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February 3, 2016

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

BY ELECTRONIC MAIL AND FIRST CLASS MAIL

Re: Docket No. 15-07-2363
Recovery Center of America - Earleville

Dear Mr. McDonald:

Please find the enclosed Comments of Father Martin's Ashley on the Modified CON Application of Recovery Center of America – Earleville.

Sincerely,

Richard J. Coughlan

Enclosures

cc: Steven Kendrick
Albert Germann
Jack J. Eller, Esq.
SuEllen Wideman
Thomas Dane

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

****

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

INTRODUCTION

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

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

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

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

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

Comment #1

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

> (1) Unless an applicant demonstrates why one or more of the following standards should not apply or should be modified, an applicant seeking to establish or to expand a Track One intermediate care facility must:
>
> (a) Establish a sliding fee scale for gray area patients consistent with a client's ability to pay;
>
> (b) Commit that it will provide 30 percent or more of its proposed annual adolescent intermediate care facility bed days to indigent and gray area patients; and
>
> (c) Commit that it will provide 15 percent or more of its proposed annual adult intermediate care facility bed days to indigent or gray area patients.
>
> (2) An existing Track One intermediate care facility may propose an alternative to the standards in Regulation D(1) that would increase the availability of alcoholism and drug abuse treatment to indigent or gray area patients in its health planning region.

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

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

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

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

Applicants revenue and expense projection tables, **Exhibit (**1),**35**, Tables G, H, J and K, reflect this commitment of 6.15%. (However, at,)calculated as a percentage of net revenue rather than patient days. At the request of the Commission staff, Applicant has produced alternative financial tables that reflect the 15% figure referenced in this standard. See **Exhibit** (2),**36**, Tables G, H, J and K.

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

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

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

Source: EXHIBIT 36, MODIFIED CON Application – RCA Earleville

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

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

> RCA believes it is clinically inappropriate to provide charity care for eligible patients' only for detox services. Thus, the Applicant has committed to provide charity care for the entire course of detox and residential treatment, although there is no requirement that RCA provide charity care for residential treatment at ASAM level III.5. In fact, if the total charity care that RCA has committed to provide was applied to detox services only, RCA's commitment would amount to almost 25% of patient days, exceeding the requirement set forth in Standard .04D(1)(c). Using the financial projections for 2017 as an example, RCA's commitment of $1,509,228 in charity care is equivalent to approximately 1,755 patient days (1,509,228 ÷ 860 = 471,754.91), which is 24.6% of the total projected patient days for detox services in that year (see Table F, line 2(i)).
>
> (See Exhibit 3, CORRECTED MODIFIED CON Application, redlined copy, p. 47)

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

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

Comment #2

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

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

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

2015, the "Applicant assumed that existing providers use 20% of their licensed beds as 'true' detox beds and the remaining 80% as inpatient beds. The Applicant concluded the 20% assumption from internal discussions with RCA's clinical and operations team who have extensive experience in the field." On that basis, the applicant shows that FMA has 20 detox beds. (See Exhibit 4, CON Application, p. 28-32; TABLE 6.)

Subsequently, in the first modified CON Application of May 18, 2015, the Applicant revised its estimates of 'true' detox beds for each existing Track One facilities based on the RCA management team's experience in the field and the 2013 National Survey of Substance Abuse Treatment Services. The modified application continues to show that FMA had 20 detox beds. The reference to the Nation Survey provides no specific information concerning the number of detox beds at FMA. The Applicant continues to show that FMA has 20 Detox beds (See Exhibit 5, Modified CON Application: p. 30, 31, 38; Exhibit 11)

Subsequently, on August 31, 2015, in response to Additional Information Questions Dated July 17, 2015, the Applicant provided Exhibit 32, determined that 41% of the beds at the three RCA proposed projects was the appropriate percentage to use to identify the number of detox beds, and applied this percentage to all Maryland facilities offering inpatient detox and residential services. At this point, FMA was estimated to have 41 detox beds, not 20 detox beds (See Exhibit 6, Modified TABLE 9).

On November 16, 2015, FMA submitted comments on the Modified CON application. In Response to these comments, RCA-E presented TABLE 1. Inventory of Existing Providers, which shows that FMA's inventory of 100 beds includes 17 detox beds (Exhibit 7).

Finally, in the CORRECTED MODIFIED CON application of December 31, 2015, the Applicant states on multiple pages that it assumed that the percentage of licensed beds in the existing non-funded inventory utilized for detox/assessment changed from 15% to 41% (See Exhibit 8: CORRRECTED MODIFIED CON Application, redlined copy, December 31, 2015, pp. 40,42,44,61, and 68).

Despite the fact that FMA has set forth a detail and precise accounting for its estimate of the number of beds that are actually utilized for subacute detox services, RCA-E continues to persist

in estimating a higher number. Astonishingly, in Modified TABLE 12 RCA-E estimates that FMA to have 41 detox beds. (Modified TABLE 12, p. 68, CORRECTED MODIFIED Application, redlined copy; also CORRECTED MODIFIED Application, redlined copy, Exhibit 37). This discrepancy illustrates numerous misunderstandings concerning the manner in which the need for subacute detoxification services, a service which is specifically defined to be facilitated in an intermediate care facility under COMAR 10.24.14.08. B. (13), is to be determined and provided. The State Health Plan could not be more specific on what it considers a reasonable length of stay for ICF services, which includes not only the detox portion of an overall stay, but also the subsequent rehabilitation portion of that stay. Nevertheless, RCA-E persists on providing alternative and changing assumptions and estimates for the need for subacute detox beds, not only for its own proposed ICF facility, but for existing ICF facilities as well.

The source of the current assumption that 41% of beds at facilities that provide subacute detox services and inpatient rehabilitation services is based on the Applicants own revised projected detox/assessment bed to total bed ratio for which a meaningful basis has not been established. RCA-E previously asserted that FMA has 20 detox beds, and now has asserted that the number of FMA detox beds should be considered to be 41, which is more than double the prior number of ascribed beds!

By contrast, the reality of the ratio of detox beds at RCA-E is now 21%: 108 total ICF beds / 21 detox beds =21%.

A second source of misunderstanding regarding the need for detox beds is provided by a statement that RCA-E will utilize a “patient-centered assessment tool” which may result in average lengths of stay longer than those that the Interested Parties experience. (Exhibit 9: Response to Interested Party Comments, p. 9). This claim should be completely discounted by the Commission in light of the fact that RCA-E, in contrast to FMA, has no established track record of providing any type of inpatient substance abuse services at all, much less any experience using a “patient assessment tool” to identify the specific need for detox beds or services in a licensed Maryland intermediate care facility that provides subacute detox services as defined in the State Health Plan.

Rather than accept FMA's own explanation as to how many of its 100 beds are actually used to provide detox services, and understanding that the utilization of those beds has previously been CON-approved and is consistent with the standards set forth in the State Health Plan, RCA-E has sought to exaggerate the volume of these services it intends to provide and the number of beds needed to provide them.

RCA-E continues to assert that there are different levels of care that are provided in intermediate care facilities, some of which do not actually constitute ICF services, and that the need for detox services and beds is currently greater than the supply. The changing estimates and inventory of detox beds RCA-E has provided the Commission over the past nine months is not based on reasonable assumptions, and should be disregarded with respect to the need for the 108 bed treatment center RCA-E has proposed.

Comment #3

The modified RCA-E application is not currently approvable because the staffing estimates provided by the Applicant do not include an assessment of the impact on existing providers of intermediate care services, which is certain to be unacceptably negative. In the absence of such documentation, the application has not demonstrated that the project is consistent with COMAR 10.24.01.08 G (3)(f). Impact on Existing Providers and the Health Care Delivery System.

The CORRECTED MODIFIED CON Application provides a great deal of information concerning the staffing levels and composition for providing services to the patients treated for detox and rehabilitation services at the proposed RCA-E. It would appear that the proposed RCA-E facility will be staffed with 124.54 FTEs when fully utilized (See Exhibit 10, which includes CORRECTED MODIFIED CON Application, redlined copy, pp. 9, 12, 13, 54, 61, 63; TABLE L. Work Force Information Detox – Earleville, November 30, 2015 Update; Response to MHCC Staff Completeness Question 5., 6.)

Despite the fact that such a large number of positions will be needed to staff this proposed 108 bed facility, whose campus will be located in a rural area distant from large labor markets, no discussion is provided on the impact on the existing providers of intermediate care services in

the region, including FMA. RCA-E is proposing to operate the single largest residential intermediate care facility in the State thirty miles from the FMA campus. Even before this CON review has been completed by the MHCC, the impact of RCA-E's plans is already being felt in the market for health care personnel currently employed by FMA. We are aware of the recruiting efforts that have already begun to attract the existing members of the staff of FMA to consider the employment opportunities at the proposed RCA-E facility.

