

October 7, 2016

VIA EMAIL & HAND DELIVERY

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

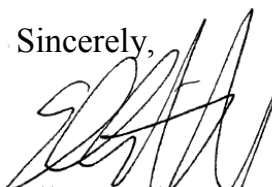
Re: Certificate of Need Application—Intermediate Care Facilities
Recovery Centers of America – Earleville
314 Grove Neck Road OPCO, LLC
Matter No. 15-07-2363

Dear Ms. Potter:

Enclosed are six copies of the “Modification in Response to September 20, 2016 Project Status Conference” with respect to the above-referenced CON application, along with two sets of full-size project drawings. Also enclosed is a CD containing searchable PDF files of the Modification and exhibits, a WORD version of the Modification, and native Excel spreadsheets.

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,

Ella R. Aiken

ERA:blr
Enclosures

Ms. Ruby Potter
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cc: Kevin McDonald, Chief, Certificate of Need
Paul Parker, Director, Center for Health Care Facilities Planning & Development,
MHCC
Joel Riklin, Program Manager
William Chan, Health Policy Analyst, HSP&P/CON
Suellen Wideman, Esq., Assistant Attorney General, MHCC
Stephanie Garrity, Health Officer, Cecil County (w/ enclosures)
JP Christen, Chief Operating Officer, Recovery Centers of America
Edmund J. Campbell, Jr., Esq.
Andrew L. Solberg, A.L.S. Healthcare Consultant Services
Thomas C. Dame, Esq.

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

Modification in Response to September 20, 2016 Project Status Conference

I. Project Costs

Each RCA applicant must submit revised cost estimates and supporting tables A through L. I request that each applicant pay close attention to these matters so that no additional filings or corrections will be needed.

[Applicant Response](#)

Revised form tables A through L are attached as **Exhibit 39**.¹

II. COMAR 10.24.14.05D: Providing Care to Indigent and Gray Area Patients

As I noted at project status conference, regarding RCA's proposal for meeting charity care requirements, I am pleased that each applicant has committed charity care dollars to provide the full range of needed care to indigent and gray area patients, both in detoxification and residential care. From a public policy perspective, the proposed provision of a full range of care is much more desirable than the situation where an indigent or low income patient would receive detox services and then be released to others for additional needed care.

Each applicant must make a charity care commitment equivalent to 15% of the net revenue associated with total detox patient days (i.e., for the Level 3.7-D patient beds for which CON approval is sought). While the 2015 modified applications' proposed charity care figures for RCA-Earleville and RCA-Waldorf appear to meet the standard, the amount of funds proposed by RCA-Upper Marlboro for charity care to such patients does not appear to be equivalent to the 15% of the net revenue for its detox bed days. As I noted, the applicants should determine whether new cost estimates and tables necessitate the need for changes from the 2015 modified applications.

[Applicant Response](#)

As demonstrated in Exhibit 39, Tables F through K, Applicant has complied with this recommendation. Applicant is committed to providing charity care in an amount equal to 15% of the net revenue associated with its detox bed days. As reflected in Exhibit 39, Tables G, H, J, and K, charity care for each calendar year is equal to 15% of (Gross Detox Revenue less [Detox Allowance for Bad Debt and Detox Contractual Allowance]). The resulting dollar amount of

¹ Exhibits are numbered to continue from prior CON application submissions in this review. Exhibit 39 is the first exhibit referenced in this document.

charity care is distributed across detox and residential services such that patients receiving care under RCA's charity care policy would receive both detox and residential treatment at the facility.

III. COMAR 10.24.14.05J: Transfer and Referral Agreements

Each applicant must update information regarding its executed transfer and referral agreements with or acknowledgement from agencies or facilities who have capabilities for managing cases that "exceed, extend, or complement" the applicant's capabilities. For each applicant, please provide documentation of transfer and referral agreements, and an updated list of the providers and agencies (categorized by provider type). If it is not possible to obtain executed agreements, please provide letters that express the provider's (or agency's) intent to enter a referral agreement after CON approval of the facility. Under those circumstances, issuance of first use (pre-licensure) approval will be conditioned on receipt of the documentation.

Applicant Response

Applicant previously submitted five referral agreements between RCA and five third-party providers. See Exhibit 17 to the May 18, 2015 Application and Exhibit 28 to the August 31, 2015 Response to Additional Information Questions. In addition, Applicant is submitting a referral agreement with Sheppard Pratt Health System, **Exhibit 40**. RCA is actively seeking additional referral relationships and will send any additional agreements to the Commission as they are executed.

IV. COMAR 10.24.14.05K: Referral Sources

Each applicant must document that it has established agreements that assure that it will provide the required level of services to indigent or gray area populations. As I pointed out, I do not know whether the applicants will be able to obtain referral agreements from the Behavioral Health Administration (successor to the Alcohol and Drug Abuse Administration) or other agencies that are named in COMAR 10.24.14.07K, since none of the applicants has received CON approval or is an existing provider. If it is not possible to enter referral agreements under these circumstances, I will accept letters that express an agency's intent to refer patients to the facility after CON approval of the facility. Again, first use approval will be conditioned on the receipt of such agreements.

Applicant Response

Applicant is actively seeking a referral agreement from the Maryland Department of Health, Behavioral Health Administration, and county Health Departments for Cecil, Charles, and Prince George's Counties. RCA is sending, on the same date of this filing, letters to those agencies informing them of this review and RCA's commitment to provide charity care. **Exhibit 41**. RCA will update those agencies upon approval of the pending application, and will continue to seek a referral agreement. Applicant will accept an approval of its application conditioned on meeting the requirement imposed by COMAR § 10.24.14.05K.

V. Project Drawings

I request updated project descriptions and current architectural drawings for each project. Please verify the continued funding commitment by the Deerfield private equity fund for the updated estimate of each project's cost.

Applicant Response

A revised project description consistent with the current project design is attached as **Exhibit 42**. Revised architectural drawings are attached as **Exhibit 43**. A letter from Deerfield Management Company, L.P., is attached as **Exhibit 44**.

Table of Exhibits

Exhibit	Description
39	Revised MHCC Form Tables A through L
40	Referral Agreement—Sheppard Pratt Health System
41	Letters re: Charity Care Referral Agreements
42	Revised Project Description
43	Revised Architectural Drawings
44	Letter from Deerfield Management Company, L.P.

I hereby declare and affirm under the penalties of perjury that the facts stated in this Modification in Response to September 20, 2016 Project Status Conference are true and correct to the best of my knowledge, information, and belief.

October 7, 2016

Date



J.P. Christen
Chief Operating Officer
Recovery Centers of America

I hereby declare and affirm under the penalties of perjury that the facts stated in this Modification in Response to September 20, 2016 Project Status Conference are true and correct to the best of my knowledge, information, and belief.

October 7, 2016

Date

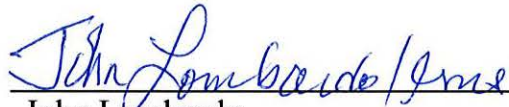


Kevin McClure
Chief Financial Officer
Recovery Centers of America

I hereby declare and affirm under the penalties of perjury that the facts stated in this Modification in Response to September 20, 2016 Project Status Conference are true and correct to the best of my knowledge, information, and belief.

October 7, 2016

Date

A handwritten signature in blue ink, appearing to read "John Lombardo / Jme", written over a horizontal line.

John Lombardo


Director of Construction

Recovery Centers of America

I hereby declare and affirm under the penalties of perjury that the facts stated in this Modification in Response to September 20, 2016 Project Status Conference are true and correct to the best of my knowledge, information, and belief.

October 7, 2016

Date

A handwritten signature in cursive script, reading "Thomas E. Hall", written over a horizontal line.

Thomas Hall

Architect

Thomas E. Hall & Associates Inc.

EXHIBIT 39

TABLE A. BED CAPACITY BY FLOOR AND NURSING UNIT BEFORE AND AFTER PROJECT - as of October 7, 2016

INSTRUCTION: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project.

Applicants should add columns and recalculate formulas to address any rooms with 3 and 4 bed capacity. See additional instruction in the column to the right of the table.

Before the Project						After Project Completion				
Service Location (Floor/Wing)	Current Licensed Beds	Based on Physical Capacity				Based on Physical Capacity				
		Room Count			Physical Bed Capacity	Service Location (Floor/Wing)	Room Count			Physical Bed Capacity
		Private	Semi-Private	Total Rooms			Private	Semi-Private	Total Rooms	
DETOX						DETOX				
						Phase I	0	0	0	0
						Phase II				
						Single	1	0	1	1
						Double	0	10	10	20
						Triple			0	0
SUBTOTAL Detox						SUBTOTAL Detox	1	10	11	21
RESIDENTIAL						RESIDENTIAL				
						Phase I				
						Single	2	0	2	2
						Double	0	14	14	28
						Triple	0	3	3	9
						Phase II				
						Single	14	0	14	14
						Double	0	17	17	34
						Triple	0	0	0	0
TOTAL RESIDENTIAL						TOTAL RESIDENTIAL	16	34	50	87
Other (Specify/add rows as needed)						Other (Specify/add rows as needed)			0	0
TOTAL OTHER						TOTAL OTHER				
FACILITY TOTAL						FACILITY TOTAL	17	44	61	108

