Certificate of Need Application

Maryland House Detox, LLC

March 21 | 2016

817 S. Camp Meade Rd. Linthicum, MD 21090

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Craig P. Tanio, M.D.
CHAIR

STATE OF MARYLAND

Ben Steffen
EXECUTIVE DIRECTOR

For internal staff use:

MARYLAND HEALTH CARE COMMISSION

_____

MATTER/DOCKET NO.

_____

DATE DOCKETED

INSTRUCTIONS: GENERIC APPLICATION FOR CERTIFICATE OF NEED (CON)

Note: Specific CON application forms exist for hospital, comprehensive care facility, home health, and hospice projects. This form is to be used for any other services requiring a CON.

ALL APPLICATIONS MUST FOLLOW THE FORMATTING REQUIREMENTS DESCRIBED IMMEDIATELY BELOW. NOT FOLLOWING THESE FORMATTING INSTRUCTIONS WILL RESULT IN THE APPLICATION BEING RETURNED.

Required Format:

Table of Contents. The application must include a Table of Contents referencing the location of application materials. Each section in the hard copy submission should be separated with tabbed dividers. Any exhibits, attachments, etc. should be similarly tabbed, and pages within each should be numbered independently and consecutively. **The Table of Contents must include:**

- **Responses to PARTS I, II, III, and IV of the this application form**
- **Responses to PART IV must include responses to the standards in the State Health Plan chapter that apply to the project being proposed.**
  - All Applicants must respond to the Review Criteria listed at 10.24.01.08G(3)(b) through 10.24.01.08G(3)(f) as detailed in the application form.
- **Identification of each Attachment, Exhibit, or Supplement**

Application pages must be consecutively numbered at the bottom of each page. Exhibits attached to subsequent correspondence during the completeness review process shall use a consecutive numbering scheme, continuing the sequencing from the original application. (For example, if the last exhibit in the application is Exhibit 5, any exhibits used in subsequent responses should begin with Exhibit 6. However, a replacement exhibit that merely replaces an

exhibit to the application should have the same number as the exhibit it is replacing, noted as a replacement.

SUBMISSION FORMATS:

We require submission of application materials and the applicant's responses to completeness questions in three forms: hard copy; searchable PDF; and in Microsoft Word.

- **Hard copy:** Applicants must submit six (6) hard copies of the application to:
  Ruby Potter
  Health Facilities Coordinator
  Maryland Health Care Commission
  4160 Patterson Avenue
  Baltimore, Maryland 21215

- **PDF:** Applicants must also submit *searchable* PDF files of the application, supplements, attachments, and exhibits.[1] All subsequent correspondence should also be submitted both by paper copy and as *searchable PDFs*.

- **Microsoft Word:** Responses to the questions in the application and the applicant's responses to completeness questions should also be electronically submitted in Word. Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

PDFs and spreadsheets should be submitted to ruby.potter@maryland.gov and kevin.mcdonald@maryland.gov.

Note that there are certain actions that may be taken regarding either a health care facility or an entity that does not meet the definition of a health care facility where CON review and approval are not required. Most such instances are found in the Commission's procedural regulations at COMAR 10.24.01.03, .04, and .05. Instances listed in those regulations require the submission of specified information to the Commission and may require approval by the full Commission. Contact CON staff at (410) 764-3276 for more information.

A pre-application conference will be scheduled by Commission Staff to cover this and other topics. Applicants are encouraged to contact Staff with any questions regarding an application.

[1] PDFs may be created by saving the original document directly to PDF on a computer or by using advanced scanning technology

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: **Maryland House Detox**

Address:

817 S Camp Meade Rd	**Linthicum**	**21090**	**Anne Arundel**
Street	City	Zip	County

2. Name of Owner **Maryland House Detox, LLC**

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

Refer to Exhibit 1.

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

Legal Name of Project Applicant (Licensee or Proposed Licensee):

Maryland House Detox, LLC

Address:

817 S Camp Meade Rd	**Linthicum**	**21090**	**MD**	**Anne Arundel**
Street	City	Zip	State	County
Telephone:	**443-900-7585**			

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

N/A

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

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

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

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

A. Lead or primary contact:

Name and Title: David Stup, CEO

Company Name Maryland House Detox

Mailing Address:

817 S Camp Meade Rd	**Linthicum**	**21090**	**MD**
Street	City	Zip	State

Telephone: 443-900-7585

E-mail Address (required): david@delphihealthgroup.com

Fax:

If company name is different than applicant briefly describe the relationship

B. Additional or alternate contact:

Name and Title: Cynthia Curtis, President, COO

Company Name: Maryland House Detox

Mailing Address:

817 S Camp Meade Rd	**Linthicum**	**21090**	**MD**
Street	City	Zip	State

Telephone: 410-961-0600
E-mail Address (required): cindicurtis@icloud.com

Fax:

If company name is different than applicant briefly describe the relationship N/A

7. TYPE OF PROJECT

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

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

(1) A new health care facility built, developed, or established ☒
(2) An existing health care facility moved to another site ☐
(3) A change in the bed capacity of a health care facility ☐
(4) A change in the type or scope of any health care service offered by a health care facility ☐
(5) A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf ☐

8. PROJECT DESCRIPTION

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

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

Maryland House Detox (MHD) proposes to establish a new Track One Intermediate Care Facility (ICF) in Anne Arundel County, Maryland.

MHD plans to provide medically monitored inpatient detoxification services for individuals suffering from chemical dependency. The facility will operate 16 detoxification beds at level III.7.D, in accordance with COMAR 10.47.02.10(F) and 10.24.14. As of July 2015, the program will be regulated by both COMAR 10.47.02.10(F) and it will comply with COMAR 10.63.01.06 (C13 & E1) – which defines and governs Level III.7.D Medically Monitored Inpatient Detoxification programs.

With 16 ICF level III.7.D detox beds operating at a projected average length of stay of 5-6 days, MHD will be able to provide medically monitored detoxification for 80-96 patients per month. MHD aims to serve as a key addition to the substance use treatment landscape in the state. It is designed to provide an additional avenue into the treatment system through immediate access to detoxification and crisis stabilization services. MHD will serve to strategically lessen a system-wide bottleneck and alleviate barriers to access to substance abuse treatment services.

MHD will implement highly personalized, patient-driven referral processes that connect patients within the fabric of the State's existing treatment providers. This approach will link patients to levels of care based on ASAM placement criteria and into treatment programs that fit into personal life circumstances. The mission is to facilitate successful entry, engagement, and sustained recovery. Strategically innovative as a stand-alone detox facility, MHD aims to improve upon the historic inflexibility of traditional entry into the III.7.D level of care and foster patients' entry into the existing treatment system.

The total cost of the project is $1,936,275. This includes $1,194,800 in design, permit, and construction costs through complete finishes; and $741,475 in start up and carrying costs related to land lease obligations, furniture, and staffing.

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.

Construction, Renovation, and Demolition Plans

MHD will operate within the physical structure of the former Hospice of the Chesapeake building located at 817 S Camp Meade Rd in Linthicum, MD. The building previously housed an 8-bed hospice operation. The construction will be classified as I-2 in order to bring the building into compliance for the specific use of Inpatient Detoxification. The major changes needed to achieve this classification involve updating the fire rating to portions of the interior structure. Many of the building's existing characteristics meet this code requirement.

The footprint of the building will not be changed, nor will there be any major construction required to bring the building to an ideal layout for operating medically monitored inpatient detoxification. The internal layout modifications are designed to create functional zone-centered services that address patient safety, patient confidentiality, storage and administration of medication, staff offices, patient and family clinical consult areas, patient examination, and a commercial kitchen to prepare and serve meals to patients. The designation of functional zones streamlines service provision and incorporates risk mitigation.

The patient centered areas encompass 4 zones with overlapping functions:

1. Resident hall with (6) spacious bedrooms each with egress windows and an adjoining bathroom; a group break out room; relaxation lounge; large group room; main lobby with communications center; a quiet contemplation room; and family meeting room.
2. Dining room that includes a commercial kitchen enclosure; an open dining area; a café style refreshments center; ample natural light and a door to the outdoor gardens.
3. Patient gathering, family meeting and consult areas.
4. A manicured outdoor area that includes an open grassy yard; a walking meditation path; flower gardens; and an area with several pathways into a tree lined nature preserve.

The business area encompasses 3 zones:

1. A medical area which includes: patient exam and consult room; MD/NP/PA office; and a nurse station for med prep, dispense and storage areas, and documentation. One ADA accessible bedroom was located near the medical zone and when not utilized for an ADA patient, will be utilized for higher acuity patients.
2. Staff offices area that includes: clinical staff, administrative staff, HR/Finance, office manager, executive staff, IT and communications, staff lounge and dining area.
3. A lab area will be off the main lobby.

Architectural drawings of the changes are included in the Exhibit 3 of this application.

A change in square footage of departments does not apply to this application.

There will be no changes to the physical plant or location, so Land Use

permitting will not be required.

The only service offered in the building will be medically monitored inpatient detoxification. No other services are present to be affected.

The permitting and project schedule goal is as follows:

Schedule	**Start**	**Days to Complete**	**Finish**
Construction Permit Submission/Bid/Contract	6/1/16	60	8/1/16
Submission for Use	6/1/16	60	8/1/16
Construction	8/1/16	152	12/31/16
Submission for Occupancy	12/31/16	0	12/31/16
Submission for Accreditation/Licensure	9/1/16	90	12/31/16
First Use			Target 1/1/17

*An alternative schedule based on CON approval can be found in Exhibit 10.