The impact of this new facility, as proposed for 108 beds, will seriously challenge FMA and other Maryland facilities to maintain their existing staffing levels to meet the current demand for services, and maintain their accessibility to the gray area and indigent patients. Addressing growing demands for their services will be that much more challenging, FMA urges the Commission to consider the impact of the proposed RCA-E project on FMA's ability to provide sufficient staff to maintain its efficient and effective services at the 100 bed level previously CON-approved, and consider alternative development plans for RCA-E that will minimize any unnecessary duplication, negative impact, and increased costs of care that could result.

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.

LIST OF EXHIBITS

1. MHCC Notice Modified CON Application, January 20, 2016
2. Exhibit 36, Corrected Modified RCA-E CON Application
3. Corrected Modified RCA-E CON Application, p. 47
4. Original CON Application, p. 28-32; TABLE 6
5. Modified CON Application: p. 30, 31, 38; Exhibit 11
6. Modified TABLE 9, August 31, 2015 Responses to Completeness Questions
7. RCA-E Response to Interested Party Comments, TABLE 1.
8. CORRRECTED MODIFIED CON Application, December 31, 2015, pp. 40,42,44,61, and 68
9. Response to Interested Party Comments, p. 9
10. CORRECTED MODIFIED CON Application pp. 9, 12, 13, 54, 61, 63; TABLE L. Work Force Information Detox – Earleville, November 30, 2015 Update; Response to MHCC Staff Completeness Question 5., 6.
11. Affirmations

EXHIBIT 1

Maryland Health Care Commission

Modification of: Certificate of Need Application
Recovery Centers of America - Earleville
314 Grove Neck Road OPCO, LLC proposes to establish an alcohol and drug abuse intermediate care facility in Cecil County, Maryland. The proposed facility will include 21 Detox / Assessment beds to be licensed as a level III.7D, Medically Monitored Inpatient Detoxification, under the placement criteria of the American Society of Addiction Medicine (ASAM). The proposed facility will also include 87 residential beds that Applicant expects to license as ASAM level III.5 – Clinically Managed High-Intensity Residential Treatment.
(Docket No. 15-07-2363)
Proposed Cost: The total project cost is $30,832,335, $7,368,855 of which is attributable to the detox/assessment portion of the project that is subject to Certificate of Need review.

Date Posted: January 20, 2016

Pursuant to COMAR 10.24.01.08E, the Maryland Health Care Commission gives notice that the above-referenced Certificate of Need application has been modified by the applicant. The modified application can be accessed on the Commission's website at www.mhcc.maryland.gov
http://mhcc.maryland.gov/mhcc/Pages/hcfs/hcfs_con/hcfs_con_filed_applications.aspx

The entire record of this project review can be viewed at the offices of the Maryland Health Care Commission, 4160 Patterson Avenue, in Baltimore, during regular business hours, 9 a.m. to 4 p.m., Monday through Friday, by appointment.

Persons desiring to provide comments on the modification to the above-referenced application should submit written comments to the Commission no later than 4:30 p.m. on February 3, 2016.

Questions may be directed to Kevin McDonald, Chief, Certificate of Need, Maryland Health Care Commission at 410-764-5982, or sent to MHCC, 4160 Patterson Avenue, Baltimore, Maryland 21215.

EXHIBIT 2

EXHIBIT 36

AITERNATIVE TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - 15% Charity Care - Earleville -Dec. 21, 2015

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	N/A	N/A	2015	2016	2017	2018				
1. REVENUE										
a. Inpatient Services			$ -	$ 18,374,400	$ 98,690,250	$ 105,156,500				
b. Outpatient Services										
Gross Patient Service Revenues	***$ -***	***$ -***	***$ -***	***$ 18,374,400***	***$ 98,690,250***	***$ 105,156,500***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt			$ -	$ 509,696	$1,989,754	$2,120,038				
d. Contractual Allowance			$ -	$ 13,277,440	$ 72,160,199	$ 76,889,322				
e. Charity Care			$ -	$ 688,090	$ 3,681,045	$ 3,922,071				
Net Patient Services Revenue	***$ -***	***$ -***	***$ -***	***$ 3,899,174***	***$ 20,859,252***	***$ 22,225,069***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)										
NET OPERATING REVENUE	***$ -***	***$ -***	***$ -***	***$ 3,899,174***	***$ 20,859,252***	***$ 22,225,069***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)			$ -	$ 2,966,587	$8,109,670	$8,458,548				
b. Contractual Services			$ -	$ 254,509	$ 588,576	$ 627,044				
c. Interest on Current Debt			$ -	$ -	$ -	$ -				
d. Interest on Project Debt			$ -	$ -	$ -	$ -				
e. Current Depreciation			$ -	$ -	$ -	$ -				
f. Project Depreciation			$ -	$ -	$ -	$ -				
g. Current Amortization			$ -	$ -	$ -	$ -				
h. Project Amortization			$ -	$ -	$ -	$ -				
i. Supplies			$ -	$ 9,897	$ 32,319	$ 34,432				
j. Administrative/office expenses			$ -	$ 1,081,078	$ 3,519,962	$ 3,821,863				
k. Facilities expenses (repairs & maintenance, rent, real estate taxes, utilities			$ -	$ 1,088,423	$ 4,187,390	$ 4,202,601				
l. Food			$ -	$ 321,109	$ 1,659,063	$ 1,767,494				
m. Marketing expense			$ -	$ 178,141	$ 920,396	$ 980,551				
n. Liability insurance			$ -	$ 32,620	$ 132,712	$ 141,386				
o. Other Expenses: Licensing & legal expenses			$ -	$ 17,250	$ 89,125	$ 94,950				
TOTAL OPERATING EXPENSES	**$ -**	**$ -**	**$ -**	**$ 5,949,614**	**$19,239,213**	**$ 20,128,869**	**$ -**	**$ -**	**$ -**	**$ -**

AITERNATIVE TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - 15% Charity Care - Earleville -Dec. 21, 2015

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	$ -	$ -	$ -	$ (2,050,440)	$ 1,620,039	$ 2,096,200	$ -	$ -	$ -	$ -
b. Non-Operating Income										
SUBTOTAL	*$ -*	*$ -*	*$ -*	*$ (2,050,440)*	*$ 1,620,039*	*$ 2,096,200*	*$ -*	*$ -*	*$ -*	*$ -*
c. Income Taxes										
NET INCOME (LOSS)	*$ -*	*$ -*	*$ -*	*$ (2,050,440)*	*$ 1,620,039*	*$ 2,096,200*	*$ -*	*$ -*	*$ -*	*$ -*
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%***

ALTERNATIVE TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - 15% Charity Care - Earleville - Dec. 21, 2015

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	**N/A**	**N/A**	**2015**	**2016**	**2017**	**2018**				
1. REVENUE										
a. Inpatient Services			$ -	$ 18,374,400	$ 103,624,762	$ 115,935,041				
b. Outpatient Services										
Gross Patient Service Revenues	***$ -***	***$ -***	***$ -***	***$ 18,374,400***	***$ 103,624,762***	***$ 115,935,041***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt			$ -	$ 509,696	$ 2,089,241	$ 2,337,342				
d. Contractual Allowance			$ -	$ 13,277,440	$ 75,768,209	$ 84,770,477				
e. Charity Care			$ -	$ 688,090	$ 3,865,097	$ 4,324,083				
Net Patient Services Revenue	***$ -***	***$ -***	***$ -***	***$ 3,899,174***	***$ 21,902,215***	***$ 24,503,139***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)			$ -	$ -	$ -	$ -				
NET OPERATING REVENUE	***$ -***	***$ -***	***$ -***	***$ 3,899,174***	***$ 21,902,215***	***$ 24,503,139***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)			$ -	$ 2,966,587	$ 8,391,622	$ 9,177,524				
b. Contractual Services			$ -	$ 254,509	$ 609,478	$ 680,342				
c. Interest on Current Debt			$ -	$ -	$ -	$ -				
d. Interest on Project Debt			$ -	$ -	$ -	$ -				
e. Current Depreciation			$ -	$ -	$ -	$ -				
f. Project Depreciation			$ -	$ -	$ -	$ -				
g. Current Amortization			$ -	$ -	$ -	$ -				
h. Project Amortization			$ -	$ -	$ -	$ -				
i. Supplies			$ -	$ 9,897	$ 33,467	$ 37,358				
j. Administrative/office expenses			$ -	$ 1,081,078	$ 3,544,207	$ 3,863,670				
k. Facilities expenses (repairs & maintenance, rent, real estate taxes, utilities			$ -	$ 1,088,423	$ 4,200,299	$ 4,235,521				
l. Food			$ -	$ 321,109	$ 1,717,979	$ 1,917,731				
m. Marketing expense			$ -	$ 178,141	$ 953,082	$ 1,063,898				
n. Liability insurance			$ -	$ 32,620	$ 137,425	$ 153,404				
o. Other Expenses: Licensing & legal expenses			$ -	$ 17,250	$ 92,290	$ 103,021				
TOTAL OPERATING EXPENSES	***$ -***	***$ -***	***$ -***	***$ 5,949,614***	***$ 19,679,849***	***$ 21,232,469***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME										