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT - as of October 7, 2016

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

DEPARTMENT/FUNCTIONAL AREA	Current	To be Added Thru New Construction Detox	To Be Renovated Detox	To Remain As Is Detox	To be Added Thru New Construction Residential	To Be Renovated Residential	To Remain As Is Residential	Total (Shared) After Project Completion
Gnd Floor Counseling								0
Gnd Floor Nursing								0
Gnd Floor Admissions								0
Gnd Floor Medical & Psychiatric								0
Gnd Floor Adjunctive/Ancillary (Yoga, Fitness, etc.)						4,650		4,650
Gnd Floor Administrative						2,006		2,006
Inpatient Rooms w/ bathrooms								0
Common Areas						1,341		1,341
Circulation						3,373		3,373
Building Mechanical/Electrical						2,743		2,743
Int & Ext. Wall Thicknesses						2,565		2,565
Gnd Floor Kitchen/Dining								0
1st Floor Counseling		653			172	3,966		4,791
1st Floor Nursing		692			182	328		1,202
1st Floor Admissions						3,643		3,643
1st Floor Medical & Psychiatric		336			89	355		780
1st Floor Adjunctive/Ancillary (Yoga, Fitness, etc.)						8,816		8,816
1st Floor Administrative						1,862		1,862
Inpatient Rooms w/ bathrooms		3,924			5,293	1,748		10,965
Common Areas		692			182	850		1,724
Circulation		2,292			568	4,849		7,709
Building Mechanical/Electrical						15,061		15,061
Int & Ext. Wall Thicknesses						2,432		2,432
1st Floor Kitchen/Dining						1,712		1,712
2nd Floor Counseling					1,264			1,264
2nd Floor Nursing					1,340	297		1,637
2nd Floor Admissions								0
2nd Floor Medical & Psychiatric								0
2nd Floor Adjunctive/Ancillary (Yoga, Fitness, etc.)								0
2nd Floor Administrative								0
Inpatient Rooms w/ bathrooms						3,728		3,728
Common Areas						227		227
Circulation						1,632		1,632
Building Mechanical/Electrical								0
Int & Ext. Wall Thicknesses						1,615		1,615
2nd Floor Kitchen/Dining								0
3rd Floor Counseling								0
3rd Floor Nursing								0
3rd Floor Admissions								0
3rd Floor Medical & Psychiatric								0
3rd Floor Adjunctive/Ancillary (Yoga, Fitness, etc.)								0
3rd Floor Administrative								0
Inpatient Rooms w/ bathrooms						790		790
Common Areas						256		256
Circulation						1,450		1,450
Building Mechanical/Electrical								0
3rd Floor Kitchen/Dining								0
Existing Wall Construction						1,576		1,576
Total		8,589	0		9,090	73,871	0	91,550

TABLE C. CONSTRUCTION CHARACTERISTICS - as of October 7, 2016

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

	DETOX NEW CONSTRUCTION	RESIDENTIAL NEW CONSTRUCTION	DETOX RENOVATION	RESIDENTIAL RENOVATION
BASE BUILDING CHARACTERISTICS	Check if applicable			
Class of Construction (for renovations the class of the building being renovated)*				
Class A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Class B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Class C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Class D	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Type of Construction/Renovation*				
Low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Average	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excellent	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Number of Stories	2	2		3

*As defined by Marshall Valuation Service

PROJECT SPACE	List Number of Feet, if applicable			
Total Square Footage	Total Square Feet			
Basement			0	16,678
First Floor	8,589	6,486	0	45,622
Second Floor	0	2,604	0	7,499
Third Floor	0	10,090	0	4,072
Fourth Floor				
Average Square Feet	2,863	6,393	0	18,468
Perimeter in Linear Feet	Linear Feet			
Basement				941
First Floor	300	690		2,482
Second Floor		847		1,226
Third Floor		0		314
Fourth Floor				
Total Linear Feet	300	1,537	0	4,963
Average Linear Feet	300	512	#DIV/0!	1,241
Wall Height (floor to eaves)	Feet			
Basement				10
First Floor	12	12		12
Second Floor	11	11		10.50
Third Floor				9
Fourth Floor				
Average Wall Height	12	12	#DIV/0!	10.38
OTHER COMPONENTS				
Elevators	List Number			
Passenger		1 elevator		1 elevator
Freight				
Sprinklers	Square Feet Covered			
Wet System	8,589	19,180	0	73,871
Dry System				
Other	Describe Type			
Type of HVAC System for proposed project	Water source heat pumps with central hydronic loop and some split systems.			
Type of Exterior Walls for proposed project	Wood frame, interior plaster finish, exterior brick veneer.			

TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS - as of October 7, 2016

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garages, medical office buildings, or energy plants), complete an

	NEW CONSTRUCTION COSTS DETOX	NEW CONSTRUCTION COSTS RESIDENTIAL	RENOVATION COSTS DETOX	RENOVATION COSTS RESIDENTIAL
SITE PREPARATION COSTS				
Normal Site Preparation				
Utilities from Structure to Lot Line				
Subtotal included in Marshall Valuation Costs				
Site Demolition Costs	\$30,001	\$68,573		\$83,480
Storm Drains	\$0	\$0		\$0
Rough Grading	\$30,001	\$68,574		\$83,480
Hillside Foundation	\$0	\$0		\$0
Paving	\$15,000	\$34,287		\$41,740
Exterior Signs	\$15,000	\$34,287		\$41,740
Landscaping	\$33,334	\$76,193		\$92,756
Walls	\$0	\$0		\$0
Yard Lighting	\$22,501	\$51,431		\$62,610
Other: Curbs, hardscaping, site amenities.	\$37,501	\$85,717		\$104,351
Septic System	\$404,793	\$690,452		\$785,229
Subtotal On-Site excluded from Marshall Valuation Costs	\$588,131	\$1,109,514	\$0	\$1,295,387
OFFSITE COSTS				
Roads				
Utilities				
Jurisdictional Hook-up Fees				
Other (Specify/add rows if needed)				
Subtotal Off-Site excluded from Marshall Valuation Costs	\$0	\$0	\$0	\$0
TOTAL Estimated On-Site and Off-Site Costs <u>not</u> included in Marshall Valuation Costs	\$588,131	\$1,109,514	\$0	\$1,295,387
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	\$588,131	\$1,109,514	\$0	\$1,295,387

*The combined total site and offsite cost included and excluded from Marshall Valuation Service should typically equal the estimated site preparation cost reported in Application Part II, Project Budget (see Table E. Project Budget). If these numbers are not equal, please reconcile the numbers in an explanation in an attachment to the application.

TABLE E. PROJECT BUDGET - as of October 7, 2016

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

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

		DETOX	RESIDENTIAL	Total
A. USE OF FUNDS				
1. CAPITAL COSTS				
a.	Land Purchase	\$1,477,778	\$6,122,222	\$7,600,000
b.	New Construction			
(1)	Building	\$1,287,825	\$3,863,475	\$5,151,300
(2)	Fixed Equipment			\$0
(3)	Site and Infrastructure	\$588,131	\$2,404,901	\$2,993,032
(4)	Architect/Engineering Fees	\$17,465	\$53,302	\$70,767
(5)	Permits (Building, Utilities, Etc.)	\$12,305	\$37,552	\$49,857
	SUBTOTAL	\$1,905,726	\$6,359,230	\$8,264,956
c.	Renovations			
(1)	Building		\$7,403,144	\$7,403,144
(2)	Fixed Equipment (not included in construction)			\$0
(3)	Architect/Engineering Fees		\$73,378	\$73,378
(4)	Permits (Building, Utilities, Etc.)		\$51,696	\$51,696
	SUBTOTAL	\$0	\$7,528,218	\$7,528,218
d.	Other Capital Costs			
(1)	Movable Equipment	\$184,800	\$2,010,638	\$2,195,438
(2)	Contingency Allowance	\$167,798	\$587,159	\$754,957
(3)	Gross interest during construction period	\$0	\$0	\$0
(4)	Legal Fees	\$107,143	\$142,857	\$250,000
(5)	Property Due Diligence	\$21,429	\$28,571	\$50,000
	SUBTOTAL	\$481,170	\$2,769,225	\$3,250,395
	TOTAL CURRENT CAPITAL COSTS	\$3,864,674	\$22,778,895	\$26,643,569
e.	Inflation Allowance			
	TOTAL CAPITAL COSTS	\$3,864,674	\$22,778,895	\$26,643,569
2. Financing Cost and Other Cash Requirements				
a.	Loan Placement Fees			\$0
b.	Bond Discount			\$0
c.	Legal Fees			\$0
d.	Non-Legal Consultant Fees			\$0
e.	Liquidation of Existing Debt			\$0
f.	Debt Service Reserve Fund			\$0
g.	Transaction Costs	\$754,424	\$2,210,204	\$2,964,628
h.	Acquisition Costs	\$162,857	\$217,143	\$380,000
i.	Due Diligence Costs	\$64,286	\$85,714	\$150,000

TABLE E. PROJECT BUDGET - as of October 7, 2016

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

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

	<i>DETOX</i>	<i>RESIDENTIAL</i>	<i>Total</i>
SUBTOTAL	\$981,567	\$2,513,061	\$3,494,628
3. Working Capital Startup Costs	\$749,143	\$1,693,995	\$2,443,138
TOTAL USES OF FUNDS	\$5,595,384	\$26,985,951	\$32,581,335
B. Sources of Funds			
1. Cash			\$0
2. Philanthropy (to date and expected)			\$0
3. Authorized Bonds			\$0
4. Interest Income from bond proceeds listed in #3			\$0
5. Mortgage	\$4,812,030	\$23,207,918	\$28,019,948
6. Working Capital Loans			\$0
7. Grants or Appropriations			
a. Federal			\$0
b. State			\$0
c. Local			\$0
8. Equity funding	\$783,354	\$3,778,033	\$4,561,387
TOTAL SOURCES OF FUNDS	\$5,595,384	\$26,985,951	\$32,581,335
Annual Lease Costs (if applicable)			
1. Land			\$0
2. Building			\$0
3. Major Movable Equipment			\$0
4. Minor Movable Equipment			\$0
5. Other (Specify/add rows if needed)			\$0

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

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

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
<i>Calendar Year</i>	N/A	N/A	2015	2016	2017	2018				
1. DISCHARGES										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	0	0	0	0	0	0	0	0	0	0
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute	0	0	0	0	0	0	0	0	0	0
f. Rehabilitation										
g. Comprehensive Care										
h. Residential ⁽¹⁾	N/A	N/A	N/A	396	1,590	1,688				
i. Detox	N/A	N/A	N/A	0	509	520				
TOTAL DISCHARGES	0	0	0	396	1,590	1,688	0	0	0	0
2. PATIENT DAYS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	0	0	0	0	0	0	0	0	0	0
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute	0	0	0	0	0	0	0	0	0	0
f. Rehabilitation										
g. Comprehensive Care										
h. Residential ⁽¹⁾	N/A	N/A	N/A	6,336	25,436	27,010				
i. Detox	N/A	N/A	N/A	0	7,122	7,282				
TOTAL PATIENT DAYS	0	0	0	6,336	32,558	34,292	0	0	0	0

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

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Calendar Year	N/A	N/A	2015	2016	2017	2018				
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Residential	N/A	N/A	N/A	16.0	16.0	16.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
i. Detox	N/A	N/A	N/A	N/A	14.0	14.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	#DIV/0!	#DIV/0!	#DIV/0!	16.0	30.0	30.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	0	0	0	0	0	0	0	0	0	0
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute	0	0	0	0	0	0	0	0	0	0
f. Rehabilitation										
g. Comprehensive Care										
h. Residential	N/A	N/A	N/A	39	87	87				
i. Detox	N/A	N/A	N/A	0	21	21				
TOTAL LICENSED BEDS	0	0	0	39	108	108	0	0	0	0