9. Current Capacity and Proposed Changes:

Service	Unit Description	Currently Licensed/ Certified	Units to be Added or Reduced	Total Units if Project is Approved
ICF-MR	Beds	____/____		
ICF-C/D	Beds	0/0	16	16
Residential Treatment	Beds	____/____		
Ambulatory Surgery	Operating Rooms			
	Procedure Rooms			
Home Health Agency	Counties	____/____		
Hospice Program	Counties	____/____		
Other (Specify)				
TOTAL				

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

Community based services typically offered within inpatient substance abuse treatment facilities will be offered to the patients at MHD. MHD is a new project, so no existing services to be affected. These may services include:

12-Step Programs (Community-based and free)

- Includes programs such as Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, or Ala-Teen
    - Typically very useful for patients trying to achieve recovery, and for family members affected by substance abuse
    - Allows opportunity for contact with individuals with many years of recovery
    - Offers support and strategies for a successful recovery
    - Research suggests that commitment to these types of programs enhances possibilities of long-term recovery

Presentations and Brief Workshops

- Yoga & Physical Strengthening
- Meditation and/or Acupuncture
- Movement & Art Therapy
- Choice options of 1 hour presentations by professional specialists in the fields of addictions, health care, and health and wellness

11. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: _1.90_____ acres

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

MHD will be improving an existing structure and will not be increasing or changing the footprint of the building. Due to the nature of the improvements being made, MHD expects that all construction permits will be approved expeditiously. The County evaluates zoning use and development requirements for a project during the site development plan and building permit process. Since actual improvements to the building and operation of the facility are dependent upon CON approval, the building permit process will begin only after CON approval. If approved, MHD plans to submit for all necessary permits on the first day after approval.

In regards to land use, the existing structure MHD intends to improve upon is zoned C3 – General Commercial District – in Anne Arundel County. Hospitals are permitted uses by right in C3 districts. MHD's counsel had a preliminary telephone conversation on February 18, 2016 with the Anne Arundel County Office of Planning and Zoning. Counsel advised the office that MHD is proposing an inpatient drug and alcohol detox facility similar in many respects in the county to an existing facility in Annapolis. After describing the proposed facility and operation, the office indicated that the use would likely be classified by Planning and Zoning as a hospital use, which is permitted by right in the C3 District. The office indicated that the classification will have to be confirmed with the County Planning Director. MHD plans to pursue final submission and approval of building and use permits if approved by MHCC for the requested CON.

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

(1) Owned by: Maryland Healthcare Real Estate

(2) Options to purchase held by: _____
Please provide a copy of the purchase option as an attachment.

(3) Land Lease held by: Maryland House Detox – Refer to Exhibit 2
Please provide a copy of the land lease as an attachment.

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

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

12. PROJECT SCHEDULE

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

For new construction or renovation projects.

Project Implementation Target Dates

A. Obligation of Capital Expenditure ____0____ months from approval date.
B. Beginning Construction _____0_____ months from capital obligation.
C. Pre-Licensure/First Use _____7_____ months from capital obligation.
D. Full Utilization _____8-12_____ months from first use.

For projects <u>not</u> involving construction or renovations.

Project Implementation Target Dates

A. Obligation or expenditure of 51% of Capital Expenditure _____ months from CON approval date.
B. Pre-Licensure/First Use _____ months from capital obligation.
C. Full Utilization _____ months from first use.

For projects <u>not</u> involving capital expenditures.

Project Implementation Target Dates

A. Obligation or expenditure of 51% Project Budget _____ months from CON approval date.
B. Pre-Licensure/First Use _____ months from CON approval.
C. Full Utilization _____ months from first use.

13. PROJECT DRAWINGS

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

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

A. Floor plans for each floor affected with all rooms labeled by purpose or function, number of beds, location of bath rooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as “shell space”.

B. For projects involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.

C. Specify dimensions and square footage of patient rooms.

Project drawings to these specifications can be found in Exhibit 3.

14. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete **Tables C and D of the Hospital CON Application Package**

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

Refer to Exhibit 4 for Project Construction Budget and Hospital CON Application Package.

Water:

- The existing main cold water line size is 3⁄4”inches which needs to be upgraded to a 1-1/4” water line to accommodate the additional water consumption fixtures in the renovation. This upgrade will be contained to the main water line entering the building and will not require an upgrade from the water supply.
- There are three (3) water heaters serving the space – 120-gallon and 40-gallon water heaters serve the right wing of the building and a 40-gallon serves the left wing of the building except for the existing toilet rooms that are served by instant water heaters. The instant water heaters are scheduled to be removed in the renovation. The hot water supply to these rooms shall be tied into the water supply from the 40-gallon water heater.

Electricity:

- The main electrical service to the space is 600 amps, 120/208V, 3Ø. Based on the electrical load estimates from the additional kitchen equipment, the existing electrical service can accommodate the additional load for the renovation. Due to the wall changes and space redesign, the existing fire alarm system has to be redesigned to meet current codes and jurisdictional regulations and requirements for the new use of the space.

Sewage:

- The sewer collection is accomplished through a septic tank that has been determined to be adequate.
- The addition of a commercial kitchen will require the installation of a 1000 gallon Fats, Oil and Grease (FOG) collection system (Grease interceptor).

Natural Gas:

- Heating is provided by propane. Propane capacity and pipe size shall be determined based on the kitchen equipment requiring propane use in the new layout.
- The space on the left side of the building that includes proposed RM 115 to Unit G is served by an existing 5-Ton residential grade Air

Handling unit (Furnace) with propane heat.

- The right side of the building that includes the existing kitchen is served by two (2) 5-Ton residential grade Air Handlers manifold into one main supply trunk. Heating is provided by Propane.

General Note:

- The addition of the commercial kitchen in the renovation shall require provision of cooling and/or heating loads. The kitchen shall also require a make-up air unit for the hood. In addition, kitchen equipment specified shall be specified for propane use.

2). Identify provider of utilities:

- Electricity – Baltimore Gas and Electric (BG&E).
- Sewage – Septic System is Private and will be maintained by MHD.
- Natural Gas – Suburban Propane is the propane vendor that is engaged and maintained by MHD.
- Water – Anne Arundel County (AACO).

3). All utilities currently serve or have been obtained for MHD.

PART II - PROJECT BUDGET

Complete Table E of the Hospital CON Application Package

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

Refer to Exhibit 4 for Project Construction Budget. The budget is delineated by each project category.

Assumptions and Explanations

Preceding the design phase, MHD engaged RPH Architecture in Annapolis, Maryland to manage, create, and design the architectural and engineering aspects of the project. RPH is a boutique architecture firm with expertise in commercial, residential and affordable housing projects that previously designed an addition to the existing structure in 2007. The architectural fees involved in this process are included in the budget.

MHD engaged Owner Rep Consulting in Annapolis, Maryland to manage the pre-construction and construction processes, including development of an initial construction budget. Owner Rep Consulting offers consulting, management and advocacy services for clients and customers seeking to develop and build. Owner Rep facilitates a professional synergy among design, construction and other support entities of the project. For the MHD project, Owner Rep is engaged to complete the following action points:

During the pre-construction process, Owner Rep invited local construction trades and suppliers to visit the site to bid on the various trades. This process involved walk-throughs with each contractor. Upon completion of inspection and information gathering, Owner Rep received multiple competitive bids for each trade based on the scope of work set forth by MHD's architectural and engineering firms. The most complete bids based on the scope of work are included in each budget line.

Because the project design phase has been completed by RPH, Owner Rep recommended that 10% contingency be included in the project budget due to its knowledge of the project and its experience with similar projects. The contingency has been accounted for within the budget.

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

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

   Maryland House Detox, LLC – 817 S Camp Meade Rd Linthicum, MD 21090
   Delphi Behavioral Health Group – 3107 Stirling Rd Suite 307 Ft. Lauderdale, FL 33312
   David Stup, CEO, BOD Maryland House Detox, BOD DCX Group – 817 S Camp Meade Rd Linthicum, MD 21090
   Cynthia Curtis, COO Maryland House Detox, BOD, DCX Group, LLC – 817 S Camp Meade Rd Linthicum, MD 21090

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

   Delphi Behavioral Health Group –
   Ocean Breeze Recovery 2011-present (2413 E. Atlantic Blvd., Pompano Beach, FL 33062);
   Las Olas Recovery d/b/a Pathway to Hope 2012-present (600 SE 2nd Court, Ft Lauderdale, FL 33301);
   Community Rehab 2014-present (127 W. Palmyra Ave., Orange, CA. 92866);
   Community Rehab OP 2015-present (321 S. Tustin St., Orange, CA. 92866);
   Elevate Recovery 2015-present (1827 N. Case St., Orange, CA. 92866);
   California Highlands Addiction Treatment 2015-present (15986 S. Highland Springs Ave. Banning, CA 92220);
   Recovery Grove 2014-present;
   Ocean Breeze Detox 2016-present (2413 E Atlantic Blvd., Pompano Beach, FL 33062)
   DCX Group/David Stup –
   The Bergand Group 1 2012-present (1300 York Rd Suite C300, Lutherville, MD 21093);
   The Bergand Group 2 2015-present (1803 Harford Rd, Fallston, MD 21047)

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

   No

4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) received inquiries in last from 10 years from any federal or state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with any state,

federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

No

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

   No

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

All authorizations can be found in Exhibit 11.

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

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

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

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

10.24.01.08G(3)(a). <u>The State Health Plan</u>.

Every applicant must address each applicable standard in the chapter of the State Health Plan for Facilities and Services[2]. Commission staff can help guide applicants to the chapter(s) that applies to a particular proposal.

Please provide a direct, concise response explaining the project's consistency with each standard. Some standards require specific documentation (e.g., policies, certifications) which should be included within the application as an exhibit.

(Insert relevant State Health Plan standards here.)