ALTERNATIVE TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - 15% Charity Care - Earleville - Dec. 21, 2015

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**				
a. Income From Operation	**$ -**	**$ -**	**$ -**	**$ (2,050,440)**	**$ 2,222,366**	**$ 3,270,670**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income										
SUBTOTAL	***$ -***	***$ -***	***$ -***	***$ (2,050,440)***	***$ 2,222,366***	***$ 3,270,670***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ -***	***$ -***	***$ -***	***$ (2,050,440)***	***$ 2,222,366***	***$ 3,270,670***	***$ -***	***$ -***	***$ -***	***$ -***
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%***

ALTERNATIVE TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE - DETOX - 15% Charity Care - Earleville
Dec. 21, 2015

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	**2015**	**2016**	**2017**	**2018**			
1. REVENUE - DETOX							
a. Inpatient Services	$ -	$ -	$ 24,927,000	$ 26,827,500			
b. Outpatient Services							
Gross Patient Service Revenues	***$ -***	***$ -***	***$ 24,927,000***	***$ 26,827,500***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ -	$ -	$ 496,615	$ 534,478			
d. Contractual Allowance			$ 18,305,465	$ 19,701,122			
e. Charity Care	$ -	$ -	$ 918,738	$ 988,785			
Net Patient Services Revenue	***$ -***	***$ -***	***$ 5,206,182***	***$ 5,603,115***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify)							
NET OPERATING REVENUE	***$ -***	***$ -***	***$ 5,206,182***	***$ 5,603,115***	***$ -***	***$ -***	***$ -***
2. EXPENSES - DETOX							
a. Salaries & Wages (including benefits)	$ -	$ -	$ 1,561,644	$ 1,622,681			
b. Contractual Services	$ -	$ -	$ 114,445	$ 121,925			
c. Interest on Current Debt	$ -	$ -	$ -	$ -			
d. Interest on Project Debt	$ -	$ -	$ -	$ -			
e. Current Depreciation	$ -	$ -	$ -	$ -			
f. Project Depreciation	$ -	$ -	$ -	$ -			
g. Current Amortization	$ -	$ -	$ -	$ -			
h. Project Amortization	$ -	$ -	$ -	$ -			
i. Supplies	$ -	$ -	$ 6,284	$ 6,695			
j. Administrative/office expenses	$ -	$ -	$ 684,437	$ 743,140			
k. Facilities expenses (repairs & maintenance, rent, real estate taxes, utilities	$ -	$ -	$ 814,215	$ 817,172			
l. Food	$ -	$ -	$ 322,596	$ 343,679			
m. Marketing expense	$ -	$ -	$ 178,966	$ 190,663			
n. Liability insurance	$ -	$ -	$ 25,805	$ 27,492			
o. Other Expenses: Licensing & legal expenses	$ -	$ -	$ 17,330	$ 18,463			
TOTAL OPERATING EXPENSES	***$ -***	***$ -***	***$ 3,725,722***	***$ 3,891,910***	***$ -***	***$ -***	***$ -***
3. INCOME - DETOX							
a. Income From Operation	**$ -**	**$ -**	**$ 1,480,460**	**$ 1,711,205**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ -***	***$ -***	***$ 1,480,460***	***$ 1,711,205***	***$ -***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ -***	***$ -***	***$ 1,480,460***	***$ 1,711,205***	***$ -***	***$ -***	***$ -***
4. PATIENT MIX - DETOX							
a. Percent of Total Revenue							
1) Medicare	0.0%	0.0%	0.0%	0.0%			
2) Medicaid	0.0%	0.0%	0.0%	0.0%			
3) Blue Cross	0.0%	0.0%	0.0%	0.0%			
4) Commercial Insurance	0.0%	0.0%	19.5%	19.5%			
5) Self-pay	0.0%	0.0%	80.5%	80.5%			
6) Other	0.0%	0.0%	0.0%	0.0%			
TOTAL	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	0.0%	0.0%	0.0%	0.0%			
2) Medicaid	0.0%	0.0%	0.0%	0.0%			
3) Blue Cross	0.0%	0.0%	0.0%	0.0%			
4) Commercial Insurance	0.0%	0.0%	25.0%	25.0%			
5) Self-pay	0.0%	0.0%	60.0%	60.0%			
6) Other	0.0%	0.0%	15.0%	15.0%			
TOTAL	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***

ALTERNATIVE TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE - DETOX - 15% Charity Care - Earleville - Dec. 21, 2015

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	**2015**	**2016**	**2017**	**2018**			
1. REVENUE							
a. Inpatient Services	$ -	$ -	$ 26,173,350	$ 29,577,319			
b. Outpatient Services							
Gross Patient Service Revenues	***$ -***	***$ -***	***$ 26,173,350***	***$ 29,577,319***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ -	$ -	$ 521,446	$ 589,262			
d. Contractual Allowance			$ 19,220,738	$ 21,720,487			
e. Charity Care	$ -	$ -	$ 964,675	$ 1,090,135			
Net Patient Services Revenue	***$ -***	***$ -***	***$ 5,466,491***	***$ 6,177,435***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)							
NET OPERATING REVENUE	***$ -***	***$ -***	***$ 5,466,491***	***$ 6,177,435***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ -	$ -	$ 1,615,732	$ 1,760,607			
b. Contractual Services	$ -	$ -	$ 118,510	$ 132,289			
c. Interest on Current Debt	$ -	$ -	$ -	$ -			
d. Interest on Project Debt	$ -	$ -	$ -	$ -			
e. Current Depreciation	$ -	$ -	$ -	$ -			
f. Project Depreciation	$ -	$ -	$ -	$ -			
g. Current Amortization	$ -	$ -	$ -	$ -			
h. Project Amortization	$ -	$ -	$ -	$ -			
i. Supplies	$ -	$ -	$ 6,507	$ 7,264			
j. Administrative/office expenses	$ -	$ -	$ 689,151	$ 751,269			
k. Facilities expenses (repairs & maintenance, rent, real estate taxes, utilities	$ -	$ -	$ 816,725	$ 823,574			
l. Food	$ -	$ -	$ 334,051	$ 372,892			
m. Marketing expense	$ -	$ -	$ 185,322	$ 206,869			
n. Liability insurance	$ -	$ -	$ 26,722	$ 29,829			
o. Other Expenses: Licensing & legal expenses	$ -	$ -	$ 17,945	$ 20,032			
TOTAL OPERATING EXPENSES	***$ -***	***$ -***	***$ 3,810,665***	***$ 4,104,625***	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ -**	**$ -**	**$ 1,655,826**	**$ 2,072,810**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ -***	***$ -***	***$ 1,655,826***	***$ 2,072,810***	***$ -***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ -***	***$ -***	***$ 1,655,826***	***$ 2,072,810***	***$ -***	***$ -***	***$ -***
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	0.0%	0.0%	0.0%	0.0%			
2) Medicaid	0.0%	0.0%	0.0%	0.0%			
3) Blue Cross	0.0%	0.0%	0.0%	0.0%			
4) Commercial Insurance	0.0%	0.0%	19.5%	19.5%			
5) Self-pay	0.0%	0.0%	80.5%	80.5%			
6) Other	0.0%	0.0%	0.0%	0.0%			
TOTAL	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
1) Medicare	0.0%	0.0%	0.0%	0.0%			
2) Medicaid	0.0%	0.0%	0.0%	0.0%			
3) Blue Cross	0.0%	0.0%	0.0%	0.0%			
4) Commercial Insurance	0.0%	0.0%	25.0%	25.0%			
5) Self-pay	0.0%	0.0%	60.0%	60.0%			
6) Other	0.0%	0.0%	15.0%	15.0%			
TOTAL	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***

EXHIBIT 3

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

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

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

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

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

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

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

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

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

.05E. Information Regarding Charges.

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

Applicant Response

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

.05F. Location.

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

Applicant Response

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

.05G. Age Groups.

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

EXHIBIT 4

CERTIFICATE OF NEED APPLICATION

INTERMEDIATE CARE FACILITY

314 Grove Neck Road
Earleville, Maryland

RECOVERY CENTERS
OF AMERICA

Applicant: 314 Grove Neck Road OPCO, LLC
March 27, 2015

Table 3
Earleville Catchment Area, 2019

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

% of out-of-state patients	Detox Beds for out-of-state	% of beds for MD Residents	Beds for MD Residents
72.2%	12	27.8%	5

Applicant also asks that the Commission note the lack of providers that will directly compete with Applicant's locations. The graphic below demonstrates the low amount of direct competition in the Mid-Atlantic Region, and provides a better understanding of Applicant's 'neighborhood' model. Applicant's 'neighborhood' model is defined as 90 miles reach from the facility, or roughly an hour and half drive.

