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November 16, 2015

VIA HAND DELIVERY AND/OR FIRST CLASS MAIL AND EMAIL

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

Re: Comments of Father Martin's Ashley On The Modified
CON Application Of Recovery Center Of America (Earleville, Maryland)
Matter No.: 15-07-2363

Dear Mr. McDonald:

On behalf of Ashley, Inc. d/b/a Father Martin's Ashley, Inc ("FMA"), I am submitting Comments of Father Martin's Ashley On The Modified CON Application Of Recovery Center Of America (Earleville, Maryland) ("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 an electronic copy of our Comments and exhibits.

FMA opposes approval of the CON application in it present form, and by submitting these Comments seeks recognition as an Interested Party.

Please let us know if any additional information is needed.

Sincerely,

John J. Eller

JJE/tjr
Enclosures
cc: Paul Parker, Director
Maryland Health Care Commission
Suellen Wideman, Esquire
Maryland Health Care Commission
Ms. Ruby Potter
Maryland Health Care Commission

cc: Steven M. Kendrick, MBA, Sr. VP and COO
Father Martin's Ashley
Tom Dame, Esquire
Gallagher Evelius & Jones LLP
Richard J. Coughlan, Director
DHG Healthcare

IN THE MATTER OF	*	BEFORE THE
RECOVERY CENTER OF AMERICA –EARLEVILLE	*	MARYLAND HEALTH
	*	CARE COMMISSION
	*	Matter 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 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

form. It believes the new 49 bed inpatient treatment center,[1] as proposed by the Applicant, raises significant concerns that need to be addressed and corrected prior to CON approval. Further, we note that if the RCA-E application is approved as proposed, it will not be possible for FMA to fulfill its commitments under the conditional CON issued for its expansion project (Docket No. 13-12-2340) which requires FMA to provide a minimum of 6.3% of patient days of care to indigent and gray area patients, as defined in the State Health Plan.

FMA Qualifies as an Interested Party to the Application

FMA qualifies as an interested party to the Application. An "interested party" includes, among others, "[a] person who can demonstrate to the reviewer that the person would be adversely affected, in an area over which the Commission has jurisdiction, by the approval of a proposed project."[2] An adversely affected person includes a person who:

A. "Is authorized to provide the same service as the applicant...in a contiguous planning region if the proposed new facility or service could reasonably provide services to residents in the contiguous area..."[3] or

B. "Can demonstrate to the reviewer that the person could suffer a potentially detrimental impact from the approval of a project before the Commission, in an issue area over which the Commission has jurisdiction..."[4]

FMA is adversely affected within the meaning of A. above. FMA provides intermediate care substance abuse treatment services, and the Application proposes intermediate care substance abuse treatment services. Further, the Application itself states that the proposed project would service residents of the mid-Atlantic region, including Maryland, in which FMA is

[1] RCA-E states that it is applying for 21 adult ICF beds and 28 other adult residential beds.
[2] COMAR 10.24.01.01(B)(20)(e).
[3] COMAR 10.24.01.01(B)(2)(a).
[4] COMAR 10.24.01.01(B)(2)(d).

located. FMA is adversely affected within the meaning of B. above, as the proposed facility would result in fewer admissions to FMA. This is a direct detrimental impact on FMA's future volumes, an issue over which the Commission has jurisdiction.

For the above reasons, FMA qualifies as an interested party to this Application, and submits these Comments of Father Martin's Ashley On The Modified CON Application Of Recovery Center Of America in Earleville, Maryland (Earleville, Maryland) (the "Comments"), These Comments will demonstrate that the Applicant has not complied with applicable provisions of the State Health Plan, COMAR 10.24.14.04 ("SHP" or "State Health Plan") and the review criteria included in COMAR 10.24.01.08G(3) .

Comment #1 -

The 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. This is a reduction from the required 15% of its projected patient days. The applicant has stated that the 15% standard should be reduced to 6.15% because treatment services are now available to more Marylanders at other substance abuse treatment facilities that are already in existence because of expanded Medicaid and private insurance coverage. RCA-E estimates that 58% of uninsured nonelderly people in the State are eligible for financial assistance to gain coverage through either Medicaid or the marketplaces. The applicant states that the 15% level of commitment to providing care to the indigent and gray area is not reasonable in light of the increased number of Medicaid covered and private insurance covered Marylanders. RCA-E proposes to reduce the required amount of care to be provided to indigent and gray area patients (15%) by the reduction the percentage of uninsured non-elderly adults (41%) to 6.15%. (See Exhibit 1: Modified CON Application, pp. 41-42).

The Applicant also provided other reasons why the 15% standard should not apply. The Applicant provided a "Response to Additional Information Questions Dated July 17, 2015." Question #5 reads:

> The standard requires an applicant to commit that it will provide 15 percent or more of its proposed annual intermediate care facility bed days to indigent or gray area patients. In proposing a lower percentage, the applicant cites a previous MHCC decision in the review of an application from Father Martin's Ashley (FMA) that accepted a lower commitment to provision of services to indigent and gray area patients (6.3% of patient-days was the accepted commitment. However, the main driver of the Commission's decision on this aspect of FMA's application was the fact that higher levels of charity care would lead to unsustainable losses. The projections shown by RCA tell a much different story: Exhibit 2, which models financial performance at that higher percentage of indigent or gray area patients, shows a healthy profit margin, with a profit of $3.4 M on total expenses of $10.9M in year 2, and profits of $3.39M on expenses of $10.9M in year 3. In light of those numbers, why should MHCC consider deviating from the guidance of this standard?

In response to this question from the Commission, the Applicant compared the proposed 6.15% commitment of projected patient days at RCA-E to the lower level of charity care provided at Maryland hospitals (median of 3.5% ratio of charity care to operating expenses in FY 2012), concluding that its proposal is "much more generous than the charity care provided by Maryland hospitals." The Applicant also suggests that RCA-E's ability to provide service to gray area patients may be limited because it is a for-profit entity, and its financial projections do not include federal income tax or state taxes, which, if included in RCA-E's expenses, would increase by more than $1.6M., that its profit margin would decrease to 4.1% if RCA-E were to provide 15% of its annual bed days to indigent or gray area patients, and that the Applicant has proposed "the largest addiction treatment awareness budget within the State of Maryland, projecting more than $4M in awareness throughout the State," and is "planning a 24/7 coverage call center that will receive calls throughout its increased awareness efforts for patients seeking care."[5]

Thus, the Applicant has argued that it needs to reduce the number of indigent and gray area Marylanders that it should commit to treat for both financial and non-financial reasons. The

[5] Letter Dame to Potter, August 31, 2015, p. 5-7.

Application does not clearly support the conclusion that the 15% commitment cannot be met, as even under the Applicant's assumptions, there will still be indigent and gray area Marylanders who will need the services RCA-E proposes to provide, and that if it provides that care at the required standard, it will still be a profitable and therefore financially viable facility.

We address the Applicants reasons below for reducing the standard from 15% to 6.1%.

RCA-E has not demonstrated a reasonable basis for the proposed reduction from 15% to 6.13%: the pool of indigent and gray area Marylanders has significantly declined, and therefore its "share" of this patient population should similarly be expected to decline.

The ACA was signed into law by President Obama in March 23, 2010 and upheld by the Supreme Court on June 28, 2012. The SHP went into effect on February 28, 2013. The MHCC could have anticipated this reduction in the number of uninsured and indigent patients, but instead retained the 15% standard.

There are still a significant number of indigent and gray area adult Marylanders who do not have Medicaid or health insurance coverage despite the expansion of Medicaid coverage and the private health insurance and the availability of existing facilities to treat those residents. According to a Gallup poll, 12.9% of Maryland residents were without health insurance in 2013, and this proportion went down to 7% in first half of 2015.[6] County-by-county estimates are available and also show that there are still Marylanders who do not have health insurance coverage.[7] Based on these estimates, there are still over 400,000 Maryland residents who do not have health coverage.

The SHP standard requires the 15% standard to apply to "adult intermediate care bed days." FMA-E has projected providing 15,202 days. If the standard were to apply, that would mean 2,280 days, or 76 discharges/year. Instead, FMA-E has committed to providing 6.1% (927

[6] http://www.gallup.com/poll/184514/uninsured-rates-continue-drop-states.aspx **(Exhibit 2)**.
[7] http://www.nytimes.com/interactive/2015/10/31/upshot/who-still-doesnt-have-health-insurance-obamacare.html?_r=0 (Exhibit 3).

days; 31 discharges). That is a 59% reduction, and a loss of access for 45 indigent and gray area patients. Among the 400,000 Maryland residents who still do not have health insurance coverage, there are certainly at least 45 per year who need inpatient substance abuse services and could benefit from the services proposed at RCA-E.

RCA-E has not demonstrated a reasonable basis for the proposed reduction from 15% to 6.13%: the proposed facility will still be profitable and therefore financially viable.

Under all of the assumptions presented by the Applicant, if the RCA-E facility provides 15% of its proposed patient days to indigent and gray area patients, it will still produce operating income and be financially viable. It admits that RCA-E will generate operating income; by definition, any profitability would contribute to its financial viability.

RCA-E has not demonstrated a reasonable basis for the proposed reduction from 15% to 6.13%: The financial projections do not include contracting discounts with private health plans.

None of the financial projections in the RCA-E CON application includes a projection of contractual adjustments to gross patient care revenues. (See Exhibit 4). It is unreasonable to assume that no adjustment to gross revenues will be made for a health care facility that intends to provide services covered and reimbursed under commercial health insurance plans. It would appear that RCA-E intends to operate as an "out-of-Network" provider with respect to privately insured patients, and would require those patients with health insurance to pay RCA-E the difference between its proposed rates, and what health insurance plans would agree to pay. In the experience of FMA, private health insurance plans pay approximately 23% of charges. By operating as an "out-of-Network" provider, this practice of "balance billing" reduces access to services by patients who do not have the means to pay this difference. FMA in contrast, has contracts with multiple health plans, and has budgeted approximately $7 Million in contractual

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.

RCA-E's mischaracterization of the meaning of the IRS Form 990s filed by FMA is an indication that RCA-E does not understand the evidence that FMA provided to the Commission to enable it to meet its commitment to the indigent and gray area population at 6.3% patient days instead of 15% of patient days. See Exhibit 8, the Responses to MHCC Request for Additional Information, August 31, 2015, pp. 4-8.

As shown in TABLE 16 and 17 of that Exhibit, Father Martin's Ashley is reported to have net operating income of $2,068,532 in 2014. This is incorrect. The actual operating income of FMA in that period was a loss of $5,485. The difference between the two numbers is the reported non-operating (emphasis added) income generated by the investments of FMA during that period. The actual financial information found on the IRS Form 990s for FMA is shown below, which is also entirely consistent with the financial information previously submitted to the Commission by FMA.

990 DATA					
	Line #	Ashley 2014	Ashley 2013	Ashley 2012	Ashley 2011
Staff	5	225	225	234	213
Volunteers	6	4	4	0	0
Contributions and Grants	8	947,686	1,301,400	820,356	3,832,267
Program Service Revenue	9	21,075,308	19,280,625	18,594,159	18,321,849
Investment Income	10	2,074,017	(159,036)	319,152	1,003,775
Other Revenue	11	109,017	178,581	208,876	191,540
Total Revenue	12	24,206,028	20,601,570	19,942,543	23,349,431
Revenue net of Invest Income	Calc	22,132,011	20,760,606	19,623,391	22,345,656
Charity Care/Grants	13	3,039,199	2,416,431	2,116,524	2,092,876
Salary and Benefits	15	11,536,458	10,937,186	10,445,249	9,212,715
Professional Fundraising Fees	16	130,039	202,635	252,558	131,744
Fundraising Expenses	16a	868,610		712,482	569,300
Other Expenses	17	7,431,800	6,636,196	6,299,420	6,265,743
Total Expenses	18	22,137,496	20,192,448	19,113,751	17,703,078
Revenue less Expenses	19	2,068,532	409,122	828,792	5,646,353
Rev net Invest Inc less Exp	Calc	(5,485)	568,158	509,640	4,642,578
Margin % of Prog Rev	Calc	0.0%	2.9%	2.7%	25.3%

Source: FMA.

FMA would respectfully suggest that the record in this matter include all of the undisputed financial information that was reviewed by the Commission during the course of its evaluation of the CON Application approved for FMA for its expansion project.

As more fully detailed in the Commission's CON approval of the FMA expansion project, the Commission took into account the projected operating losses at FMA in determining that the 6.3% target should apply because FMA would be able to cover those future operating losses with investment income (See Exhibit 8: In the Matter of Ashley, Inc. dba Father Martin's Ashley, Docket No. 13-12-2340, September 19, 2013).

Summary and Conclusion

FMA appreciates that RCA-E seeks to meet the need for more ICF treatment capacity for inpatient substance abuse treatment for adults in Maryland. While FMA would not object to the CON approval of a facility that meets all standards and criteria, the RCA-E application would need to be modified to address its deficiencies that are identified above. In particular, its assessment of bed need and its forecasts of future revenues are not consistent with the State Health Plan and do not recognize the need to provide access to all Marylanders for ICF services, whether indigent or non-indigent.

A remedy for these errors in projecting need and deficiencies in providing sufficient financial access would be for RCA-E to BOTH reduce its proposed number of beds from 49 to 34 to more accurately address the actual needs of the future patients to be treated in a private intermediate care facility for adults[8], and to provide 15% of its patient days to indigent and gray area patients. This reduction in bed capacity will also reduce the negative impact that will result if FMA is not able to meet its utilization projections and charity care commitment as approved

[8] Of course, RCA-E may return to seek Commission approval for an expansion of its ICF bed complement, after becoming an established provider with a track record of success, if future demand for RCA-E's services can be demonstrated at that point.

by the MHCC for its expansion project. RCA-E has forecasted providing 15,202 patient days, of which 935 days (6.15%) will be for indigent and gray area patients, 3,800 will be commercial insurance (25%), and 10,467 (68.85%) will be self-pay. RCA-E's projections compare with FMA's CON Approved projections of 2,183 (6.3%) indigent and gray area patient days for charity care. It can certainly do better. However, unlike RCA-E, FMA also committed to continue to provide discounted days of care to privately insured patients, which amounted to $7 Million in contractual adjustments in its CON approved forecasts. Together these commitments will cost FMA over $10 M per year in lost revenue. No such commitment has been incorporated into the financial projections of RCA-E, which has both financial implications and implications for patient access for those patients who are privately insured. We ask that the same standard of performance projected by FMA and approved by the Commission include requirements that RCA-E also contract with third party payers (and quantify its projected level of discounts as contractual allowances in its revenue projections) in order to maximize accessibility to Marylanders with coverage through private health plans. FMA projected, and the MHCC approved, $7.1 Million in contractual adjustment in FY 2017; this represented 23% of FMA's gross inpatient revenues. A similar level of discounting for contractual adjustments for RCA-E in FY 2017 would yield $3.3 Million in savings to the health care system, payers and patients ($14.3 M X 23% = $3.29 M). RCA-E should be required to address the affordability of its programs as a non-contracting provider in comparison to FMA.

RCA-E did not project any lost revenues for contractual adjustments, although it stated it would be negotiating for volume discounts. These lost revenues reflect market conditions, and should be included in the financial projections of RCA-E in order to demonstrate financial

feasibility as well as accessibility to both indigent and gray area patients, and privately insured patients.

In order to be approvable, the RCA-E CON Application would need to be modified to quantify its commitment to providing a specific amount of discounted care to privately insured patients comparable to the amount FMA projected in its approved CON.

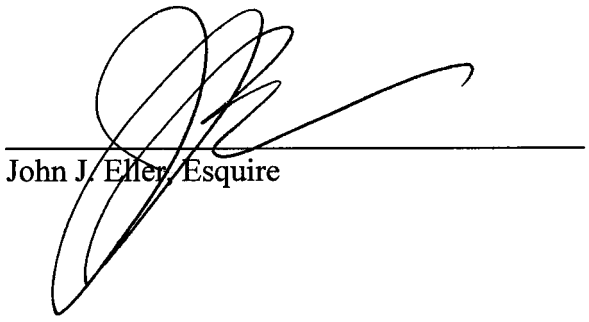
If the MHCC finds the RCA-E application approvable as submitted, and conditions the RCA-E to meet its proposed 6.1% level of patient days to indigent and gray area patients with no commitment to following through on its intentions to negotiate discounts to third party payers or reduce the number of subacute detox beds it intends to fill, FMA will surely be impacted to the point where it will be unable to meet its CON commitments, and will need to seek MHCC approval to lower the level of patient days to be provided to indigent and gray area patients. All providers should be treated the same way, and be required to meet the same targets for accessibility, affordability and financial feasibility.

Without appropriate changes to the RCA-E application and payer mix, and because FMA and RCA-E will both likely be charging ~$1,100/day in FY 2017 to "self-pay" patients (on average), i.e., those patients who pay 100% of the charges, it is likely that some of those self-pay patients who would otherwise choose FMA will unfairly and inappropriately elect to be treated at RCA-E.

Currently, approximately 17 patients on any given day at FMA are 100% self-pay. It is possible that the self-pay census at FMA could be reduced by half, substantially reducing the revenues of FMA. It is difficult if not impossible to accurately project the number of such patients that would seek care at RCA-E instead of at FMA. FMA initial estimates are that it could be as few as 65 admissions to as many as 130 admissions/year among self-pay patients to

RCA-E, resulting in estimated losses of between $1.6 Million and $3 Million, which would make FMA an unsustainable enterprise, even after reducing staffing and other expenses. It would no longer be a "break-even" facility. Keeping the Condition for providing 6.3% of its patient days on FMA would not be feasible under these circumstances, and FMA would need to seek an amendment to the CON issued to FMA if the financial impact of RCA-E results in the anticipated revenue losses described above.

For the reasons discussed above, FMA respectfully requests that the RCA-E application not be approved unless and until it remedies the deficiencies identified in these Comments, and its application is brought into full compliance with all applicable Commission CON and SHP review criteria.



John J. Eller, Esquire

CERTIFICATE OF SERVICE

I HEREBY CERTIFY THAT, on this 16th of November, 2015, a copy of the foregoing Comments of Father Martin's Ashley On The Modified CON Application Of Recovery Center Of America (Earleville, Maryland) was sent via e-mail and first class mail, postage prepaid, to:

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LIST OF EXHIBITS

1. Excerpts from RCA-E Modified CON application re charity care standard

2. Article: " In U.S., Uninsured Rates Continue to Drop in Most States," reporting on Gallup Poll results

3. New York Times Article: "Uninsured. You'll Notice a Pattern."

4. RCA-E Table G. Revenues and Expenses, Uninflated, Entire Facility (Corrected) showing no contractual adjustments

5. RCA-E Price Schedule

6. FMA Break-even Tables G and H (Corrected)

7. RCA-E Bed Capacity Table A

8. FMA Final Decision: In the Matter of Ashley, Inc. d/b/a Father Martin's Ashley, Docket No. 13-12-2340, September 19, 2013

9. Affirmations

EXHIBIT 1

Applicant Response

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

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

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

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

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

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

Medicaid's role in purchasing and delivering substance abuse services is changing dramatically. Prior to the implementation of the ACA, most state Medicaid programs did not cover childless adults and covered only a limited number of parents. Moreover, coverage of substance abuse services has traditionally been an optional Medicaid benefit and, as a result,

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

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

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

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

Given that the Affordable Care Act has expanded Medicaid and private insurance coverage for an estimated 59% of previously uninsured Marylanders, Applicant believes it would be reasonable to reduce the amount of indigent care required by this standard decision, which preceded the effect of the ACA act, by 59%. Applying this figure, it would be reasonable to provide 6.15% of patient days for indigent and gray area patients. (15% x 41% = 6.15%). Applicants revenue and expense projection tables, Exhibit 1, Tables G, H, J and K, reflect this commitment of 6.15%. However, 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, Tables G, H, J and K.