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

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

> **(1) The Commission will approve a Certificate of Need application for an intermediate care facility having less than 15 beds only if the applicant dedicates a special population as defined in Regulation .08.**
>
> **(2) The Commission will approve a Certificate of Need application for a new intermediate care facility only if the facility will have no more than 40 adolescent or 50 adult intermediate care facility beds, or a total of 90 beds, if the applicant is applying to serve both age groups.**
>
> **(3) The Commission will not approve a Certificate of Need application for expansion of an existing alcohol and drug abuse intermediate care facility if its**

[2] [1] Copies of all applicable State Health Plan chapters are available from the Commission and are available on the Commission's web site here:http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/hcfs_shp

approval would result in the facility exceeding a total of 40 adolescent or 100 adult intermediate care facility beds, or a total of 140 beds, if the applicant is applying to serve both age groups.

Standard .05A (1) does not apply: MHD seeks a total of 16 ICF beds.

Standard .05A (2) does apply: MHD will only have (16) Adult ICF beds.

Standard .05A (3) does not apply to MHD: MHD is a new facility.

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

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

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

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

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

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

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

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

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

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

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

Standard .05B(1)(a) is met and discussed in detail in **10.24.01.08G(3)(b)** following this segment.

COMAR 10.24.14.08(B)(20) defines Track One beds as "'private beds' intermediate care facility beds not sponsored by local jurisdictions and without significant funding by the state or local jurisdictions, the need for which is identified in accordance with Regulation .07 of this Chapter" (State Health Plan p. 34). MHD plans to operate Track One beds, will not have a significant amount of revenue sponsored by any local jurisdictions (outside of the collaboration with and wishes of those jurisdictions to utilize MHD services for constituents) nor will it receive a significant amount of funding from state or federally sponsored third party payers. MHD sets forth detailed discussions and calculations in accordance with COMAR 10.24.14.07(B) that establish a clearly defined need for an additional 16 Track One ICF beds in the state of Maryland.

Standard .05B(1)(b) does not apply.

Standard .05B(2) does not apply.

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

MHD Financial Assistance Policy will provide financial assistance options to individuals who request such assistance and meet specified financial criteria guidelines: are uninsured; underinsured; or otherwise unable to pay for medically necessary care based on their individual financial situation. Financial assistance may also be extended when a review of a patient's individual financial circumstances has been conducted and documented. MHD retains the right in its sole discretion to determine a patient's ability to pay.

A patient must submit all requested financial information in order to verify income and eligibility for the program. Patients whose insurance program or policy denies coverage for services by their insurance company are not eligible for the financial assistance program. Coverage amounts will be calculated based on the Sliding Fee Schedule.

Admissions staff will be responsible for taking applications for financial assistance. Applications initiated by the patient will be tracked and eligibility determined as quickly as reasonably possible. A letter of final determination will be submitted to each patient that has formally requested financial assistance.

Patients may be required to submit these documents:

*A copy of their most recent federal tax return;
*A copy of their most recent pay stub or other evidence of income;
*A copy of their eligibility statement for Social Security Income or Disability Income benefits;
*If unemployed, a copy of their annual earnings history available at the SSA website;
*Other reasonable financial information as requested by the financial team at MHD

MHD approves utilization of the following sliding fee schedule that represents discount percentages:

If Patient's income level is	< 100% of Federal Poverty Level (FPL)	75% discount
If Patient's income level is	< 150% but > 100% of FPL	50% discount
If patient's income level is	< 200% but > 150% of FPL	25% discount

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

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

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

Answered above in .05C.

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

This standard does not apply. MHD is not applying for adolescent beds.

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

MHD is requesting a small variance in the requirement that 15% of bed days be apportioned to a gray area and/or indigent population. Operationally, MHD will commit a special procedure to reserve 2 out of its 16 beds at all times specifically for indigent and gray area populations. This translates into a 12.5% dedication of total bed days to charity care. In reality, MHD expects that the total portion of bed days committed to actual care of these patients will reach 15% or higher annually. In order to successfully operate a procedure in which beds are dedicated for a special use, MHD must dedicate whole beds. It cannot dedicate a percentage of a bed to attempt to meet this standard.

In order to guarantee the provision of 2 beds to charity care, MHD will identify an open bed, which will subsequently be placed on a 24-hour hold for an individual meeting criteria for this specific population. At all times, the total number of these beds identified, held, and/or occupied will be equal to 2. During this holding period, MHD will accept indigent and gray area patients into these beds. The date and time of the vacated bed will be captured for tracking. At any time, when a discharge occurs, that open bed will be listed on the 24-hour reserve hold unless the 2-bed charity provision is being met with current patients. When the bed remains unoccupied for a complete 25 hours following the commencement of a 24-hour hold reserve, the hold reserve will be released and it will be available to the next potential admission.

Operationally, MHD finds that dedicating 2 beds full time to indigent and gray area patients is the only way to guarantee that it meets this requirement. The physical location of these beds within the facility will flex, as bed placement procedures are based on medical necessities like acuity, physical disabilities, and patient interaction with staff and patient population. At all times, 2 beds within the facility will be used to treat this population in this manner. MHD cannot commit a portion or percentage of a bed to this operation and it is unrealistic to present to the Commission that it can operationally do so. In contrast, if MHD were to dedicate a third bed to this population, the amount of charity care provided would be 18.75%, well above the required amount.

While MHD will operate 16 detox beds, these 16 beds will serve many more unique patients per month than a detox bed that is connected to a treatment program. At an average length of stay of 6 days, a single bed will be able to admit 5 patients per month. This means that MHD will be able to admit at least 80 unique patients per month (shorter lengths of stay would result in an increase in unique admissions). Translated to charity care, MHD's 2-bed provision will result in admitting 10 unique indigent/gray area patients into detox per month and 120 per year. These 120 patients will be stabilized and referred into the treatment system, whereas without this admission, the possibility exists that they would not have otherwise entered the treatment system.

MHD would not be the only provider with an exception to the charity care provision. In 2013, the Commission approved Father Martin Ashley's 15-bed expansion to 100 beds operate with a 6.3% provision for charity care. Because FMA operates its detox beds within the auspices of its long term residential treatment program, each one of its detox beds is also considered a bed for lower levels of care – and each bed flexes as such. Accordingly, these beds are not cycled as detox beds as frequently as MHD beds are because they are also utilized for longer-term treatment. In FMA's Interested Party response to Recovery Centers of America's Earleville CON Application, FMA's Medical Director, Dr. Bernadette Soloniuos states that FMA does not limit how many patients it can treat for withdrawal at a time – meaning that all 100 beds are used for detox and the subsequent lower levels of care. With 100 beds and an average length of stay of 28-30 days, FMA admits approximately 100 unique patients per month. A 6.3% provision for charity care equates to 6-7 indigent or gray area patients per month and 72-80 per year. MHD is able to commit a larger percentage of patient days translating into larger number of unique patient admissions than a provision that has previously been approved by the Commission.

Additionally, because it is MHD's practice to only discharge patients that are medically stable and have the ability to successful engage in a lower level of treatment, natural variances in Length of Stay for the patients being treated in charity care beds will exist. MHD expects that these variances will result in longer average length of stays for charity care patients. These longer lengths of stay will result in a greater total portion of bed days being attributed to indigent and gray area patients annually.

MHD has taken steps to secure its ability to meet its commitment of at least 12.5% charity care. It has conducted meetings with local health agencies and providers in Anne Arundel County and

the larger Central Maryland Planning Region and has secured referral agreements to accept indigent and gray area patients for admission. These agreements are provided in Exhibit 6 and include the Emergency Department at Baltimore Washington Medical Center and the Anne Arundel County Mental Health Agency, which operates the warm Crisis Line for the county. MHD expects that these referral partners alone have the ability to satisfy the charity care provision.

Of the 2 beds proposed to dedicate, MHD has expressed interest to local agencies that 1 of these beds has the ability to be reserved specifically for Anne Arundel County residents. This commitment, in no way, should alter or have impact upon any prior commitments or contracts that the agencies may have with existing treatment providers to provide reimbursement for indigent patients. MHD's desire is to support the current framework of local agencies, medical professionals, and substance abuse treatment providers.

It is our firm intent to offer services to the financially vulnerable patient. This population will not be segregated or isolated in any form or fashion from the comprehensive array of medical, clinical and referral services offered to the insured or self-pay population at MHD.

*The assumed ALOS stated throughout this application is substantiated by DBHG's experience in operating detox beds in its existing facilities. This operational ALOS experienced by DBHG in other states is confirmed for level III.7.D in the Outlooks and Outcomes Reports produced by the Maryland BHA for every year it was reported from 2009-2014.

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

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

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

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

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

Standards .05D(2-4) do not apply. MHD is applying as a new Track One facility.

.05E. Information Regarding Charges. An applicant must agree to post information concerning charges for services, and the range and types of services provided, in a conspicuous place, and must document that this information is available to the public upon request.

MHD will post informative document regarding the statement of charges, it's range and types of services it will provide. This will be posted in an area that is conspicuous and available for ease of visual access.

.05F. Location. An applicant seeking to establish a new intermediate care facility must propose a location within a 30-minute one-way travel time by automobile to an acute care hospital.

Maryland House Detox is located approximately 12 miles from Baltimore Washington Medical Center. BWMC is also is the proposed location to access emergent care services; specialty provider services and acute inpatient care for emergent or exacerbating co-morbidities rendering the patient condition as unstable. Referral agreements have been executed in this matter and are contained in Exhibit 5.

.05G. Age Groups.

(1) An applicant must identify the number of adolescent and adult beds for which it is applying, and document age-specific treatment protocols for adolescents ages 12-17 and adults ages 18 and older.

MHD is applying for adult beds only. Age specific treatment protocols will be contained within the Policies and Procedures Manual. The manual will be approved by JCAHO and the BHA prior to licensure. These policies are located in Exhibit 8.

(2) If the applicant is proposing both adolescent and adult beds, it must document that it will provide a separate physical, therapeutic, and educational environment consistent with the treatment needs of each age group including, for adolescents, providing for continuation of formal education.

This Standard does not apply. MHD is proposing only Adult beds.