Table 4
Neighboring Providers

	Name of Facility	Address	Beds	Detox Offered	Private Pay Daily Rate	Distance in miles from Facility: From Earleville	From Upper Marlboro	From Waldorf
1	Williamsville Wellness	Hanover, VA	16	No	$ 933	182	92	76
2	Sagebrush	Great Falls, VA	N/Av	N/Av	$ 1,167	118	45	69
3	Hudson Health Services	Salisbury, MD	N/Av	Yes	$ 575	92	109	133
4	Father Martin's Ashley (28 Day Program)	Havre De Grace, MD	100	Yes	$ 657	32	70	84
5	Serenity Acres	Crownsville, MD	35	Yes	$ 667	69	22	49
6	Trinity Way	Hanover, PA	23	Yes	$ 1,000	89	76	99
7	Caron Treatment Centers Adult Primary Care Services	Wernersville, PA	257	Yes	$ 1,167	78	141	160
8	Retreat: Lancaster	Lancaster, PA	150	Yes	$ 1,000	68	103	139
9	Malvern Institute	Malvern, PA & Willow Grove, PA	172	Yes	$ 680	61	126	146
10	Mirabount	Media, PA	115	Yes	$ 625	59	127	137
11	Meadowwood	New Castle, DE	58	Yes	$ 800	30	103	42
	Total / Average		431		$852			

Existing Track One Beds in Maryland

Applicant modified the calculation of Track one beds provided in Table 3 in the State Health Plan. Because the CON requirement only applies to Applicant's Detox and Assessment beds, which are those that will provide intermediate care, or Level III.7 and III.7-D under the American Society of Addiction Medicine (ASAM) Patient Placement Criteria, rather than to all beds that provide lower levels of care.

Applicant assumes that existing providers use 20% of their licensed beds as 'true' detox beds and the remaining 80% as inpatient beds. The Applicant concluded the 20% assumption from internal discussions with RCA's clinical and operations team who have extensive experience in the field.

Table 5
Existing Track One Detox Beds
Eastern Shore, Maryland

	All Beds	Detox Beds (20%)
Warwick Manor	42	8

Table 6
Existing Track One Detox Beds
Maryland State

	All Beds	Detox Beds (20%)
Mountain Manor	111	23
Father Martin Ashley	100	20
Montgomery General	10	2
Warrick Manor	8	2
Total	229	47

B. Results – Bed Need by Region and Statewide

Applying this methodology, Applicant has calculated the following bed need for the Eastern Shore region, and statewide.

Table 7
Regional Bed ICF Need Projection
Eastern Shore, Maryland

			MD Population 2010 (3)	RCA 2014 Population (2)	RCA Projected 2019 (2)
	Projected Population for 18 Years and older - Projected 2018		350,176	407,905	418,847
a	Estimated # of privately insured (1)	64.2%	224,813 (1)	261,875 (1)	268,900 (1)
b	Estimated # of Substance Abuse Users	8.64%	19,424	22,626	23,233
c1	Estimated Annual Target Population	25.00%	4,856	5,657	5,808
c2	Estimated # requiring Treatment	95.00%	4,613	5,374	5,518
d	Estimated Population requiring ICF (25-35%)				
d1	Min %	25.00%	1,153	1,343	1,379
d2	Max %	35.00%	1,615	1,881	1,931
e	Estimated Range requiring Readmission				
e1	Min %	10.00%	115	134	138
e2	Max %	10.00%	161	188	193
		(5)			
f	Range of Adults requiring ICF Care				
	Min = (d1+e1)		1,269	1,478	1,517
	Max = (d2+e2)		1,776	2,069	2,124
g	Gross # of Adult ICF Bed Needed				
g1	Min = {{f*14 ALOS}}/365}/0.85	14	57	67	68
g2	Max = {{f*14 ALOS}}/365}/0.85	14	80	93	96
h	Existing Track One Inventory ICF beds		-	-	-
i	Net Private ICF Bed Needed				
	Min = (g1-h)		57	67	68
	Max = (g2-h)		80	93	96
j	Net All ICF Bed Needed				
	Min = (iMin x(1 + % of population w/out private insurance))	35.8%	78	91	93
	Min = (iMax x (1 + % of population w/out private insurance))	35.8%	109	127	130

Notes:

(1) 2013 National Health Interview Survery - CDC

(2) Numbers based off ESRI data

(3) State calculation based off Maryland Department of Planning, Projections and Data Analysis/State Data Center Feb. 2011

(4) Track One calculation based on 20% of existing beds in region being 'true' detox beds

(5) Out-of-state need accounted for in the beds requested, details regarding the calculation to come later in report

(6) Percentages for b-e from COMAR 10.24.14

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

RCA Beds Requested for Region - for both Maryland and out-of-State Patients

RCA Requested Detox / Assessment Beds	Total
Earleville, MD	17
Queenstown, MD	18
Total Detox / Assesment Beds	35

Earleville, MD		Queenstown, MD	
Total Detox / Assesment Beds	17	Total Detox / Assesment Beds	18
2014		*2014*	
Individuals 18 + in facility catcment area	15,054,302	Individuals 18 + in facility catcment area	11,845,578
Individuals 18 + in MD in facility catchment area	4,528,933	Individuals 18 + in MD in facility catchment area	4,422,484
% of patients from MD in catchment area	30.1%	% of patients from MD in catchment area	37.3%
Detox / Assement Beds for MD Residents	6	Detox / Assement Beds for MD Residents	7
2019		*2019*	
Individuals 18 + in facility catcment area	16,470,407	Individuals 18 + in facility catcment area	12,364,701
Individuals 18 + in MD in facility catchment area	4,584,056	Individuals 18 + in MD in facility catchment area	4,599,466
% of patients from MD in catchment area	27.8%	% of patients from MD in catchment area	37.2%
Detox / Assement Beds for MD Residents	5	Detox / Assement Beds for MD Residents	7

RCA Requested Detox / Assesment Beds to serve MD population	2010	2014	2019
Earleville, MD	N/A	6	5
Queenstown, MD	N/A	7	7
Total Detox / Assesment Beds	N/A	13	12

Table 9
Regional Bed ICF Need Projection
Maryland State

				MD Population 2010-Development (3)	RCA 2014 Population (2)	RCA Projected 2019 (2)
	MD Population for 18 Years and older			4,420,588	4,612,691	4,793,500
	E. Shore Region Population for 18 Years and older			350,176	407,905	418,847
	MD Population 18 and older excluding E. Shore Region			4,770,764	5,020,596	5,212,347
a	**Estimated # of privately insured (1)**	*64.2%* (1)		3,062,830	3,223,222	3,346,327
b	**Estimated # of Substance Abuse Users**	*8.64%*		264,629	278,486	289,123
c1	**Estimated Annual Target Population**	*25.00%*		66,157	69,622	72,281
c2	**Estimated # requiring Treatment**	*95.00%*		62,849	66,141	68,667
d	**Estimated Population requiring ICF (12.5-15%)**					
d1	Min % - All Regions excluding E. Shore	*12.50%*		7,856	8,268	8,583
d2	Max % - All Regions excluding E.Shore	*15.00%*		9,427	9,921	10,300
d3	Min % - E. Shore Region	*25.00%*		1,153	1,343	1,379
d4	Max % - E. Shore Region	*35.00%*		1,615	1,881	1,931
e	**Estimated Range requiring Readmission**					
e1	Min %	*10.00%*		901	961	996
e2	Max %	*10.00%*		1,104	1,180	1,223
		(5)				
f	**Range of Adults requiring ICF/CD Care**					
	Min = (d1+d3+e1)			9,910	10,572	10,959
	Max = (d2+d4+e2)			12,146	12,982	13,454
g	**Gross # of Adult ICF Bed Needed**					
g1	Min = ((f*14 ALOS))/365)/0.85		14	447	477	495
g2	Max = ((f*14 ALOS))/365)/0.85		14	548	586	607
h	**Existing Track One Inventory ICF/CD beds**	*(4)*		47	47	47
i	**Net Private ICF/CD Bed Needed**					
	Min = (g1-h)			400	430	448
	Max = (g2-h)			501	539	560
j	**Net All ICF Bed Needed**					
	Min = (iMin x(1 + % of population w/out private insurance))	*35.8%*		543	584	608
	Min = (iMax x (1 + % of population w/out private insurance))	*35.8%*		680	732	761

Notes:

(1) 2013 National Health Interview Survery - CDC

(2) Numbers based off ESRI data

(3) State calculation based off State of MD Development Census numbers

(4) Track One calculation based on 20% of existing beds in region being 'true' detox beds

(5) Out-of-state need accounted for in the beds requested, details regarding the calculation to come later in report

(6) Percentages for b-e from COMAR 10.24.14

Table _
RCA Beds Requested, Maryland and out-of-State Patients
Maryland State

RCA Requested Detox / Assessment Beds	Total
Earleville, MD	17
Queenstown, MD	18
Waldorf, MD	21
Upper Marlboro, MD	25
Total Detox / Assesment Beds	81

Earleville, MD	
Total Detox / Assesment Beds	*17*
2014	
Individuals 18 + in facility catcment area	*15,054,302*
Individuals 18 + in MD in facility catchment area	*4,528,933*
% of patients from MD in catchment area	*30.1%*
Detox / Assement Beds for MD Residents	*6*
2019	
Individuals 18 + in facility catcment area	*16,470,407*
Individuals 18 + in MD in facility catchment area	*4,584,056*
% of patients from MD in catchment area	*27.8%*
Detox / Assement Beds for MD Residents	*5*

