox beds at RCA-E and the likely impact of their utilization on FMA.

The Average Length of Stay projected for Detox Services at RCA-E is not consistent with the State Health Plan Intermediate Care Private Bed Need Average Length of Stay standard found at COMAR 10.24.14.07 B. (7) (g). The projected number of detox days at RCA-E needed are also unrealistically high in comparison to the actual number of subacute detox days of care provided at FMA. Hence, the RCA-E projections do not serve as a reasonable basis for the 21 beds required to treat the 507 patients projected in CY 2018 and CY 2019.

A review of the State Health Plan definitions is provided to illuminate the meaning of the terms used in the RCA-E Modified CON Application.

First, the State Health Plan, at COMAR 10.24.14.08 B. (13), states that an "intermediate care facility" means a facility designed to facilitate the subacute detoxification and rehabilitation of alcohol and drug abusers by placing them in an organized therapeutic environment in which they receive medical services, diagnostic services, individual and group therapy and counseling, vocational rehabilitation, and work therapy while benefiting from the support that a residential setting can provide. The State Health Plan further states that an adult intermediate care facility is programmatically designed to serve those 18 and older for lengths of stay of 7-21 days.

Second, the Plan states, at COMAR 10.24.14.08 B. (6) that "Detoxification" means the systematic medically-supervised reduction of the effects of alcohol or drugs and the effects of alcohol or drug withdrawal in the body, which commonly occurs in one of four settings: acute general hospitals (acute detoxification only); alcoholism rehabilitation units and intermediate care facilities (sub-acute detoxification only); non-hospital detoxification (sub-acute only); or non-health care settings (self-induced withdrawal). At COMAR 10.24.14.08 B. (25) "Subacute detoxification" means short-term treatment for the intoxicated or overdosed individual who may be appropriately treated outside an acute care hospital. At COMAR 10.24.14.08 B (3) "Alcoholism and drug abuse rehabilitation" means rehabilitation provided in any of five settings: intermediate care (ICF-C/D) facilities for the treatment of alcohol abuse (previously called quarterway programs); hospital-based alcoholism rehabilitation units; long-term residential care programs; residential drug abuse treatment facilities; and alternative rehabilitation care (alternative living unit, non-residential intermediate care, intensive and other outpatient programs).

The proposed RCA-E facility would appear to meet the State Health Plan definition of an "intermediate care facility," that has proposed an inpatient clinical program for both "subacute detoxification" and "alcoholism and drug abuse rehabilitation." The RCA-E CON Application states that the facility will treat adults only (RCA-E Modified CON Application, p. 27).

The State Health Plan provides a methodology for projecting the need for intermediate care private beds (Track One). This methodology is found at COMAR 10.24.14.07B. (7) and includes a calculation at (g) for determining the need for adult intermediate care beds by multiplying the total number of persons requiring intermediate care by a 14-day average length of stay for adults, and dividing the product by 365 and 0.85. The bed need methodology does not

distinguish between intermediate care beds need to provide subacute detox services, or any of the other services outlined at COMAR10.24.14.08 B. (13).

The RCA-E need projection for providing intermediate care private beds are shown on Tables A., F. and I. of the Modified CON Application, May 18, 2015. Two types of intermediate care services are proposed for RCA-E: Detox and Residential, of which 21 beds are designated for detox and 28 are designated for residential. RCA-E has assumed that the average length of stay for 507 adult intermediate care patients discharged in CY 2017 and CY 2018 will be 30 days, of which 14 days will be in detox beds and 16 days will be in residential beds. (Modified CON Application Corrected Exhibits, TABLE A. See Exhibit 7).

With respect to the 14 day ALOS for detox services, RCA-E has stated the following:

> 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 Applicants detox program due to co-occurring mental disorders, complicated medical issues or longer benzodiazepine tapers. (Modified CON Application, Footnote 5, p. 30)

It would appear that the State Health Plan methodology for determining the need for adult intermediate care beds, with respect to the 14-day average length of stay, has only been applied to the "detox" portion of the patient days proposed by RCA-E for the 507 admitted patients, whereas it specifically addresses the need for all intermediate care facility beds for adults.

FMA has reviewed the ALOS projection presented by RCA-E and finds that the explanation for needing 14 days to provide detox services there is insufficient to warrant a finding that the 21 detox beds proposed are needed.

RCA-E's application of the State Health Plan methodology is not correct and yields an inaccurate projection of need for the intermediate care services proposed by RCA-E.