(3) A facility proposing to convert existing adolescent intermediate care substance abuse treatment beds to adult beds, or to convert existing adult beds to adolescent beds, must obtain a Certificate of Need.

This Standard does not apply. MHD is applying as a new facility.

.05H. Quality Assurance.

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

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

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

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

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

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

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

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

Upon CON approval and completion of construction, MHD will apply for state licensure and accreditation through The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and the Maryland Behavioral Health Administration (BHA). According to COMAR 10.63.01.02, licenses “may be issued or received only if the provider is accredited by an approved accreditation organization” beginning for all new programs December 1, 2015. In

addition, MHD will be certified by the Office of Health Care Quality before it begins operation and will maintain that certifications as a condition of continuing authority to operate an ICF for substance abuse treatment in Maryland.

.05I. Utilization Review and Control Programs.

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

MHD will vigorously participate in utilization review practices and control programs, will implement treatment protocols, and have written policies governing admission, length of stay, discharge planning and referral. These policies are developed in coordination with the best practices developed and published by JCAHO and SAMHSA. They are contained within the Policies and Procedures Manual, which will be approved by JCAHO and the BHA prior to licensure.

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

MHD will document that each patient's treatment plan contains referral provisions identified for at least one year of aftercare following discharge from MHD facility. To further implement continuity of care oversight, MHD will provide follow up survey calls at 90, 180 and 365 days to determine status of sobriety, recovery and continued engagement in follow up substance abuse aftercare treatment. These policies are contained within the Policies and Procedures Manual, which will be approved by JCAHO and the BHA prior to licensure. These policies are located in Exhibit 8.

.05J. Transfer and Referral Agreements.

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

Transfers and referrals represent one of the most critical functions of MHD. MHD has identified and secured referral partners located within the Central Maryland Planning Region. The collection of these partners represents the lower levels of care available and has representation from each of the counties in the central region. The referral agreements listed in Exhibit 5 represent only pre-approval and pre-licensure partners for MHD. MHD plans to extend its working referral relationships with every level of care in every county in the state (when applicable) to achieve its mission.

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

(a) Acute care hospitals;

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

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

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

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

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

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

Refer to Exhibit 5 for executed referral agreements. Below are explanations of each.

(a) Acute care hospitals
   - **i. Baltimore Washington Medical Center** (emergency medical and psychiatric care)

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

   - i. **Maryland Recovery Partners** (PHP, IOP, OP, Halfway Housing, Long-Term Care)
   - ii. **Tranquility Woods** (RES, PHP, IOP, OP)
   - iii. **Congruent Counseling** (IOP, OP, Mental Health, Individual, Family, Medication Management, Psychiatry)
   - iv. **Bergand Group** (IOP, OP, Mental Health, Individual, Family, Medication Management, Psychiatry)
   - v. **New Life Addiction** (IOP)
   - vi. **Hope House** (RES, PHP, IOP, OP)
   - vii. **Harbor of Grace** (RES, PHP, IOP, OP, Individual)
   - viii. **Epoch Counseling Center** (IOP, OP)

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

   - i. **Baltimore Washington Medical Center** (Inpatient Psychiatry)
   - ii. **Congruent Counseling** (Psychiatry)

iii. **Bergand Group** (Psychiatry)

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

i. **Anne Arundel County Health Department**
*MHD has conducted meetings with AACHD and has discussed plans to work with the agency regarding referrals to and from MHD. In lieu of a referral agreement, a letter of support has been furnished. *

ii. **Anne Arundel County Mental Health Agency**
MHD has conducted meetings with AACMHA and has discussed plans to work with the agency regarding referrals to and from MHD. In lieu of a referral agreement, a letter of support has been furnished.

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

Once approved by MHCC for CON, MHD will apply with the Maryland Behavioral Health Administration for licensure. At this time, MHD will request letters of acknowledgement with the agency. As a new project yet to be approved by MHCC, referral agreements with this agency do not exist at this time

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

i. **Anne Arundel County Health Department**
MHD has conducted meetings with AACHD and has discussed plans to work with the agency regarding referrals to and from MHD. In lieu of a referral agreement, a letter of support has been furnished.

ii. **Anne Arundel County Mental Health Agency**
MHD has conducted meetings with AACMHA and has discussed plans to work with the agency regarding referrals to and from MHD. In lieu of a referral agreement, a letter of support has been furnished.

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

This standard does not apply, as MHD is not applying to serve adolescents.

.05K. Sources of Referral.

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

This standard does not apply. MHD is seeking to establish a new Track One facility.

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

The referral agreements located in Exhibit 6 represent pre-approval and pre-licensure agreements with the local agencies and health care providers that have the ability to refer a number of indigent and gray area patients. MHD has secured 7 such agreements that represent the ability of these providers to refer more than sufficient numbers of patients to satisfy this provision.

A goal for MHD is to engage with its local communities and to become a fundamental piece of the healthcare landscape. These agreements represent two commonplace services for indigent and private patients seeking detox – a hospital emergency room and a crisis phone line. The ability of MHD to accept indigent referrals from these organizations will also help to alleviate their burden of non-viable referrals for detox.

Existing treatment providers have also entered into agreements with MHD to refer indigent and gray area patients. These providers receive daily inquiries from this population regarding access to treatment services.

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

MHD will ensure that the mission of the organization is met by providing appropriately qualified staff to deliver services to patients and by ensuring that ongoing education and training needs are identified and provided. MHD will manage the ongoing educational and training needs specific to various roles, positions and tasks to assure the highest level of competence and compliance with all federal, state licensure and certification level requirements are maintained. Auxiliary training across complementary disciplines will grant greater flexibility in patient service provision. These policies are contained within the Policies and Procedures Manual, which will be approved by JCAHO and the BHA prior to licensure. These policies are located in Exhibit 8.

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

MHD will implement appropriate admission standards, treatment protocols, staffing standards and physical plant configuration. The policies are in accord with ASAM Patient Placement Criteria and promote compliance to JCAHO guidelines and National Patient Safety Goals and industry standards. Federal and state level regulations are followed, in particular respect to patient care and staffing requirements. MHD will adhere to the regulations of COMAR 10.47.02.10(F). These policies are contained within the Policies and Procedures Manual, which will be approved by JCAHO and the BHA prior to licensure. These policies are located in Exhibit 8.

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

MHD executive medical staff has garnered 30 years of expertise in this area through direct nursing and case management experience. Staff will be trained in the treatment, care and management of individuals effected by all Communicable Diseases. The Infection Control Policy will identify training for all staff that includes appropriate methods of infection control, universal precautions and any special environmental considerations for HIV+ persons and those living with AIDS. All MHD staff will be trained on MHD Infection Control Policy upon hire and annually thereafter. These policies are contained within the Policies and Procedures Manual, which will be approved by JCAHO and the BHA prior to licensure. These policies are located in Exhibit 8.

.05O. Outpatient Alcohol & Drug Abuse Programs.

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

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

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

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

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

Standards .05O (1-4) do not apply to MHD as it will provide only inpatient level of care.

Standard .05O (5) does apply. MHD has obtained and will continue to obtain additional referral agreements that include providers at every level of treatment in the Central Maryland Planning Region and across the state. These providers meet the requirements of (1) through (4) of this standard. As evidenced by the referral agreements in Exhibit 5, MHD has demonstrated not only that outpatient programs are available to its patients, but also that these outpatient programs will accept its patients for care. Discharge policies are contained within the Policies and Procedures Manual, which will be approved by JCAHO and the BHA prior to licensure. These policies are located in Exhibit 8.

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

MHD will collect its own aggregate utilization data and other required information of the Alcohol and Drug Abuse Administration (now Behavioral Health Administration). Effective January 1, 2015 data reporting by substance-related disorder treatment programs was directed away from SAMIS to an Administrative Service Organization. In the state's case, this organization is Beacon Health Options (Value Options). The organization administers an Outcome Measuring System that only requires participation from publically funded programs. In an effort to share valuable data with the state and to evaluate its own effectiveness, MHD will participate in comparable data collection programs developed internally and as specified by the Department of Health and Mental Hygiene (BHA). A more detailed discussion of data reporting is found in the Need Analysis following this section.

10.24.01.08G(3)(b). Need.

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

INSTRUCTIONS: Please discuss the need of the population served or to be served by the Project.

Responses should include a quantitative analysis that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. If the relevant chapter of the State Health Plan includes a need standard or need projection methodology, please reference/address it in your response. For applications proposing to address the need of special population groups, please specifically identify those populations that are underserved and describe how this Project will address their needs.

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

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

Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) "is working to build a behavioral health system that enables Americans to find effective treatments and services in their communities for mental and/or substance use disorders" (SAMHSA). SAMSHA admits, "while effective treatments exist, far too few people with behavioral health conditions receive the help they need" (SAMHSA). Maryland House Detox plans to fit into the current landscape of treatment offered in Maryland – not by replacing or competing with current providers, but by working within the system by providing a vital addition to the framework. SAMHSA indicates that "individual paths to recovery differ, and packages of treatments and supportive services for mental and substance use disorders should be tailored to fit individual needs" (SAMHSA). As a supplement to what is currently available in Maryland, and an alternative to the status quo, MHD will serve as a direct avenue for affected individuals to enter the larger treatment system by individualizing "warm hand-offs" to the most appropriate levels and care settings.

By examining the State Health Plan's methodology to determine ICF Track One bed need and applying a thorough real-world assessment of the current bed inventory,

Maryland House Detox will illustrate a deficiency in the number of required beds in the Central Maryland Planning Region and across the state. In its incorporation of guidelines for best practices in substance abuse treatment and experience in the treatment landscape, MHD will advance and diversify the alcohol and drug abuse treatment system across the entire state.