Queenstown, MD	
Total Detox / Assesment Beds	18
2014	
Individuals 18 + in facility catcment area	11,845,578
Individuals 18 + in MD in facility catchment area	4,422,484
% of patients from MD in catchment area	*37.3%*
Detox / Assement Beds for MD Residents	*7*
2019	
Individuals 18 + in facility catcment area	12,364,701
Individuals 18 + in MD in facility catchment area	4,599,466
% of patients from MD in catchment area	*37.2%*
Detox / Assement Beds for MD Residents	*7*

Waldorf, MD	
Total Detox / Assesment Beds	*21*
2014	
Individuals 18 + in facility catcment area	*9,348,695*
Individuals 18 + in MD in facility catchment area	*4,528,933*
% of patients from MD in catchment area	*48.4%*
Detox / Assement Beds for MD Residents	*11*
2019	
Individuals 18 + in facility catcment area	*10,264,804*
Individuals 18 + in MD in facility catchment area	*4,709,044*
% of patients from MD in catchment area	*45.9%*
Detox / Assement Beds for MD Residents	*10*

Upper Marlboro, MD	
Total Detox / Assesment Beds	25
2014	
Individuals 18 + in facility catcment area	9,524,374
Individuals 18 + in MD in facility catchment area	4,513,229
% of patients from MD in catchment area	*47.4%*
Detox / Assement Beds for MD Residents	*12*
2019	
Individuals 18 + in facility catcment area	10,371,320
Individuals 18 + in MD in facility catchment area	4,689,719
% of patients from MD in catchment area	*45.2%*
Detox / Assement Beds for MD Residents	*12*

RCA Requested Detox / Assesment Beds to serve MD population	2010	2014	2019
Earleville, MD	N/A	6	5
Queenstown, MD	N/A	7	7
Waldorf, MD	N/A	11	10
Upper Marlboro, MD	N/A	12	12
Total Detox / Assesment Beds	N/A	36	34

.05C. Sliding Fee Scale.

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

EXHIBIT 5

MODIFIED

CERTIFICATE OF NEED APPLICATION

INTERMEDIATE CARE FACILITY

314 Grove Neck Road
Earleville, Maryland

RECOVERY CENTERS
OF AMERICA

Applicant: 314 Grove Neck Road OPCO, LLC
Original Application: March 27, 2015
Modified Application: May 18, 2015

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

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

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

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

Identifying Existing Non-Funded Facilities

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

Determining Number of Detox Beds

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

Source of 20% Assumption

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

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

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

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

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

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

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

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

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

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

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

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

Table 9
Existing Detox Beds
Maryland State

Not Funded [1]	All Beds [2]	Detox Beds (20%) [3]
Anchor @ Walden-Sierra	20	4
Father Martin's Ashley	100	20
Hudson Center	33	7
I'm Still Standing By Grace [4]	42	12
Warrick Manor	42	9
Total	*283*	*52*

Funded [1]	All Beds	Detox Beds (20%)
Arc House	16	4
Avery Treatment Center	32	7
Carroll Addiction Rehab Center	20	4
Finan Center, Jackson Unit		
Massie Unit	25	5
Jackson Unit	0	0
Hope House	18	4
Mountian Manor, Baltimore City [5]	46	10
Pathways	20	4
Shoemaker Women's Program	19	4
Turek House	63	13
Whitsett Rehab Center	20	4
Gaudenzia at Park Heights [6]	-	-
Hope House, Anne Arundel [6]	-	-
Hope House, Laurel [6]	-	-
Mountian Manor, Emmitsville	-	-
Total	*186*	*39*

Total Existing ICF Bed Inventory	**91+**
Total Existing Not-Funded ICF Bed Inventory	***52***

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

EXHIBIT 1 1

2011 State Profile — Maryland
National Survey of Substance Abuse Treatment Services (N-SSATS)

The National Survey of Substance Abuse Treatment Services (N-SSATS) is an annual survey of facilities providing substance abuse treatment. It is conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA). N-SSATS is designed to collect data on the location, characteristics, services offered, and number of clients in treatment at alcohol and drug abuse treatment facilities (both public and private) throughout the 50 States, the District of Columbia, and other U.S. jurisdictions.

More information on N-SSATS methodology is available at the following URL:

http://www.samhsa.gov/data/2k3/NSSATS/NSSATS.pdf

In Maryland, 349 substance abuse treatment facilities were included in the 2011 N-SSATS, reporting that there were 38,792 clients in substance abuse treatment on March 31, 2011. The survey response rate in Maryland was 94.2%.

Facility Operation

	Facilities		Clients in Treatment on March 31, 2011			
			All Clients		Clients Under Age 18	
	No.	%	No.	%	No.	%
Private non-profit	136	39.0	13,202	34.0	553	31.6
Private for-profit	153	43.8	17,607	45.4	423	24.2
Local, county, or community government	24	6.9	3,281	8.5	235	13.4
State government	27	7.7	3,573	9.2	535	30.6
Federal government	9	2.6	1,129	2.9	5	0.3
Dept. of Veterans Affairs	2	0.6	803	2.1	0	0.0
Dept. of Defense	5	1.4	285	0.7	5	0.3
Indian Health Service	0	0.0	0	0.0	0	0.0
Other	2	0.6	41	0.1	0	0.0
Tribal government	0	0.0	0	0.0	0	0.0
Total	**349**	**100.0**	**38,792**	**100.0**	**1,751**	**100.0**

Primary Focus of Facility

	Facilities		Clients in Treatment on March 31, 2011			
			All Clients		Clients Under Age 18	
	No.	%	No.	%	No.	%
Substance abuse treatment services	251	71.9	30,785	79.4	1,311	74.9
Mental health services	8	2.3	175	0.5	43	2.5
Mix of mental health & substance abuse treatment services	83	23.8	7,547	19.5	397	22.7
General health care	5	1.4	268	0.7	0	0.0
Other/unknown	2	0.6	17	0.0	0	0.0
Total	**349**	**100.0**	**38,792**	**100.0**	**1,751**	**100.0**

Substance Abuse Problem Treated

	Facilities[1, 2]		Clients in Treatment on March 31, 2011		
			Clients[3]		Clients per 100,000 Pop.
	No.	%	No.	%	Aged 18 or Older
Clients with both alcohol and drug abuse	310	92.0	14,193	36.6	298
Clients with drug abuse only	278	82.5	18,556	47.8	401
Clients with alcohol abuse only	255	75.7	6,042	15.6	127
Total[2]	**337**		**38,791**	**100.0**	**827**

[1] Facilities may be included in more than one category.

[2] Facilities excluded because they were not asked or did not respond to this question: 12

[3] Sum of individual items may not agree with the total due to rounding.

Type of Care

	Facilities[1]		Clients in Treatment on March 31, 2011				
			All Clients			Clients Under Age 18	
	No.	%	No.	%	Median No. of Clients Per Facility	No.	%
Outpatient	**289**	**82.8**	**35,993**	**92.8**	**67**	**1,624**	**92.7**
Regular	262	75.1	16,302	42.0	38		
Intensive	150	43.0	3,760	9.7	13		
Day treatment/partial hospitalization	15	4.3	127	0.3	1		
Detoxification	53	15.2	432	1.1	0		
Methadone maintenance	62	17.8	15,372	39.6	228		
Residential (non-hospital)	**74**	**21.2**	**2,326**	**6.0**	**20**	**80**	**4.6**
Short term	28	8.0	459	1.2	12		
Long term	68	19.5	1,739	4.5	15		
Detoxification	16	4.6	128	0.3	3		
Hospital Inpatient	**16**	**4.6**	**473**	**1.2**	**11**	**47**	**2.7**
Treatment	13	3.7	374	1.0	13		
Detoxification	16	4.6	99	0.3	4		
Total	**349**		**38,792**	**100.0**	**57**	**1,751**	**100.0**

[1]Facilities may provide more than one type of care.

Opioid Treatment Programs (OTPs)

	No.	%
Facilities with OTPs[1]	**57**	**4.8**
Clients in Facilities with OTPs		
Methadone	16,166	97.9
Buprenorphine	343	2.1
Total	**16,509**	**100.0**

[1] Percentage of all OTP facilities that are in this State or jurisdiction.

Facility Payment Options

	Facilities[1]	
	No.	%
Cash or self-payment	323	92.6
Private health insurance	203	58.2
Medicare	84	24.1
Medicaid	209	59.9
Other State-financed health insurance	133	38.1
Federal military insurance	75	21.5
Access to Recovery (ATR) vouchers[2]	N/A	N/A
Accepts HIS/638 contract care funds	4	1.1
No payment accepted	10	2.9
Accepts other payments	4	1.1
Sliding fee scale	218	62.5
Treatment at no charge for clients who cannot pay	148	42.4

[1] Facilities may accept more than one type of payment.