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

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Calendar Year	N/A	N/A	2015	2016	2017	2018				
5. OCCUPANCY PERCENTAGE *IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.										
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Residential ⁽¹⁾	N/A	N/A	N/A	66.3%	80.1%	85.1%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
i. Detox	N/A	N/A	N/A	N/A	92.9%	95.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	#DIV/0!	#DIV/0!	#DIV/0!	66.3%	82.6%	87.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
6. OUTPATIENT VISITS										
a. Emergency Department										
b. Same-day Surgery										
c. Laboratory										
d. Imaging										
h. Residential	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
i. Detox	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
TOTAL OUTPATIENT VISITS	0	0	0	0	0	0	0	0	0	0
7. OBSERVATIONS**										
a. Number of Patients	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
b. Hours	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

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

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

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

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

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	N/A	N/A	2015	2016	2017	2018				
1. REVENUE										
a. Inpatient Services			\$ -	\$ 18,374,400	\$ 98,690,250	\$ 103,816,000				
b. Outpatient Services										
Gross Patient Service Revenues	\$ -	\$ -	\$ -	\$ 18,374,400	\$ 98,690,250	\$ 103,816,000	\$ -	\$ -	\$ -	\$ -
c. Allowance For Bad Debt			\$ -	\$ 509,696	\$ 1,989,754	\$ 2,093,332				
d. Contractual Allowance			\$ -	\$ 13,277,440	\$ 72,160,199	\$ 75,904,908				
e. Charity Care			\$ -	\$ -	\$ 918,738	\$ 939,378				
Net Patient Services Revenue	\$ -	\$ -	\$ -	\$ 4,587,264	\$ 23,621,559	\$ 24,878,382	\$ -	\$ -	\$ -	\$ -
f. Other Operating Revenues (Specify/add rows if needed)										
NET OPERATING REVENUE	\$ -	\$ -	\$ -	\$ 4,587,264	\$ 23,621,559	\$ 24,878,382	\$ -	\$ -	\$ -	\$ -
2. EXPENSES										
a. Salaries & Wages (including benefits)			\$ -	\$ 2,966,587	\$ 8,109,670	\$ 8,458,548				
b. Contractual Services			\$ -	\$ 254,509	\$ 588,576	\$ 627,044				
c. Interest on Current Debt			\$ -	\$ -	\$ -	\$ -				
d. Interest on Project Debt			\$ -	\$ -	\$ -	\$ -				
e. Current Depreciation			\$ -	\$ -	\$ -	\$ -				
f. Project Depreciation			\$ -	\$ -	\$ -	\$ -				
g. Current Amortization			\$ -	\$ -	\$ -	\$ -				
h. Project Amortization			\$ -	\$ -	\$ -	\$ -				
i. Supplies			\$ -	\$ 9,897	\$ 32,319	\$ 34,432				
j. Administrative/office expenses			\$ -	\$ 1,081,078	\$ 3,519,962	\$ 3,821,863				
k. Facilities expenses (repairs & maintenance, rent, real estate taxes, utilities)			\$ -	\$ 1,088,423	\$ 4,187,390	\$ 4,202,601				
l. Food			\$ -	\$ 321,109	\$ 1,659,063	\$ 1,767,494				
m. Marketing expense			\$ -	\$ 178,141	\$ 920,396	\$ 980,551				
n. Liability insurance			\$ -	\$ 32,620	\$ 132,712	\$ 141,386				
o. Other Expenses: Licensing & legal expenses			\$ -	\$ 17,250	\$ 89,125	\$ 94,950				
TOTAL OPERATING EXPENSES	\$ -	\$ -	\$ -	\$ 5,949,614	\$ 19,239,213	\$ 20,128,869	\$ -	\$ -	\$ -	\$ -

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

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	N/A	N/A	2015	2016	2017	2018				
3. INCOME										
a. Income From Operation	\$ -	\$ -	\$ -	\$ (1,362,350)	\$ 4,382,346	\$ 4,749,513	\$ -	\$ -	\$ -	\$ -
b. Non-Operating Income										
SUBTOTAL	\$ -	\$ -	\$ -	\$ (1,362,350)	\$ 4,382,346	\$ 4,749,513	\$ -	\$ -	\$ -	\$ -
c. Income Taxes										
NET INCOME (LOSS)	\$ -	\$ -	\$ -	\$ (1,362,350)	\$ 4,382,346	\$ 4,749,513	\$ -	\$ -	\$ -	\$ -
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare			0.0%	0.0%	0.0%	0.0%				
2) Medicaid			0.0%	0.0%	0.0%	0.0%				
3) Blue Cross			0.0%	0.0%	0.0%	0.0%				
4) Commercial Insurance			0.0%	19.5%	19.5%	19.5%				
5) Self-pay			0.0%	80.5%	80.5%	80.5%				
6) Other			0.0%	0.0%	0.0%	0.0%				
TOTAL	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%
b. Percent of Equivalent Inpatient Days										
1) Medicare			0.0%	0.0%	0.0%	0.0%				
2) Medicaid			0.0%	0.0%	0.0%	0.0%				
3) Blue Cross			0.0%	0.0%	0.0%	0.0%				
4) Commercial Insurance			0.0%	25.00%	25.00%	25.00%				
5) Self-pay			0.0%	68.85%	68.85%	68.85%				
6) Other			0.0%	6.15%	6.15%	6.15%				
TOTAL	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%

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

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	N/A	N/A	2015	2016	2017	2018				
1. REVENUE										
a. Inpatient Services			\$ -	\$ 18,374,400	\$ 103,624,762	\$ 114,457,140				
b. Outpatient Services										
Gross Patient Service Revenues	\$ -	\$ -	\$ -	\$ 18,374,400	\$ 103,624,762	\$ 114,457,140	\$ -	\$ -	\$ -	\$ -
c. Allowance For Bad Debt			\$ -	\$ 509,696	\$ 2,089,241	\$ 2,307,898				
d. Contractual Allowance			\$ -	\$ 13,277,440	\$ 75,768,209	\$ 83,685,161				
e. Charity Care			\$ -	\$ -	\$ 964,675	\$ 1,035,664				
Net Patient Services Revenue	\$ -	\$ -	\$ -	\$ 4,587,264	\$ 24,802,637	\$ 27,428,417	\$ -	\$ -	\$ -	\$ -
f. Other Operating Revenues (Specify/add rows if needed)			\$ -	\$ -	\$ -	\$ -				
NET OPERATING REVENUE	\$ -	\$ -	\$ -	\$ 4,587,264	\$ 24,802,637	\$ 27,428,417	\$ -	\$ -	\$ -	\$ -
2. EXPENSES										
a. Salaries & Wages (including benefits)			\$ -	\$ 2,966,587	\$ 8,391,622	\$ 9,177,524				
b. Contractual Services			\$ -	\$ 254,509	\$ 609,478	\$ 680,342				
c. Interest on Current Debt			\$ -	\$ -	\$ -	\$ -				
d. Interest on Project Debt			\$ -	\$ -	\$ -	\$ -				
e. Current Depreciation			\$ -	\$ -	\$ -	\$ -				
f. Project Depreciation			\$ -	\$ -	\$ -	\$ -				
g. Current Amortization			\$ -	\$ -	\$ -	\$ -				
h. Project Amortization			\$ -	\$ -	\$ -	\$ -				
i. Supplies			\$ -	\$ 9,897	\$ 33,467	\$ 37,358				
j. Administrative/office expenses			\$ -	\$ 1,081,078	\$ 3,544,207	\$ 3,863,670				
k. Facilities expenses (repairs & maintenance, rent, real estate taxes, utilities)			\$ -	\$ 1,088,423	\$ 4,200,299	\$ 4,235,521				
l. Food			\$ -	\$ 321,109	\$ 1,717,979	\$ 1,917,731				
m. Marketing expense			\$ -	\$ 178,141	\$ 953,082	\$ 1,063,898				
n. Liability insurance			\$ -	\$ 32,620	\$ 137,425	\$ 153,404				
o. Other Expenses: Licensing & legal expenses			\$ -	\$ 17,250	\$ 92,290	\$ 103,021				
TOTAL OPERATING EXPENSES	\$ -	\$ -	\$ -	\$ 5,949,614	\$ 19,679,849	\$ 21,232,469	\$ -	\$ -	\$ -	\$ -
3. INCOME										
a. Income From Operation	\$ -	\$ -	\$ -	\$ (1,362,350)	\$ 5,122,788	\$ 6,195,948	\$ -	\$ -	\$ -	\$ -
b. Non-Operating Income										

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

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	N/A	N/A	2015	2016	2017	2018				
SUBTOTAL	\$ -	\$ -	\$ -	\$ (1,362,350)	\$ 5,122,788	\$ 6,195,948	\$ -	\$ -	\$ -	\$ -
c. Income Taxes										
NET INCOME (LOSS)	\$ -	\$ -	\$ -	\$ (1,362,350)	\$ 5,122,788	\$ 6,195,948	\$ -	\$ -	\$ -	\$ -
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare			0.0%	0.0%	0.0%	0.0%				
2) Medicaid			0.0%	0.0%	0.0%	0.0%				
3) Blue Cross			0.0%	0.0%	0.0%	0.0%				
4) Commercial Insurance			0.0%	19.5%	19.5%	19.5%				
5) Self-pay			0.0%	80.5%	80.5%	80.5%				
6) Other			0.0%	0.0%	0.0%	0.0%				
TOTAL	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare			0.0%	0.0%	0.0%	0.0%				
2) Medicaid			0.0%	0.0%	0.0%	0.0%				
3) Blue Cross			0.0%	0.0%	0.0%	0.0%				
4) Commercial Insurance			0.0%	25.00%	25.00%	25.00%				
5) Self-pay			0.0%	68.85%	68.85%	68.85%				
6) Other			0.0%	6.15%	6.15%	6.15%				
TOTAL	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%