FMA, an existing provider of adult intermediate care services, estimates that the need for subacute detoxification, one of the services specifically defined to be facilitated in an intermediate care facility under COMAR 10.24.14.08 B. (13) is significantly less that the need projected by RCA-E.

The following is an assessment of Bernadette Solounias, M.D., VP Treatment Services at FMA, regarding this issue:

> I have been involved in the treatment of people with substance use disorders for over 25 years and the last 20 have been as the Medical Director of Ashley, Inc., a residential treatment program. We have an 85 bed capacity with an average length of stay of 25 days. Eighty per cent of our patients have either an alcohol use disorder or an opioid use disorder as a primary diagnosis and I would expect RCA to have similar demographic of substance use disorders. We do not set a limit on how many patients we can treat for withdrawal at a time. The typical acute alcohol withdrawal symptoms last three to five days and the typical acute opioid withdrawal symptoms last five to six days. Withdrawal symptoms can be objectively measured by standardized assessment tools. The CIWA (Clinical Institute Withdrawal Assessment for Alcohol) and the COWS (Clinical Opiate Withdrawal Scale) each provide a scoring system to measure withdrawal severity for alcohol and opiates, respectively. When acute withdrawal is resolved, the scores on these scales are low indicating that monitoring and medications are no longer needed. The treatment of these withdrawal states is protocol driven, protocols that are consistent with the industry standard of care and rely on the CIWA and COWS. Our average days authorized for inpatient detoxification is 4.24 days. Detoxification in an intermediate care facility that lasts 14 days would be unusual and not typical.

The perspective and track record of FMA on the question of a reasonable average length of stay for subacute detox services to be provided in an intermediate care facility is relevant, and contradicts one of the basic assumptions found in the RCA-E CON application concerning the availability and utilization of intermediate care services: that future RCA-E patients will need 14 days of detox services and 21 intermediate care facility beds there to treat them. A 14 day stay, as an <u>average</u> length of stay, would certainly be excessive and unrealistic. If 14 days is an

"average," that would mean some significant portion of the patient population is experiencing a length of stay well above 14 days, which is simply not a credible expectation in an ICF setting.

In the Modified CON Application, RCA-E provides an inventory of 52 "Not Funded" Existing Detox Beds in the State, of which Father Martin's Ashley (FMA) accounts for 20. The source of the detox bed inventory is "RCA's management teams experience" the 2011 National Survey of Substance Abuse Treatment Services, which is attached as Exhibit 11. (Modified CON Application, pp. 36-38). Our review of this Exhibit, entitled the "2011 State Profile – Maryland, National Survey of Substance Abuse Treatment Services (N-SSATS) shows no specific references to FMA, much less the 20 detox beds attributed to FMA's clinical program which appears in RCA-E inventory. Furthermore, as is discussed below, FMA does not operate, has never operated, nor does it intend to operate 20 of its 100 beds to provide subacute detox services. Therefore, this inventory of detox beds presented by RCA-E should not be relied upon by the Commission to determine the need for the additional intermediate care beds proposed for RCA-E, particularly as 21 additional beds being proposed appear to be limited to subacute care detox beds, and not all of the intermediate care beds available in existing comparable facilities.

Consistent with the assessment provided by Dr. Solounias, we have prepared the following chart which indicates the reasonable need forecast for ICF beds at RCA to serve the number of patients, including the sub-acute detox services to be provided:

Calendar Year	**Projected ICF Patients**		**ALOS: Detox**	**ALOS: Residential**	**Total Days**		**Beds Needed (@85% Occupancy)**	
	Detox	**Residential**			**Detox**	**Residential**	**Detox**	**Residential**
2016	**377**	**377**	**4 days**	**16 days**	**1,508**	**6,032**	**5**	**20**
2017	**507**	**507**	**4 days**	**16 days**	**2,028**	**8,112**	**7**	**27**
2018	**507**	**507**	**4 days**	**16 days**	**2,028**	**8,112**	**7**	**27**

For the reasons outlined above, the projections of RCA-E patient days should not be accepted, as they do not reflect a reasonable average length of stay estimate for subacute detox

services, are inconsistent with the State Health Plan standard, and do not reflect the actual utilization of detox services provided at FMA. Projections that should be accepted by the Commission would be those that are realistic and comport with the State Health Plan standards and definitions, and the reality of the FMA historical experience. As demonstrated above, those projections would reduce the number of detox beds needed at RCA-E from 21 to 7.