Studies show that "detoxification and its linkage to the appropriate levels of treatment lead to increased recovery and decreased use of detoxification and treatment services in the future. In addition, recovery leads to reductions in crime, general healthcare costs, and expensive acute medical and surgical treatments consequent to untreated substance abuse" (TIP 45 p. 8). A resounding need for treatment in Maryland lies within the detox level of care. Detoxification is a modality proven to increase access to substance abuse treatment services, contribute to the delivery of care, and subsequently reduce costs to society.

The provision of an in-house continuum of care – with treatment progressing through several consecutive levels of care – has been regarded as an optimal setting or ideal treatment approach to follow. The "ideal treatment approach" has become so deeply ingrained and access to care so standardized, that the treatment community at large may have lost the ability to be flexible to meet patients' individual needs and/or unique life obligations. History has shown that when reliable, tried and true methods fall short, innovation and adaptation is necessary. The onus falls on the healthcare community to recognize that many of today's substance users have unique requirements that often fall outside of what is made available for the greater good.

Local state agencies, healthcare providers, and treatment providers alike support the development of an alternative approach to entry into the treatment system. MHD is supported by a selection of all of these stakeholders, as evidenced by the attestations in the form of referral agreements and letters of support found in the exhibits and discussions later in this application. The documents assist in confirming the nature of the healthcare and treatment system in Maryland today.

The current state of emergency related to heroin, opiate, and other substance use in the state has contributed to a 60% increase in alcohol and drug intoxication deaths since 2010, and a remarkable 21% increase over the number of deaths in 2013, according to the 2014 annual Drug and Alcohol-Related Intoxication Deaths in Maryland released by the Maryland Department of Health and Mental Hygiene in May 2015 (p. 5). Updated reports for Q3 2015 show that intoxication deaths across the state will increase again for the 2015 year, with both heroin and prescription opioid related death rates continuing to increase over 2014. Inaction to comprehensively identify and implement additional healthcare options would only serve to exacerbate these startling numbers and further contribute to the devastation endured by the residents of our state.

State Health Plan

In 2002, The Maryland Health Care Commission developed the State Plan for Facilities and Services: Alcohol and Drug Abuse Intermediate Care Facility Treatment Services to replace COMAR 10.24.14. This chapter was prepared in order to plan for the establishment of an integrated system of care that assures geographic and financial access to a range of quality health care services at a reasonable cost for all residents. The Commission views the State Health Plan, of which this Chapter is a part, as a policy

blueprint for shaping and reshaping the health care system toward these ends through the action of public agencies and the cooperation of the private sector. MHCC designed the planning and review process for individual Certificate of Need decisions to **"**carefully weigh issues of access to services against the cost of those services to society**"** (State Health Plan, p. 1).

In developing this chapter for State Health plan, "The Commission undertakes an active role in proposing needed changes in the system, including the reallocation of resources to achieve a health care system that is cost-effective, and that balances considerations of affordability, access, and quality" (p. 1).

The State Health Plan establishes two very clear purposes:

> (1) It establishes health care policy to guide the Commission's policies and those of other health-related public agencies, and to foster specific actions in the private sector. Activities of state agencies must, by law, be consistent with the Plan.
>
> (2) It is the legal foundation for the Commission's decisions in its regulatory programs. These programs ensure that appropriate changes in service capacity are encouraged, and that all major expenditures for health care facilities are needed and consistent with the Commission's policies. The State Health Plan, therefore, contains policies, standards, and service-specific need projection methodologies that the Commission uses in making Certificate of Need decisions.

It is important for MHD to highlight the plan's policy directives to "foster specific actions in the private sector" and "ensure that appropriate changes in service capacity are encouraged." MHD will demonstrate that its approval is consistent with the policies created in state health plan – policies that are designed to create an ideal healthcare system.

In developing the guidelines for the planning of alcohol and drug abuse treatment services, MHCC identified five issue areas and developed policies designed to address each broad issue. The categories for consideration are: access to care, funding, quality, data collections, and continuum of care (State Health Plan, p. 6). Maryland House Detox will address each of these issues with its own unique solutions – all while adhering to the applicable laws and policies set forth by the State Health Plan and MHCC. The issues raised by MHCC should be considered as part of the overall goal of balancing access to services with the cost of those services to society.

Access to Care

The State Health Plan designates COMAR Chapter 10.24.14.07 as the mechanism for determining ICF Track One bed need in the state of Maryland. Because MHD is located in Anne Arundel County, it falls under the Central Maryland Planning Region (which encompasses Baltimore City, Baltimore County, Harford County, Howard County, and Anne Arundel County). MHCC calculated the ICF bed need in 2002 when this chapter was adopted, but the population data used for those calculations has significantly changed. New calculations for bed need had not been made since this chapter was adopted in 2002.

Due to recent interest in determining accurate bed need projections across the state, MHCC recalculated the numbers for each planning region in August 2015. MHD uses these updated calculations to illustrate a need for additional beds in the central planning region and a need across the state. Tables 1- 5 included in this section use 2015 as the base year and project bed need for the next 5 years to 2020. The quantitative analysis included in this section follows the State Health Plan's methodology in determining service area, population size, characteristics, and projected growth.

It is of particular importance to call attention to MHD's calculation of the current bed inventory, as an adjustment has been made to MHCC's count. MHD utilizes data gathered directly from the state's Behavioral Health Administration and combines it with industry knowledge to deliver an accurate depiction of the current Track One ICF beds. From the BHA Treatment Locator, the following facilities are licensed at the III.7.D level of care, which determines their status as ICF beds.

Facility	**Track**
Hope House Treatment Center	Track Two
Pathways	Track One
Baltimore Crisis Response Inc.	Track Two
I'm Still Standing By Grace	Track Two
Mountain Manor Treatment Center	Track Two
Tuerk House	Track Two
The Shoemaker Center	Track Two
Warwick Manor Behavioral Health	Track One
Father Martin's Ashley	Track One
Kent County Behavioral Health/AF Whitsett Center	Track Two
Adventist Behavioral Health	Track Two
Avery Road Treatment Center	Track Two
Anchor of Walden	Track Two
Hudson Health Services	Track Two

Of these facilities, only Father Martin's Ashley, Pathways, and Warwick Manor can be considered Track One. The updated bed need calculations performed by MHCC in August 2015 account for only 100 Track One ICF beds in the Central Maryland Planning Region. The 100 beds accounted only for Father Martin's Ashley. MHD increased the inventory from 100 to 132 to account for Pathways' 32 beds. These changes are reflected and highlighted in the following tables (Tables 1-6).

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

	Base Year 2015	MHCC Projected 2020
Projected Population for 18 years and older – Projected 2020[(1)]	2,010,055	2,078,614
Indigent Population- Central Maryland[(2)]	236,802	243,385
(a) **Non-Indigent Population**	1,773,253	1,835,229
(b) **Estimated Number of Substance Abusers (a*8.64%[(3)])**	153,209	158,564
(c1) **Estimated Annual Target Population (b*25%)**	38,302	39,641
(c2) **Estimated Number Requiring Treatment (c1*95%)**	36,387	37,659
(d) **Estimated Population requiring ICF/CD (12.5%-15%)**		
(d1) Minimum (c2*0.125)	4,548	4,707
(d2) Maximum (c2*0.15)	5,458	5,649
(e) **Estimated Range requiring Readmission (10%)**		
(e1) Minimum (d1*0.1)	455	471
(e2) Maximum (d2*0.1)	546	565
Total Discharges from out-of-state	251	262
(f) Range of Adults **Requiring ICF/CD Care**		
Minimum (d1+e1+out of state)	5,254	5,440
Maximum (d2+e2+out of state)	6,255	6,476
(g) **Gross Number of Adult ICF Beds Needed**		
(g1) Minimum = ((f*14 ALOS)/365)/0.85	237	245
(g2) Maximum = ((f*14 ALOS)/365)/0.85	282	292
(h) **Existing Track One Inventory ICF/CD beds[(4)]**	132	132
(**i) Net Private ICF/CD Bed Need**		
Minimum (g1-h)	137	145
Maximum (g2-h)	182	192

Source:

(1) MHCC projections –population interpolation from Maryland Department of Planning Total Population Projections for Non-Hispanic White and All Other by Age, Sex and Race (7/8/14).

(2) Medicaid Enrollment of Maryland residents grouped in ages 12 through 17 and ages 18 and older by Maryland counties. The data of enrollees is as of July 31, 2015, DHMH Decision Support System.

(3) The prevalence rate for alcohol or Illicit drug dependence or abuse is 8.31% according to the 2013 SAMHSA Maryland report. http://www.samhsa.gov/data/sites/default/files/NSDUHsaeSpecificStates2013/NSDUHsaeMaryland2013.pdf

(4) Medically Monitored Intensive Inpatient & Detox Facilities (non-forensic) as of 5/8/15, Behavioral Health Administration, DHMH.

Table 2: Projected Bed Need for Alcoholism and Drug Abuse ICF Beds in Eastern Shore Serving Adults (18 years and older)

	Base Year 2015	MHCC Projected 2020
Projected Population for 18 years and older – Projected 2020[(1)]	364,013	386,194
Indigent Population- Eastern Shore[(2)]	47,647	50,504
(a) **Non-Indigent Population**	316,366	335,690
(b) **Estimated Number of Substance Abusers (a*8.64%**[(3)]**)**	27,334	29,004
(c1) **Estimated Annual Target Population (b*25%)**	6,834	7,251
(c2) **Estimated Number Requiring Treatment (c1*95%)**	6,492	6,888
(d) **Estimated Population requiring ICF/CD (12.5%-15%)**		
(d1) Minimum (c2*0.125)	811	861
(d2) Maximum (c2*0.15)	974	1,033
(e) **Estimated Range requiring Readmission (10%)**		
(e1) Minimum (d1*0.1)	81	86
(e2) Maximum (d2*0.1)	97	103
Total Discharges from out-of-state	0	0
(f) Range of Adults **Requiring ICF/CD Care**		
Minimum (d1+e1+out of state)	893	947
Maximum (d2+e2+out of state)	1,071	1,137
(g) **Gross Number of Adult ICF Beds Needed**		
(g1) Minimum = ((f*14 ALOS)/365)/0.85	40	43
(g2) Maximum = ((f*14 ALOS)/365)/0.85	48	51
(h) **Existing Track One Inventory ICF/CD beds**[(4)]	25	25
(**i) Net Private ICF/CD Bed Need**		
Minimum (g1-h)	15	18
Maximum (g2-h)	23	26

Source:

(1) MHCC projections –population interpolation from Maryland Department of Planning Total Population Projections for Non-Hispanic White and All Other by Age, Sex and Race (7/8/14).