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.

EXHIBIT 2

GALLUP

AUGUST 10, 2015

In U.S., Uninsured Rates Continue to Drop in Most States

by Dan Witters

Story Highlights

- *Arkansas and Kentucky continue to set pace among states*
- *Medicaid expansion, state exchanges linked to greater reductions*
- *No state reported statistically significant increase in uninsured*

WASHINGTON, D.C. -- Arkansas and Kentucky continue to have the sharpest reductions in their uninsured rates since the healthcare law took effect at the beginning of 2014. Oregon, Rhode Island and Washington join them as states that have at least a 10-percentage-point reduction in uninsured rates.

Ten States With Largest Reductions in Percentage of Uninsured, 2013 vs. First Half of 2015

"Do you have health insurance?" (% No)

State	% Uninsured, 2013	% Uninsured, first half of 2015	Change in uninsured (pct. pts.)	Medicaid expansion and/or state/ partnership exchange in 2014
Arkansas	22.5	9.1	-13.4	Both
Kentucky	20.4	9.0	-11.4	Both
Oregon	19.4	8.8	-10.6	Both
Rhode Island	13.3	2.7	-10.6	Both
Washington	16.8	6.4	-10.4	Both
California	21.6	11.8	-9.8	Both
West Virginia	17.6	8.3	-9.3	Both
Alaska	18.9	10.3	-8.6	Neither
Mississippi	22.4	14.2	-8.2	One
North Dakota	15.0	6.9	-8.1	One

Gallup-Healthways Well-Being Index

GALLUP

Seven of the 10 states with the greatest reductions in uninsured rates have expanded Medicaid and established a state-based marketplace exchange or state-federal partnership, while two have implemented one or the other. The marketplace exchanges opened on Oct. 1, 2013, with new insurance plans purchased during the last quarter of that year typically starting on Jan. 1, 2014. Medicaid expansion among initially participating states also began with the onset of 2014. As such, 2013 serves as a benchmark year for uninsured rates as they existed prior to the enactment of the two major mechanisms of the healthcare law.

Through the first half of 2015, there are now seven states with uninsured rates that are at or below 5%: Rhode Island, Massachusetts, Vermont, Minnesota, Iowa, Connecticut and Hawaii. Previously -- from 2008 through 2014 -- Massachusetts had been the only state to be at or below this rate. No state, in turn, has reported a statistically significant increase in the percentage of uninsured thus far in 2015 compared with 2013. Nationwide, the uninsured rate fell from 17.3% in full-year 2013 to 11.7% in the first half of 2015.

These data, collected as part of the Gallup-Healthways Well-Being Index, are based on Americans' answers to the question, "Do you have health insurance coverage?" These state-level data are based on daily surveys conducted from January through June 2015 and include sample sizes that range from 232 randomly selected adult residents in Hawaii to more than 8,600 in California.

States That Have Embraced Multiple Parts of Health Law Continue to See More Improvement

Collectively, the uninsured rate in states that have chosen to expand Medicaid *and* set up their own state exchanges or partnerships in the health insurance marketplace has declined significantly more since 2013 than the rate in states that did not take these steps. The uninsured rate declined 7.1 points in the 22 states that implemented both of these measures by Dec. 31, 2014, compared with a 5.3-point drop across the 28 states that had implemented only one or neither of these actions.

Change in Uninsured Rate Between 2013 and First Half of 2015 Among States With Medicaid Expansion AND State Exchange/Partnership Compared With All Others*

State type	% Uninsured, 2013	% Uninsured, first half of 2015	Change in uninsured (pct. pts.)	% Reduction in uninsured rate
States with Medicaid expansion AND state exchange	16.0%	8.9%	-7.1	44%
States with only one or neither	18.7%	13.4%	-5.3	28%

Gallup-Healthways Well-Being Index
*As of Dec. 31, 2014

GALLUP

Although the 22 states that implemented both mechanisms before Jan. 1, 2015, had a lower uninsured rate to begin with, the 7.1-point drop is larger than what is reported among the other 28 states, and represents a 44% decline since 2013 in the uninsured rate among adults residing there. The 5.3-point drop in the 28 states that have implemented one or neither of the mechanisms represents a 28% decline in uninsured rates. Still, the difference in the *rate of decline* in uninsured rates between the two groups of states has now leveled off, and is unchanged relative to the same 1.8-point gap in the rate of decline measured in midyear 2014.

The end of this article contains a full list of all 50 states, and the 2013 and first-half 2015 uninsured rates for each.

Implications

Americans' attitudes about the law known as "Obamacare" have become more positive in recent months, and now as many Americans approve of the law as disapprove, a shift from the last several years in which disapproval had consistently outweighed approval. This is happening as uninsured rates for most states have continued to decline. The Supreme Court ruling in the King v. Burwell case preserved subsidies for qualifying, low-income adults in states that have defaulted to the federal exchange rather than set up their own locally managed and promoted insurance marketplaces. That decision preserves health insurance for the millions of American adults in those states who have gained health insurance via the federal marketplace in the last two years.

A few states, including Utah, continue to consider Medicaid expansion under modified specifications from what is detailed in the Affordable Care Act. In addition to New Hampshire last August, Indiana and Pennsylvania each enacted Medicaid expansion in early 2015, becoming the 27th and 28th states (plus the District of Columbia) to expand Medicaid. Implementation of this type of expansion in Montana is pending federal waiver approval, and Alaska Gov. Bill Walker has announced that he will proceed with expansion, submitting plans on July 16 to accept federal funds for Medicaid, with a Sept. 1 target date for expansion. While some additional progress can be made, therefore, in the reduction of the uninsured rate via further Medicaid expansion, this mechanism for reduction has likely reached most of its potential unless additional states choose to implement it. As such, the marketplace exchanges that enable people to select and purchase their own plan directly from insurers will likely be the primary means by which the national uninsured rate would be reduced in the immediate future.

Change Analysis Rules

Some states have chosen to implement state-federal "partnership" exchanges, where states manage certain functions and make key decisions based on local market and demographic conditions. For the purposes of this analysis, these partnerships are included with the state exchanges. States with Medicaid expansion that occurred on or after Jan. 1, 2015, were excluded from the "States With Medicaid Expansion and State Exchange/Partnerships" group. For example, Pennsylvania, which manages a state-based exchange but did not enact Medicaid expansion until Jan. 1, 2015, is excluded, while New Hampshire -- which expanded in August 2014 and has been excluded in previous analyses -- qualified for this one. Four states -- North Dakota, New Jersey, Ohio and Arizona -- decided to expand Medicaid without also administering a state-based exchange or partnership, while several others continue to debate expansion. Pennsylvania enacted Medicaid expansion effective Jan. 1, 2015, and Indiana did so on Feb. 1. The District of Columbia, which has expanded Medicaid and has implemented a locally managed exchange, is not included in this analysis.

Survey Methods

Results are based on telephone interviews conducted Jan. 2-Dec. 30, 2013, and Jan. 2-June 30, 2015, as part of the Gallup-Healthways Well-Being Index, with a random sample of 178,072 adults in 2013 and 88,667 adults through the first half of 2015, aged 18 and older, living in all 50 U.S. states and the District of Columbia. The margin of sampling error is ±1 to ±2 percentage points for most states, but climbs as high as ±4 percentage points for 2015 results for states with small populations such as North Dakota, Wyoming, Vermont and Alaska. All reported margins of sampling error include computed design effects for weighting.

Each sample of national adults includes a minimum quota of 50% cellphone respondents and 50% landline respondents, with additional minimum quotas by time zone within region. Landline and cellular telephone numbers are selected using random-digit-dial methods.

Learn more about how the Gallup-Healthways Well-Being Index works.

2015 Midyear Uninsured Rates, by State

State	2013 sample sizes	First half of 2015 sample sizes	% of Residents without health insurance, 2013	% of Residents without health insurance, first half of 2015
Alabama	3,070	1,486	17.7	12.0
Alaska	564	236	18.9	10.3
Arizona	4,062	2,201	20.4	14.5
Arkansas	1,959	1,036	22.5	9.1
California	17,053	8,628	21.6	11.8
Colorado	3,495	1,767	17.0	10.6
Connecticut	2,110	942	12.3	5.0
Delaware	554	268	10.5	9.9
Florida	9,770	5,072	22.1	15.2
Georgia	5,128	2,606	21.4	15.3
Hawaii	601	232	7.1	5.2
Idaho	1,232	641	19.9	16.2
Illinois	5,958	2,769	15.5	8.8
Indiana	3,972	2,005	15.3	11.1
Iowa	2,327	979	9.7	5.0
Kansas	1,871	925	12.5	11.3
Kentucky	2,755	1,350	20.4	9.0
Louisiana	2,598	1,287	21.7	16.3
Maine	1,143	579	16.1	9.4
Maryland	3,223	1,527	12.9	7.0
Massachusetts	3,712	1,808	4.9	3.0
Michigan	5,198	2,501	12.5	8.5
Minnesota	2,600	1,604	9.5	4.6

Mississippi	1,753	839	22.4	14.2
Missouri	3,652	1,740	15.2	11.4
Montana	1,034	511	20.7	14.4
Nebraska	1,403	674	14.5	10.0
Nevada	1,440	734	20.0	15.2
New Hampshire	902	464	13.8	8.7
New Jersey	4,582	2,246	14.9	9.7
New Mexico	1,514	717	20.2	13.1
New York	9,650	5,121	12.6	8.3
North Carolina	5,913	2,966	20.4	14.7
North Dakota	547	242	15.0	6.9
Ohio	6,189	3,163	13.9	6.1
Oklahoma	2,771	1,391	21.4	17.7
Oregon	3,064	1,486	19.4	8.8
Pennsylvania	8,564	4,125	11.0	7.7
Rhode Island	599	269	13.3	2.7
South Carolina	2,735	1,447	18.7	12.6
South Dakota	584	277	14.0	7.2
Tennessee	4,138	2,149	16.8	12.9
Texas	12,473	6,563	27.0	20.8
Utah	2,109	1,047	15.6	13.2
Vermont	588	295	8.9	4.6
Virginia	4,993	2,559	13.3	12.5
Washington	4,897	2,240	16.8	6.4
West Virginia	1,261	631	17.6	8.3
Wisconsin	3,652	1,834	11.7	5.6
Wyoming	558	284	16.6	18.2

Gallup-Healthways Well-Being Index

GALLUP

RELEASE DATE: August 10, 2015
SOURCE: Gallup http://www.gallup.com/poll/184514/uninsured-rates-continue-drop-states.aspx
CONTACT: Gallup World Headquarters, 901 F Street, Washington, D.C., 20001, U.S.A
+1 202.715.3030

EXHIBIT 3

1.
1. 

   Economic View

   ### The Tax Code Can Be Simpler. But Not Three Pages.

2. 

   Readers' Turn

   ### The Chore Wars: Tales of Houses Divided

3. 

   Road to 2016

   ### How Many Lanes Do the Republicans Really Have?

4. 

   Best of the Web

   ### Stuff We Liked: Prussian Cavalrymen and Congressional Excuses

5. 

   The Second Shift

   ### Men Do More at Home, but Not as Much as They Think

6.

Road to 2016

The G.O.P. Tax Debate: Low or Lower; Flat or Flatter?

7.

Gender Gap

Even Famous Female Economists Get No Respect

8.

Monetary Policy

Why Jeffrey Lacker Is Worried About Inflation

9.

Readers' Turn

Is Rubio Too Young for Republicans?

10.

T.M.Q. — Tuesday Morning Quarterback

Football Inequality, and a Patriots-Panthers Super Bowl?

11.

By the Numbers

Your Kids Will Live Longer Than You Thought

12.

Playoff Chase

Where Humans and Computers Agree in College Football

13.

The New Health Care

Good Talks Needed to Combat HPV Vaccine Myth

14.

By the Numbers

More Details on Rising Mortality Among Middle-Aged Whites

15.

Monetary Policy

Is the Economy Overheating? Here's Why It's So Hard to Say

16.

Public Opinion

The Limits of the 'Tobacco Strategy' on Climate Change

17.

Economic View

Obamacare Not as Egalitarian as It Appears

18.

Best of the Web

Stuff We Liked: Food Trucks and Tourist Lanes

19.

Jobs Report

The October Jobs Numbers Are a Big Relief

20.

The Road to 2016

Marco Rubio and Republican Party Seem Near a Turning Point

21. 

Road to 2016

Ted Cruz Has a Chance to Win. Here's the Path.

22. 

Work-Life Balance

Stressed, Tired, Rushed: A Portrait of the Modern Family

23. 

Public Health

Health Insurance and the States: A Closer Look

2. Loading...

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- Sports

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- Fashion & Style
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- Obituaries
- Video
- The Upshot
- Conferences

- Crossword
- Times Insider

- Multimedia
- Photography

- NYT Store
- NYT Wine Club
- nytEducation
- Times Journeys

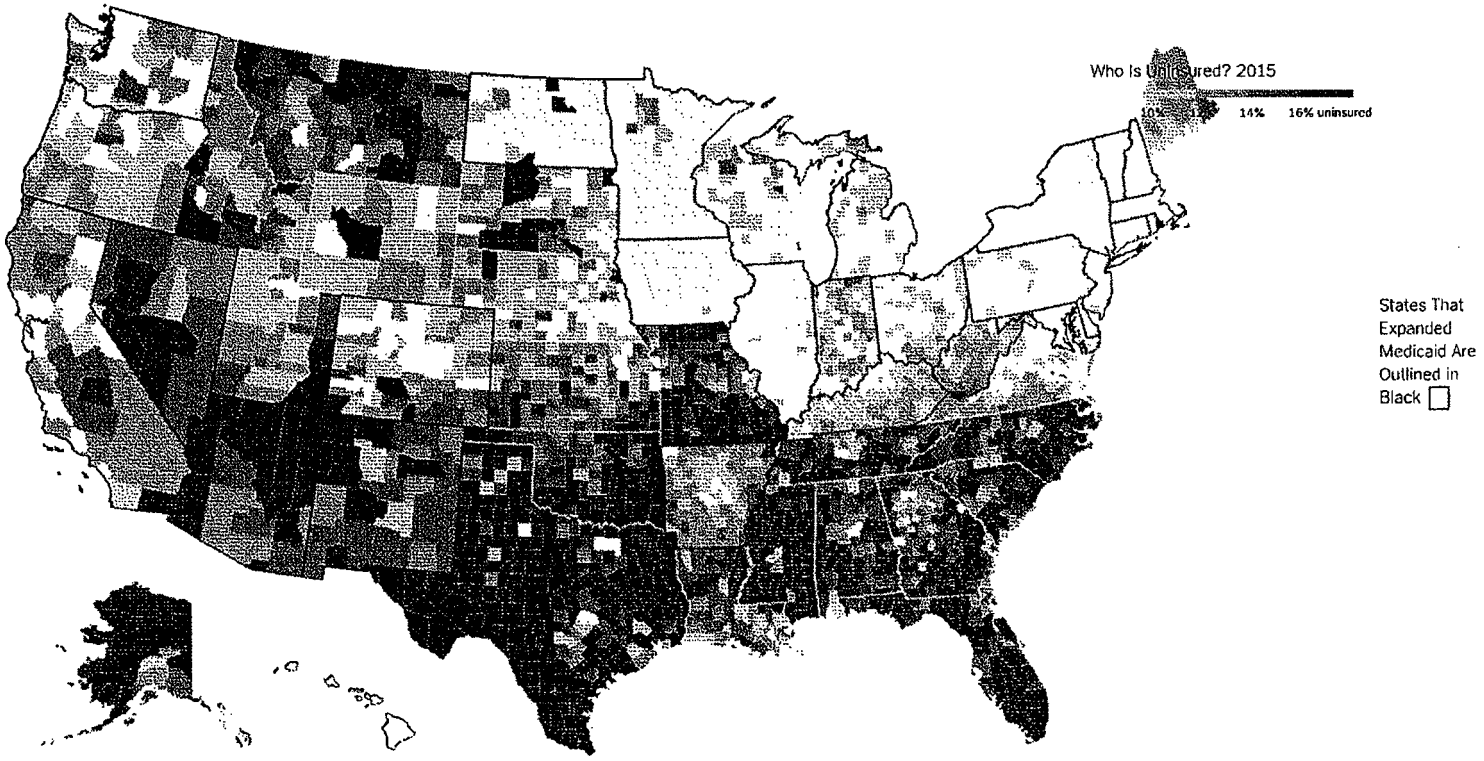
- Subscribe
- Manage Account
- Today's Paper

Edited by David Leonhardt

We Mapped the Uninsured. You'll Notice a Pattern.

By QUOCTRUNG BUI and MARGOT SANGER-KATZ OCT. 30, 2015

They tend to live in the South, and they tend to be poor.



Two years into Obamacare, clear regional patterns are emerging about who has health insurance in America and who still doesn't.

The remaining uninsured are primarily in the South and the Southwest. They tend to be poor. They tend to live in Republican-leaning states. The rates of people without insurance in the Northeast and the upper Midwest have fallen into the single digits since the Affordable Care Act's main provisions kicked in. But in many parts of the country, obtaining health insurance is still a problem for many Americans.