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

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
<i>Calendar Year</i>	N/A	N/A	2015	2016	2017	2018				
1. DISCHARGES										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	0	0	0	0	0	0	0	0	0	0
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute	0	0	0	0	0	0	0	0	0	0
f. Rehabilitation										
g. Comprehensive Care										
h. Residential										
i. Detox	N/A	N/A	N/A	N/A	509	520				
TOTAL DISCHARGES	0	0	0	N/A	509	520	0	0	0	0
2. PATIENT DAYS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	0	0	0	0	0	0	0	0	0	0
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute	0	0	0	0	0	0	0	0	0	0
f. Rehabilitation										
g. Comprehensive Care										
h. Residential										
i. Detox	N/A	N/A	N/A	N/A	7,122	7,282				
TOTAL PATIENT DAYS	0	0	0	0	7,122	7,282	0	0	0	0
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

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

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
<i>Calendar Year</i>	N/A	N/A	2015	2016	2017	2018				
Total Acute	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Residential	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
i. Detox	N/A	N/A	N/A	N/A	14.0	14.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	0	0	0	0	0	0	0	0	0	0
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute	0	0	0	0	0	0	0	0	0	0
f. Rehabilitation										
g. Comprehensive Care										
h. Residential										
i. Detox	N/A	N/A	N/A	N/A	21	21				
TOTAL LICENSED BEDS	0	0	0	0	21	21	0	0	0	0

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

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Calendar Year	N/A	N/A	2015	2016	2017	2018				
5. OCCUPANCY PERCENTAGE *IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.										
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Residential	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
i. Detox	N/A	N/A	N/A	N/A	92.9%	95.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	92.9%	95.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
6. OUTPATIENT VISITS										
a. Emergency Department										
b. Same-day Surgery										
c. Laboratory										
d. Imaging										
h. Residential	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
i. Detox	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
TOTAL OUTPATIENT VISITS	0	0	0	0	0	0	0	0	0	0
7. OBSERVATIONS**										
a. Number of Patients	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
b. Hours	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

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

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

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

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	2015	2016	2017	2018			
1. REVENUE - DETOX							
a. Inpatient Services	\$ -	\$ -	\$ 24,927,000	\$ 25,487,000			
b. Outpatient Services							
Gross Patient Service Revenues	\$ -	\$ -	\$ 24,927,000	\$ 25,487,000	\$ -	\$ -	\$ -
c. Allowance For Bad Debt	\$ -	\$ -	496,615.00	\$ 507,771			
d. Contractual Allowance			18,305,465	\$ 18,716,708			
e. Charity Care	\$ -	\$ -	468,236	\$ 478,755			
Net Patient Services Revenue	\$ -	\$ -	\$ 5,656,684	\$ 5,783,766	\$ -	\$ -	\$ -
f. Other Operating Revenues (Specify)							
NET OPERATING REVENUE	\$ -	\$ -	\$ 5,656,684	\$ 5,783,766	\$ -	\$ -	\$ -
2. EXPENSES - DETOX							
a. Salaries & Wages (including benefits)	\$ -	\$ -	\$ 1,561,644	\$ 1,622,681			
b. Contractual Services	\$ -	\$ -	\$ 114,445	\$ 121,925			
c. Interest on Current Debt	\$ -	\$ -	\$ -	\$ -			
d. Interest on Project Debt	\$ -	\$ -	\$ -	\$ -			
e. Current Depreciation	\$ -	\$ -	\$ -	\$ -			
f. Project Depreciation	\$ -	\$ -	\$ -	\$ -			
g. Current Amortization	\$ -	\$ -	\$ -	\$ -			
h. Project Amortization	\$ -	\$ -	\$ -	\$ -			
i. Supplies	\$ -	\$ -	\$ 6,284	\$ 6,695			
j. Administrative/office expenses	\$ -	\$ -	\$ 684,437	\$ 743,140			
k. Facilities expenses (repairs & maintenance, rent, real estate taxes, utilities)	\$ -	\$ -	\$ 814,215	\$ 817,172			
l. Food	\$ -	\$ -	\$ 322,596	\$ 343,679			
m. Marketing expense	\$ -	\$ -	\$ 178,966	\$ 190,663			
n. Liability insurance	\$ -	\$ -	\$ 25,805	\$ 27,492			
o. Other Expenses: Licensing & legal expenses	\$ -	\$ -	\$ 17,330	\$ 18,463			

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

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	2015	2016	2017	2018			
TOTAL OPERATING EXPENSES	\$ -	\$ -	\$ 3,725,722	\$ 3,891,910	\$ -	\$ -	\$ -
3. INCOME - DETOX							
a. Income From Operation	\$ -	\$ -	\$ 1,930,962	\$ 1,891,856	\$ -	\$ -	\$ -
b. Non-Operating Income							
SUBTOTAL	\$ -	\$ -	\$ 1,930,962	\$ 1,891,856	\$ -	\$ -	\$ -
c. Income Taxes							
NET INCOME (LOSS)	\$ -	\$ -	\$ 1,930,962	\$ 1,891,856	\$ -	\$ -	\$ -
4. PATIENT MIX - DETOX							
a. Percent of Total Revenue							
1) Medicare	0.0%	0.0%	0.0%	0.0%			
2) Medicaid	0.0%	0.0%	0.0%	0.0%			
3) Blue Cross	0.0%	0.0%	0.0%	0.0%			
4) Commercial Insurance	0.0%	0.0%	19.5%	19.5%			
5) Self-pay	0.0%	0.0%	80.5%	80.5%			
6) Other	0.0%	0.0%	0.0%	0.0%			
TOTAL	0.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%

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

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	2015	2016	2017	2018			
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	0.0%	0.0%	0.0%	0.0%			
2) Medicaid	0.0%	0.0%	0.0%	0.0%			
3) Blue Cross	0.0%	0.0%	0.0%	0.0%			
4) Commercial Insurance	0.0%	0.0%	25.00%	25.00%			
5) Self-pay	0.0%	0.0%	68.85%	68.85%			
6) Other	0.0%	0.0%	6.15%	6.15%			
TOTAL	0.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%

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

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	2015	2016	2017	2018			
1. REVENUE							
a. Inpatient Services	\$ -	\$ -	\$ 26,173,350	\$ 28,099,418			
b. Outpatient Services							
Gross Patient Service Revenues	\$ -	\$ -	\$ 26,173,350	\$ 28,099,418	\$ -	\$ -	\$ -
c. Allowance For Bad Debt	\$ -	\$ -	\$ 521,446	\$ 559,819			
d. Contractual Allowance			\$ 19,220,738	\$ 20,635,171			
e. Charity Care	\$ -	\$ -	\$ 491,648	\$ 527,828			
Net Patient Services Revenue	\$ -	\$ -	\$ 5,939,518	\$ 6,376,600	\$ -	\$ -	\$ -
f. Other Operating Revenues (Specify/add rows of needed)							
NET OPERATING REVENUE	\$ -	\$ -	\$ 5,939,518	\$ 6,376,600	\$ -	\$ -	\$ -
2. EXPENSES							
a. Salaries & Wages (including benefits)	\$ -	\$ -	\$ 1,615,732	\$ 1,760,607			
b. Contractual Services	\$ -	\$ -	\$ 118,510	\$ 132,289			
c. Interest on Current Debt	\$ -	\$ -	\$ -	\$ -			
d. Interest on Project Debt	\$ -	\$ -	\$ -	\$ -			
e. Current Depreciation	\$ -	\$ -	\$ -	\$ -			
f. Project Depreciation	\$ -	\$ -	\$ -	\$ -			
g. Current Amortization	\$ -	\$ -	\$ -	\$ -			
h. Project Amortization	\$ -	\$ -	\$ -	\$ -			
i. Supplies	\$ -	\$ -	\$ 6,507	\$ 7,264			
j. Administrative/office expenses	\$ -	\$ -	\$ 689,151	\$ 751,269			
k. Facilities expenses (repairs & maintenance, rent, real estate taxes, utilities)	\$ -	\$ -	\$ 816,725	\$ 823,574			

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

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	2015	2016	2017	2018			
l. Food	\$ -	\$ -	\$ 334,051	\$ 372,892			
m. Marketing expense	\$ -	\$ -	\$ 185,322	\$ 206,869			
n. Liability insurance	\$ -	\$ -	\$ 26,722	\$ 29,829			
o. Other Expenses: Licensing & legal expenses	\$ -	\$ -	\$ 17,945	\$ 20,032			
TOTAL OPERATING EXPENSES	\$ -	\$ -	\$ 3,810,665	\$ 4,104,625	\$ -	\$ -	\$ -
3. INCOME							
a. Income From Operation	\$ -	\$ -	\$ 2,128,853	\$ 2,271,975	\$ -	\$ -	\$ -
b. Non-Operating Income							
SUBTOTAL	\$ -	\$ -	\$ 2,128,853	\$ 2,271,975	\$ -	\$ -	\$ -
c. Income Taxes							
NET INCOME (LOSS)	\$ -	\$ -	\$ 2,128,853	\$ 2,271,975	\$ -	\$ -	\$ -
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	0.0%	0.0%	0.0%	0.0%			
2) Medicaid	0.0%	0.0%	0.0%	0.0%			
3) Blue Cross	0.0%	0.0%	0.0%	0.0%			
4) Commercial Insurance	0.0%	0.0%	19.5%	19.5%			
5) Self-pay	0.0%	0.0%	80.5%	80.5%			
6) Other	0.0%	0.0%	0.0%	0.0%			
TOTAL	0.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%

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

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	2015	2016	2017	2018			
b. Percent of Equivalent Inpatient Days							
1) Medicare	0.0%	0.0%	0.0%	0.0%			
2) Medicaid	0.0%	0.0%	0.0%	0.0%			
3) Blue Cross	0.0%	0.0%	0.0%	0.0%			
4) Commercial Insurance	0.0%	0.0%	25.00%	25.00%			
5) Self-pay	0.0%	0.0%	68.85%	68.85%			
6) Other	0.0%	0.0%	6.15%	6.15%			
TOTAL	0.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%

TABLE L. WORK FORCE INFORMATION - DETOX - as of October 7, 2016

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.

Job Category	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) *	
	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

TABLE L. WORK FORCE INFORMATION - DETOX - as of October 7, 2016

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)
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

* The projected FTEs and cost for the entire facility should equal the current number of FTEs and cost plus changes in FTEs and cost related to the proposed project plus other expected changes in staffing.

EXHIBIT 40



Recovery Centers of America

REFERRAL AGREEMENT

The undersigned acknowledges that a reciprocal agreement has been established between Recovery Centers of America (RCA) and Sheppard Pratt Health System ("Sheppard Pratt"). Sheppard Pratt agrees to receive patient referrals from RCA for services provided by Sheppard Pratt, including acute inpatient co-occurring care and co-occurring partial hospitalization care. Access to those services will be based on availability of treatment capacity at the time of referral.