This reduction in beds at RCA-E would also be consistent with the projections of needed utilization approved by the Commission with respect to the FMA's expansion project. At the time the CON was approved in 2013, no Maryland competitor was present in the marketplace. With the addition of RCA-E, FMA will be competing for patients who require intermediate care services. As stated earlier in these Comments, FMA would not object to the CON approval of RCA-E to provide additional treatment capacity and services if they are demonstrated to be needed and meet all standards and criteria. Our concern is that the clinical program for the proposed RCA-E facility has been designed around flawed and incorrect assumptions concerning the policies of the State, as articulated in the State Health Plan, concerning the need for intermediate care facilities, and the range and types of services they can provide, as well as the mischaracterization of FMA's capacity to provide needed services, particularly subacute detox services.

While FMA did not specifically show a distinction between subacute detox services, residential/rehabilitation services and beds to be located in its expanded 100 bed intermediate care facility, the CON-approval and utilization of additional intermediate care beds that are not needed for detox services at RCA-E, will have a negative impact on FMA's ability to meet its CON Approved projections for 2016, 2017, and 2018.

RCA-E has not met its burden of proof that the project as proposed is CON approvable under the definitions and need methodology set forth in the State Health Plan. The number and utilization of intermediate care beds that are specifically programmed to provide on average 14 days of inpatient detox services is an excessive number.

Comment #3 - The applicant has not complied with applicable provisions of COMAR 10.24.01.08 G.(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.

In light of the deficiencies noted above concerning: 1) the reduction in RCA-E commitment to providing 15% of its projected patient days for indigent and gray area patients, and 2) the excess number of subacute detox beds that are forecasted to be needed, the CON approval of the RCA-E would have a negative impact on FMA. First, a reduction from 15% to 6.1% of indigent and gray area patient days would likely reduce the number of non-indigent patients in the service area of RCA-E who would utilize the services of FMA. Second, the CON approval of 21 beds to provide subacute detox services to 507 intermediate care patients in 2017 and 2018 duplicates the treatment capacity of FMA's 100 CON-approved ICF beds. Such duplication of available bed capacity would have a negative impact on FMA, by providing an incentive to RCA-E to treat patients that might otherwise be treated at FMA. Any reductions in demand for services at FMA that result from the approval and operation of a new ICF facility with treatment capacity that has not been demonstrated to be needed will have a negative impact on the future revenues of FMA, and will challenge FMA's ability to meet its own commitments to provide 6.3% of its patient days to indigent and gray area patients, and provide access to privately insured patients as well.

EXHIBIT 9

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Comments of Ashley, Inc., D/B/A Ashley Addiction Treatment (F/K/A Father Martin's Ashley) on the Modification in Response to September 20, 2016 Project Status Conference are true and correct to the best of my knowledge, information and belief.

Date: October 17, 2016

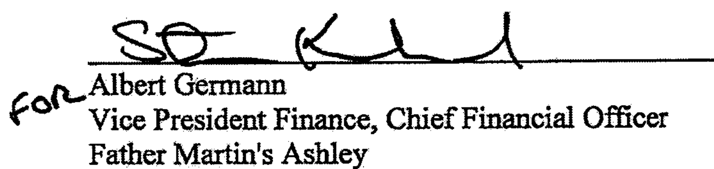
Steven M. Kendrick, MBA
Chief Operating Officer, Senior Vice President
Father Martin's Ashley

3008002.2

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Comments Ashley, Inc., D/B/A Ashley Addiction Treatment (F/K/A Father Martin's Ashley) on the Modification in Response to September 20, 2016 Project Status Conference are true and correct to the best of my knowledge, information and belief.

Date: October 17, 2016



for Albert Germann
Vice President Finance, Chief Financial Officer
Father Martin's Ashley

3008004.2

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Comments of Ashley, Inc., D/B/A Ashley Addiction Treatment (F/K/A Father Martin's Ashley) on the Modification in Response to September 20, 2016 Project Status Conference are true and correct to the best of my knowledge, information and belief.

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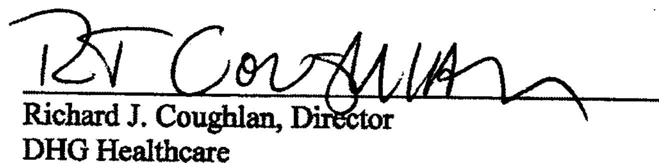

Richard J. Coughlan, Director
DHG Healthcare