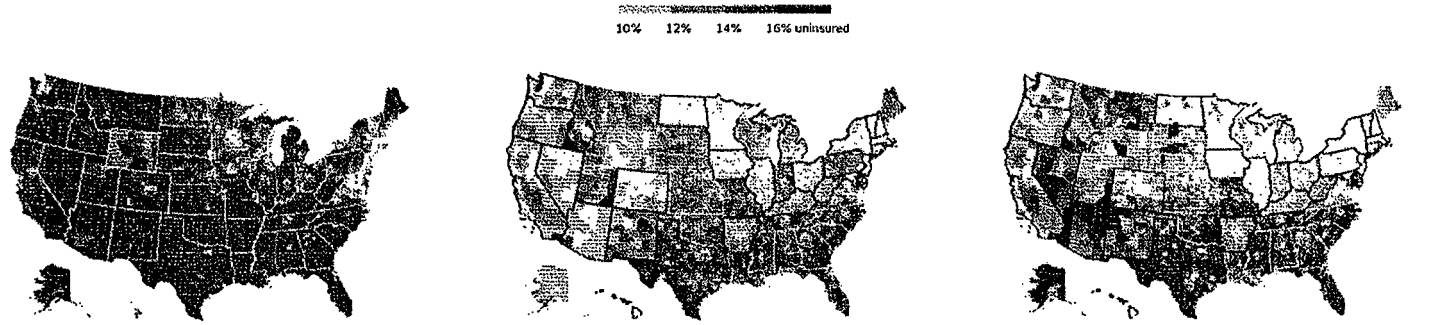
These trends emerged in an analysis we undertook with the help of two organizations that are closely monitoring the progress of the health law. Last year, we used similar data to show the the substantial effects Obamacare had on reducing the number of Americans without health insurance. This year, the same groups updated their estimates of where America's uninsured live, and the change is a lot less drastic. States that were late to expand Medicaid, including Pennsylvania and Indiana, showed substantial reductions in their uninsured residents compared with last year. In other places, the changes have been more modest. In a few — like Mississippi — things appear to have gotten worse, with fewer people having health insurance this year than last.

"This year it's more of a state-specific story," said Ed Coleman, the director of data and analytics at Enroll America, an organization devoted to finding uninsured people and signing them up for insurance. Enroll worked with the data firm Civis Analytics to produce the numbers in our map. "There was a pronounced drop pretty much everywhere last year, and we don't see that pattern again this time around."

The incremental changes in our map are consistent with other data. Fewer people signed up for insurance this year using the new state marketplaces than some analysts had expected. Medicaid enrollment leveled off. And many of the people who lack insurance in states with a lot of uninsured people are effectively unable to benefit from Obamacare programs because of their low incomes and local politicians' decisions to forgo Medicaid expansion. More than three million people in 19 states remain stuck in a "Medicaid gap," too poor to qualify for subsidies in the new marketplaces, but unable to get into a government program.

Medicaid expansion continues to be a huge predictor of how many people remain uninsured in a given state. We've outlined the states that expanded Medicaid in black to make them easy to see. But we almost don't have to, because many of the state lines are so clear from the uninsured rates alone. Look at the difference between Missouri and Illinois, for example.

Percentage Uninsured, by County, 2013 to 2015



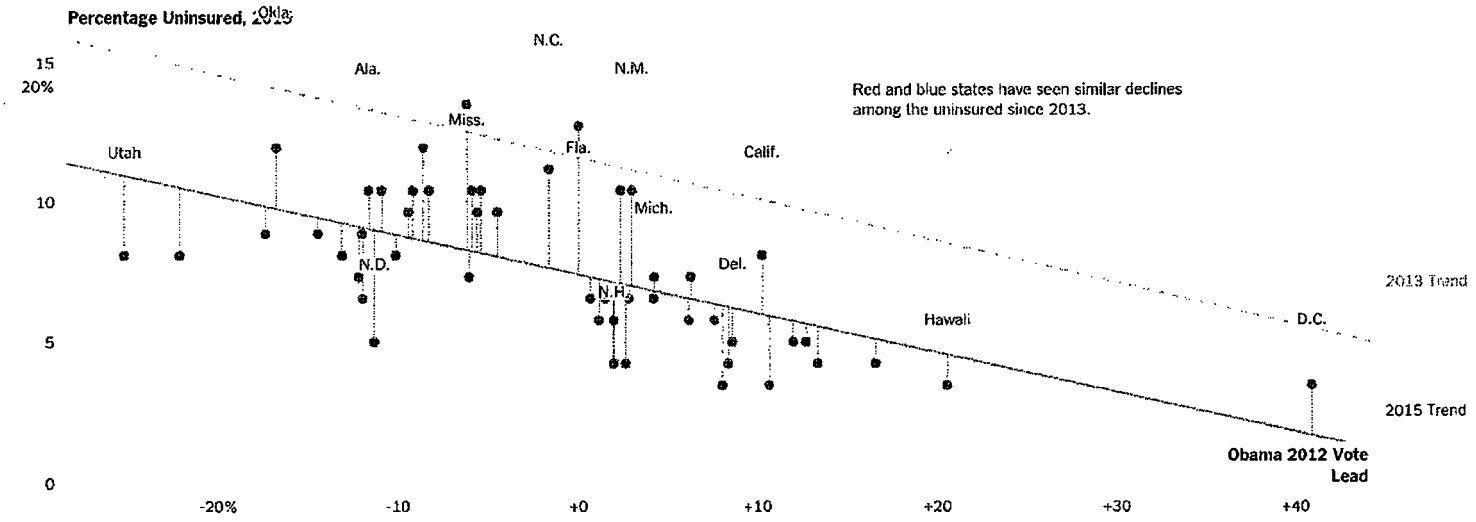
In **2013**, there were only 10 states where the percentage of residents who lacked health insurance was lower than 9 percent.

In **2014**, the Affordable Care Act was rolled out, reducing the number of Americans without health insurance. States that expanded Medicaid, outlined in black, saw the biggest changes.

In **2015**, Pennsylvania and Indiana also expanded their Medicaid programs. Now states with the highest rates of uninsured residents are in the South and Southwest.

Politics matters. Though several states with Republican leadership have expanded their Medicaid programs, many have not. Over all, Republican-leaning states continue to have more uninsured people than Democratic-leaning ones. But they also tended to have many more uninsured people at the start.

More Uninsured in Red States



Source: Enroll America and the Federal Elections Commission

This year's map looks a lot like last year's. When the health law passed, the hope was for new insurance opportunities to provide coverage to some 32 million people. It has become increasingly clear that the law will not achieve that goal. In addition to the incomplete Medicaid expansion, the result of a 2012 Supreme Court ruling, interest in the individual marketplaces has proved more tepid than many had hoped. The Congressional Budget Office, when it estimated the effects of the law in 2010, had expected that eight million people would buy marketplace plans in 2014, and 21 million would have them by the end of 2016. At the end of 2014, only 6.3 million had enrolled. This month, the Department of Health and Human Services released its estimates for enrollment for 2016: 10 million Americans. (Over the two years, there has also been some unanticipated good news: More people have remained insured through work than the C.B.O. had estimated.)

It is undeniable, however, that the law has had a substantial effect. Compare this year's map, where dark purple regions represent areas where the uninsured rate remains above 16 percent, with the map from 2013, when nearly the whole country looked purple. Medicaid expansion is being considered in a few more states. Montana has decided to move forward next year. (Alaska started its expansion in September.)

The data used to make this map are unlike any other data about the number and location of the uninsured. They're based on a complex model that Enroll and Civis undertook using a large survey conducted in May and tools often used by political campaigns to target likely voters. That strategy allows us to show more detail than is available using more conventional surveys — like these state-level surveys from Gallup — but they also use different assumptions than more conventional polling. The census, which provides the industry gold standard data on the uninsured and where they live, takes a long time to collect and publish data. Last fall, Enroll's model showed us insurance rates around the country in 2014. The census published 2014 data with a similar level of specificity only this week.

Some of the changes between last year's map and this one may reflect refinements of the Enroll model more than major shifts in the level of the uninsured. In a few states, Enroll's 2014 estimates differed from the 2014 census by more than a few percentage points. The states with these errors were those that had large rural, Hispanic or Native American populations: Alaska, New Mexico, Texas and Arizona, for example. On this year's map, it looks as if New Mexico's uninsured rate has rebounded, but that might just be a correction from an incorrect 2014 estimate. In most states, however, Enroll has confidence in its estimates for all three years and thinks the shifts are real.

For a detailed discussion of the methods used to make these calculations, read our article from last year on this model.

Correction: October 30, 2015

An earlier version of a map with this article incorrectly outlined Utah in black, indicating that it had expanded Medicaid. Utah has not done so.

Correction: November 3, 2015

A caption for a map last Sunday with an article about which Americans still lack health insurance misstated the start of Alaska's Medicaid expansion. It began in September; it is not scheduled to begin next year.

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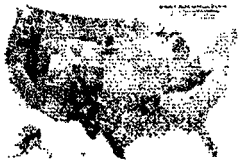
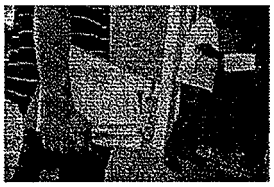
More on NYTimes.com



Obama's Health Law: Who Was Helped Most

OCT. 29, 2014



Public Health

A Formula to Find the Uninsured Around the Country

OCT. 29, 2014

Who Would Have Health Insurance if Medicaid Expansion Weren't Optional

NOV. 3, 2014

Public Health

Now the Hard Part: The Rate of Health Care Enrollment Seems Set to Slow

MARCH 23, 2015

Kurdish Fighters Retake Iraqi City of Sinjar From ISIS

Nov. 13, 2015

Go to the next story

EXHIBIT 4

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	N/A	N/A	2015	2016	2017	2018				
1. REVENUE										
a. Inpatient Services			$ -	$ 12,398,566	$ 16,670,179	$ 16,670,179				
b. Outpatient Services										
Gross Patient Service Revenues	$ -	$ -	$ -	$ 12,398,566	$ 16,670,179	$ 16,670,179	$ -	$ -	$ -	$ -
c. Allowance For Bad Debt			$ -	$ 1,156,413	$1,166,119	$1,166,119				
d. Contractual Allowance										
e. Charity Care @ 6.15%			$ -	834,441	1,121,926	1,121,926				
Net Patient Services Revenue	$ -	$ -	$ -	$ 10,407,712	$ 14,382,134	$ 14,382,134	$ -	$ -	$ -	$ -
f. Other Operating Revenues (Specify/add rows if needed)										
NET OPERATING REVENUE	$ -	$ -	$ -	$ 10,407,712	$ 14,382,134	$ 14,382,134	$ -	$ -	$ -	$ -
2. EXPENSES										
a. Salaries & Wages (including benefits)			$ 88,293	$ 4,297,294	$4,851,909	$4,851,909				
b. Contractual Services			$ -	$ 394,848	$ 560,685	$ 560,685				
c. Interest on Current Debt			$ -	$ -	$ -	$ -				
d. Interest on Project Debt			$ -	$ -	$ -	$ -				
e. Current Depreciation			$ -	$ -	$ -	$ -				
f. Project Depreciation			$ -	$ -	$ -	$ -				
g. Current Amortization			$ -	$ -	$ -	$ -				
h. Project Amortization			$ -	$ -	$ -	$ -				
i. Supplies			$ -	$ 16,838	$ 23,910	$ 23,910				
j. Administrative/office expenses			$ 874,467	$ 1,651,104	$ 1,815,505	$ 1,840,450				
k. Facilities expenses (repairs & maintenance, rent, real estate taxes, utilities			$ 312,724	$ 2,074,966	$ 2,158,388	$ 2,158,388				
l. Food			$ -	$ 642,347	$ 912,135	$ 912,135				
m. Marketing expense			$ -	$ 356,354	$ 506,024	$ 506,024				
n. Liability insurance			$ -	$ 59,087	$ 83,904	$ 83,904				
o. Other Expenses: Licensing & legal expenses			$ -	$ 34,507	$ 49,000	$ 49,000				
TOTAL OPERATING EXPENSES	$ -	$ -	$ 1,275,484	$ 9,527,345	$10,961,460	$ 10,986,405	$ -	$ -	$ -	$ -

EXHIBIT 5

Recovery Centers of America
Pricing Schedule
DRAFT

Service	Standard Rates
Inpatient Detoxification - Daily	$ 3,500 Per Day
Inpatient Rehabilitation - Daily	$ 2,900 Per Day
Partial Hospitalization Program - Daily	$ 2,200 Per Day
Intensive Outpatient Group Session - 3 Hour Session	$ 1,700 Per Session
General Outpatient Group Session - 1 Hour Session	$ 900 Per Session

RCA will also offer our patients a package of services at a discounted price and will negotiate volume discounts with payors.

Note: The above pricing is draft and is subject to change.

NOT INCLUDED IN FINANCIAL PROTECTIONS!

EXHIBIT 6

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - PROJECTIONS WITH 15% CHARITY CARE

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			$ -	$ 12,398,566	$ 16,670,179	$ 16,670,179				
b. Outpatient Services										
Gross Patient Service Revenues	$ -	$ -	$ -	$ 12,398,566	$ 16,670,179	$ 16,670,179	$ -	$ -	$ -	$ -
c. Allowance For Bad Debt			$ -	$ 1,036,335	$1,045,033	$1,045,033				
d. Contractual Allowance										
e. Charity Care			$ -	2,035,221	2,736,405	2,736,405				
Net Patient Services Revenue	$ -	$ -	$ -	$ 9,327,010	$ 12,888,741	$ 12,888,741	$ -	$ -	$ -	$ -
f. Other Operating Revenues (Specify/add rows if needed)										
NET OPERATING REVENUE	$ -	$ -	$ -	$ 9,327,010	$ 12,888,741	$ 12,888,741	$ -	$ -	$ -	$ -
2. EXPENSES										
a. Salaries & Wages (including benefits)			$ 88,293	$ 4,297,294	$4,851,909	$4,851,909				
b. Contractual Services			$ -	$ 394,848	$ 560,685	$ 560,685				
c. Interest on Current Debt			$ -	$ -	$ -	$ -				
d. Interest on Project Debt			$ -	$ -	$ -	$ -				
e. Current Depreciation			$ -	$ -	$ -	$ -				
f. Project Depreciation			$ -	$ -	$ -	$ -				
g. Current Amortization			$ -	$ -	$ -	$ -				
h. Project Amortization			$ -	$ -	$ -	$ -				
i. Supplies			$ -	$ 16,838	$ 23,910	$ 23,910				
j. Administrative/office expenses			$ 874,467	$ 1,651,104	$ 1,815,505	$ 1,840,450				
k. Facilities expenses (repairs & maintenance, rent, real estate taxes, utilities			$ 312,724	$ 2,074,966	$ 2,158,388	$ 2,158,388				
l. Food			$ -	$ 642,347	$ 912,135	$ 912,135				
m. Marketing expense			$ -	$ 356,354	$ 506,024	$ 506,024				
n. Liability insurance			$ -	$ 59,087	$ 83,904	$ 83,904				
o. Other Expenses: Licensing & legal expenses			$ -	$ 34,507	$ 49,000	$ 49,000				
TOTAL OPERATING EXPENSES	$ -	$ -	$ 1,275,484	$ 9,527,345	$10,961,460	$ 10,986,405	$ -	$ -	$ -	$ -

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - PROJECTIONS WITH 15% CHARITY CARE

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	$ -	$ -	$ (1,275,484)	$ (200,335)	$ 1,927,281	$ 1,902,336	$ -	$ -	$ -	$ -
b. Non-Operating Income										
SUBTOTAL	$ -	$ -	$ (1,275,484)	$ (200,335)	$ 1,927,281	$ 1,902,336	$ -	$ -	$ -	$ -
c. Income Taxes										
NET INCOME (LOSS)	$ -	$ -	$ (1,275,484)	$ (200,335)	$ 1,927,281	$ 1,902,336	$ -	$ -	$ -	$ -
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%	25.0%	25.0%	25.0%				
5) Self-pay			0.0%	60.0%	60.0%	60.0%				
6) Other			0.0%	15.0%	15.0%	15.0%				
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 - PROJECTIONS WITH 15% CHARITY CARE

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			$ -	$ 12,398,566	$ 17,432,897	$ 18,304,542				
b. Outpatient Services										
Gross Patient Service Revenues	$ -	$ -	$ -	$ 12,398,566	$ 17,432,897	$ 18,304,542	$ -	$ -	$ -	$ -
c. Allowance For Bad Debt			$ -	$ 1,036,335	$ 1,092,847	$ 1,147,489				
d. Contractual Allowance										
e. Charity Care			$ -	$ 2,035,221	$ 2,861,605	$ 3,004,685				
Net Patient Services Revenue	$ -	$ -	$ -	$ 9,327,010	$ 13,478,445	$ 14,152,368	$ -	$ -	$ -	$ -
f. Other Operating Revenues (Specify/add rows if needed)			$ -	$ -	$ -	$ -				
NET OPERATING REVENUE	$ -	$ -	$ -	$ 9,327,010	$ 13,478,445	$ 14,152,368	$ -	$ -	$ -	$ -
2. EXPENSES										
a. Salaries & Wages (including benefits)			$ 88,293	$ 4,297,294	$ 5,074,288	$ 5,328,003				
b. Contractual Services			$ -	$ 394,848	$ 586,384	$ 615,702				
c. Interest on Current Debt			$ -	$ -	$ -	$ -				
d. Interest on Project Debt			$ -	$ -	$ -	$ -				
e. Current Depreciation			$ -	$ -	$ -	$ -				
f. Project Depreciation			$ -	$ -	$ -	$ -				
g. Current Amortization			$ -	$ -	$ -	$ -				
h. Project Amortization			$ -	$ -	$ -	$ -				
i. Supplies			$ -	$ 16,838	$ 25,006	$ 26,257				
j. Administrative/office expenses			$ 874,467	$ 1,700,172	$ 1,943,458	$ 2,081,357				
k. Facilities expenses (repairs & maintenance, rent, real estate taxes, utilities			$ 312,724	$ 2,074,966	$ 2,177,701	$ 2,199,735				
l. Food			$ -	$ 642,347	$ 953,941	$ 1,001,638				
m. Marketing expense			$ -	$ 356,354	$ 529,217	$ 555,678				
n. Liability insurance			$ -	$ 59,087	$ 87,749	$ 92,137				
o. Other Expenses: Licensing & legal expenses			$ -	$ 34,507	$ 51,246	$ 53,808				
TOTAL OPERATING EXPENSES	$ -	$ -	$ 1,275,484	$ 9,576,413	$ 11,428,990	$ 11,954,315	$ -	$ -	$ -	$ -

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - PROJECTIONS WITH 15% CHARITY CARE

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	N/A	N/A	2015	2016	2017	2018				
3. INCOME										
a. Income From Operation	$ -	$ -	$ (1,275,484)	$ (249,403)	$ 2,049,455	$ 2,198,053	$ -	$ -	$ -	$ -
b. Non-Operating Income										
SUBTOTAL	$ -	$ -	$ (1,275,484)	$ (249,403)	$ 2,049,455	$ 2,198,053	$ -	$ -	$ -	$ -
c. Income Taxes										
NET INCOME (LOSS)	$ -	$ -	$ (1,275,484)	$ (249,403)	$ 2,049,455	$ 2,198,053	$ -	$ -	$ -	$ -
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%	25.0%	25.0%	25.0%				
5) Self-pay			0.0%	60.0%	60.0%	60.0%				
6) Other			0.0%	15.0%	15.0%	15.0%				
TOTAL	*0.0%*	*0.0%*	*0.0%*	*100.0%*	*100.0%*	*100.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

EXHIBIT 7

TABLE A. BED CAPACITY BY FLOOR AND NURSING UNIT BEFORE AND AFTER PROJECT--EARLEVILLE

INSTRUCTION: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project.
Applicants should add columns and recalculate formulas to address any rooms with 3 and 4 bed capacity. See additional instruction in the column to the right of the table.