This agreement is for all RCA program locations listed below.

Recovery Centers of America

314 Grove Neck Rd
Earleville, MD 21919

Recovery Centers of America

11100 Billingsley Road
Waldorf, MD 20602

Recovery Centers of America

4620 Melwood Road
Upper Marlboro MD 20772

RCA provides comprehensive addiction treatment and dual diagnosis services. RCA programs provide inpatient rehabilitation, partial hospitalization, and outpatient services.

As appropriate, RCA will refer patients in accordance with program policy and procedures and in compliance with federal, state and county standards governing the confidentiality of patient information. Any information needed for continuity of care will be furnished upon request provided that all confidentiality requirements have been met. In addition, it is understood that patients appropriate for admission shall be treated without regard to race, religion, sex, sexual preference, national origin, or physical disability.

Nothing in this agreement shall be construed as limiting the rights of either party to enter into similar agreements with any other facility. This agreement may be terminated by either party with 30 days written notice to the other. This agreement becomes effective on the date signed below and will remain in effect for two years unless terminated in writing by either party.

RCA

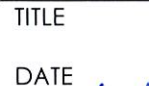


SIGNATURE



TITLE

DATE



10/6/16

SHEPPARD PRATT HEALTH SYSTEM, INC.



SIGNATURE

Vice President, Operations & Bus. Dev.

TITLE

DATE

10/7/16

EXHIBIT 41



Recovery Centers of America

October 7, 2016

VIA FIRST CLASS MAIL

Department of Health and Mental Hygiene
Behavioral Health Administration
Barbara J. Barzon, Ph.D., Executive Director
201 W. Preston Street
Baltimore, MD 21201

RE: Residential and Detox Charity Care Services

Dear Dr. Barzon:

I write on behalf of Recovery Centers of America (RCA) to inform you of RCA's intent to operate three substance use disorder treatment centers in Maryland and to seek an agreement from the Maryland Behavioral Health Administration for the referral of indigent and gray area patients to RCA's Maryland centers for treatment.

RCA provides comprehensive addiction treatment and dual diagnosis services. RCA programs provide inpatient rehabilitation, partial hospitalization and outpatient services.

RCA intends to operate a total of three Maryland substance use disorder treatment centers with beds licensed at level III.5 - Clinically Managed High Intensity Residential Services, and level III.7D - Medically Monitored Inpatient Detoxification. To achieve this goal, RCA filed three applications for a Certificate of Need (CON) with the Maryland Health Care Commission for approval of the Detox portion of its plans, which are subject to CON review. In addition, RCA recently opened residential services at one of the proposed project sites, Bracebridge Hall in Cecil County, Maryland. The three planned Maryland treatment centers are:

Recovery Centers of America

314 Grove Neck Rd
Earleville, MD 21919

Recovery Centers of America

11100 Billingsley Road
Waldorf, MD 20602

Recovery Centers of America

4620 Melwood Road
Upper Marlboro MD 20772

As a part of the Certificate of Need application and review process before the Maryland Health Care Commission, RCA has committed to dedicating a portion of its net revenue to providing charity care to the indigent and gray area population, defined as persons who qualify for services under the Maryland Medical Assistance Program, regardless of whether Medical Assistance will reimburse for alcohol and drug abuse treatment, and those persons who do not qualify for services under the Maryland Medical Assistance Program but

1-800-RECOVERY | 1800recovery.com

2701 Renaissance Blvd 4th Floor King of Prussia, PA 19406

whose annual income from any sources is no more than 180 percent of the most recent Federal Poverty Index, and who have no insurance for alcohol and drug abuse treatment services.

RCA seeks the commitment of the Maryland Behavioral Health Administration to develop a referral process for indigent and gray area patients to be evaluated and, if appropriate, treated at an RCA facility if the Maryland Health Care Commission issues a certificate of need for the proposed projects.

A draft agreement committing to develop a referral process in the event of CON approval is enclosed with this letter. A representative of RCA will be reaching out to the Behavioral Health Administration to provide additional information about RCA's services and to follow up on this letter. In the meantime, please feel free to contact me directly if you have any questions.

RCA will continue to update the Behavioral Health Administration of significant developments in the CON process and licensure of its facilities.

Very Truly Yours,

A handwritten signature in black ink, appearing to read "John Paul Christen", with a stylized flourish at the end.

John Paul Christen
Chief Operating Officer
Recovery Centers of America



Recovery Centers *of* America

October 7, 2016

VIA FIRST CLASS MAIL

Cecil County Department of Health
Core Service Agency
401 Bow Street
Elkton, Maryland 21921

RE: Residential and Detox Charity Care Services

Dear Sir/Madam:

I write on behalf of Recovery Centers of America (RCA) to inform you of RCA's intent to operate three substance use disorder treatment centers in Maryland and to seek an agreement from the Cecil County Department of Health for the referral of indigent and gray area patients to RCA's Maryland centers for treatment.

RCA provides comprehensive addiction treatment and dual diagnosis services. RCA programs provide inpatient rehabilitation, partial hospitalization and outpatient services.

RCA intends to operate a total of three Maryland substance use disorder treatment centers with beds licensed at level III.5 - Clinically Managed High Intensity Residential Services, and level III.7D - Medically Monitored Inpatient Detoxification. To achieve this goal, RCA filed three applications for a Certificate of Need (CON) with the Maryland Health Care Commission for approval of the Detox portion of its plans, which are subject to CON review. In addition, RCA recently opened residential services at one of the proposed project sites, Bracebridge Hall in Cecil County, Maryland. The three planned Maryland treatment centers are:

Recovery Centers of America

314 Grove Neck Rd
Earleville, MD 21919

As a part of the Certificate of Need application and review process before the Maryland Health Care Commission, RCA has committed to dedicating a portion of its net revenue to providing charity care to the indigent and gray area population, defined as persons who qualify for services under the Maryland Medical Assistance Program, regardless of whether Medical Assistance will reimburse for alcohol and drug abuse treatment, and those persons who do not qualify for services under the Maryland Medical Assistance Program but whose annual income from any sources is no more than 180 percent of the most

1-800-RECOVERY | 1 800recovery.com

2701 Renaissance Blvd 4th Floor King of Prussia, PA 19406

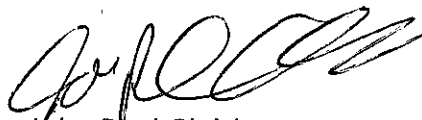
recent Federal Poverty Index, and who have no insurance for alcohol and drug abuse treatment services.

RCA seeks the commitment of the Cecil County Department of Health to develop a referral process for indigent and gray area patients to be evaluated and, if appropriate, treated at an RCA facility if the Maryland Health Care Commission issues a certificate of need for the proposed projects.

A draft agreement committing to develop a referral process in the event of CON approval is enclosed with this letter. A representative of RCA will be reaching out to the Cecil County Department of Health to provide additional information about RCA's services and to follow up on this letter. In the meantime, please feel free to contact me directly if you have any questions.

RCA will continue to update the Cecil County Department of Health of significant developments in the CON process and licensure of its facilities.

Very Truly Yours,

A handwritten signature in black ink, appearing to read 'John Paul Christen', is positioned above the printed name.

John Paul Christen
Chief Operating Officer
Recovery Centers of America

EXHIBIT 42

PROJECT DESCRIPTION

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

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

Applicant Response:

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

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

¹ COMAR § 10.47.02.09 defines a level III.7.D program as “[a] medically monitored intensive inpatient treatment program” that shall: (1) [o]ffer a planned regimen of 24-hour professionally directed evaluation, care, and treatment in an inpatient setting; (2) [a]ct as an Intermediate Care Facility Type C/D; and (3) [m]eet the certification requirements for detoxification services as described in COMAR 10.47.02.10E.” *Id.* at .09(A). Patients appropriate for this level of care “(1) Meet the current edition of the American Society of Addiction Medicine Patient Placement Criteria for Level III.7, or its equivalent as approved by the Administration; and (2) [r]equire 24-hour monitoring and care for subacute biomedical and emotional or behavioral conditions severe enough to warrant inpatient treatment.” *Id.* at .09(B).

ASAM defines Level III.7 Services as “Medically Monitored High-Intensity Inpatient Services,” and described as “24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. 16 hour/day counsel ability.” The ASAM Criteria: Treatment for Addictive, Substance-related, and Co-occurring Conditions, Third ed., Ch. 3, Ed. David Mee-Lee, American Society of Addiction Medicine, 2013. Dimension 1 is defined as “Acute Intoxication and/or Withdrawal Potential,” Dimension 2 is defined as “Biomedical Conditions and Complications”; Dimension 3 is defined as “Emotional, Behavioral or Cognitive Conditions and Complications.” *Id.*, Ch. 7.

² COMAR § 10.47.02.08 defines a level III.5 program as “[a] clinically managed high intensity residential program” that shall “(1) [p]rovide a highly structured environment in combination with moderate to high intensity treatment and ancillary services to support and promote recovery; and (2) [b]e characterized by its reliance on the treatment community as a therapeutic agent.” *Id.* at .08(A). Patients appropriate for this level of care “meet the current edition of the American Society of Addiction Medicine Patient Placement Criteria for Level III.5, or its equivalent as approved by the Administration.” The ASAM Criteria, Ch. 3.

ASAM defines Level III.5 Services as “Clinically Managed High Intensity Residential Services,” described as “24 hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community.” *Id.*, Ch. 7.

Thousands of Maryland residents who are suffering from addiction need treatment today. Relying on data from Maryland Department of Health and Mental Hygiene (DHMH), the Washington Post reported that “Heroin-related deaths in Maryland spiked 88 percent from 2011 to 2013 . . . and intoxication overdoses of all types now outnumber homicides in the state.” See *Exhibit 4 to the December 21, 2016 Corrected Modified Application*. Dr. Joshua Sharfstein, former DHMH Secretary, has remarked “Overdose is a public-health crisis in Maryland, as it is in many states...and we are bringing everything we can to bear against this challenge.” *Id.*

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

Applicant, together with its investors, is prepared to devote significant financial and clinical resources to not only developing the facility and treatment regimens, but to providing education and support to its surrounding communities. The total project cost is \$32,581,335, \$5,595,384 of which is attributable to the detox/assessment portion of the project that is subject to Certificate of Need review. Because Applicant will fund the project entirely through private channels, rather than seek state or local, or charitable funding, this cost represents a significant gain to the State and its efforts to combat the current addiction crises.