(2) Medicaid Enrollment of Maryland residents grouped in ages 12 through 17 and ages 18 and older by Maryland counties. The data of enrollees is as of July 31, 2015, DHMH Decision Support System.

(3) The prevalence rate for alcohol or Illicit drug dependence or abuse is 8.31% according to the 2013 SAMHSA Maryland report. http://www.samhsa.gov/data/sites/default/files/NSDUHsaeSpecificStates2013/NSDUHsaeMaryland2013.pdf

(4) Medically Monitored Intensive Inpatient & Detox Facilities (non-forensic) as of 5/8/15, Behavioral Health Administration, DHMH.

Table 3: Projected Bed Need for Alcoholism and Drug Abuse ICF Beds in Southern Maryland
Serving Adults (18 years and older)

	Base Year 2015	MHCC Projected 2020
Projected Population for 18 years and older – Projected 2020[1]	969,255	1,015,278
Indigent Population- Southern Maryland[2]	95,855	100,316
(a) **Non-Indigent Population**	873,400	914,962
(b) **Estimated Number of Substance Abusers (a*8.64%[3])**	75,462	79,053
(c1) **Estimated Annual Target Population (b*25%)**	18,865	19,763
(c2) **Estimated Number Requiring Treatment (c1*95%)**	17,922	18,775
(d) **Estimated Population requiring ICF/CD (12.5%-15%)**		
(d1) Minimum (c2*0.125)	2,240	2,347
(d2) Maximum (c2*0.15)	2,688	2,816
(e) **Estimated Range requiring Readmission (10%)**		
(e1) Minimum (d1*0.1)	224	235
(e2) Maximum (d2*0.1)	269	282
Total Discharges from out-of-state	0	0
(f) Range of Adults **Requiring ICF/CD Care**		
Minimum (d1+e1+out of state)	2,464	2,582
Maximum (d2+e2+out of state)	2,957	3,098
(g) **Gross Number of Adult ICF Beds Needed**		
(g1) Minimum = ((f*14 ALOS)/365)/0.85	111	116
(g2) Maximum = ((f*14 ALOS)/365)/0.85	133	140
(h) **Existing Track One Inventory ICF/CD beds[4]**	0	0
(**i) Net Private ICF/CD Bed Need**		
Minimum (g1-h)	111	116
Maximum (g2-h)	133	140

Source:

(1) MHCC projections –population interpolation from Maryland Department of Planning Total Population Projections for Non-Hispanic White and All Other by Age, Sex and Race (7/8/14).

(2) Medicaid Enrollment of Maryland residents grouped in ages 12 through 17 and ages 18 and older by Maryland counties. The data of enrollees is as of July 31, 2015, DHMH Decision Support System.

(3) The prevalence rate for alcohol or Illicit drug dependence or abuse is 8.31% according to the 2013 SAMHSA Maryland report. http://www.samhsa.gov/data/sites/default/files/NSDUHsaeSpecificStates2013/NSDUHsaeMaryland2013.pdf

(4) Medically Monitored Intensive Inpatient & Detox Facilities (non-forensic) as of 5/8/15, Behavioral Health Administration, DHMH.

Table 4: Projected Bed Need for Alcoholism and Drug Abuse ICF Beds in Western Maryland
Serving Adults (18 years and older)

	Base Year 2015	MHCC Projected 2020
Projected Population for 18 years and older – Projected 2020[1]	522,968	558,263
Indigent Population- Western Maryland[2]	48,597	51,538
(a) **Non-Indigent Population**	474,371	506,724
(b) **Estimated Number of Substance Abusers (a*8.64%[3])**	40,986	43,781
(c1) **Estimated Annual Target Population (b*25%)**	10,246	10,945
(c2) **Estimated Number Requiring Treatment (c1*95%)**	9,734	10,398
(d) **Estimated Population requiring ICF/CD (12.5%-15%)**		
(d1) Minimum (c2*0.125)	1,217	1,300
(d2) Maximum (c2*0.15)	1,460	1,560
(e) **Estimated Range requiring Readmission (10%)**		
(e1) Minimum (d1*0.1)	122	130
(e2) Maximum (d2*0.1)	146	156
Total Discharges from out-of-state	0	0
(f) Range of Adults **Requiring ICF/CD Care**		
Minimum (d1+e1+out of state)	1,338	1,430
Maximum (d2+e2+out of state)	1,606	1,716
(g) **Gross Number of Adult ICF Beds Needed**		
(g1) Minimum = ((f*14 ALOS)/365)/0.85	60	65
(g2) Maximum = ((f*14 ALOS)/365)/0.85	72	77
(h) **Existing Track One Inventory ICF/CD beds[4]**	0	0
(**i) Net Private ICF/CD Bed Need**		
Minimum (g1-h)	60	65
Maximum (g2-h)	72	77

Source:

(1) MHCC projections –population interpolation from Maryland Department of Planning Total Population Projections for Non-Hispanic White and All Other by Age, Sex and Race (7/8/14).

(2) Medicaid Enrollment of Maryland residents grouped in ages 12 through 17 and ages 18 and older by Maryland counties. The data of enrollees is as of July 31, 2015, DHMH Decision Support System.

(3) The prevalence rate for alcohol or Illicit drug dependence or abuse is 8.31% according to the 2013 SAMHSA Maryland report. http://www.samhsa.gov/data/sites/default/files/NSDUHsaeSpecificStates2013/NSDUHsaeMaryland2013.pdf

(4) Medically Monitored Intensive Inpatient & Detox Facilities (non-forensic) as of 5/8/15, Behavioral Health Administration, DHMH.

Table 5: Projected Bed Need for Alcoholism and Drug Abuse ICF Beds in Montgomery County
Serving Adults (18 years and older)

	Base Year 2015	MHCC Projected 2020
Projected Population for 18 years and older – Projected 2020[1]	800,019	828,646
Indigent Population- Montgomery County[2]	56,040	58,045
(a) **Non-Indigent Population**	743,979	770,601
(b) **Estimated Number of Substance Abusers (a*8.64%[3])**	64,280	66,580
(c1) **Estimated Annual Target Population (b*25%)**	16,070	16,645
(c2) **Estimated Number Requiring Treatment (c1*95%)**	15,266	15,813
(d) **Estimated Population requiring ICF/CD (12.5%-15%)**		
(d1) Minimum (c2*0.125)	1,908	1,977
(d2) Maximum (c2*0.15)	2,290	2,372
(e) **Estimated Range requiring Readmission (10%)**		
(e1) Minimum (d1*0.1)	191	198
(e2) Maximum (d2*0.1)	229	237
Total Discharges from out-of-state	0	0
(f) Range of Adults **Requiring ICF/CD Care**		
Minimum (d1+e1+out of state)	2,099	2,174
Maximum (d2+e2+out of state)	2,519	2,609
(g) **Gross Number of Adult ICF Beds Needed**		
(g1) Minimum = ((f*14 ALOS)/365)/0.85	95	98
(g2) Maximum = ((f*14 ALOS)/365)/0.85	114	118
(h) **Existing Track One Inventory ICF/CD beds[4]**	0	0
(**i) Net Private ICF/CD Bed Need**		
Minimum (g1-h)	95	98
Maximum (g2-h)	114	118

Source:

(1) MHCC projections –population interpolation from Maryland Department of Planning Total Population Projections for Non-Hispanic White and All Other by Age, Sex and Race (7/8/14).

(2) Medicaid Enrollment of Maryland residents grouped in ages 12 through 17 and ages 18 and older by Maryland counties. The data of enrollees is as of July 31, 2015, DHMH Decision Support System.

(3) The prevalence rate for alcohol or Illicit drug dependence or abuse is 8.31% according to the 2013 SAMHSA Maryland report. http://www.samhsa.gov/data/sites/default/files/NSDUHsaeSpecificStates2013/NSDUHsaeMaryland2013.pdf

(4) Medically Monitored Intensive Inpatient & Detox Facilities (non-forensic) as of 5/8/15, Behavioral Health Administration, DHMH.

The inventory of ICF beds in the central region currently does fall within the minimum required by the State Health Plan. For the base year 2015, the Health Plan requires that, at a minimum, there are 137, and a maximum, there are 182 track one beds. For the projected needs in 2020, the figures grow to a minimum of 145 and a maximum of 192. MHD plans to add 16 track one ICF beds. For the year 2015, the addition of MHD's beds will bring the total to 148, which is within minimum required, and 34 short of the maximum allowed. For the projected 2020 year, this remains 44 short of the maximum allowed. With the addition of MHD's 16 beds to the Central Maryland Region inventory, the inventory of beds will meet the state's minimum requirements while not exceeding the range or demand in the state (see Table 1 Summary below).

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

	Base Year 2015	MHCC Projected 2020	Addition of MHD Beds
(h) **Existing Track One Inventory ICF/CD beds**[4]	132	132	148
(i) Net Private ICF/CD Bed Need			
Minimum (g1-h)	137	145	137
Maximum (g2-h)	182	192	182

In considering the need for additional beds, it is important to note that while the current inventory is fairly close to the minimum required, it still falls short. Of equal or greater importance is fact that the entire inventory of beds in the region is located within 2 facilities – Father Martin's Ashley and Pathways. The range of adults requiring ICF/CD care for the year 2015 is between 5,254 and 6,255. This means that more than 5,000 to 6,000 affected individuals who qualify for admission into a track one bed are left with only 2 facilities to choose from in the region. The sheer number of individuals needing ICF care per year in 2 private facilities coupled with the logistics and costs associated with a 28-day length of stay can create strong barriers to entry into the treatment system.