Before the Project						After Project Completion				
		Based on Physical Capacity					Based on Physical Capacity			
		Room Count			Physical		Room Count			Physical
Service Location (Floor/Wing)	Current Licensed Beds	Private	Semi-Private	Total Rooms	Bed Capacity	Service Location (Floor/Wing)	Private	Semi-Private	Total Rooms	Bed Capacity
DETOX						DETOX				
	N/A	N/A	N/A	0	#VALUE!			10	10	17
				0	0				0	0
				0	0				0	0
				0	0				0	0
				0	0				0	0
SUBTOTAL Detox						SUBTOTAL Detox	0	10	10	17
RESIDENTIAL						RESIDENTIAL				
	N/A	N/A	N/A				5	10	15	32
TOTAL RESIDENTIAL						TOTAL RESIDENTIAL	5	10	15	32
Other *(Specify/add rows as needed)*				0	0	Other *(Specify/add rows as needed)*			0	0
TOTAL OTHER						TOTAL OTHER				
FACILITY TOTAL	0	0	0	0	0	FACILITY TOTAL	5	20	25	49

EXHIBIT 8

Craig P. Tanio, M.D.
CHAIR

STATE OF MARYLAND

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION
4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

Memorandum

To: Commissioners

From: Joel Riklin, Acting Chief
Certificate of Need

Date: September 19, 2013

Re: Ashley, Inc. d/b/s Father Martin's Ashley
Docket No. 13-12-2340

* *

Ashley, Inc. operates Father Martin's Ashley ("FMA"), an 85-bed intermediate care facility ("ICF") for the care and treatment of patients with alcoholism and drug addiction, in Havre de Grace in Harford County. FMA proposes the construction of a new two-story building, encompassing 41,824 gross square feet to address deficiencies in the existing physical facilities and add 15 beds increasing the facility's capacity to 100 beds. The proposed project will eliminate nine rooms designed to accommodate three or four patients and eliminate four patient rooms that are currently located in attics that FMA does not consider suitable for patient occupancy. The project will increase the number of private patient rooms from eleven to twenty, consolidate and relocate the Admissions Department and Patient Intake into the new building, establish a permanent location for the Wellness/Fitness Center in the new building, and expand and consolidate other administrative and support spaces.

The total estimated cost of the project is $18,653,000. The initial funding of the project is projected to come from $6 million in cash from the applicant, pledged funds of $4 million, and $1,653,000 in gifts and bequests that have already been received, with the balance of needed funds ($7 million) being borrowed. FMA expects that future fund raising will provide the necessary funds to replace or pay off the bond or letter of credit that will be used for borrowing.

Staff recommends approval of this project with three conditions. The project meets an institutional need for facility modernization, it is a cost-effective alternative for meeting this need, it is viable, and will have no substantive impact on other facilities. The additional beds are likely to be needed based on the demand for FMA's services that is generated by a service area population that extends well beyond the borders of Maryland. The first recommended condition

requires reporting to insure FMA compliance with its commitment to provide charity care to the indigent and gray area populations. The second condition requires that FMA report data to the Alcohol and Drug Abuse Administration's Substance Abuse Management Information System (SAMIS) and the third condition requires FMA to report to MHCC, detailing its efforts to systematically evaluate its effectiveness in alcohol and substance abuse treatment.

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

Table of Contents

STAFF REPORT AND RECOMMENDATION

I. INTRODUCTION

A. The Applicant

Ashley, Inc. operates Father Martin's Ashley ("FMA"), an 85-bed intermediate care facility ("ICF") for the care and treatment of patients with alcoholism and drug addiction, also known as an ICF-Chemical Dependency or ICF-CD. Located in Havre de Grace in Harford County, 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.

FMH opened in 1983 and operates on a 147-acre campus. The facility is named after Father Joseph Martin, a priest who received treatment for his alcoholism, and who later helped to establish this chemical addiction treatment center.

The applicant offers all patients an inpatient treatment program, based on a 28-day model, and also provides medically supervised detoxification on site. FMA embraces the "twelve-step program" approach, a set of principles outlining a course of action for recovery from addiction originally developed by Alcoholics Anonymous over 70 years ago. It reports specialized programs that address patient relapse into addiction, the treatment of women, the treatment of young adults, the needs of families, and the needs of children living in homes affected by addiction. It operates an outpatient intervention program for persons convicted of driving under the influence of alcohol or drugs and driving while intoxicated. FMA employs a medical and clinical care staff that is addiction-certified.

FMA is a unique health care facility Certificate of Need ("CON") applicant in that it does not participate in and does not propose to participate in the Medicare or Maryland Medical Assistance (Medicaid) program.

B. The Project

The applicant proposes to construct a new two-story building, encompassing 41,824 gross square feet ("SF") of new construction on its campus. The applicant's 85 ICF beds are currently distributed over three existing buildings – Noble Hall, Carpenter Hall, and Bantle Hall. The proposed project is planned to address deficiencies in the existing physical facilities of FMA and the need for additional beds. The proposed project will add 15 "Track One" beds, increasing total bed capacity to 100.

"Track One" or "private" beds are non-governmental ICF beds without significant funding by state or local government. The State Health Plan ("SHP") defines a "Track One" facility as one that provides "no less than 30 percent of its annual patient days to the indigent and gray area population for an adolescent intermediate care facility and (as applicable to FMA) no less than 15 percent of the facility's annual patient days for an adult ICF." The SHP defines the

"indigent population" as "those persons who qualify for services under the Maryland Medical Assistance Program, regardless of whether Medical Assistance will reimburse for alcohol and drug abuse treatment" and it defines the "gray area population" as "those persons who do not qualify for services under the Maryland Medical Assistance Program but whose annual income from any source is no more than 180 percent of the most current Federal Poverty Index, and who have no insurance for alcohol and drug abuse treatment services."

Through the proposed project, FMA plans to eliminate nine rooms designed to accommodate three or four patients and eliminate four patient rooms that are currently located in attics that it does not consider suitable for patient occupancy. The project will increase the number of private patient rooms from eleven to twenty, consolidate and relocate the Admissions Department and Patient Intake into the new building, establish a permanent location for the Wellness/Fitness Center in the new building, and expand and consolidate other administrative and support spaces. The project will also include infrastructure improvements. FMA views the project as a means for upgrading and improving the level of its programs and allowing it to more effectively market its program to prospective patients.

The total estimated cost of the project is $18,653,000, which includes $18,361,000 in total capital costs, and $292,000 in loan placement, legal, and consultant fees. The initial funding of the project is projected to come from $6 million in cash from the applicant, pledged funds of $4 million, and $1,653,000 in gifts and bequests that have already been received, with the balance of needed funds ($7 million) being borrowed. FMA expects that future fund raising will provide the necessary funds to replace or pay off the bond or letter of credit used for borrowing.

C. Background

In 2012, FMA petitioned MHCC to amend the docketing requirements of COMAR 10.24.14.04A and B, the State Health Plan chapter containing policies and standards for Certificate of Need ("CON") review of projects by ICF for the treatment of alcohol and drug addiction. Those docketing rules addressed the occupancy rate to be attained by an ICF in order to docket an application for expansion, the percentage of total proposed bed days that a "Track One" ICF applicant must propose for indigent and "gray area" patients to obtain docketing of an application to establish or expand a "Track One" ICF, and the percentage of total existing bed days that an existing "Track One" ICF must demonstrate were generated by charity care, indigent, or the "gray area' population, including publicly-funded patients, in the preceding 12 months to obtain docketing of an application to increase the number of beds in an existing "Track One" ICF.

FMA did not meet the licensed bed occupancy docketing requirement because it did not operate all of its licensed beds, excluding some patient rooms (located in the attic floor of Noble Hall) from use because of their lack of privacy. More importantly, FMA did not meet the docketing requirements associated with service to indigent and gray area patients and claimed that it could not meet these requirements and viably operate. It proposed that the SHP be amended to allow a Track One ICF applicant to "show evidence as to why the standards in this § .04 (the docketing requirements) should not be applied to the applicant."

Alternatively, MHCC staff proposed specific amendment of the occupancy rate docketing rule to addresses FMA's concern with respect to how bed occupancy will be considered. Essentially, the amended docketing rule allowed for consideration of the occupancy rate for operating bed capacity when some portion of licensed bed capacity is not usable. Additionally, staff proposed eliminating the docketing rule that incorporated a charity care and service to the indigent and gray area population standard as a requirement for docketing. Consistent with the approach taken in most SHP chapters, it was proposed that the financial access requirements of those docketing rules be placed in the project review standards section of the Chapter, Section .05, and that project review standard allow an applicant like FMA to address its historic and proposed commitment to serving the indigent and gray area population in a CON application that could be docketed for review and given appropriate consideration by the Commission in acting on the CON application.

Those amendments to the SHP were adopted as final regulatory amendments that became effective in February of this year.

D. Summary of Staff Recommendation

Staff finds that the proposed project complies with the applicable State Health Plan standards and that consideration of the project in the light of the required review criteria support approval of the project. Staff finds that the proposed project will provide a needed modernization of the FMA campus including the elimination of three and four bed rooms. The addition of 15 beds will have little or no impact on other providers in the Central Maryland region. A summary of the Commission Staff's analysis of the proposed project is provided below.

State Health Plan Standards

- While staff has found FMA to be consistent with all of the State Health Plan standards, FMA's commitment to provide charity care to the indigent and gray area population of the State is significantly less than the amount targeted in the SHP. Therefore, staff recommends that this approval be conditioned on FMA submitting audited reports of its compliance with its commitment to provide at least 6.3% of its patient days to this indigent and near indigent population. The audit report should commence with the first full year following completion of the project and continue for five years.

- Staff also finds that FMA's failure to report data to the Alcohol and Drug Abuse Administration's Substance Abuse Management Information System (SAMIS) is unacceptable. While FMA has not been required to report because it receives no public funds and standard O, Program Reporting, only requires that FMA agree to report, FMA has been familiar with the SHP standards and in the process of developing the proposed project for a sufficient period of time to have commenced reporting. Therefore, staff recommends that this approval be conditioned on FMA commencing reporting within six months of CON approval.

Need

- Staff finds that there is a need to modernize FMA's current facilities especially to eliminate all patient rooms with more than two beds. Staff finds that the need for additional private beds to serve the residents of the Central Maryland regions. Staff also finds that the proposed addition of beds is likely to be needed based on the demand for FMA's services.

Costs and Effectiveness of Alternatives

- The proposed project is primarily a replacement of existing facilities to modernize FMA's physical plant. It is secondarily an addition of beds. Both the modernization and additional beds are needed and FMA has demonstrated selection of the most cost-effective alternative to accomplish its objectives to modernize and add beds.

- FMA takes a single approach to treatment and has not demonstrated that it has made efforts to systematically evaluate the effectiveness of its approach or its level of performance compared to peer facilities, despite 30 years of operation. For this reason, conditioning approval on a requirement that FMA report back to MHCC in this regard is recommended.

Viability

- The applicant has demonstrated that FMA has the resources available to implement this project and, based on the financial data reviewed, the proposed project is financially feasible and viable, on a long-term basis.

Impact

- The applicant is a private Track One provider serving patients with substance abuse and chemical dependency issues that serves individuals throughout the east coast. Therefore, the modest increase in bed capacity should have little or no impact on the costs or utilization of existing substance abuse treatment programs in this region. The fact that it does not receive public funds (i.e., Medicare, Medicaid, or public grants) for treating this patient population means that its expansion will have no impact on these payers.

II. PROCEDURAL HISTORY

A. Review of the Record

On September 24, 2012, Jack Eller, Esquire, from Ober, Kaler, Grimes & Shriver, PC, filed on behalf of FMA a letter of intent for the project. MHCC acknowledged receipt of this letter on October 31, 2012. (Docket Item [DI] #1)

On January 25, 2013, Richard J. Coughlan, from Cohen, Rutherford & Knight, filed on behalf of FMA the CON application. (DI #2)

On January 28, 2013, Commission staff acknowledged receipt of the application on January 25, 2013 and assigned Docket No. 13-12-2340. Staff informed the applicant regarding publication of notice of receipt of the application in the next *Maryland Register.* (DI #3)

On January 28, 2013, staff requested publication of legal notice on receipt of the CON in the next edition of the *Harford Democrat Record* and *The Aegis.* (DI #4)

On January 28, 2013, staff submitted a request for publication on the receipt of application in the *Maryland Register* on February 22, 2013. (DI #5)

On February 8, 2013, Richard J. Coughlan submitted on behalf of FMA the copies of the affirmations from persons who assisted in the preparation of the CON application for the proposed modernization and expansion project. (DI #6)

On February 11, 2013, staff sent completeness questions Father Mark Hushen of FMA. (DI #7)

On February 15, 2013, the *Harford Democrat Record* and *The Aegis* provided proof of publication regarding notice of receipt of the application (DI #8).

On February 26, 2013, FMA submitted a request for an extension of time to respond to the staff's February 11, 2013 completeness questions. On February 28, 2013, staff granted an extension from February 26th to March 19, 2013 to respond to the questions. (DI #9)

On March 11, 2013copy of draft first completeness letter sent to applicant prior to application review conference is entered into the record. (DI #10)

On March 19, 2013, Richard J. Coughlan submitted on behalf of FMA the responses to the first completeness letter. (DI #11)

On March 26, 2013, Richard J. Coughlan submitted on behalf of FMA a replacement to the responses for Questions #22 A and B of the March 19th response to completeness questions. (DI #12)

On April 5, 2013, staff sent FMA by email a second completeness letter. DI #13)

On April 14, 2013, Richard J. Coughlan submitted on behalf of FMA the responses to the second completeness letter. (DI #14)

On May 2, 2013, staff requested publication of the notice of docketing of the CON in the next edition of the *Harford Democrat Record* and *The Aegi.s* (DI #15)

On May 2, 2013, staff submitted a request for publication of the notice of docketing in the *Maryland Register* on May 17, 2013. (DI #16)

On May 10, 2013, the *Harford Democrat Record* and *The Aegis* provided proof of publication regarding notice of docketing of the application. (DI #17)

On May 22, 2013, staff notified the applicant of docketing and sent additional information questions. (DI #18)

On May 23, 2013, Richard J. Coughlan submitted the response to the additional information questions. (DI #19)

On June 20, 2013, staff submitted request to the Harford County Department of Health for review and comment on the Father Martin's Ashley CON application. (DI #20)

On July 9, 2013, Susan Kelly, Harford County Health Officer, submitted a response stating the Harford County Department of Health "choose(s) not to comment on this proposed project". (DI #21)

On August 9, 2013, staff submitted a request in the form of questions seeking additional information to clarify information previously provided. (DI #22)

On August 23, 2013, Richard J. Coughlan submitted the responses to the August 9th request for additional information. (DI #23)

On September 6, 2013, staff requested additional information by email and Steven Kendrick of Father Martin's Ashley responded by email on September 7, 2013. (DI #24)

B. Local Government Review and Comment

No comments on this application were received from the Harford County Health Department.

C. Interested Parties in Review

There are no interested parties in this review.

III. STAFF REVIEW AND ANALYSIS

A. STATE HEALTH PLAN

COMAR 10.24.01.08G(3)(a) State Health Plan. An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.

The relevant State Health Plan chapter is COMAR 10.24.14, *State Health Plan for Facilities and Services: Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services*. This regulation, at Section .05, includes the following sixteen "C*ertificate of Need Approval Rules and Review Standards for New Substance Abuse Treatment Facilities and for Expansions of Existing Facilities.*"

.05A. Approval Rules Related To Facility Size. Unless the applicant demonstrates why a relevant standard should not apply, the following standards apply to applicants seeking to establish or to expand either a Track One or a Track Two intermediate care facility.

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

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

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

FMA seeks to expand the size of the facility from 85 to 100 intermediate care beds serving only adults. Therefore, this CON application is consistent with subpart (3) of this approval rule.

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

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

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

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

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

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

(2) 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:

(c) 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*.

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

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

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

At the time this application was filed, the Commission had not updated the private intermediate care bed need projection since the plan chapter became effective in January, 2002. No project requiring an evaluation of this standard was filed with MHCC since that time, until this project. At the request of Commission staff, FMA updated the projections for Central Maryland following the methodology set forth in COMAR 10.24.14.07B(7). Commission staff prepared its own update for Central Maryland as well. Both the FMA and the staff projections are for a target year of 2018, as presented in the Table below. For comparison, the table also presents the last set of projections developed for a target year of 2005 with a base year of 2000.

Table 1: Projected Bed Need for Alcoholism and Drug Abuse ICF Beds in Central Maryland Serving Adults (18 years and older)

	SHP Projected 2005	FMA Projected 2018	MHCC Projected 2018
Projected Population for 18 years and older – Projected 2018	2,308,229	2,057,322	2,033,895
Indigent Population- Central Maryland	129,424	187,906	270,326
(a) **Non-Indigent Population**	2,178,805	1,869,416	1,763,569
(b) **Estimated Number of Substance Abusers (a*8.64%)**	188,249	161,906	152,372
(c1) **Estimated Annual Target Population (b*25%)**	47,062	40,379	38,093
(c2) **Estimated Number Requiring Treatment (c1*95%)**	44,709	38,360	36,188
(d) **Estimated Population requiring ICF/CD (12.5%-15%)**			
(d1) Minimum (c2*0.125)	5,589	4,795	4,524
(d2) Maximum (c2*0.15)	6,709	5,754	5,428
(e) **Estimated Range requiring Readmission (10%)**			
(e1) Minimum (d1*0.1)	559	479	452
(e2) Maximum (d2*0.1)	671	575	543
Total Discharges from out-of-state	204	275	593
(f) Range of Adults **Requiring ICF/CD Care**			
Minimum (d1+e1+out of state)	6,352	5,549	5,569
Maximum (d2+e2+out of state)	7,581	6,604	6,564
(g) **Gross Number of Adult ICF Beds Needed**			
(g1) Minimum = ((f*14 ALOS)/365)/0.85	287	250	251
(g2) Maximum = ((f*14 ALOS)/365)/0.85	342	298	296
(h) **Existing Track One Inventory ICF/CD beds**	80	78	144
(i) Net Private ICF/CD Bed Need			
Minimum (g1-h)	207	172	107
Maximum (g2-h)	262	220	152

Source: SHP Projected 2005from the SHP chapter for Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services; FMA projections from response to first completeness letter (DI #11, pp. 54-55); MHCC projections –population interpolation from Maryland Department of Planning Total Population Projections by Age, Sex, and Race March 27, 2012, Indigent Population - From request for data received on August 15, 2013 from Maryland Medicaid for number of Medicaid enrollees age 18 years and older for period July 2012 to June 2013, Total Discharges from out of state are for FMA for FY 2013 from September 6, 2013 additional information question (DI #24)

The 80 Track One ICF/CD beds identified in the 2005 SHP projection column were the beds identified for FMA at that time. The inventory of 78 Track One ICF/CD beds identified in FMA's projections is based on the applicant's understanding that it is the only Track One facility in Central Maryland serving the adult population. The 78 beds only include the beds currently in use at the facility, which *excludes* the 7 beds taken out of service in the attic of Noble Hall. Commission staff identified 59 additional beds at facilities that provide care for less than 50% publicly budgeted patients; Serenity Acres with 27 beds and Anne Arundel Medical Center Pathways with 32 adult beds, both in Anne Arundel County.