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

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

Applicant Response:

I. THE RECOVERY CENTERS OF AMERICA GROVE NECK ROAD FACILITY

A. The Grove Neck Road Facility

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

Applicant will need to upgrade the facilities to comply with the requirements that will result from a change in occupancy from “residential” to I-1 institutional group occupancy.

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

RCA has renovated the Manor House to contain 31 residential beds consistent with its plans to open a residential treatment facility while awaiting CON approval for detox/assessment beds. RCA also added a terrace addition of 8 residential beds to the Manor House and received growth allocation approval from the Critical Area Commission. The plans for the Manor house include a circular sunroom with sweeping views of the property that will be utilized as large group meeting space. The dining area faces the southeastern part of the property and includes a gourmet kitchen. Patio space may be used for outdoor dining, group therapy and events. Phase I opened on October 5, 2016.

Once RCA receives CON approval for its detox/ assessment beds, it plans to add a two story addition to the Manor House. The first floor will contain a 21 bed detox unit and a 20 bed residential treatment unit. The second floor will contain a 28 bed residential treatment unit, for a total of 48 residential beds. Construction on the addition will begin immediately once the CON is approved and all permits are received, and is anticipated to take 8 months (Phase II).

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

RCA has also renovated structures other than the Manor House to support its residential treatment facility during Phase I. Two Gatehouses at the entrance to the Manor House area are renovated to house admissions, family programming and meeting space. Two of three freestanding buildings ranging from 6,000-10,000 square feet, the "Car Barns," have been renovated. One will be renovated to include a gymnasium and fitness center. Another will hold two offices for the Personal Trainer and Recreation/Adventure staff. The bulk of that building will house the new water treatment plant. The total square footage affected by the proposed project, including both the Manor House and additional structures, is 76,695 square feet.

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

B. Recovery Centers of America

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

- Residential and Outpatient Treatment Facilities
- Acute Care Hospitals
- Behavioral Health Services

- Academic Research
- Governmental Drug Policy Initiatives

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

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

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

II. RCA'S TALENTED WORKFORCE

A. RCA Chief Clinical Officer

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

Dr. Carise has worked in the field of substance abuse and behavioral healthcare, as a researcher and clinician, for more than 28 years. She has extensive personal knowledge, know-how, and experience with regard to the types of activities she will be undertaking for RCA. Dr. Carise's areas of expertise include:

- Development, implementation and measurement of treatment tools and evidence-based practices such as computer software, clinical toolkits, program descriptors, assessment, intake and treatment planning instruments and procedures, continuing care, fidelity assessment, relapse prevention, family therapy, 12-step support, decreasing paperwork burden, diagnosing systems, psychodrama;
- Developing systems of care and partnerships such as performance-based contracting, 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 to the December 21, 2016 Corrected Modified Application. Dr. Carise also is an Adjunct Clinical Professor at the University of Pennsylvania School of Medicine. She is a frequent contributor to Huffington Post's Healthy Living blog – a list of her contributions is included in Exhibit 5, together with additional news and media contributions or appearances by Dr. Carise. Exhibit 5 also lists various lectures Dr. Carise has given, and other relevant professional activities.

B. RCA Staff

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

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

C. RCA Collaboration

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

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

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

III. TREATMENT AND PROGRAMMING

A. Approach to Treatment and Recovery

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

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

RCA insists on having a full continuum of care at its facilities. The National Institute on Drug Abuse – Principles of Drug Addiction Treatment: A Research Based Guide (Third Edition)

("NIDA Guide"), reports that good outcomes are contingent on adequate treatment length. Exhibit 6 to the December 21, 2016 Corrected Modified Application, at p. 14.

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

The NIDA Guide remarks:

Individuals progress through drug addiction treatment at various rates, so there is no predetermined length of treatment. However, research has shown unequivocally that good outcomes are contingent on adequate treatment length. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited effectiveness, and treatment lasting significantly longer is recommended for maintaining positive outcomes. For methadone maintenance, 12 months is considered the minimum, and some opioid-addicted individuals continue to benefit from methadone maintenance for many years.

Treatment dropout is one of the major problems encountered by treatment programs; therefore, motivational techniques that can keep patients engaged will also improve outcomes. By viewing addiction as a chronic disease and offering continuing care and monitoring, programs can succeed, but this will often require multiple episodes of treatment and readily readmitting patients that have relapsed.

Exhibit 6 to the December 21, 2016 Corrected Modified Application, at p. 14.

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

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

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

B. Clinical Programming

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

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

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

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

C. Patient Treatment Path

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

1. Contact Center

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

and knowledgeable in regard to its callers and access to neighborhood resources. It will also offer insurance advocacy, and will be dedicated and committed to helping anyone who suffers from the disease of addiction.

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

The Contact Center will have full integration of all RCA systems, including its 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. Continuing Recovery Monitoring

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

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

7. Post-Treatment Alumni Services

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

D. Elective Patient and Community Programming

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

1. Self-Help Groups

Also known as mutual help, mutual aid, or support groups, these groups will be comprised of people who share a common problem or addiction and provide mutual support to help each other to cope with and heal or recover from, their problems. RCA will provide space on the grounds of its programs for numerous self-help groups to meet on a regular basis. Patients can attend these meetings before, during, and after their treatment to help develop their support network and provide the highest likelihood of maintaining recovery. Examples of

Mutual or Self-Help Groups include: Alcoholics Anonymous, Cocaine Anonymous, Narcotics Anonymous, Secular Organization for Sobriety, SMART Recovery, Adult Children of Alcoholics, Al-Anon, Alateen, Debtors Anonymous, Gamblers Anonymous, Emotions Anonymous, and Overeaters Anonymous.

2. Spiritual Services

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

3. Speaker Series

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

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

IV. CONCLUSION

There is no greater problem facing Maryland today than the scourge of drug and alcohol addiction, and the deplorable shortage of facilities needed to help thousands of individuals and families return to healthy, productive lives. Applicant believes that 314 Grove Neck Road is the ideal location for a top-quality, state of the art facility to help those in need and reduce the state's deficit in care.

EXHIBIT 43

Project

BRACEBRIDGE
FACILITY

314 GROVE NECK ROAD
EARLEVILLE, MARYLAND 21919
CECIL COUNTY



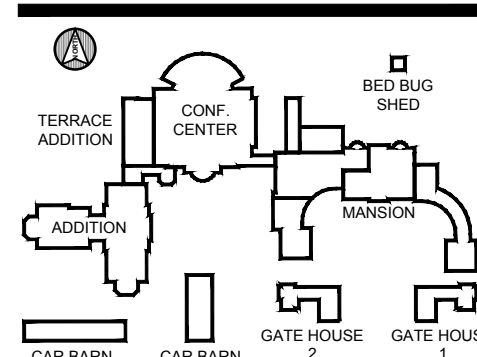
Thomas E Hall & Associates, Inc.
240 Conestoga Rd.
Wayne, Pa. 19087
Tel. : (610) 293-9900
Email : teh-architects.com
Architecture • Interiors • Planning

Seal

THESE DRAWINGS ARE PRELIMINARY AND NOT OFFICIAL UNTIL SIGNED AND SEALED. CONTRACTOR SHALL VERIFY DIMENSIONS AND SITE CONDITIONS AND REPORT ANY DISCREPANCIES TO THE ARCHITECT. THE ARCHITECTS IS NOT RESPONSIBLE FOR ANY UNREPORTED DISCREPANCIES.

Consultant

Key Plan



Project Type

- ☐ Alteration
- ☐ Remodel
- ☐ New Addition
- ☐ New Construction

Drawing Status

- ☐ Design Phase
☐ Not For Construction
☐ For Pricing
☐ For Permit
☐ Revision
☐ For Construction

Revisions

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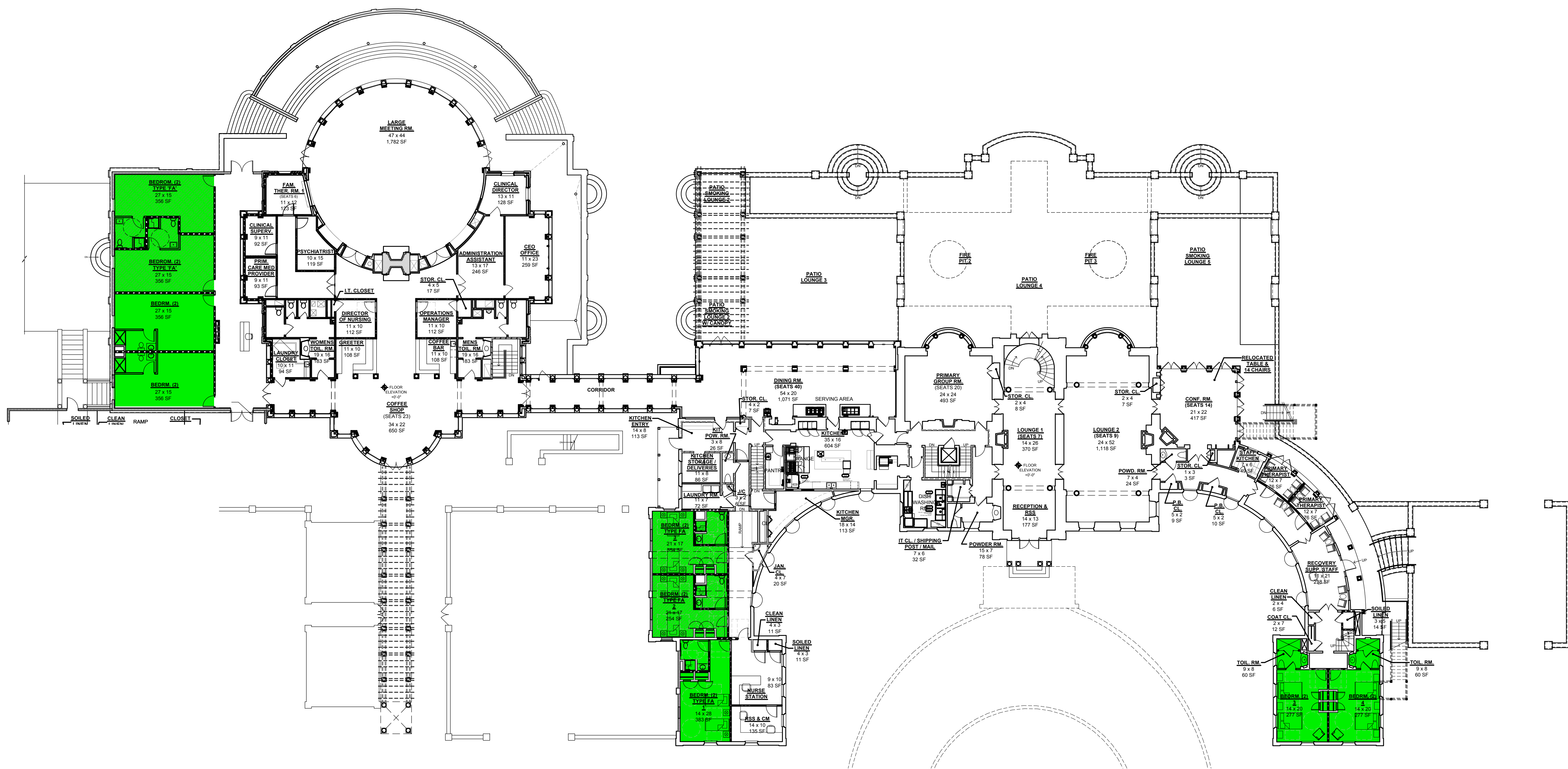
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 Checked By: TEH
 Date: 30 SEPT 16
 Scale: AS NOTED
 Drawing Title:
 MD CON