[2] Available only in AK, AZ, CA, CO, CT, DC, FL, HI, IA, ID, IL, IN, LA, MI, MO, MT, NJ, NM, OH, OK, RI, TN, TX, WA, WI, WY.

N/A - Not applicable.

Facility Licensing, Approval, Certification, or Accreditation

	Facilities[1]	
	No.	%
Any listed agency/organization	334	95.7
State substance abuse agency	306	87.7
State mental health department	126	36.1
State department of health	210	60.2
Hospital licensing authority	20	5.7
The Joint Commission	82	23.5
CARF[2]	57	16.3
NCQA[3]	8	2.3
COA[4]	9	2.6
Other State/Local Agency/Org	20	5.7

[1] Facilities may be licensed by more than one agency/organization.

[2] Commission on Accreditation of Rehabilitation Facilities

[3] National Committee for Quality Assurance

[4] Council on Accreditation

Facility Funding

	Facilities	
	No.	%
Receives Federal, State, county, or local government funds for substance abuse treatment programs	179	51.3

Types of Services Offered

	Facilities	
	No.	%
Assessment and Pre-Treatment Services	**345**	**98.9**
Screening for substance abuse	334	95.7
Screening for mental health disorders	232	66.5
Comprehensive substance abuse assessment or diagnosis	322	92.3
Comprehensive mental health assessment or diagnosis	124	35.5
Screening for tobacco use	188	53.9
Outreach to persons in the community who may need treatment	187	53.6
Interim services for clients when immediate admission is not possible	138	39.5
Testing	**340**	**97.4**
Breathalyzer or blood alcohol testing	304	87.1
Drug or alcohol urine screening	334	95.7
Screening for Hepatitis B	122	35.0
Screening for Hepatitis C	123	35.2
HIV testing	113	32.4
STD testing	85	24.4
TB screening	173	49.6
Counseling	**347**	**99.4**
Individual counseling	342	98.0
Group counseling	332	95.1
Family counseling	299	85.7
Marital/couples counseling	209	59.9
Transitional Services	**338**	**96.8**
Discharge planning	330	94.6
Aftercare/continuing care	305	87.4
Pharmacotherapies	**183**	**52.4**
Medications for psychiatric disorders	116	33.2
Nicotine replacement	60	17.2
Campral®	58	16.6
Antabuse®	75	21.5
Naltrexone (oral)	65	18.6
Vivitrol® (injectable Naltrexone)	25	7.2
Buprenorphine	124	35.5
Subutex® or generic	69	19.8
Suboxone®	121	34.7
Methadone	74	21.2
Non-nicotine smoking/tobacco cessation medications	38	10.9
Ancillary Services	**348**	**99.7**
Case management services	254	72.8
Social skills development	219	62.8
Mentoring/peer support	149	42.7
Child care for clients' children	19	5.4
Assistance with obtaining social services	207	59.3
Employment counseling or training for clients	128	36.7
Assistance in locating housing for clients	146	41.8
Domestic violence	119	34.1
Early intervention for HIV	127	36.4

continued

Types of Services Offered (cont.)

	Facilities	
	No.	%
HIV or AIDS education, counseling, or support	234	67.0
Hepatitis education, counseling, or support	174	49.9
Health education other than HIV/AIDS or hepatitis	204	58.5
Substance abuse education	335	96.0
Transportation assistance to treatment	127	36.4
Mental health services	203	58.2
Acupuncture	38	10.9
Residential beds for clients' children	11	3.2
Self-help groups	170	48.7
Smoking cessation counseling	103	29.5

Clinical/Therapeutic Approaches Used Always or Often or Sometimes

	Facilities	
	No.	%
Substance abuse counseling	340	97.4
Relapse prevention	327	93.7
Cognitive-behavioral therapy	327	93.7
12-step facilitation	269	77.1
Motivational interviewing	296	84.8
Anger management	263	75.4
Brief intervention	287	82.2
Contingency management/motivational incentives	202	57.9
Trauma-related counseling	200	57.3
Rational emotive behavioral therapy (REBT)	185	53.0
Matrix model	104	29.8
Community reinforcement plus vouchers	41	11.7
Other treatment approaches	41	11.7

Facility Capacity and Utilization Rate[1]

	Residential	Hospital Inpatient
Number of facilities	68	11
Number of clients[2]	2,277	391
Number of designated beds	2,662	350
Utilization rate (%)	85.5	111.7
No. of designated beds/facility (avg.)	39	32

[1] Excludes facilities not reporting both client counts and number of beds, facilities whose client counts were reported by another facility, facilities that included client counts from other facilities, and facilities that did not respond to this question.

[2] Number of clients on March 31, 2011.

Programs for Special Groups

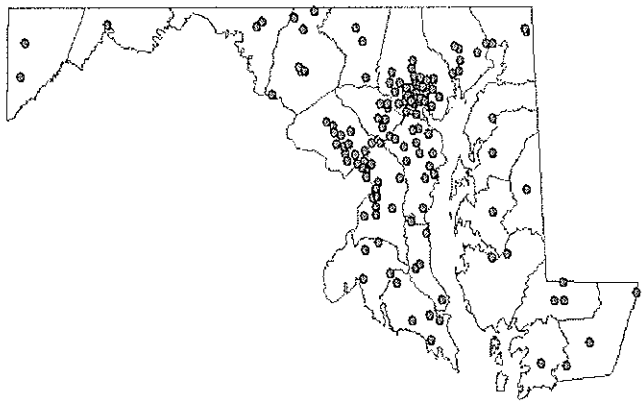
	Facilities	
	No.	%
Any program or group	296	84.8
Co-occurring disorders	146	41.8
Adult women	138	39.5
Adolescents	83	23.8
DUI/DWI offenders	144	41.3
Criminal justice clients	87	24.9
Adult men	123	35.2
Pregnant or postpartum women	51	14.6
Persons with HIV or AIDS	42	12.0
Seniors or older adults	27	7.7
Lesbian, gay, bisexual, or transgender clients (LGBT)	22	6.3
Other groups	42	12.0

Services in Sign Language for the Hearing Impaired and in Languages Other then English

	No.	%
Hearing impaired/sign language	56	16.0
Any language other than English	99	28.4
Non-English Language Provided by:		
On-call interpreter only	37	37.4
Staff counselor only	33	33.3
Both staff counselor and on-call interpreter	29	29.3
Languages Provided by Staff Counselor:[1]		
Spanish	58	93.5
American Indian/Alaska Native languages	0	0.0
Other	17	27.4

[1] Percentages based on the number of facilities reporting that they provided substance abuse treatment in a language other than English by a staff counselor only or by both staff counselors and on-call interpreters.

Location of Treatment Facilities



Data are from facilities that reported to N-SSATS for the survey reference date March 31, 2011. All material appearing in this report is in the public domain and may be reproduced without permission from SAMHSA. Citation of the source is appreciated.

Access the latest N-SSATS reports at:
http://www.samhsa.gov/data/DASIS.aspx#N-SSATS

Access the latest N-SSATS public use files at:
http://www.datafiles.samhsa.gov

Other substance abuse reports are available at:
http://www.samhsa.gov/data/

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Behavioral Health Statistics and Quality
www.samhsa.gov/data/

- Access N-SSATS profiles for individual States at:
http://wwwdasis.samhsa.gov/webt/NewMapv1.htm

- For information on individual facilities, access SAMHSA's Treatment Facility Locator at:
http://findtreatment.samhsa.gov/

EXHIBIT 6

GALLAGHER
EVELIUS & JONES LLP
ATTORNEYS AT LAW

THOMAS C. DAME
tdame@gejlaw.com
direct dial: 410 347 1331
fax: 410 468 2786

August 31, 2015

Ms. Ruby Potter
ruby.potter@maryland.gov
Health Facilities Coordination Officer
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

VIA EMAIL and HAND DELIVERY

Re: Certificate of Need Application—Intermediate Care Facilities
Recovery Centers of America – Earleville
314 Grove Neck Road OPCO, LLC
Matter No. 15-07-2363

Dear Ms. Potter:

Enclosed are six copies of the "Response to Additional Information Questions Dated July 17, 2015" with respect to the above-referenced CON application. Also enclosed is a CD containing searchable PDF files of the responses and exhibits, a WORD version of the responses, and native Excel spreadsheets of the tables and projections.

I also enclose Exhibit 32, which is a revised set of tables supporting the Applicant's bed need analysis.

We submit these responses on International Overdose Awareness Day. The Applicant feels very strongly that this project is needed urgently to help address the epidemic of deaths in Maryland and the surrounding region caused by heroin and other addictive substances. The enclosed newspaper headlines reflect recent news coverage of this critical problem. Today's news unfortunately brings yet another story of an apparent heroin-related death of a worker at the Maryland State Fair.

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

Please sign and return to our waiting messenger the enclosed acknowledgment of receipt. Thank you for your assistance.