Each of the projections indicate greater need for additional private (Track One) beds to serve adults in the Central Maryland Region than the number of additional beds proposed by FMA. The proposed addition of 15 beds at FMA, which involves an effective addition of 22 beds, given that the project will enable FMA to use all 100 of the beds, is consistent with this standard.

.05C. Sliding Fee Scale. An applicant must establish a sliding fee scale for gray area patients consistent with the client's ability to pay.

The applicant has a sliding fee scale for those unable to pay in full for services including gray area patients. The sliding fee schedule is determined by a point system that takes into account family income, equity in primary residence, net worth, and debt to income ratio all as detailed in the following table.

Table 2: FMA's Means Testing Scoring Model

Means			Means Test
	Family Income	**Points**	
Factor 1	$150,000	5 points	This is the total annual gross income for the household.
	$90,000 – 149,999	4 points	
	$80,000 – 89,999	3 points	
	$70,000 – 79,999	2 points	
	$60,000 – 69,999	1 point	
	<$59,000	0 points	
	Equity (Primary Residence)	**Points**	
Factor 2	>$150,000	5 points	This is the current market value, less any mortgage debt due, for the home in which the financial guarantor resides. No points are available for renters.
	$90,000 – 149,999	4 points	
	$80,000 – 89,999	3 points	
	$70,000 – 79,999	2 points	
	$60,000 – 69,999	1 point	
	<$59,999	0 points	
	Net Worth (=amount in value column – amount in loan column – primary home equity)	**Points**	
Factor 3	>$25,000	5 points	The sum value of all assets minus liabilities (including all secured or unsecured debt) minus the equity in the primary residence.
	$20,000 – 24,999	4 points	
	$15,000 – 19,999	3 points	
	$10,000 – 14,999	2 points	
	$5,000 – 9,999	1 point	
	<$5,000	0 points	
	Debt to Income Ratio	**Points**	
Factor 4	<35%	5 points	Household monthly expenses divided by household monthly gross income.
	36 – 40%	4 points	
	41 – 45%	3 points	
	46 – 50%	2 points	
	51 – 55%	1 point	
	>56%	0 points	

Source: Father Martin's Ashley response to the first completeness letter (DI #11, pp. 33-34)

The points for each factor are summed and the prospective patient is assigned a tier that coincides with a percentage discount, as shown in the following table.

Table 3

Tier	Discount	Scoring
Tier 8	75% & higher	0 points
Tier 7	70%	1 to 2 points
Tier 6	60%	3 to 5 points
Tier 5	50%	6 to 8 points
Tier 4	40%	9 to 11 points
Tier 3	30%	12 to 14 points
Tier 2	20%	15 to 17 points
Tier 1	10%	18 points
Tier 0	0%	19 or more points

Source: Father Martin's Ashley response to the second completeness letter (DI #14, pp. 11)

The applicant states that gray area patients generally fall into Tiers 7 and 8 with the indigent generally falling into Tier 8. The applicant also states that patients with zero points receive a 100% discount unless there is financial support from a guarantor in which case the guarantor's financial condition is evaluated to determine whether a smaller discount is appropriate.

FMA has documented that it has a sliding fee scale for all prospective patients consistent with each patient's ability to pay including gray area patients. Therefore, the applicant complies with this standard.

.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) 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 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.

The purpose of this standard is to require applicants for new or expanded Track One ICF-CDs to serve a minimum percentage of indigent and gray area patients. The standard does this by requiring applicants to establish a sliding fee scale for gray area patients consistent with a client's ability to pay and by requiring that applicants commit to providing a specific percentage of its bed days to indigent and gray area patients. The standard permits an applicant to demonstrate why one or more of the requirements should not apply. The standard also offers applicants the opportunity to propose an alternative to providing the minimum required indigent and gray area patient days that would increase the availability of alcoholism and drug abuse treatment to indigent or gray area patients in its health planning region.

As discussed under standard C above, FMA does have a sliding fee scale consistent with a client's ability to pay that is applied to gray area patients as well as others. With respect to the requirement that the applicant provide a minimum percent of bed days to indigent and gray area patients, FMA, which exclusively serves an adult population, is required to commit to provide a minimum of 15 percent of its bed days to those populations or demonstrate why the standard should not apply. FMA states that it is not financially feasible for it to provide that many bed days of care to indigent and gray area patients. (DI #11, p. 19) and provided substantial documentation in support of this position. While FMA is proposing to commit to provide the minimum number of bed days to indigent and gray patients, it is proposing an increase its bed days for these populations as a percent of total days as well as in absolute terms from 901 days in FY 2012 to 2,190 days in FY 2017 as detailed in the following table.

Table 4: Historic and Projected Charity Care Patient Days

	Actual FY 2012		Projected FY 2017	
	Patient Days	Percent of Total Days	Patient Days	Percent of Total Days
Indigent and Gray Area	901	3.4%	2,190	6.3%
Non-Indigent	1,483	5.6%	1,825	5.3%
Total Charity Care Days	2,384	9.0%	4,015	11.6%
Total Patient Days	26,489		34,660	

Source: Father Martin's Ashley CON Application (DI #2, pp. 20 & 45) and March 19, 2013 responses to first completeness letter (DI #11, p. 37)

In evaluating a Track One facility proposal to provide a lower required minimum percentage of days committed to indigent and gray area patients the Commission is required to consider the needs of the population of the applicant's health planning region, and the ability of the applicant to feasibly meet the requirements of the standard. With respect to the needs of the population of the health planning region, the updated projections using the SHP methodology detailed under standard A indicates a need for more beds to serve the non-indigent population of Central Maryland. Staff also sought information on the needs of the indigent and gray area population for intermediate care facility beds. While no specific analysis of the needs of the indigent and gray area population was found, a recent report of the Maryland Alcohol and Drug Abuse Administration, Outlook and Outcomes, FY 2012 reveals that waiting time for admission to State-supported alcoholism and drug abuse treatment programs has declined from 7.6 days in FY 2008 to 4.7 days in FY 2012. More to the point, in FY 2012, the average and median wait for the program levels offered by FMA were reported to be as shown in the following table. Note that a median of zero means that more than half the admissions to the level III.5 programs involved same day admission.

Table 5: Mean and Median Wait Times for Admission to State Supported Alcohol And Drug Abuse Treatment Programs in FY 2012

Program Level	Mean (days)	Median (days)
III.5 – High Intensity Residential	3.26	0.0
III.7 – Monitored Intensive Inpatient	4.96	2.0
III.7D – Detoxification	3.55	1.0

Source: FY 2012, Outlook and Outcomes report of the Maryland Alcohol and Drug Abuse Administration

As for the financial feasibility of FMA meeting the required 15 percent of bed days for the indigent and gray area population, the applicant indicated that reaching such a level would result in operating losses of over one million dollars and that this level of charity care would require that operating losses be subsidized from non-operating income. (DI #2, p. 20) While the CON standard in subparagraph (D)(1)(c) only identifies indigent or gray area patients in the 15% of annual adult bed days offered for charity care, FMA includes a third category called non-indigent patients who will receive discounted service. The applicant states that this non-indigent category includes patients who have private health insurance policies that do not provide sufficient payment for the services offered at FMA.

In response to staff questions, FMA submitted a number of alternative financial projections at various levels and mixes of charity care to show the impact on operating profits. However, FMA is not willing to take the approach of providing charity care for the indigent and gray area population at 15% of patient days by reducing the uncompensated care it provides for the non-indigent population described above, that includes patients who have private health insurance policies that do not provide sufficient payment for the services offered. The applicant states that it is committed to continue to meet the financial needs of these non-indigent patients in the future, and is not willing to increase the financial commitment to fund indigent and gray patients at the prescribed 15% level by denying care to those patients with inadequate health insurance who need its services. (DI #11, #16, pp. 36-39 and DI #14-20)

Table 6 outlines the applicant's projection scenarios. All assume achieving a 95% average annual occupancy rate after the proposed 100 beds are put into operation. Only Scenario 2 satisfies the target requirement of Subpart (1)(c) of the standard for a minimum of 15%

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.

Given these projections and FMA's investments of over $50 million reported in the applicant's audited financial statement (DI #2, Attachment 13), the applicant was asked to explore the potential for using non-operating income to provide more charity care to the indigent and gray area population, especially given the fact that FMA has no short or long term debt at this time and projects modest amounts of debt related to this project that it anticipates can be retired within a short period of time. FMA responded that it requires a minimum level of operating income for predictable returns to satisfy future investment needs of the organization as well as to offset potential future underperformance. FMA also stated that non-operating income cannot be relied upon to fund on-going operating needs of the organization because it is not sufficiently predictable to fund charity care that is a year-over-year requirement. (DI #11, p. 39). The applicant presented an investment strategy that it felt would be necessary to produce the predictability necessary to fund a higher level of qualifying charity care. FMA estimates that this investment strategy would return less than 2% per year and at that rate of return an investment of $81.2 million would be required to fund the $1.6 million necessary to increase qualifying charity care days by five percent. (DI #23, p. 4)

FMA complies with subpart (1)(a) of this standard. FMA has also complied with subpart (4) of the standard by providing information regarding the percentage of its annual patient days in the preceding 12 months that were generated by charity care, indigent, and gray area patients. FMA has submitted reasonable information to demonstrate that it is not financially feasible for it to commit to provide 15 percent of its projected bed days to indigent and gray area patients, but has committed to increase the number of bed days provided to these populations. Commission staff has considered the needs of the population in the health planning region as required by the standard when an applicant is proposing to provide a lower percentage of bed days to indigent and gray area populations than the minimum required by the standard. In this regard the State Health Plan methodology indicates a need for additional private ICF beds for alcoholism and drug abuse treatment. Commission staff also considered the financial feasibility of the applicant meeting the 15% target of qualifying charity care and has concluded that it is not financially feasible for FMA to achieve this minimum level given its current financial condition and its operation as an exclusively private facility with no Medicaid participation and no public grant support. Therefore, staff recommends a finding of compliance with this standard. However, to ensure that FMA achieves the levels of service to the indigent and gray area population, staff recommends that this approval be conditioned on FMA submitting audited reports of its compliance with its commitment to provide 6.3% of its patient days as qualified charity care. The filing of the audited report should commence with the first full year following completion of the project and continue for five years.

.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.

The applicant provided a copy of its list of charges with the CON application. (DI #3, Attachment 14). A list of the charges is posted in the admissions office and the financial coordinator's offices. FMA agrees to make information regarding its charges available to the public upon request. The applicant is consistent with this standard.

.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.

Since FMA is an existing 85-bed intermediate care facility seeking to increase the number of beds operating in Harford County, this standard does not apply.

.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.

Consistent with this standard FMA has specified that it is applying for an increase of 15 ICF beds for the treatment of adults only. FMA does not provide substance abuse treatment care to adolescents.

.05H. Quality Assurance.

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

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

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

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

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

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

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

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

FMA submitted documentation of its Joint Commission accreditation under its Behavioral Health Care Program effective January 29, 2011. This accreditation is customarily valid for up to 36 months. The applicant also submitted documentation of the general certificate of approval granted by the Department of Health and Mental Hygiene's Alcohol and Drug Abuse Administration to FMA on March 29, 2012 to for the following three programs: *Level III.5 – Clinically Managed High-Intensity Residential Treatment*; *Level III.7 – Medically Monitored Intensive Inpatient Treatment*; and *Level III.7D – Medically Monitored Intensive Inpatient Treatment – Detoxification*. The state certificate of approval for the three programs will expire on March 29, 2014. Therefore, staff finds that FMA complies with this standard.

.05I. Utilization Review and Control Programs.

(1) An applicant must document the commitment to participate in utilization review and control programs, and have treatment protocols, including written policies governing admission, length of stay, discharge planning, and referral.

(2) An applicant must document that each patient's treatment plan includes, or will include, at least one year of aftercare following discharge from the facility.

FMA provided documentation of all required policies. Details regarding the Admission policy are included under the section "Orientation/Clinical Assessment, Treatment Planning and under Bio-Psycho-Social Assessment." (DI #2, Attachment 7). The applicant's length of stay

policy is found in its policies and procedures for "Treatment Services/Case Management/Clinical Protocols," which was submitted as Attachment 4 of the applicant's response to the first completeness letter (DI #11, p. 43 and Attachment 4) The policy states that, "it is the philosophy of Father Martin's Ashley that our clinical program is a recommended 28 day length of stay. Any variance to this will be approved, or not approved, by members of the clinical staff."[1] (DI #12, Question #17, p. 43). The discharge policy is located under the section "Treatment Services/Case Management/Clinical Protocols." (DI #11, Attachment 4). The policies regarding referrals were included in Attachment 6 of FMA's application. (DI #2, Attachment 6).

Regarding subpart (2) of this standard, FMA policies have included the development of a continuing care plan specific to the needs of each patient prior to discharge. (DI #2, p. 25 and DI # 11, Attachment 4) FMA states that, "each patient's continuing care/aftercare plan will address a minimum one-year time period following each patient's discharge." [2]

Given the documentation cited above, FMA complies with this standard.

.05J. Transfer and Referral Agreements.

(1) An applicant must have written transfer and referral agreements with facilities capable of managing cases which exceed, extend, or complement its own capabilities, including facilities which provide inpatient, intensive and general outpatient programs, halfway house placement, long-term care, aftercare, and other types of appropriate follow-up treatment.

(2) The applicant must provide documentation of its transfer and referral agreements, in the form of letters of agreement or acknowledgement from the following types of facilities:

(a) Acute care hospitals;

(b) Halfway houses, therapeutic communities, long-term care facilities, and local alcohol and drug abuse intensive and other outpatient programs;

(c) Local community mental health center or center(s);

(d) The jurisdiction's mental health and alcohol and drug abuse authorities;

(e) The Alcohol and Drug Abuse Administration and the Mental Hygiene Administration;

(f) The jurisdiction's agencies that provide prevention, education, driving-while-intoxicated programs, family counseling, and other services; and,

[1] Father Martin's Ashley's March 19, 2013 response to completeness questions (DI #11, p. 43)
[2] Father Martin's Ashley's CON application ((DI #2, p. 25)

(g) The Department of Juvenile Justice and local juvenile justice authorities, if applying for beds to serve adolescents.

FMA currently operates two outpatient programs that provide intervention services for DUI and DWI patients. The applicant submitted copies of a number of referral agreements with local providers of inpatient and outpatient substance abuse treatment programs. (DI #3, Attachment 6). FMA submitted a copy of a referral agreement with Upper Chesapeake Health, Inc., which includes arrangements with Harford Memorial Hospital. The applicant also included copies of agreements with New Life Addiction Counseling Services and with Colonial House who both provide outpatient treatment services and family counseling, and 15 providers that are halfway houses/transitional living programs. Beyond the formal referral agreements that were submitted, FMA maintains a database with over 1,000 providers that staff uses for continuing care services such as living arrangements, intensive outpatient or outpatient substance abuse treatment, and mental health/psychiatric treatment. (DI #14, p. 21). Included in this database are local Maryland community mental health centers, and mental health and alcohol and drug abuse authorities. Referrals to the providers in this database are made based on the discharged patient's needs, resources and/or insurance plan. If a patient is uninsured and private financial resources are not available for services post-treatment, a state-funded program is located using the Substance Abuse and Mental Health Services Administration's ("SAMHSA") treatment locator website. FMA also refers uninsured Maryland residents to the respective jurisdiction's county substance abuse/addiction program, and an initial appointment is made for the discharged patient and medical records sent when appropriate.

FMA complies with this standard.

.05K. Sources of Referral.

(1) An applicant proposing to establish a new Track Two facility must document to demonstrate that 50 percent of the facility's annual patient days, consistent with Regulation .08 of this Chapter, will be generated by the indigent or gray area population, including days paid under a contract with the Alcohol and Drug Abuse Administration or a jurisdictional alcohol or drug abuse authority.

(2) An applicant proposing to establish a new Track One facility must document referral agreements to demonstrate that 15 percent of the facility's annual patient days required by Regulation .08 of this Chapter will be incurred by the indigent or gray area populations, including days paid under a contract with the Alcohol or Drug Abuse Administration or a jurisdictional alcohol or drug abuse authority, or the Medical Assistance program.

Since FMA is not proposing to establish a new facility, this standard does not apply.

.05L. In-Service Education. An applicant must document that it will institute or, if an existing facility, maintain a standardized in-service orientation and continuing education program for all categories of direct service personnel, whether paid or volunteer.

The applicant has complied with this standard by providing documentation of its in-service orientation and continuing education program for all administrative, professional and

support personnel at FMA. The Clinical Program Director is responsible for supervising and directing the staff development activities of the clinical staff, and the Human Resources Director, Safety Officer and Infection Control Nurse for the non-clinical staff. The facility provides in-house training courses, and encourages participation in outside workshops/seminars, and continuing education programs. (DI #2, Attachment 7)

.05M. Sub-Acute Detoxification. An applicant must demonstrate its capacity to admit and treat alcohol or drug abusers requiring sub-acute detoxification by documenting appropriate admission standards, treatment protocols, staffing standards, and physical plant configuration.

The applicant provided a copy of the admission standards, treatment protocols, staffing standards, and physical configuration of the space used for sub-acute detoxification. (DI #3, Attachment 8 and DI #11, Question #19, p. 45). These treatment protocols include the use of certain medications and the use of acupuncture to help patients manage withdrawal symptoms, as well as the use of the Clinical Institute Withdrawal Assessment for Alcohol for alcohol addiction.

The design and location of the detoxification unit on the first floor of the proposed new building will place the patients in close proximity to the nurse's station and medical services. Staff will be able to observe, and the patients will be closer to exam rooms, medical provider spaces, medication administration space, and treatment and therapy locations.

The applicant, with this project, has demonstrated consistency with this standard.

.05N. Voluntary Counseling, Testing, and Treatment Protocols for Human Immunodeficiency Virus (HIV). An applicant must demonstrate that it has procedures to train staff in appropriate methods of infection control and specialized counseling for HIV-positive persons and active AIDS patients.

The applicant demonstrated compliance with this standard by submitting a copy of its policies and procedures that address how the staff conducts testing for HIV and counseling and treatment of HIV-positive patients. (DI #2, Attachment 9).

.05O. Outpatient Alcohol & Drug Abuse Programs.

(1) An applicant must develop and document an outpatient program to provide, at a minimum: individual needs assessment and evaluation; individual, family, and group counseling; aftercare; and information and referral for at least one year after each patient's discharge from the intermediate care facility.