BASEMENT AND FIRST FLOOR PLANS

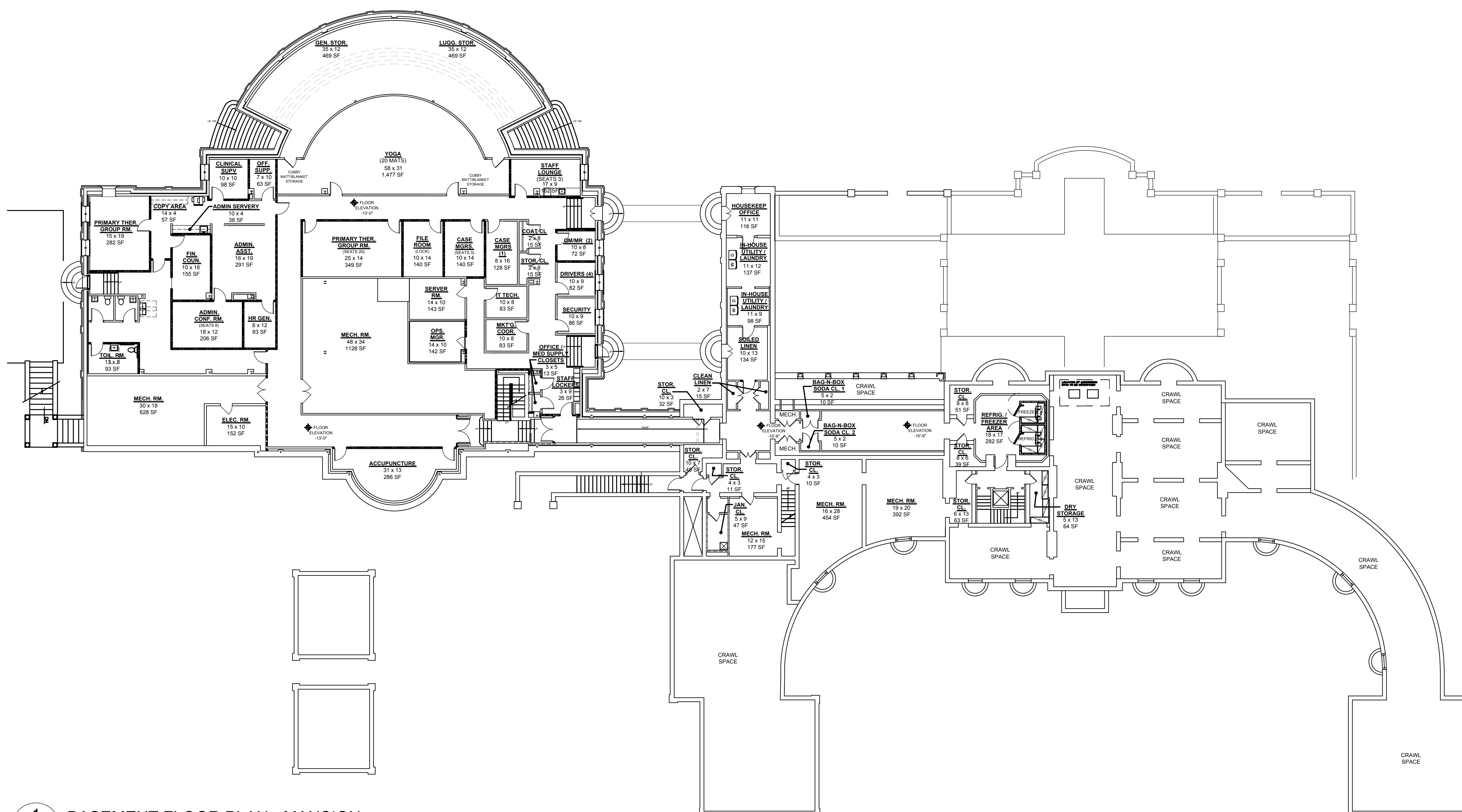
Sheet No:

SK-1.0

BRACEBRIDGE BUILDINGS



2 FIRST FLOOR PLAN - MANSION
SK-1.0 SCALE: 1/16" = 1'-0"



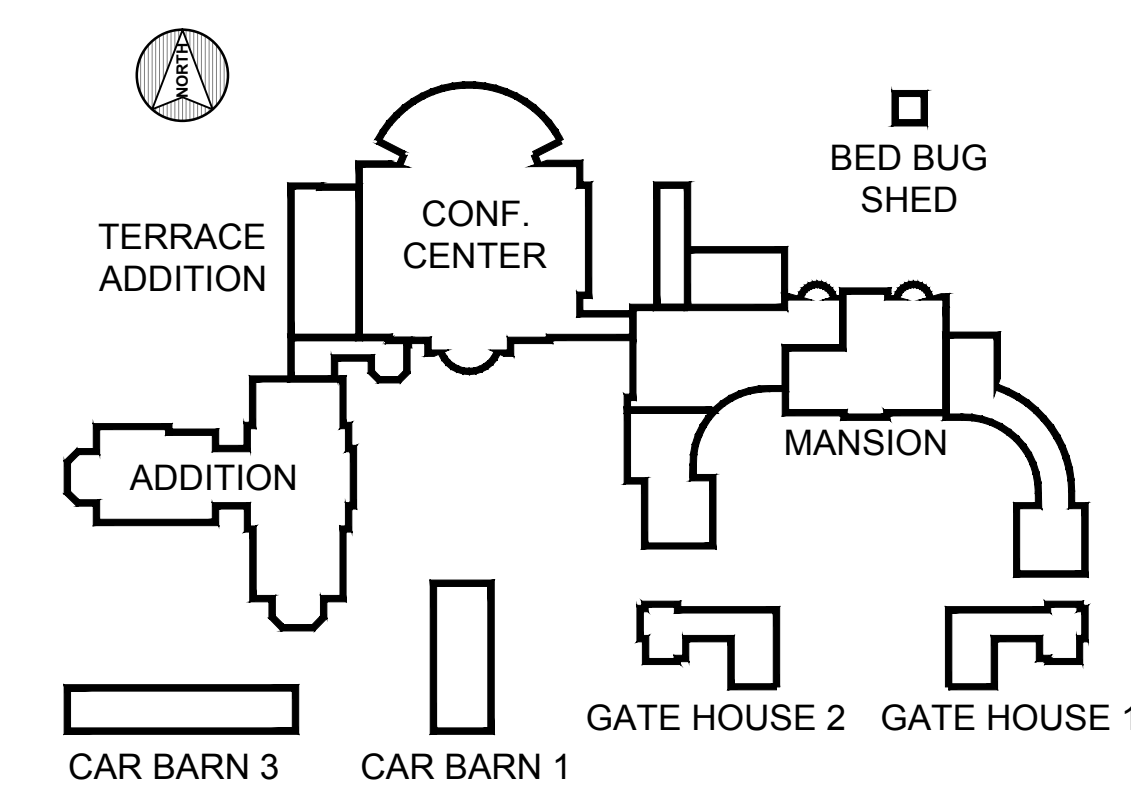
1 BASEMENT FLOOR PLAN - MANSION
SK-1.0 SCALE: 1/16" = 1'-0"

LEGEND

DETOX

INPATIENT

KEY PLAN



TOTAL BED COUNT:

DETOX SINGLES -	1 BED (1 ROOM)
DETOX DOUBLES -	20 BEDS (10 ROOMS)
INPATIENT SINGLES -	16 BEDS (16 ROOMS)
INPATIENT DOUBLES -	62 BEDS (31 ROOMS)
INPATIENT TRIPLES -	9 BEDS (3 ROOMS)
TOTAL:	108 BEDS (61 ROOMS)

BRACEBRIDGE
FACILITY

314 GROVE NECK ROAD
EARLEVILLE, MARYLAND 21919
CECIL COUNTY



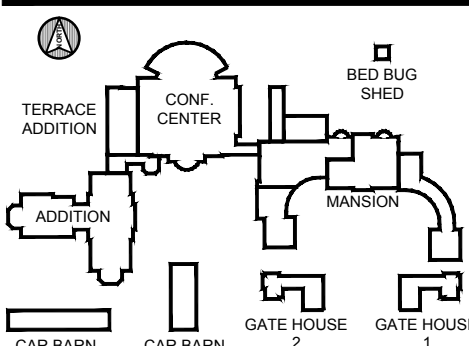
Thomas E Hall & Associates, Inc.
240 Conestoga Rd.
Wayne, Pa. 19087
Tel. : (610) 293-9900
Email : teh-architects.com
Architecture • Interiors • Planning

Seal

THESE DRAWINGS ARE PRELIMINARY AND NOT OFFICIAL UNTIL SIGNED AND SEALED. CONTRACTOR SHALL VERIFY DIMENSIONS AND SITE CONDITIONS AND REPORT ANY DISCREPANCIES TO THE ARCHITECT. THE ARCHITECTS IS NOT RESPONSIBLE FOR ANY UNREPORTED DISCREPANCIES.