Sincerely,

Thomas C. Dame

TCD:blr
Enclosures

#537222
013522-0004

Modified Table 9
Existing Detox Beds
Applying RCA 41% blended average
Maryland State

Not Funded [1]	All Beds [2]	Detox Beds (41%) [3]
Anchor @ Walden-Sierra	20	8
Father Martin's Ashley	100	41
Hudson Center	33	14
I'm Still Standing By Grace [3]	42	12
Warrick Manor	42	17
Total	*283*	*92*

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

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

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

EXHIBIT 7

Table 1
Inventory of Existing Providers

Not Funded[1]	Region	All Beds[2]	Detox Beds[3]
Anchor @ Walden-Sierra	Southern	20	8
Father Martin's Ashley[4]	Central	100	17
Hudson Center	Eastern Shore	33	7
I'm Still Standing By Grace[5]	Central	42	12
Pathways	Central	32	8
Warrick Manor	Eastern Shore	42	17
Total		*269*	*69*

(1) As identified by DHMH, Behavioral Health Administration Maryland Certified Treatment Locator. Pathways, identified as Funded, is listed as Not Funded based on its Comments in this review.
(2) Based on phone calls to the facilities, http://addictionresourceguide.com/, or the SAMHSA treatment locator
(3) Unless otherwise noted, RCA assumed 41% of beds are utilized for detox care based on RCA's ratio of detox / assessment beds to total beds, except for certain Earleville residential beds, see FN 9.
(4) Based on 25.2 day ALOS and 4.24 detox ALOS (16.83% detox)
(5) Facility self-identified number of residential and detox beds by phone

ii. Average Length of Stay

COMAR § 10.24.14.07 requires that the need for private beds be calculated using a 14-day average length of stay for adults. *Id.* at .07(g). Accordingly, Applicant's need analysis complies with the regulation and appropriately relies on a 14-day length of stay.

Applicant will utilize several patient centered assessment tools such as the Clinical Institute Withdrawal Assessment for Alcohol and the Clinical Opiate Withdrawal Scale to create a patient focused detoxification plan which may result in an average length of stay longer than those that the Interested Parties experience. These scales will be serially administered to patients in order to track changes in the severity of withdrawal symptoms over time in response to the course of treatment. This will allow the clinical team the ability to titrate the medication being utilized during the detoxification process to alleviate specific withdrawal symptoms the client may be experiencing.

Applicant also notes that the 14-day length of state includes both detox and medically managed care patients. Medically managed care requires twenty-four hour nursing care, daily onsite counseling services, and physician services available twenty-four hours per day, seven

EXHIBIT 8

CORRECTED MODIFIED

CERTIFICATE OF NEED APPLICATION

INTERMEDIATE CARE FACILITY

314 Grove Neck Road
Earleville, Maryland

RECOVERY CENTERS
OF AMERICA

Applicant: 314 Grove Neck Road OPCO, LLC

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

Corrected Modified Application: December 21, 2015

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 12
Neighboring Providers

	Name of Facility	City	Total Beds	Detox Offered	Detox Beds	Private Pay Daily Rate	Miles from Earleville
1	Williamsville Wellness	Hanover, VA	16	No	0	$833	*182*
2	Sagebrush	Great Falls, VA	N/Av	N/Av	N/Av	$1,167	*113*
3	Warwick Manor [1]	East New Market, MD	42	Yes	9	N/Av	*71*
4	Father Martin's Ashley [1]	Havre De Grace, MD	100	Yes	20	$857	*32*
5	Mountain Manor [1]	Emmitsburg, MD	46	Yes	10	$245	*120*
6	Hudson Health Services [1]	Salisbury, MD	33	Yes	7	$575	*88*
7	Anchor of Walden [1]	Charlotte Hall, MD	20	Yes	4	N/Av	*124*
8	I'm Still Standing By Grace [2]	Baltimore, MD	42	Yes	12	N/ Av	*72*
9	Clarity Way	Hanover, PA	23	Yes	7	$1,000	*89*
10	Caron Treatment Centers Adult Primary Care Services	Wernersville, PA	257	Yes	10	$1,167	*76*
11	Retreat: Lancaster	Lancaster, PA	150	Yes	40	$1,000	*64*
12	Malvern Institute (two locations)	Malvern, PA & Willow Grove, P	172	Yes	42	$680	*61*
13	Mirmount	Media, PA	115	Yes	33	$625	*59*
14	Meadowwood	New Castle, DE	58	Yes	N/Av	$800	*30*
	Total / Average		**1074**		**194**	**$814**	

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

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

facility, or roughly an hour and half drive. A full page rendering of Table 12 appears in **Exhibit** ~~40.~~**37.**

Modified Table 12[13]
Neighboring Providers

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

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

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

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

EXHIBIT 9

Table 1
Inventory of Existing Providers

Not Funded[1]	Region	All Beds[2]	Detox Beds[3]
Anchor @ Walden-Sierra	Southern	20	8
Father Martin's Ashley[4]	Central	100	17
Hudson Center	Eastern Shore	33	7
I'm Still Standing By Grace[5]	Central	42	12
Pathways	Central	32	8
Warrick Manor	Eastern Shore	42	17
Total		*269*	*69*

(1) As identified by DHMH, Behavioral Health Administration Maryland Certified Treatment Locator. Pathways, identified as Funded, is listed as Not Funded based on its Comments in this review.
(2) Based on phone calls to the facilities, http://addictionresourceguide.com/, or the SAMHSA treatment locator
(3) Unless otherwise noted, RCA assumed 41% of beds are utilized for detox care based on RCA's ratio of detox / assessment beds to total beds, except for certain Earleville residential beds, see FN 9.
(4) Based on 25.2 day ALOS and 4.24 detox ALOS (16.83% detox)
(5) Facility self-identified number of residential and detox beds by phone

ii. Average Length of Stay

COMAR § 10.24.14.07 requires that the need for private beds be calculated using a 14-day average length of stay for adults. *Id.* at .07(g). Accordingly, Applicant's need analysis complies with the regulation and appropriately relies on a 14-day length of stay.

Applicant will utilize several patient centered assessment tools such as the Clinical Institute Withdrawal Assessment for Alcohol and the Clinical Opiate Withdrawal Scale to create a patient focused detoxification plan which may result in an average length of stay longer than those that the Interested Parties experience. These scales will be serially administered to patients in order to track changes in the severity of withdrawal symptoms over time in response to the course of treatment. This will allow the clinical team the ability to titrate the medication being utilized during the detoxification process to alleviate specific withdrawal symptoms the client may be experiencing.

Applicant also notes that the 14-day length of state includes both detox and medically managed care patients. Medically managed care requires twenty-four hour nursing care, daily onsite counseling services, and physician services available twenty-four hours per day, seven

EXHIBIT 10

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

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

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

B. RCA Staff

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

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

C. RCA Collaboration

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

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

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

- Social Skills Training (Texas Christian University Model)

C. Patient Treatment Path

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

1. Contact Center

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

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

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

2. Intervention

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

3. Detoxification

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

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

4. **Inpatient/Residential Treatment**

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

5. **Recovery Support Services**

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

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

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

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

7. **Post-Treatment Alumni Services**

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

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

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

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

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

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

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

.05M. Sub-Acute Detoxification.

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

Applicant Response

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

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

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

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

- Complete applicable Revenue & Expense Tables and the Workforce and Bedside Care Staffing worksheets in the CON Table Package, as required. Attach additional pages as necessary detailing assumptions with respect to each revenue and expense line item. Instructions are provided in the cover sheet of the CON package and on each worksheet. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable. If the projections are based on Medicare percentages above the median for the jurisdiction in which the nursing home exists or is proposed, explain why the projected Medicare percentages are reasonable.
- Audited financial statements for the past two years should be provided by all applicant entities and parent companies to demonstrate the financial condition of the entities involved and the availability of the equity contribution. If audited financial statements are not available for the entity or individuals that will provide the equity contribution, submit documentation of the financial condition of the entities and/or individuals providing the funds and the availability of such funds. Acceptable documentation is a letter signed by an independent Certified Public Accountant. Such letter shall detail the financial information considered by the CPA in reaching the conclusion that adequate funds are available.
- If debt financing is required and/or grants or fund raising is proposed, detail the experience of the entities and/or individuals involved in obtaining such financing and grants and in raising funds for similar projects. If grant funding is proposed, identify the grant that has been or will be pursued and document the eligibility of the proposed project for the grant.
- Describe and document relevant community support for the proposed project.
- Identify the performance requirements applicable to the proposed project (see question 12, "Project Schedule") and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, obtaining State and local land use, environmental, and design approvals, contracting and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame(s).