(2) An applicant must document continuity of care and appropriate staffing at off-site outpatient programs.

(3) Outpatient programs must identify special populations as defined in Regulation .08, in their service areas and provide outreach and outpatient services to meet their needs.

(4) Outpatient programs must demonstrate the ability to provide services in the evening and on weekends.

(5) An applicant may demonstrate that outpatient programs are available to its patients, or proposed patient population, through written referral agreements that meet the requirements of (1) through (4) of this standard with existing outpatient programs.

The applicant operates two ADAA certified outpatient programs for DUI and DWI patients; one is a Level I – Outpatient Treatment program and the other is a Level 0.5 – Early Intervention – DWI Education program. (DI #12, Question #20, p. 49). It does not operate any other outpatient programs

The applicant states that FMA's inpatient program operates within an informal network of both inpatient and outpatient treatment service providers both within the State of Maryland and in other States and the outpatient programs in the network are organized to meet the requirements of Parts (1) through (4) of the standard. (DI #2, p. 31) FMA pointed to the written referral agreement it has with New Life Addiction Counseling Services, Inc., located in Pasadena, Maryland, stating that New Life provides individual needs assessment and evaluation; individual, family and group counseling; aftercare; and information and referral.

With the inclusion of signed referral agreement with an outpatient treatment program in the Central Maryland region, staff finds that the applicant complies with this standard.

.05P. Program Reporting. Applicants must agree to report, on a monthly basis, utilization data and other required information to the Alcohol and Drug Abuse Administration's Substance Abuse Management Information System (SAMIS) program, and participate in any comparable data collection program specified by the Department of Health and Mental Hygiene.

Currently, only providers who receive public funding (i.e., Medicare, Medicaid, or public grants) are required by ADAA to participate in the monthly data reporting through the SAMIS program. FMA stated that it will comply with this standard by agreeing to submit data to ADAA's SAMIS program, and will commence reporting of the data immediately following Commission approval of this CON. The applicant indicated that it will obtain technical assistance and training from ADAA staff and others responsible for SAMIS such as the University of Maryland's Institute for Governmental Service and Research.

Because FMA does not currently participate in the SAMIS program, staff recommends that the approval of this project be conditioned on FMA's participation in this information system within six months of CON approval.

B. NEED

COMAR 10.24.01.08G(3)(b) Need. The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

FMA is a private, non-denominational, Joint Commission-accredited facility that provides alcoholism and drug addiction treatment on its campus located in Harford County, Maryland. The proposed project involves modernizing its' existing facilities by replacing or converting nine rooms used for three and four patient occupancy, by replacing four patient rooms that are currently located in attic space that are not suitable for patient occupancy, and by increasing the number of private patient rooms from eleven to twenty. The proposed modernization is to be accomplished by constructing a new two-story building with approximately 42,000 gross square feet of space. The new building is designed for 36 beds, which will increase FMA's licensed capacity by 15 beds from 85 to 100 and effective bed capacity from 78 to 100. The proposed project would also consolidate and relocate the Admissions and Intake areas into the new building space, establish a permanent location for the Wellness/Fitness Center in the new space, and expand and consolidate other administrative and support spaces.

The need criterion requires the Commission to consider the applicable need analysis in the State Health Plan ("SHP"). Where there is no need analysis, the Commission is required to consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs. The SHP chapter for ICF-CD services includes a need projection method. This methodology, applied to the Central Maryland region established in the SHP for use with this methodology, supports the bed addition proposed, as previously outlined in this report.

In considering the need for the additional beds it is important to note that FMA services a multi-state area that extends well beyond the State of Maryland. For the fiscal year ending June 30, 2013 approximately 48 percent of FMA's patients originated in Maryland. (DI #24) The proportion of patients from the Central Maryland region was only 26% in FY 2012. (DI #12, replacement page 53) Assuming the this patient origin pattern, it can be anticipated that, on average, seven of the 15 additional beds will serve Maryland residents, of which approximately four will serve residents of Central Maryland.

FMA states that the need for FMA's services is reflected in the actual utilization and the number of inquiries received. While its occupancy rate has been about 85 percent of licensed beds, for the past two years it has been between 93% and 95% of the 78 beds that have been used in recent years due to physical plant issues with the other seven beds. FMA pointed to the level of interest in its program as evidenced by an average of 55 inquiries per week over the 30 months prior to submission of the CON application. During this period, FMA admitted 20 patients per week, 14 from immediate telephone calls, and six related to previous calls. The facility does not maintain a waiting list. (DI #2, p. 37)

It is reasonable to interpret the need criterion more broadly than applying to the need for additional bed capacity to include the need to modernize this facility. The proposed project will modernize the facility by eliminating rooms with more than two beds. While the applicable SHP chapter does not address this specific aspect of the physical plant, other SHP chapters for institutional services, such as the chapter covering nursing homes, limits new construction to resident rooms with a maximum capacity of two beds and requires renovation projects to reduce the number of patient rooms with more than two beds.

The proposed project will also include additional treatment and support space within the new building by establishing a state of the art wellness program that would allow FMA to offer fitness programs, yoga, meditation, relaxation, massage, acupuncture and art and music therapies. Finally, FMA will consolidate and locate the admissions process in one location, eliminating the need of having patients move from one floor to the next and between two buildings to complete the admissions.

In summary, the SHP bed need analysis indicates a need for more private ICF beds for alcoholism and drug abuse treatment as proposed by the applicant, and FMA has reasonably demonstrated its need for additional bed capacity. More importantly the proposed modernization will bring patient services, especially patient rooms, up to modern standards by improving patient comfort and facilitating treatment. Staff finds that the proposed addition of beds is likely to be needed, based on the demand for FMA's services. More importantly, the proposed modernization of the facility is needed.

C. AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

COMAR 10.24.01.08G(3)(c)Availability of More Cost-Effective Alternatives. The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

This review criterion requires the Commission to compare the cost effectiveness of the proposed project with the cost effectiveness of providing the services through alternative existing service providers or through an alternative facility that has submitted a competitive application as part of a comparative review. The proposed project involves modernizing an existing facility by replacing or converting nine rooms with occupancies of three or four patients, by replacing four patient rooms that are currently located in attic space that are not suitable for patient occupancy, and by increasing the number of private patient rooms from eleven to twenty, all as detailed in the following tables.

Table 7: Father Martin's Ashley
Before Project Completion

Building	Room Count					Bed Count
	Four Bed Room	Three Bed Room	Semi-Private	Private	Total Patient Rooms	Physical Capacity
Noble Hall	1	3	6	4	14	29
Carpenter Hall	0	0	8	6	14	22
Bantle Hall	2	3	8	1	14	34
Total	**3**	**6**	**22**	**11**	**42**	**85**

Source: CON Application

Table 8: Father Martin's Ashley
After Project Completion

Building	Room Count					Bed Count
	Four Bed Room	Three Bed Room	Semi-Private	Private	Total Patient Rooms	Physical Capacity
Noble Hall	0	0	8	1	9	17
Carpenter Hall	0	0	6	8	14	20
Bantle Hall	0	0	13	1	14	27
New Building	0	0	13	10	23	36
Total	**0**	**0**	**40**	**20**	**60**	**100**

Source: CON Application

While the campus operations date from the early 1980's, some of the buildings used by FMA are much older and were retrofitted to create the ICF. The proposed project would consolidate and relocate the Admissions and Patient Intake into the new building space, establish a permanent location for the Wellness/Fitness Center in the new building, and expand and consolidate other administrative and support spaces. The changes proposed and the services affected are an integral part of FMA's program of service. Therefore, modernizing an alternative facility and providing the additional private patient rooms at such a facility would not meet any objectives that FMA has for improving its patient care. While the 15 additional beds proposed could be added to another facility, no alternative facility has submitted a competitive application and, as noted in this report, FMA is a unique facility in Maryland with respect to its program emphasis, total absence of public funding or participation in governmental third-party payment programs, and multi-state patient origin.

The location for the proposed new construction, west of Bantle Hall, is on a relatively flat site with no trees. The applicant considered renovating Noble Hall, but rejected this alternative for a number of reasons including the fact that the building has multiple levels of stairs and no elevator, limiting access for patients with mobility impairments.

The applicant also considered constructing a new building south of the existing buildings before selecting the proposed alternative. The advantage of locating a new building on the site south of the existing buildings would be the opportunity to increase the number of views of the Chesapeake Bay for the staff and patients. While this alternative would provide benefits to both patient and staff from a therapeutic and marketing/aesthetic perspective, there are a number of drawbacks. The location of this site would require FMA to meet Chesapeake Bay protection and storm water management requirements. FMA estimated addressing these and other site issues would potentially add months to the project, and an estimated $750,000 to the overall cost. The applicant also considered the impact that the location south of the existing buildings would have on the patients and staff since the site would be further away from the current buildings and infrastructure of the campus.

FMA selected the proposed site location west of Bantle Hall because it determined it would be less costly to construct and less costly to operate than the other campus alternatives to the south that would achieve similar space and facility objectives, due to the proximity of the new facility to the existing buildings. Another factor in the selection was the expectation that the selected alternative will allow the applicant to reasonably meet its project implementation timetable by employing a less complicated site approval process involving less developmental requirements.

Beyond the limited perspective of the project itself and the costs and effectiveness of various approaches to modernizing FMA's facilities for the purposes to which they are used, the review required for this project does present the Commission with an opportunity to examine the larger question of costs and effectiveness in substance abuse treatment. FMA is philosophically wedded to a single basic treatment modality, involving admission of patients for a 28-day stay on its campus. The applicant was not able to provide and staff was unable to find, in the literature, support for the idea that this approach to treatment is the most cost effective approach to treating alcohol or drug dependency or an approach that is the most cost-effective for a majority of persons in need of such treatment. This is not a treatment modality that third-party payors are universally willing to fund, at full cost, under most plans with benefit coverage for addictions treatment and this fact has shaped the way in which FMA operates and markets it program. It appears to be a major factor in the limited number of such programs in operation. In fairness, FMA is not claiming that its program is the best option for all patients in need of addictions treatment but believes it is the most effective approach for some types of patient. It has not attempted to systematically evaluate its level of effectiveness in comparison with similar 28-day programs in other states.

The most recent research identified by staff comparing treatment modalities was published in 2003.[3] This research compared the cost and effectiveness of four modes: inpatient, residential, outpatient detox/methadone, and outpatient drug-free. It found cost-effectiveness, when compared to other health interventions, for all four modes and found that outpatient drug-free settings were the most cost-effective, in terms of cost per successfully treated abstinent case.[4] It noted that, although variations in settings, modalities, and outcomes makes comparisons of cost-effectiveness estimates across studies difficult, its findings were, in general, consistent with the results of most prior cost-effectiveness studies of alcohol and substance abuse treatment.[5] While this study did not conclude that different modalities might not be more cost-

[3] Mojtabai, R and Zivin, JG, "Effectiveness and Cost-effectiveness of Four Treatment Modalities for Substance Abuse Disorders: A Propensity Score Analysis." Health Services Research, 2003, Feb; 38(1 Pt 1):233-259

[4] Two nonmutually exclusive measures were "operationalized;" (1) abstinence during a five-year follow-up after discharge from index discharge (i.e., no use of any substances), and (2) any reduction in the use of substances from the five-year period before index treatment and the five-year period following treatment.

[5] Longabaugh R, McCrady B, Fink E, Stout R, McAuley T, Doyle C, McNeill D. "Cost-effectiveness of Alcoholism Treatment in Partial vs. Inpatient Settings; Six-Month Outcomes."Journal of Studies of Alcohol. 1983;44(6):1049-71.
Pettinati HM, Meyers K, Evan BD, Ruetsch CR, Kaplan FN, Jensen JM, Hadley TR. "Inpatient Alcohol Treatment in a Private Healthcare Setting: Which Patients Benefit and at What Cost?" American Journal on Addiction. 1999; 8(3):220-33.
Annis HM, "Is Inpatient Rehabilitation of Alcoholics Cost-effective? Con Position." In: Stimmel B, editor. Controversies in Alcoholism and Substance Abuse, New York: Haworth Press,; 1986. pp. 175-90.
French MT, "Economic Evaluation of Drug Abuse Treatment Programs: Methodology and Findings." American Journal of Drug and Alcohol Abuse. 1995;21(1): 111-35.

effective for particular types of patients, it noted that no evidence was found in its study that patients could be "selected" into programs for improved effectiveness and cited the "mixed" evidence in the literature that matching clients and client-problems to the "right kinds" of programs to maximize or optimize effectiveness can be successfully implemented.

The State Health Plan and the Cost and Effectiveness of Alternatives criterion do not provide a clear basis for denying a project such as that proposed by FMA based on questions concerning the effectiveness of the singular treatment approach it employs or the lack of evidence developed by FMA itself with respect to effectiveness or cost effectiveness when compared with comparable facilities. Denying the ability of a program such as this, that has viably operated for thirty years and can point to success in assisting many patient over that time, to modernize its facilities on the basis of these questions is obviously problematic. FMA has agreed and staff has recommended conditioning CON approval on participation in the program data reporting system of ADAA. In addition, staff is proposing conditioning approval on agreement by FMA to document that it is meeting its promised increase in qualifying charity care provision over a five-year period. Given these conditions, it is also appropriate that FMA also be conditioned on reporting back to MHCC, at the end of that five-year period, on its efforts to systematically evaluate its effectiveness in alcohol and substance abuse treatment, through more rigorous follow-up evaluation of treatment success and collaborative efforts with similar programs in other states to institute standardized peer review to study and improve program effectiveness.

Staff finds that the proposed project has been demonstrated to be the most cost-effective alternative for modernizing FMA and better meeting the demand for its services.

D. VIABILITY OF THE PROPOSAL

COMAR 10.24.01.08G(3)(d) Viability of the Proposal. The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Availability of Financial Resources

FMA presents the following budget estimate for the project:

Table 9: Project Budget
Father Martin's Ashley

USES OF FUNDS	
New Construction	
Building	$10,750,000
Site Preparation	3,900,000
Architect/Engineering Fees	1,042,000
Permits	95,000
Subtotal New Construction	**$15,787,000**
Other Capital Costs	
Minor Movable Equipment	$525,000
Other Equipment	
Wellness/Fitness Center Equipment	200,000
Telecommunications Equipment	60,000
Information Technology*	100,000
Miscellaneous, e.g., Security System	350,000
Subtotal Other Capital Costs	$17,022,000
Contingencies	$962,000
Total Current Capital Costs	$17,984,000
Inflation (based on 3.45% construction cost increase over 12 month period)	$377,000
TOTAL PROPOSED CAPITAL COSTS	**$18,361,000**
Financing Cost and Other Cash Requirements	
Loan Placement Fees	$237,000
Legal Fees, (CON Related).	35,000
CON Application Assistance	20,000
SUBTOTAL	$292,000
TOTAL USES OF FUNDS	**$18,653,000**
SOURCES OF FUNDS	
Cash	$6,000,000
Pledges	4,000,000
Gifts, bequests	1,653,000
Bond or Letter of Credit	7,000,000
TOTAL SOURCES OF FUNDS	**$18,653,000**

Sources: Father Martin's Ashley CON application (DI #2, p. 8) and March 19, 2013 Response to first completeness questions (DI #11, p. 14)

FMA expects that future development fundraising will provide the necessary funds to replace or pay off the bond or letter of credit. (DI #14, p. 7) FMA reports that it already has pledges of $5.4 million of which $4.2 million has been collected. (DI #11, p. 13) The audited financial statement ending June 30, 2012 indicates FMA had $851,385 in cash and cash equivalents and $50.1 million in investments. The investments primarily consisted of mutual funds and limited partnerships. (DI #2, Attachment 13) The audited financial statements indicate a sufficient balance of cash and cash equivalents as well as investments to fund FMA estimated $6.0 million equity contribution. As for the $4 million in pledges and the $1,653,000 in gifts and

bequests, FMA's Capital Campaign for the Certificate of Need has already received pledges in advance of the official kick-off for this campaign almost equal to the amounts budgeted.

The remaining $7 million will be financed either through a bond or a letter of credit through a bank. FMA assumes that it will issue a five year bond, at an expected rate of 3.44% with the issuance cost of $235,000 amortized over the five years. The applicant states that the assumed payback period will provide time for FMA to raise and collect developmental fundraising dollars for the bonds. The Board of Trustees will review the prevailing rate and fees for this bond, and determine the best terms for either issuing a bond or seeking a line of credit from a bank. The applicant has provides sufficient evidence on the availability of funds for this project.

Projected Financial Performance

The applicant provided the following projected financial results through 2017:

Table 10: Projected Financial Performance
Father Martin's Ashley ($000s)

	Actual		Current Year Projected	Projected			
Projected Years	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Inpatient Revenue	$ 22,428	$ 23,777	$ 23,986	$ 24,403	$ 25,756	$ 30,016	$ 30,947
Outpatient Revenue	57	75	137	172	172	172	172
Gross Pt. Revenue	**22,485**	**23,852**	**24,123**	**24,575**	**25,928**	**30,188**	**31,119**
Allowance For Bad Debt	59	24	15	15	54	96	103
Contractual Allowance	4,498	5,510	5,736	5,980	6,199	7,091	7,127
Charity Care	2,069	2,117	2,300	2,294	2,836	3,305	3,585
Net Pt. Service Revenue	**15,859**	**16,201**	**16,072**	**16,286**	**16,839**	**19,696**	**20,304**
Other Operating Revenues	542	438	564	564	564	564	564
Net Operating Revenue	**$ 16,401**	**$ 16,639**	**$ 16,636**	**$ 16,850**	**$ 17,403**	**$ 20,260**	**$ 20,868**
Salaries, Wages, Etc.	9,291	10,402	10,991	10,991	11,403	12,011	12,011
Contractual Services	1,476	1,361	1,448	1,448	1,448	1,448	1,448
Interest on Current & Project Debt	0	0	0	0	0	0	0
Current Depreciation	1,061	1,051	1,256	1,456	1,656	1,856	2,056
Project Depreciation	0	0	0	0	479	575	575
Current Amortization	20	20	20	20	20	20	20
Loan Cost	0	0	0	172	288	219	151
Supplies	426	432	403	403	403	403	403
Other Expenses	2,829	3,044	3,013	3,013	3,886	4,149	4,183
Operating Expenses	**$ 15,103**	**$ 16,310**	**$ 17,131**	**$ 17,503**	**$ 19,583**	**$ 20,681**	**$ 20,847**
Income from Operation	**$ 1,298**	**$ 329**	**$ (495)**	**$ (653)**	**$ (2,180)**	**$ (421)**	**$ 21**
Non-operating Income	$ 12,118	$ (1,276)	$ 2,062	$ 2,062	$ 1,630	$ 1,630	$ 1,630
Net Income (loss)	$ 13,416	$ (947)	$ 1,567	$ 1,409	$ (550)	$ 1,209	$ 1,651
Operating Margin	8.2%	2.0%	-3.1%	-4.0%	-12.9%	-2.1%	0.1%

Source: Father Martin's Ashley March 19, 2013 response to firs completeness letter (DI #11, pp. 67-68)

The facility projects opening operations with the new building and increased bed inventory in 2015. FMA will assume increasing expenses (or revenue deductions) for charity care and depreciation expenses will also have a negative impact on its operating margin. The financial projections show that FMA anticipates a return to operational profitability by 2017.