Consultant

Key Plan



Project Type

- ☐ Alteration
- ☐ Remodel
- ☐ New Addition
- ☐ New Construction

Drawing Status

- ☐ Design Phase
☐ Not For Construction
☐ For Pricing
☐ For Permit
☐ Revision
☐ For Construction

Revisions

No.	Date	Description
1	30 SEPT 16	REVISION 1
2		
3		
4		
5		
6		
7		
8		
9		
10		

Job No: 6147.00
 Drawn By: EMH
 Checked By: TEH
 Date: 30 SEPT 16
 Scale: AS NOTED
 Drawing Title:
 MD CON

SECOND AND

Sheet No:

SK-1.1

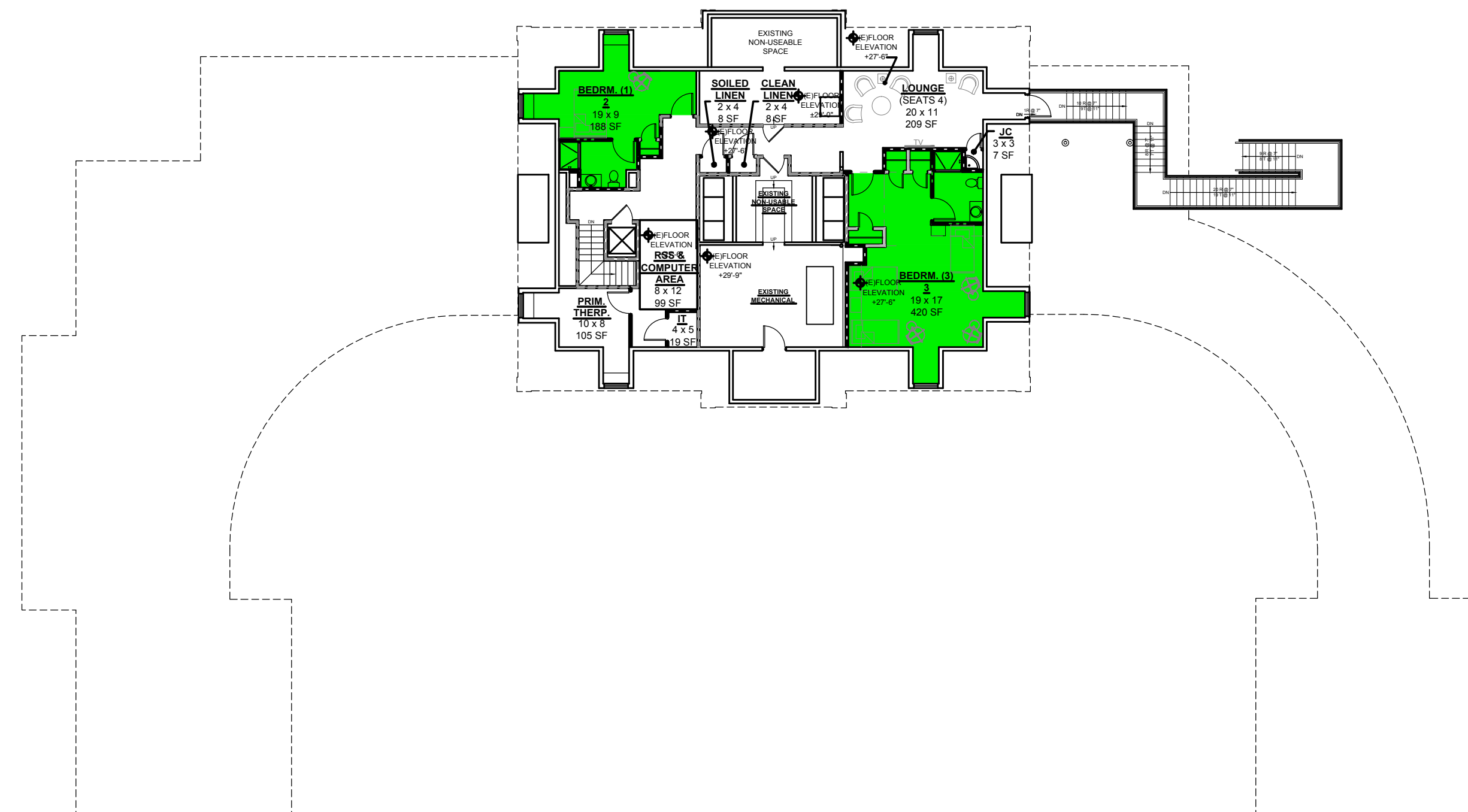
BRACEBRIDGE BUILDINGS



4 SECOND FLOOR PLAN - ADDITION
SK-1.1 SCALE: 1/16" = 1'-0"



3 FIRST FLOOR PLAN - ADDITION
SK-1.1 SCALE: 1/16" = 1'-0"



2 THIRD FLOOR PLAN - MANSION
SK-1.1 SCALE: 1/16" = 1'-0"



1 SECOND FLOOR PLAN - MANSION
SK-1.1 SCALE: 1/16" = 1'-0"

TOTAL BED COUNT:

DETOX SINGLES -	1 BED (1 ROOM)
DETOX DOUBLES -	20 BEDS (10 ROOMS)
INPATIENT SINGLES -	16 BEDS (16 ROOMS)
INPATIENT DOUBLES -	62 BEDS (31 ROOMS)
INPATIENT TRIPLES -	9 BEDS (3 ROOMS)
TOTAL:	108 BEDS (61 ROOMS)

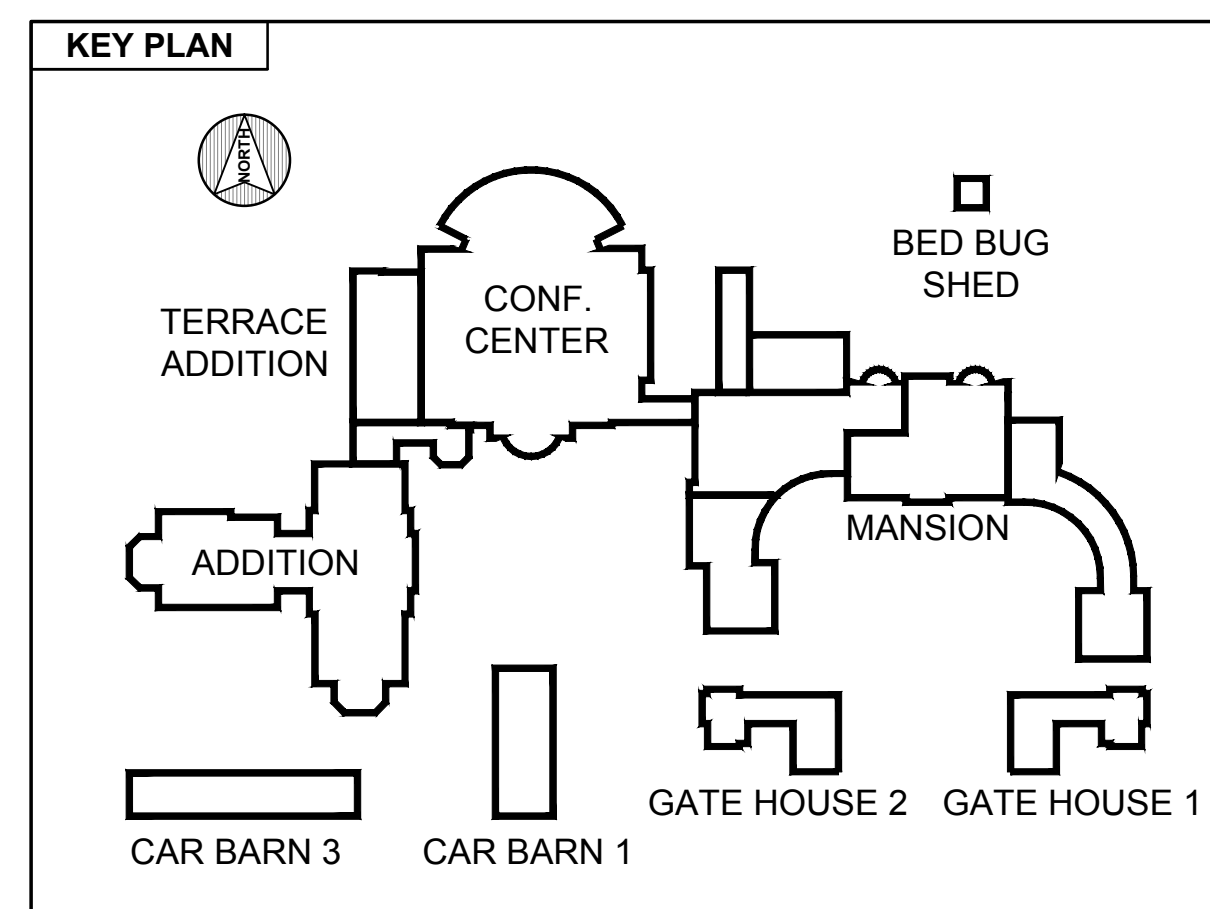


EXHIBIT 44

September 29, 2016 CONFIDENTIAL TREATMENT REQUESTED

Mr. Ben Steffen
Health Facilities Coordination Officer
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

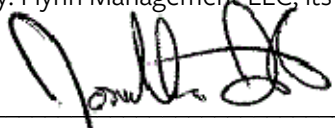
Re: *\$231.5 million financing*

Dear Mr. Steffen,

At the request of our partner, Recovery Centers of America, we would like to provide an update to our original letter to the Commission dated December 8, 2015. As we indicated at the time, Deerfield Management entered into a financing transaction with Recovery Centers of America on May 12, 2015. Pursuant to this transaction, Deerfield Private Design Fund III, L.P. agreed to provide Recovery Centers of America with up to \$231.5 million in financing to develop a portfolio of addiction treatment facilities, including the three subject properties in Maryland. The company remains in good standing with regard to the terms of the agreement and continues to have access to the funding described.

We remain excited by the opportunity to help address what we believe to be a shortage of addiction treatment beds within the state of Maryland. Please feel free to reach out to one of our partners, Leslie Henshaw (212.922.1345), who is managing this investment on the firm's behalf should you require further clarification.

Sincerely,
DEERFIELD MANAGEMENT COMPANY, L.P. (Series C)
By: Flynn Management LLC, its General Partner



Name: Jonathan Isler
Title: CEO & Authorized Signatory