In its approval of FMA's CON application in 2013, the Commission specifically noted that only 48% of FMA's admissions are procured from within the State of Maryland:

> In considering the need for the additional beds it is important to note that FMA services a multi-state area that extends well beyond the State of Maryland. For the fiscal year ending June 30, 2013 approximately 48 percent of FMA's patients originated in Maryland. The proportion of patients from the Central Maryland region was only 26% in FY 2012. Assuming the this patient origin pattern, it can be anticipated that, on average, seven of the 15 additional beds will serve Maryland residents, of which approximately four will serve residents of Central Maryland (FMA p. 22).

If these calculations are taken within the context of the entire 100 licensed beds, then the argument can be made that only 48 of FMA's beds can be counted towards the state totals, and only 26 of those beds can be counted towards the central region inventory. The SHP does not ask MHD to provide an analysis outside of the scope it set forth. Although MHD illustrates a need within the SHP's scope, it is significant to affirm the considerations made by MHCC in

approving FMA's CON request. These same considerations can be made when examining how the inventory of existing beds truly serves the residents of Maryland.

While MHD is located within the Central Maryland Planning Region, its location and treatment modality allow for easy access from across the entire state. MHD does not contend that the entire state should be considered as the means for which bed need is calculated for the project, as its case within the scope set forth by the State Health Plan illustrates a regional need for ICF beds. MHD would be remiss if it did not bring the calculations and real world implications from across the state of Maryland it considered during its planning process to the attention of the Commission.

Table 6 below summarizes need projections for the entire state of Maryland for the years of 2015 and 2020. Utilizing the same data and combining anecdotal knowledge of the treatment system, MHD has found a very startling deficiency in the number ICF track one beds across the state. The deficit of private ICF beds is so pronounced, that MHD is compelled to call attention it. The systematic lack of available III.7.D beds across the state requires the solutions that MHD offers be addressed.

Table 6: Projected Bed Need for Alcoholism and Drug Abuse ICF Beds in State of Maryland Serving Adults (18 years and older)

Central Maryland	**Base Year 2015**	**MHCC Projected 2020**
(f) Range of Adults **Requiring ICF/CD Care**		
Minimum (d1+e1+out of state)	5,254	5,440
Maximum (d2+e2+out of state)	6,255	6,476
(h) **Existing Track One Inventory ICF/CD beds**[4]	132	132
(i) Net Private ICF/CD Bed Need		
Minimum (g1-h)	137	145
Maximum (g2-h)	182	192
Eastern Shore	**Base Year 2015**	**MHCC Projected 2020**
(f) Range of Adults **Requiring ICF/CD Care**		
Minimum (d1+e1+out of state)	893	947
Maximum (d2+e2+out of state)	1,071	1,137
(h) Existing Track One Inventory ICF/CD beds(4)	25	25
(i) Net Private ICF/CD Bed Need		
Minimum (g1-h)	15	18
Maximum (g2-h)	23	26
Southern Maryland	**Base Year 2015**	**MHCC Projected 2020**
(f) Range of Adults **Requiring ICF/CD Care**		
Minimum (d1+e1+out of state)	2,464	2,582
Maximum (d2+e2+out of state)	2,957	3,098
(h) Existing Track One Inventory ICF/CD beds(4)	0	0
(i) Net Private ICF/CD Bed Need		
Minimum (g1-h)	111	116
Maximum (g2-h)	133	140
Western Maryland	**Base Year 2015**	**MHCC Projected 2020**
(f) Range of Adults **Requiring ICF/CD Care**		
Minimum (d1+e1+out of state)	1,338	1,430
Maximum (d2+e2+out of state)	1,606	1,716
(h) Existing Track One Inventory ICF/CD beds(4)	0	0
(i) Net Private ICF/CD Bed Need		
Minimum (g1-h)	60	65
Maximum (g2-h)	72	77
Montgomery County	**Base Year 2015**	**MHCC Projected 2020**
(f) Range of Adults **Requiring ICF/CD Care**		

Minimum (d1+e1+out of state)	2,099	2,174
Maximum (d2+e2+out of state)	2,519	2,609
(h) Existing Track One Inventory ICF/CD beds(4)	0	0
(i) Net Private ICF/CD Bed Need		
Minimum (g1-h)	95	98
Maximum (g2-h)	114	118
Total State	**Base Year 2015**	**MHCC Projected 2020**
(f) Range of Adults **Requiring ICF/CD Care**		
Minimum (d1+e1+out of state)	12,048	12,573
Maximum (d2+e2+out of state)	14,408	15,036
(h) Existing Track One Inventory ICF/CD beds(4)	157	157
(i) Net Private ICF/CD Bed Need		
Minimum (Sum of All Regions)	418	442
Maximum (Sum of All Regions)	524	553

For the base year of 2015, the current existing track one ICF bed inventory in the state is 157. This figure accounts for 3 facilities – Father Martin's Ashley, Pathways, and Warwick Manor. The current inventory does not meet the minimum required by the State Health Plan. For the base year 2015, the Health Plan requires that, at a minimum, there are 418, and a maximum, there are 524 track one beds. With the addition of MHD's 16 beds, this will bring the total to 173, which is still a resounding 245 beds short of the minimum beds required and 351 beds short of the maximum allowed by the SHP. For the projected needs in 2020, the minimum increases to 442 and the maximum to 553. In 2020, this is a remarkable 269 beds short of the minimum required, and 380 short of the maximum allowed. If MHCC approves MHD as well as the pending CON applications under review, the state will be able to comfortably add detox beds and consider additional options in the years to come.

Not only does a severe deficiency of track one beds exist at a state level, the entire inventory of Private ICF beds located in the state are contained within 3 facilities – Father Martin's Ashley, Pathways, and Warwick Manor. The range of adults requiring ICF/CD care for the year 2015 is between 12,048 and 14,408. More than 12,000 to 14,000 affected individuals who qualify for admission into a track one ICF bed are left with the limited choice of only 3 facilities in the state. This number grows to over 15,000 needing entry into detox the year 2020.

MHD applies evidence-based best practices in its treatment modalities and its philosophy as whole. Throughout this section, MHD will reference TIP 45 as a guide for industry-wide practices that are supported by evidence from national research conducted by SAMHSA. Treatment Improvement Protocols (TIPs) are developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention (TIP 45, p. vii). TIP 45 – Detoxification and Substance Abuse Treatment was most recently updated in 2015 to reflect the current position detox occupies in substance abuse treatment and to assist agencies and providers implement best practices in the delivery of care.

SAMHSA explicitly states, “there can be no wrong door to treatment” (TIP 45 p. 7). MHD will provide an alternative avenue to enter detox and continue through to the treatment system that is in place. If the current approach in the state is not improved upon - with only 3 track one options to enter detox - many individuals will continue to seek treatment outside of the state, seek treatment modalities that do adequately address acuity, or simply stop seeking treatment. The 2014 Annual Report Outlook and Outcomes produced by the Maryland Behavioral Health Administration reported that the average wait time to enter the III.7.D level detox across the state was 4.37 days (p. 27). This data represents the wait time for publically funded beds, as private providers are not required to report data to the state at this time. While there is no data reported from private providers, the SHP’s projected number of private patients needing to enter III.7.D (12,048) is more than double the number of public patients that entered the III.7.D level of care (4,972). HHS and SAMHSA recognize “the importance of detoxification as one component in the continuum of healthcare services for substance-related disorders. The TIP reinforces the urgent need for non-traditional settings to be prepared to participate in the process of getting the patient who is in need of detoxification services into treatment as quickly as possible” (TIP 45 p.p. xv-xvi).

Funding

The state health plan that governs the ICF approval process was written in 2002. In the decade precluding the writing of the health plan, due to “budget cuts and managed care, twelve private intermediate care facilities for addiction rehabilitation care were closed and several substance abuse programs were discontinued within hospitals” (State Health Plan p.10). In 1998, a Drug Treatment Task Force established by the General Assembly published a needs assessment for the State of Maryland. In it, the task force “identified scarce availability of several treatment modalities in each jurisdiction, including detoxification services” (State Health Plan p. 10). The health plan goes on to source this report as identifying 20 of 24 jurisdictions of specifically needing ICF detox facilities (State Health Plan p. 11).

One of the most profound pieces of evidence supporting the approval of MHD’s ICF beds is the fact that in the 14 years since this State Health Plan was adopted, there have been no new track one projects approved by the state. The absence of new projects conflicts with the State Health Plan’s Policy 2.0 that the “Commission will support efforts to significantly increase both public and private funding for drug and alcohol treatment to close the treatment gaps and to create an effective system of care” (State Health Plan p. 11). Not only have providers not replaced the private intermediate care facilities that closed, no new private facilities have opened to meet the growing demand.

Conversations with MHCC and anecdotal knowledge confirm that the only addition to track one ICF beds in the state since 2002 is the 15 beds granted to Father Martin’s Ashley in 2013. In fact, on September 19, 2013 during the MHCC hearing on the matter related to FMA’s CON application, Mr. Joel Riklin, the then Acting Chief of Certificate of Need remarked that it was “only the second application from an alcoholism and drug abuse treatment facility in the last 12 years and the only private application we’ve received in the past 12 years. The other application was from a state-run facility” (Official FMA Transcript, p. 4). MHD urges the Commission to consider these facts as a grave set of circumstances for the treatment delivery system in the state. Approval of MHD allows it to help close the treatment gaps and assist in bringing the state in line with the current demand for substance abuse services.