FMA does not participate in either Medicare or Medicaid. The applicant is a contracted provider with CareFirst BC/BS and with United Behavioral Health (Optum), Compsych, Managed Health Network, and Value Options. FMA also is a contracted provider for two union groups – Princeton Health Services and Tri State Health & Welfare Fund and three employer groups. As a result, the applicant provides the following breakdown of utilization by payor.

Table 11: Percent of Patient Days by Payor
Father Martin's Ashley

	2011	2012	2013	2014	2014	2016	2017
Blue Cross	27.9%	32.1%	36.0%	34.9%	33.0%	32.0%	30.0%
Commercial Insurance	25.6%	24.3%	24.2%	27.7%	28.0%	28.5%	29.4%
Self-Pay	39.6%	34.6%	30.2%	28.0%	28.0%	28.5%	29.0%
Other–Charity	6.9%	9.0%	9.6%	9.4%	11.0%	11.0%	11.6%

Source: Father Martin's Ashley March 19, 2013 response to first completeness letter (DI #11, p. 69)

Conclusion

Staff finds that this facility has a history of successful financial performance and has the cash and investments available to fund the project and finance at the projected level of borrowing projected for the project. Staff also believes that FMA's assumptions with respect to its ability to fill the increased inventory of beds and generate the revenue necessary to sustain the modernization and expansion are reasonable and supportable. Staff concludes that the proposal is viable, based on the availability of resources and the likely level of support for the expansion of bed capacity.

E. COMPLIANCE WITH CONDITIONS OF PREVIOUS CERTIFICATES OF NEED

COMAR 10.24.01.08G(3)(e) Compliance with Conditions of Previous Certificates of Need. An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

Only one FMA CON has been identified in MHCC records. In 1990, FMA was authorized to replace a building on campus to house 20 beds, dietary facilities, administrative offices, activity areas, clinical staff offices, and treatment areas. The CON was conditioned on FMA notifying the Commission of any increases in patient charges and demonstrating that such increases were not the result of capital expenditures for the approved project. MHCC records do not indicate any non-compliance with this condition. No debt was identified as a source of funding for this project, which had an approved cost of $6,558,700.

F. IMPACT ON EXISTING PROVIDERS AND THE HEALTH CARE DELIVERY SYSTEM

COMAR 10.24.01.08G(3)(f)Impact on Existing Providers and the Health Care Delivery System. An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

Given that the proposed project is a modernization and expansion of an existing facility, it will have no impact on geographic accessibility. This project is aimed at improving FMA's competitiveness on a national basis, regional, or state basis, where it is not confronted with competitors that are drawing from the same market. FMA considers its primary competitors to be The Betty Ford Center, Hazelden Foundation, CRC-Sierra Tucson, The Farley Center, Williamsburg Place, and other facilities of this type in other states. Staff research supports the validity of this conclusion. (DI. #2, Attachment 11).

FMA's commitment to an increase the amount of charity care days including the days of care for the indigent and gray area population should improve access for these populations. However, the direct impact on accessibility for the regional population is likely be modest, given FMA's historic patient origin pattern. This expansive service area will also minimize the potential impact of the proposed project on occupancy at other Central Maryland ICF-CDs. While the proposed facility modernization and expansion in bed capacity may have some impact on other area providers, it is likely to be very small and, as noted, to the extent that the SHP need methodology has merit (see SHP Project Review Standard B), it would be expected that demand exceeds supply for beds of this type. While FMA is proposing to increase its licensed bed capacity by 15 beds (and effective capacity by 22 beds), assuming that FMA's current utilization pattern continues, only three to four of these beds are likely to be utilized by Central Maryland residents and approximately seven of these beds are likely to be used by residents from anywhere in Maryland. For Central Maryland four beds would be a 2.8 percent increase over the current number of Track One beds and a 0.6 percent increase in total beds as detailed in the following table.

Table 12: Intermediate Care Facility Level Alcohol and Drug Abuse Administration Certified Substance Abuse Treatment Programs Operating in Central Maryland Region

COUNTY/FACILITY	TRACK	ADULT BEDS
Anne Arundel County		
Anne Arundel Medical Center (Pathways) - Annapolis	One	32
Chrysalis House, Inc. - Crownsville	Two*	35
Hope House Treatment Center - Crownsville	Two	45
Serenity Acres Treatment Center - Crownsville	One	27
Baltimore County		
Gaudenzia, Inc. at Owings Mills - Owings Mills	Two	50
Baltimore City		
Baltimore Crisis Response, Inc. - Baltimore	Two	28
Gaudenzia at Park Heights - Baltimore	Two	135
Gaudenzia Inc., Weinberg Center - Baltimore	Two	140
Tuerk House, Inc. - Baltimore	Two	78
Harford County		
Father Martin's Ashley - Havre de Grace	One	85
Total Track One Beds		**144**
Total Track Two Beds		**511**
Total Beds		**655**

Source: MHCC telephone survey
*Track Two facilities are defined in the SHP as intermediate care facilities with "beds owned and wholly operated by the State or substantially funded by the budget process of the State or substantially funded by one or more jurisdictional governments, which are established jointly by providers and the jurisdiction or jurisdictions to meet the special needs of their residents and that reserve at least 50 percent of their proposed annual adolescent or adult bed capacity for indigent and gray area patients."

Based on all of the above, staff concludes that the proposed modernization and expansion should have minimal if any impact on occupancy, costs and charges of other providers in the Central Maryland region or other providers in the state.

IV. STAFF RECOMMENDATION

Staff has analyzed the proposed project's compliance with the applicable State Health Plan criteria and standards in COMAR 10.24.14.05, and with the other general review criteria, COMAR 10.24.01.08G(3)(b)-(f).

Based on these findings, Staff recommends that the project be approved with the following conditions:

1. Father Martin's Ashley shall commence reporting data and other required information to the Alcohol and Drug Abuse Administration's Substance Abuse Management Information System (SAMIS) program within six months of this approval and first use approval shall not be granted until FMA submits documentation of such reporting.

2. Father Martin's Ashley shall provide a minimum of 6.3% of patient days of care to indigent and gray area patients, as defined in the State Health Plan, commencing with the first full

year of operation following completion of the approved project. Father Martin's Ashley shall document the provision of such charity care by submitting annual reports auditing its total days of care and the provision of days of care to indigent and gray area patients as a percentage of total days of care. Such audited reports shall be submitted to the Maryland Health Care Commission following the first full year of operation following completion of the approved project and continuing for five years thereafter.

3. At the end of the fifth year of full operation following completion of the approved project, FMA will provide a report to MHCC, detailing its efforts to systematically evaluate its effectiveness in alcohol and substance abuse treatment. This should include follow-up evaluation of treatment success and collaborative efforts with similar treatment programs in other states to institute standardized peer review to study and improve program effectiveness.

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

* *

FINAL ORDER

Based on Commission Staff's analysis and findings, it is this 19th day of September 2013, **ORDERED** that the application for a Certificate of Need, submitted by Ashley, Inc. d/b/a Father Martin's Ashley to construct a new building at an estimated cost of $18,653,000, and increase the number of licensed beds from 85 to 100 ICF/CD beds, Docket No. 13-12-2340, be **APPROVED** subject to the following conditions.

1. Father Martin's Ashley shall commence reporting data and other required information to the Alcohol and Drug Abuse Administration's Substance Abuse Management Information System (SAMIS) program within six months of this approval and first use approval shall not be granted until FMA submits documentation of such reporting.

2. Father Martin's Ashley shall provide a minimum of 6.3% of patient days of care to indigent and gray area patients, as defined in the State Health Plan, commencing with the first full year of operation following completion of the approved project. Father Martin's Ashley shall document the provision of such charity care by submitting annual reports auditing its total days of care and the provision of days of care to indigent and gray area patients as a percentage of total days of care. Such audit reports shall be submitted to the Maryland Health Care Commission following the first full year of operation following completion of the approved project and continuing for five years thereafter.

3. At the end of the fifth year of full operation following completion of the approved project, FMA will provide a report to MHCC, detailing its efforts to systematically evaluate its effectiveness in alcohol and substance abuse treatment. This should include follow-up evaluation of treatment success and collaborative efforts with similar treatment programs in other states to institute standardized peer review to study and improve program effectiveness.

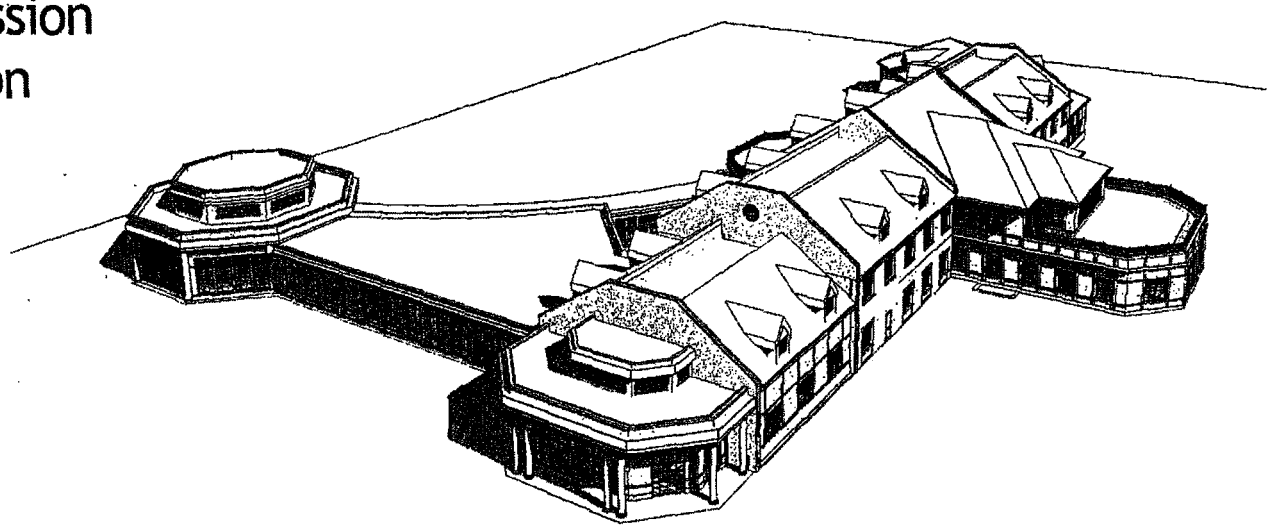
APPENDIX A

Site Plan and Floor Plans

FATHER MARTIN'S ASHLEY PATIENT INTAKE BUILDING

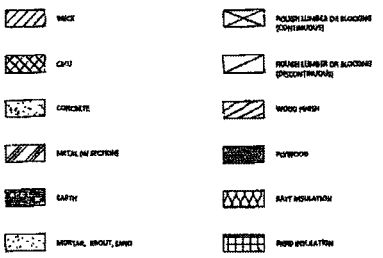
HAVRE DE GRACE, MARYLAND

Maryland Health Care Commission
Certificate of Need Application



DRAWING LIST

MATERIAL FILL PATTERNS



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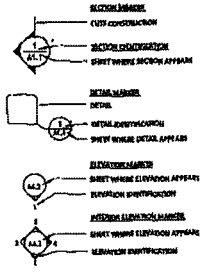
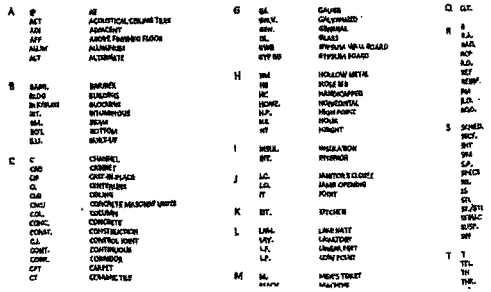
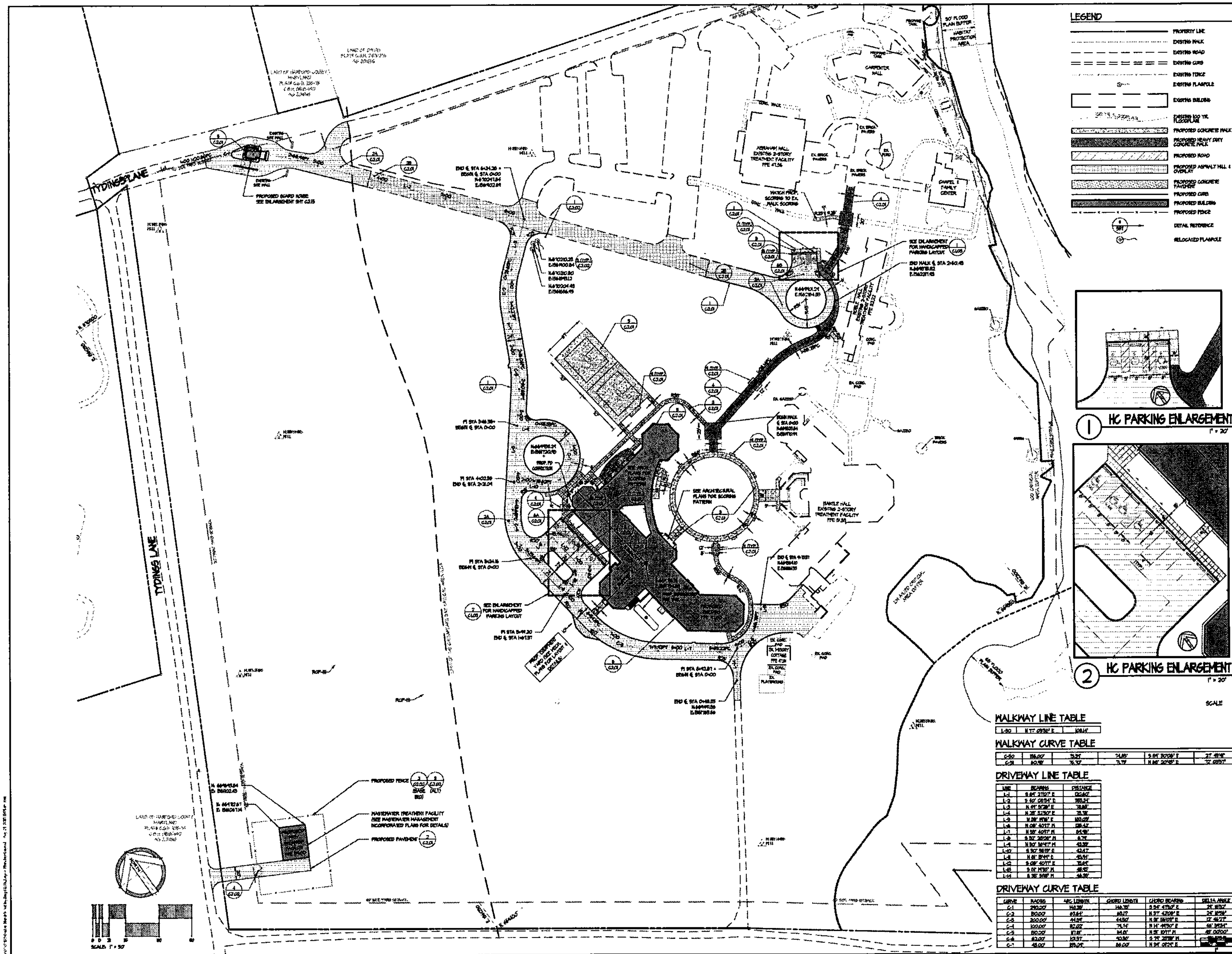


ABBREVIATIONS





WALKWAY LINE TABLE

L-50	N 17° 09'38" E	108.14'

WALKWAY CURVE TABLE

C-50	156.07'	75.21'	74.89'	S 64° 30'08" E	27° 49'41"
C-51	60.58'	76.37'	71.79'	N 86° 20'45" E	72° 09'57"

DRIVEWAY LINE TABLE

LINE	BEARING	DISTANCE
L-1	S 64° 21'07" E	120.40'
L-2	S 60° 08'54" E	355.24'
L-3	N 49° 51'28" E	32.80'
L-4	N 28° 52'30" E	35.38'
L-5	N 39° 11'18" E	100.09'
L-6	N 08° 40'17" W	238.42'
L-7	N 58° 40'17" W	84.98'
L-8	S 32° 28'08" W	6.75'
L-9	N 50° 58'47" W	43.38'
L-10	S 50° 58'19" E	42.47'
L-11	N 61° 13'44" E	45.98'
L-12	S 08° 40'17" E	30.64'
L-13	S 51° 14'50" W	48.52'
L-14	S 35° 58'05" W	48.32'

DRIVEWAY CURVE TABLE

CURVE	RADIUS	ARC LENGTH	CHORD LENGTH	CHORD BEARING	DELTA ANGLE
C-1	290.20'	148.38'	146.78'	S 54° 41'57" E	29° 18'52"
C-2	150.00'	63.64'	63.17'	N 57° 47'08" E	24° 18'58"
C-3	200.00'	44.58'	44.50'	N 31° 58'09" E	12° 46'27"
C-4	100.00'	82.02'	79.14'	N 14° 49'30" E	46° 59'34"
C-5	150.20'	117.81'	114.81'	N 57° 10'17" W	45° 00'00"
C-6	60.00'	101.37'	90.96'	S 79° 25'58" W	[illegible]
C-7	45.00'	109.24'	86.00'	N 34° 08'21" E	[illegible]

ARCHITECT
Hord Coplan Macht, Inc.
750 E. Pratt St, Suite 1100 Baltimore, MD 21202
p. 410.837.7311 f. 410.837.6530
STRUCTURAL ENGINEER
[illegible]
MEP ENGINEER
[illegible]
CIVIL ENGINEERS / LANDSCAPE ARCHITECTS
[illegible]
Owner