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

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

Project Design

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

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

Revenue & Expense, and Workforce Projections

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

Community Support

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

TABLE L. WORK FORCE INFORMATION - DETOX - EARLEVILLE - Nov. 30, 2015 Update

INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables G and J. See additional instruction in the column to the right of the table.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	Current Year FTEs	Average Salary per FTE	Current Year Total Cost	Detox FTEs	Average Salary per Detox FTE	Total Detox Cost *(should be consistent with projections in Table J)*	FTEs	Average Salary per FTE	Total Cost	FTEs	Total Cost *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Site Director				0.39	$184,723	$72,042			$0	0.4	$72,042
Admissions				1.24	$57,282	$71,030			$0	1.2	$71,030
Administrative Support				1.17	$51,852	$60,667			$0	1.2	$60,667
Medical Records				1.00	$56,117	$56,117			$0	1.0	$56,117
Operations Manager				0.19	$93,126	$17,694			$0	0.2	$17,694
Total Administration			$0	3.99	$443,101	$277,550		$0	$0	4.0	$277,550
Direct Care Staff *(List general categories, add rows if needed)*											
Psychiatrist				0.42	$234,000	$98,280			$0	0.4	$98,280
Nurse Practitioner				0.70	$108,333	$75,833			$0	0.7	$75,833
Nursing Director				0.19	$107,763	$20,475			$0	0.2	$20,475
Case Manager				0.84	$49,936	$41,946			$0	0.8	$41,946
Nursing - LPN				8.42	$51,355	$432,410			$0	8.4	$432,410
Nursing - RN				4.20	$74,758	$313,984			$0	4.2	$313,984
Recovery Support				5.40	$39,107	$211,176			$0	5.4	$211,176
Second Shift Supervisor*				0.19	$86,479	$16,431			$0	0.2	$16,431
Site Medical Director				0.19	$332,600	$63,194			$0	0.2	$63,194
Spiritual Advisor				0.19	$55,774	$10,597			$0	0.2	$10,597
Total Direct Care			$0	20.74	$1,140,104	$1,284,326	0.0	$0	$0	20.7	$1,284,326
Support Staff *(List general categories, add rows if needed)*											
Administrative Support			$0	1.45	$36,837	$53,414			$0	1.5	$53,414
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support			$0	1.45	$36,837	$53,414		$0	$0	1.5	$53,414
REGULAR EMPLOYEES TOTAL			$0	26.18	$1,620,042	$1,615,290		$0	$0	26.2	$1,615,290
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0	0.00	$0	$0		$0	$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff			$0	0.00	$0	$0		$0	$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*											
Activities			$0	0.12		$7,391			$0	0.1	$7,391
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0	0.12	$0	$7,391		$0	$0	0.1	$7,391
CONTRACTUAL EMPLOYEES TOTAL			$0	0.12	$0	$7,391		$0	$0	0.1	$7,391
Benefits *(State method of calculating benefits below):*											
Benefits and taxes have been applied to employed staff based on management experience with the costs for similar benefit packages at other organizations at a rate of approximately 30%.											
TOTAL COST	0.0		$0	26.30		$1,622,681	0.0		$0		$1,622,681

4. **Please provide some documentation from a financial institution indicating that the applicant will be able to obtain a mortgage loan of about $26.6 million for the Earleville facility.**

Applicant Response

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

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

5. **Questions related to Table G:**

   a) **Charity care declines precipitously as a % of total revenue and/or expenses. Apparently the basis that RCA has figured it on has changed. Please explain.**

Applicant Response

As modified, the charity care commitment was not reduced. RCA calculates its charity care commitment as a percentage of net operating revenue for all services, including the residential services that are not subject to the CON requirement. For purposes of calculating charity care, RCA values each day of detox / assessment level care at $860, and each day of residential level care at $724.

RCA believes it is clinically inappropriate to provide charity care for eligible patients' only for detox services. Thus, the Applicant has committed to provide charity care for the entire course of detox and residential treatment, although there is no requirement that RCA provide charity care for residential treatment at ASAM level III.5. In fact, if the total charity care that RCA has committed to provide was applied to detox services only, RCA's commitment would amount to almost 25% of patient days, exceeding the requirement set forth in Standard .04D(1)(c). Using the financial projections for 2017 as an example, RCA's commitment of $1,509,228 in charity care is equivalent to approximately 1,755 patient days (1,509,228 ÷ 860 = 1,754.91), which is 24.6% of the total projected patient days for detox services in that year (see Table F, line 2(i)).

   b) **Contractual allowances amount to more than 72% of total revenue for the facility as a whole and for detox. Using the table below, please state the assumptions regarding charges and payment by payor.**

Applicant Response

The Applicant has not yet entered any contracts with payers, so it cannot calculate the amount of contractual allowances by each payer. The Applicant used the following assumptions and support to derive projected revenue and contractual allowances:

- The daily charge for detox services is $3,500, and the daily reimbursement rate is $860.
- The daily charge for residential services is $2,900, and the daily reimbursement rate is $724.
- As shown in Table 14, submitted in RCA's August 31, 2015 responses to completeness questions, the average reimbursement rate for Maryland in 2013 was $872, and the neighboring state average reimbursement rate was $1,072.

c) Administrative/office expenses more than double, from $1.8 million to $3.8 million. What makes up this cost center? Please explain the doubling of these costs, which would seem to be more fixed than variable.

Applicant Response

The "Administrative/office expenses" line increased based upon the addition of more residential beds, and additional revenue. This amount includes an allocation of RCA's corporate office expenses, which is spread across all RCA facilities and is calculated based upon the proportion of the Applicant's revenue to all RCA facilities. The amount is not related to site specific administration expenses.

6. Table J of the May 18 version of the application showed operating expenses of $4.8 million (2018) with 32.4 FTES devoted to detox (Table L). The November 30th revision shows operating expenses of $3.9 million with 26.3 FTES devoted to detox. Both projections were for 21 detox beds, but in the November 30 modification patient days rose from 7,094 to 7,665. These changes should be explained.

Applicant Response

Salaries and wages (including benefits) included in Tables G & H include the cost of positions 100% dedicated to detox patients, positions 100% dedicated to residential patients and positions that are shared between both detox and residential. The following positions are 100% dedicated to detox: case managers, LPNs, and RNs. There are also case managers, LPNs and RNs 100% dedicated to the residential patients in addition to certain therapists. The remaining positions listed on Table L are shared between the detox and residential patients. The cost of the shared positions is allocated to the detox component of the facility in schedules J, K and L based on the percentage of detox beds to total beds in the facility.

The May 18, 2105 Modified Application included 14.67 detox dedicated FTEs, which has remained unchanged in the November 30, 2015 modification. Due to the increase in residential beds, the number of FTEs dedicated to residential patients increased from 15.13 to 50.04, and the number of FTEs shared increased from 41.29 to 59.83. The number of shared FTEs

allocated to detox patients in Table L decreased from 17.70 in the May 18 submission to 11.63 in the November 30 submission, representing approximately 43% and 19%, respectively, of the total shared FTEs which approximates the percentage of detox beds.

The operating expenses and FTEs declined for detox in connection with the November 30 modification because the addition of 59 residential beds caused more of the expense of the shared positions to be borne by the residential bed component of the facility. The following summarizes the allocation of FTEs for the May 18 Modified Application and the November 30 modification:

Description of FTEs	May 18 Modified Application	November 30 Modification
Detox Only	14.67	14.67
Residential Only	15.13	50.04
Shared Positions	41.29	59.83
TOTALS	71.09	124.54

The allocation of the shared positions to the detox beds decreased from 42.86% under the May 18 Modified Application (21 of 49 total beds) to 19.44% under the November 30 modification (21 of 108 total beds). Thus, the total FTEs for detox in the May 18 Modified Application was 14.67 detox only positions plus an allocation of 17.70 of the shared positions (41.29 x 42.86%), which equals 32.37. The total FTEs for detox in the November modification was 14.67 detox only positions plus an allocation of 11.63 of the shared positions (59.83 x 19.44%), which equals 26.30.

7. **Please explain how overhead costs, such as facility expenses, marketing, liability insurance, legal, etc. are allocated on Table J.**

Applicant Response

Certain operating expenses, including salaries/FTEs, are shared between the detox and residential components of the facility, while some resources are devoted 100% to one or the other. Any FTEs that are devoted 100% to detox beds were included at 100% of their value in Tables J & L, which did not change from the May 18, 2015 Modified Application to the November 30, 2015 Modification. However, the majority of FTEs and operating expenses for the facility are shared, including the overhead facility costs. These expenses were allocated to the detox beds (as shown in Tables J and L) based on the percentage of detox beds in the proposed facility (approx. 19.4%). This percentage decreased from the May 18 submission (21 of 49 vs. 21 of 108) resulting in a decrease of operating expenses and FTEs from that submission to the November 30 submission.

8. **This modification increases the number of residential III.5 treatment beds proposed at this facility from 21 to 87. Combined with RCA's other pending applications, the number of these beds in Maryland would increase by 259 if all were approved. Has RCA done a scientific demand study that supports the**

EXHIBIT 11 - AFFIRMATIONS

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 Center of America (Earleville, Maryland), Docket No. 15-07-2326 are true and correct to the best of my knowledge, information, and belief.

[signature] -COO

Name and Title

2/3/16

Date

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 Center of America (Earleville, Maryland), Docket No. 15-07-2326 are true and correct to the best of my knowledge, information, and belief.

RT Coughlin

Name and Title

2/3/16

Date