FATHER MARTIN'S ASHLEY PATIENT INTAKE BUILDING

HAVRE DE GRACE, MARYLAND

hord | coplan | macht

ARCHITECTURE
LANDSCAPE ARCHITECTURE
PLANNING
INTERIOR DESIGN

8/29/13

no.	date	revision
4	07.12.13	Addendum # 4
3	07.08.13	Addendum # 3

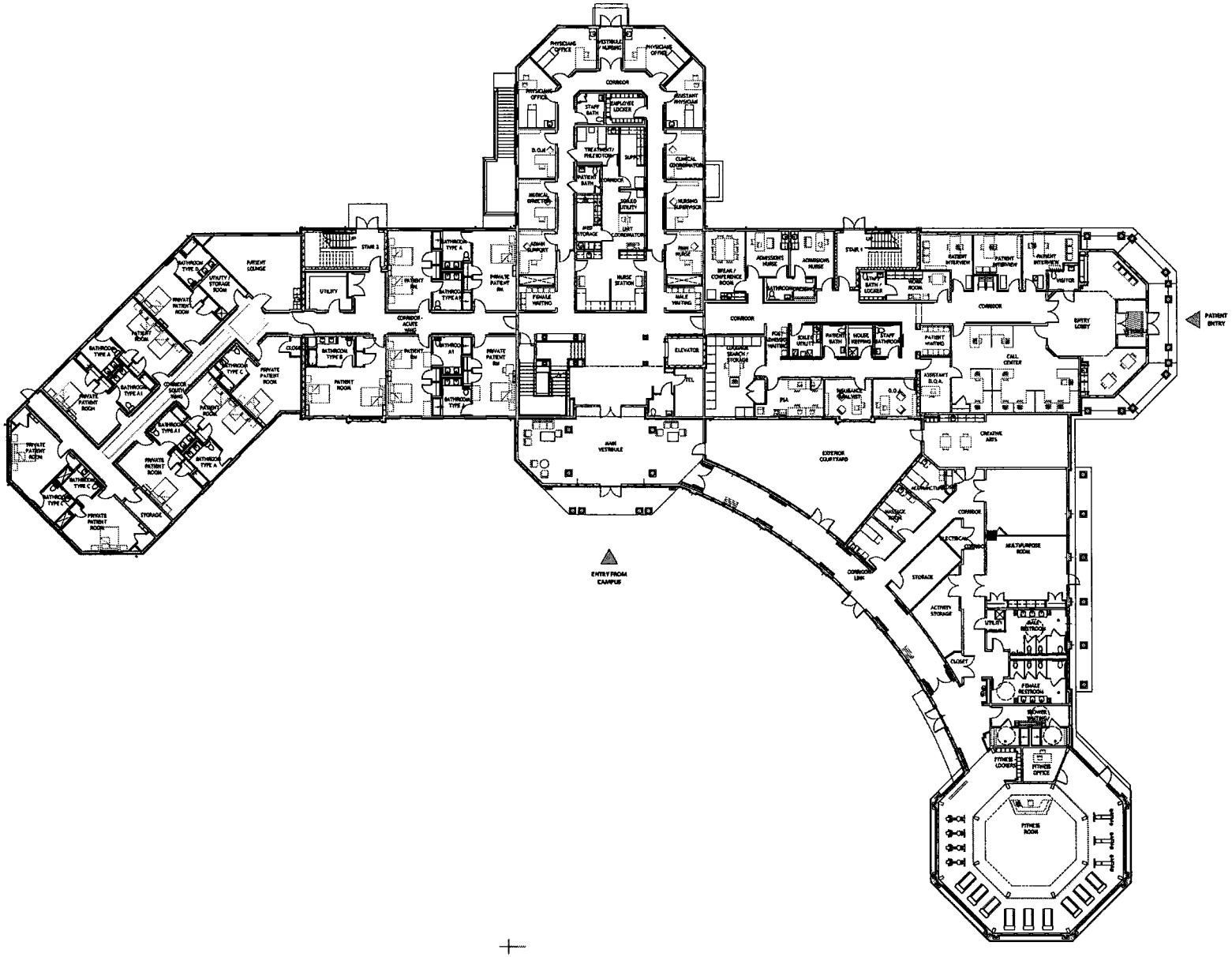
Project Name
FATHER MARTIN'S ASHLEY PATIENT INTAKE BUILDING
Project Number
212070.00
Date
08.29.2013
Scale
AS NOTED
Drawing
LAYOUT & DETAIL REFERENCE PLAN

C1.03

BID SET

FIRST FLOOR PLAN

A1.2



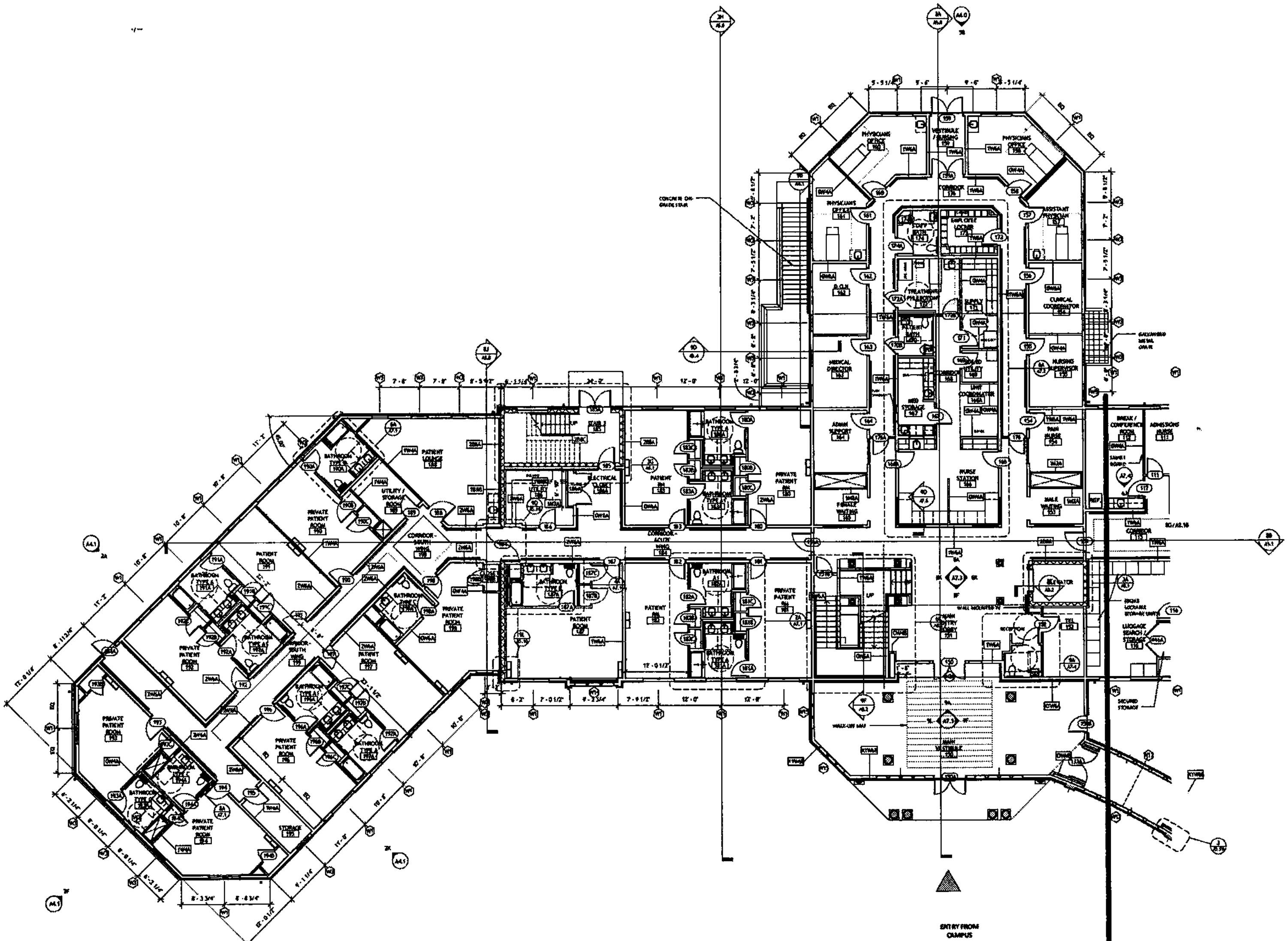
FATHER MARTIN'S ASHLEY PATIENT INTAKE BUILDING

HAVRE DE GRACE, MARYLAND

08.26.2013

hord | coplan | macht

750 E. Pratt Street, Suite 1100 Baltimore MD 21202
410.837.7311 www.hcm2.com



8E FIRST FLOOR PLAN - PART A
1/8" = 1'-0"

GENERAL NOTES:
1. SEE SHEET A2.2 FOR FLOOR DIMENSIONS.
2. OPERABLE PARTITION TO BE DORMA ACOUSTI-SEAL PAIRED PANEL SYSTEM W/ MAN DOOR. PROVIDE ALL STRUCTURAL SUPPORTS NEEDED FOR COMPLETE INSTALLATION.
3. SEE INTERIOR DESIGN DRAWINGS FOR CORNER GUARD LOCATIONS

FATHER MARTIN'S ASHLEY PATIENT INTAKE BUILDING

HAVRE DE GRACE, MARYLAND

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ARCHITECTURE
LANDSCAPE ARCHITECTURE
PLANNING
INTERIOR DESIGN

no.	date	revision
5	07.18.13	Addendum # 5
4	07.12.13	Addendum # 4
3	07.09.13	Addendum # 3

Project Name
FATHER MARTIN'S ASHLEY PATIENT INTAKE BUILDING

Project Number
212070.00

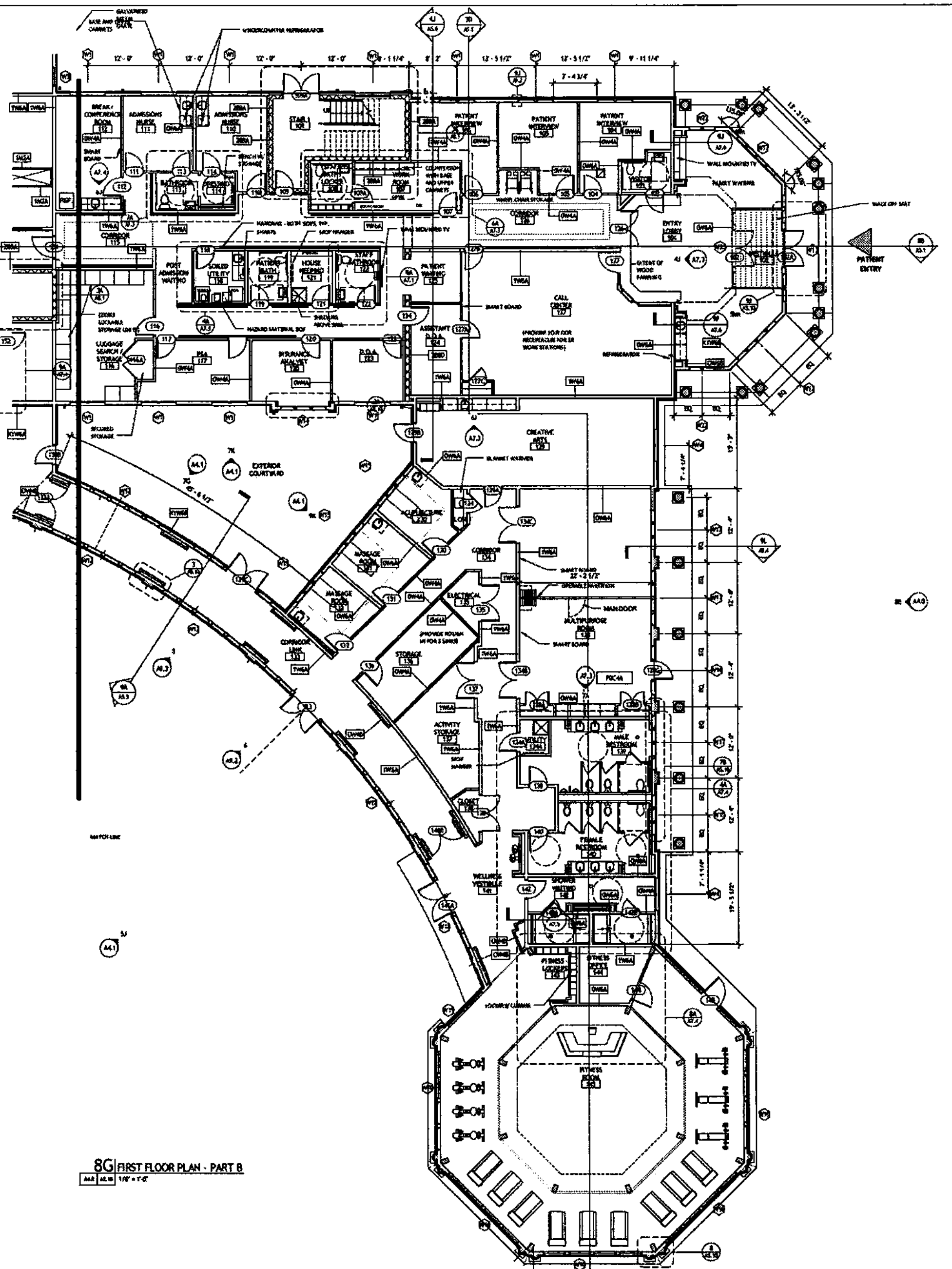
Date
06.26.2013

Scale
1/8" = 1'-0"

Drawing
FIRST FLOOR PLAN - PART A

A2.1A

PERMIT SET



8G FIRST FLOOR PLAN - PART B
1/8" = 1'-0"

GENERAL NOTES:
1. SEE SHEET A2.2 FOR FLOOR DIMENSIONS.
2. OPERABLE PARTITION TO BE DORMA ACOUSTI-SEAL PAIRED PANEL SYSTEM W/ MAN DOOR. PROVIDE ALL STRUCTURAL SUPPORTS NEEDED FOR COMPLETE INSTALLATION.
3. SEE INTERIOR DESIGN DRAWINGS FOR CORNER GUARD LOCATIONS

FATHER MARTIN'S ASHLEY PATIENT INTAKE BUILDING

HAVRE DE GRACE, MARYLAND

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4	37.12.13	Addendum # 4

Project Name: FATHER MARTIN'S ASHLEY PATIENT INTAKE BUILDING

Project Number: 212070.00

Date: 08.26.2013

Scale: 1/8" = 1'-0"

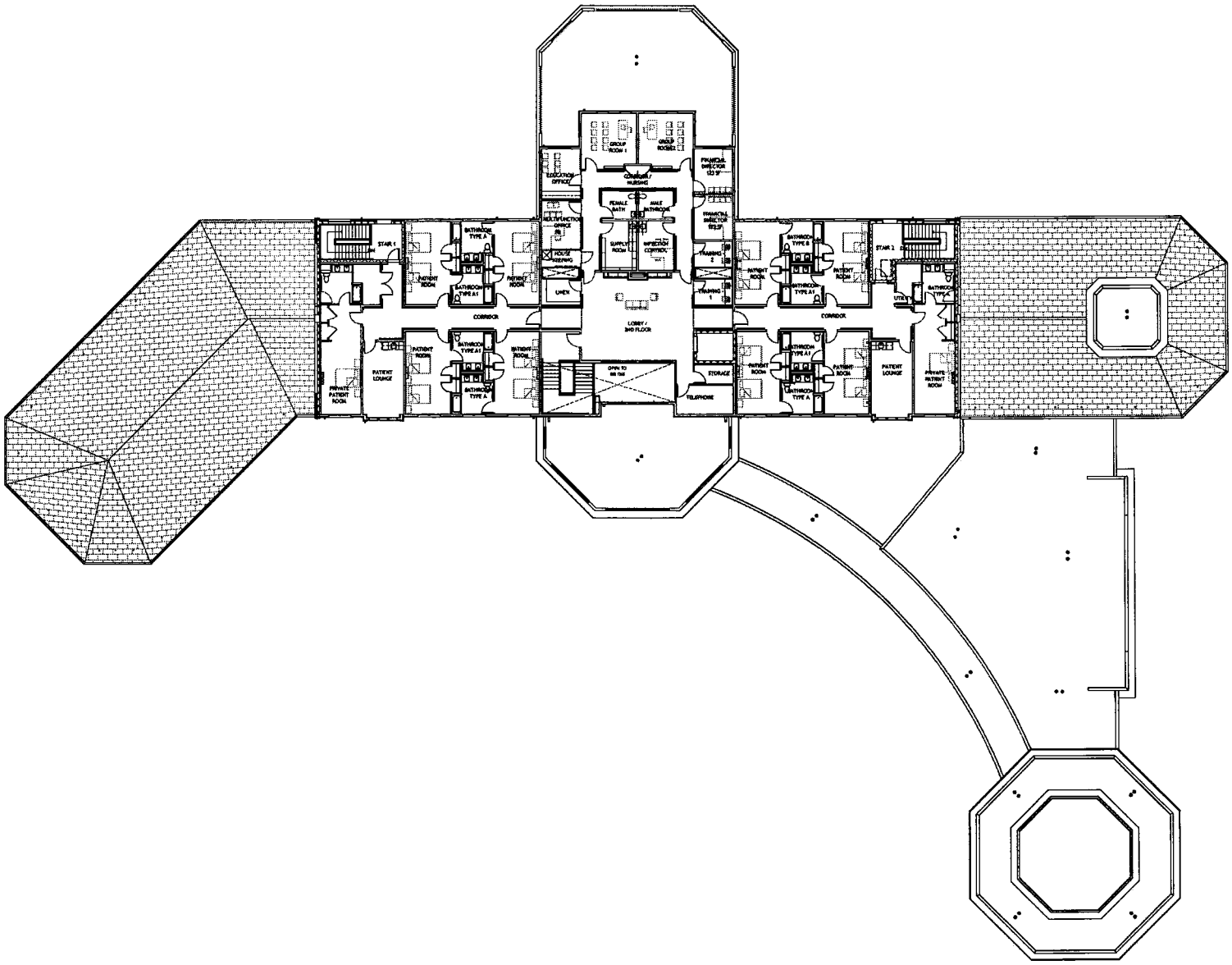
Drawing: FIRST FLOOR PLAN - PART B

A2.1B

PERMIT SET

SECOND FLOOR PLAN

A1.3



FATHER MARTIN'S ASHLEY PATIENT INTAKE BUILDING

HAVRE DE GRACE, MARYLAND

08.26.2013

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750 E. Pratt Street, Suite 1100 Baltimore MD 21202
410.837.7311 www.hcm2.com

EXHIBIT 9

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Comments of Father Martin's Ashley on the Modified CON Application of Recovery Centers of America to establish an Intermediate Care Facility in Earleville, Maryland are true and correct to the best of my knowledge, information and belief.

Date: November 16, 2015

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

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Comments of Father Martin's Ashley on the Modified CON Application of Recovery Centers of America to establish an Intermediate Care Facility in Earleville, Maryland are true and correct to the best of my knowledge, information and belief.

Date: November 16, 2015

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

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Comments of Father Martin's Ashley on the Modified CON Application of Recovery Centers of America to establish an Intermediates Care Facility in Earleville, Maryland are true and correct to the best of my knowledge, information and belief.

Date: November 16, 2015

Bernadette Solounias, M.D.

Bernadette Solounias, M.D.
Senior Vice President of Medical Services
Father Martin's Ashley

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Comments of Father Martin's Ashley on the Modified CON Application of Recovery Centers of America to establish an Intermediate Care Facility in Earleville, Maryland are true and correct to the best of my knowledge, information and belief.

Date: November 16, 2015

Richard J. Coughlan, Director
DHG Healthcare