The healthcare and insurance industry’s great move towards organized and efficient healthcare has inevitably resulted in a reduction of substance abuse treatment services. In large part, this

shift occurred due to the national adoption and implementation of the managed care philosophies across third party payers. Mental health and substance abuse service benefits have been separately carved out. This has lead to the promotion of restrictive limits of both inpatient days and outpatient visits, with separate annual/lifetime caps of coverage. Complex authorization requirements made mental health benefits substantially less generous than those for physical health conditions.

One of the remedies the state health plan recommends to address the lack of treatment options is a very specific "operational and capital expansion of $300 million" of the drug and alcohol treatment system from both "public and private sources such as private health insurance" (State Health Plan p. 11). MHD plans to use private capital investment as its primary funding source and utilize private insurance carriers as its primary source of reimbursement and revenue. MHD is not seeking any assistance from public funding sources, and its short-term goals do not involve seeking reimbursement from Medical Assistance or Medicaid.

The medically monitored inpatient detoxification level of care is accepted by third party payers as an appropriate placement and is reimbursed as such. In fact, updated information in 2015 from TIP 45 reinforces that "third party payers sometimes prefer to manage payment for detoxification separately from other phases of addiction treatment, thus treating detoxification as if it occurred in isolation from addiction treatment. This "unbundling" of services has promoted the separation of all services into somewhat scattered segments" (TIP 45 p. 8). The model that MHD will operate is a self-sustaining model that is operational in other states like New Jersey, Georgia, and Florida.

Quality of Care

In the state health plan, MHCC admits that a "lack of understanding and skepticism about the effectiveness of treatment has been a barrier to its expansion" in the state of Maryland (p. 11). MHD agrees that this is yet another reason substance use treatment services are not readily available. The state health plan goes on to specifically state that in order "to attain higher standards of care, the alcohol and drug abuse treatment system must promote the development and application of new knowledge and treatment approaches as well as innovations that improve efficiency and responsiveness" (p. 11). As the first of its kind in the state as a new modality, improving efficiency and responsiveness is the essence of what MHD will do.

In regards to measuring quality of care for providers in the state, Policy 3.1 developed by MHCC in the State Health Plan establishes that:

> Each Maryland intermediate care facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or CARF The Rehabilitation Accreditation Commission or other accrediting body deemed appropriate by the Department of Health and Mental Hygiene and must also be certified by the Office of Health Care Quality of the Department of Health and Mental Hygiene. (p. 12)

The inclusion of this policy was designed to create a "move towards a one-tier system of care [and] uniformity among accreditation requirements" (p. 12). As a provider of medical level of care, MHD's plans have always included accreditation by JCAHO.

Although the state health plan was written 14 years ago, in a twist of fate, the recent integration of Maryland's BHA and DHMH has created new guidelines for licensure in the state for substance abuse treatment programs. According to COMAR 10.63.01.02, in order to establish

new licensing and accreditation requirements for an integrated behavioral heath system, licenses "may be issued or received only if the provider is accredited by an approved accreditation organization" beginning for all new programs December 1, 2015. Essentially, licensure to operate in the state is now a function of accreditation. Throughout its program and physical design stages, MHD has been in close contact with its assigned JCAHO behavioral health advisors and surveyors to ensure that from inception to licensure, delivery of care meets the highest standards and will receive accreditation and licensure. DBHG operates two facilities that are currently JCAHO accredited, while the remaining facilities are awaiting their site visits and accreditation.

JCAHO has accredited facilities with the exact design and delivery of care as MHD in other states. The following is only a small sampling of these facilities that are currently accredited by JCAHO:

Summit Behavioral Health – Summit, NJ
Sunrise Detox II – Stirling, NJ
Sunrise Detox Tom's River – Tom's River, NJ
Sunrise Detox Alpharetta – Alpharetta, GA
Sunrise Detox – Lake Worth, FL
The Haven Detox – West Palm Beach, FL
The Gardens Wellness Center – Miami, FL
Serenity House Detox – Fort Lauderdale, FL
Serenity House Detox – West Palm Beach, FL

As mentioned previously, SAMHSA publishes Treatment Improvement Protocols to encourage the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. In 2015, TIP 45 updated these guidelines for Detoxification. Its description of Medically Monitored Inpatient Detoxification reads: "Inpatient detoxification provides 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal. The treatment mission in this setting should be clearly focused and limited in scope. Primary emphasis should be placed on ensuring that the patient is medically stable (including the initiation and tapering of medications used for the treatment of substance use withdrawal); assessing for adequate bio-psychosocial stability, quickly intervening to establish this adequately; and facilitating effective linkage to and engagement in other appropriate inpatient and outpatient services" (TIP 45 p. 17). MHD is designed to evaluate, stabilize, and engage patients throughout the course of the withdrawal management period; and to connect patients with the most appropriate treatment services, as determined by their individual needs and ability to participate in treatment in a meaningful way.

It is significant to note that without proper management of the withdrawal process, individuals seeking treatment in any setting – either inpatient, residential, or outpatient – will face extreme hardships as they strive to engage in treatment in a meaningful way. With the current perception of inaccessibility, many individuals are faced with the reality that they may be forced to address the withdrawal process in an inadequate and often inappropriate setting. Furthermore, if an individual is not placed in the proper level of care based on patient placement criteria, the risk significantly increases for inadvertent medical instability, psychiatric crisis, and death. These risks can stem from a host of often-unreported medical conditions such as advanced dehydration, cardiac instability and history of seizures. The presence of objective findings in the physical assessment with visual observation of symptoms coupled with laboratory confirmations for detection of listed substances will assist in guiding the withdrawal management process. Ascertaining the current patho-physiological and bio-psychosocial status

further substantiates the basis for determining both appropriate interventions and level of treatment for patient placement.

The consensus clarified the broad detox process with three essential components that may take place concurrently or as a series of steps:

Evaluation entails testing for the presence of substances of abuse in the bloodstream, measuring their concentration, and screening for co-occurring mental and physical conditions. Evaluation also includes a comprehensive assessment of the patient's medical and psychological conditions and social situation to help determine the appropriate level of treatment following detoxification. Essentially, the evaluation serves as the basis for the initial substance abuse treatment plan once the patient has successfully.
Stabilization includes the medical and psychosocial processes of assisting the patient through acute intoxication and withdrawal to the attainment of a medically stable, fully supported, substance-free state. This often is done with the assistance of medications, though in some approaches to detoxification no medication is used. Stabilization includes familiarizing patients with what to expect in the treatment milieu and their role in treatment and recovery. During this time practitioners also seek the involvement of the patient's family, employers, and other significant people when appropriate and with release of confidentiality.
Fostering the patient's entry into substance abuse treatment involves preparing the patient by stressing the importance of following through with the complete substance abuse treatment continuum of care. For patients who demonstrate a pattern of completing the detoxification phase and then fail to engage in the subsequent substance abuse treatment, a written treatment contract may encourage entrance into the continuum of care. This contract, which is not legally binding, is signed by patients voluntarily, once stable. In it, the patient agrees to participate in a continuing care plan, with details and contacts established prior to the completion of detoxification.
All three components (evaluation, stabilization, and fostering a patient's entry into treatment) involve treating the patient with compassion and understanding. Patients undergoing detoxification need to know that someone cares about them, respects them as individuals, and has hope for their future. Actions taken during detoxification will demonstrate to the patient that the provider's recommendations can be trusted and followed. (TIP 45 pp. 4-5)

The Treatment Improvement Protocol for Detoxification differentiates between detoxification and the subsequent phase or level of treatment, recognizing the need to treat each as separate processes. "The Washington Circle Group (WCG), a body of experts organized to improve the quality and effectiveness of substance abuse prevention and treatment, defines detoxification as 'a medical intervention that manages an individual safely through the process of acute withdrawal'". The WCG makes an important distinction, however, in noting that "a detoxification program is not designed to resolve the long-standing psychological, social, and behavioral problems associated with alcohol and drug abuse". The SAMHSA consensus panel supports this statement and has taken special care to note that detoxification is not substance abuse

treatment and rehabilitation (TIP 45 pp. 4-5). Notably, for some patients it represents a point of first contact with the treatment system and the first step to recovery.

At the patient care and operations level, MHD will operate within the requirements of COMAR 10.47.02.10(F) in regards to staffing, provider licensure, and structure of programming and care. MHD will not only employ a full medical staff to manage patient care but in accordance with sub-section (3)(b) of this standard will employ two full time social workers with drug and alcohol counseling experience (or equivalent drug and alcohol counselors) to provide education and therapy as appropriate during patients' stays. In addition to the therapeutic and social staffing, MHD also plans to employ two full time case managers to facilitate warm hand-offs to providers in the treatment system. As the hallmark of MHD's modality is to stabilize and refer, it has committed to staffing the positions responsible for successful handoffs beyond what is required by code.

TIP 45 reinforces this course of action – "Many treatment programs have found substance abuse counselors to be of special help with resistant patients, especially for patients with severe underlying shame over the fact that their substance use is out of control" - even though "some reimbursement and utilization policies dictate that only 'detoxification' currently can be authorized, and 'detoxification' for that policy or insurer does not cover the nonmedical counseling that is an integral part of substance abuse treatment" (p. 8). Although it will not be reimbursed separately for these substance abuse counseling services, MHD has budgeted for and plans to deliver care in line with best practices.

Each patient admitted into MHD will be assigned a team comprised of a social worker or addictions counselor and a case manager. For 16 beds, MHD will employ 2 full time licensed social work or addictions counselors and 2 full time case managers to work in teams of one each. These teams will work through social and therapeutic models in conjunction with insurance utilization review and authorization to place patients into the highest possible level of care based on the likelihood of successful engagement upon discharge from MHD.

Exhibit 5 contains referral agreements that have been executed by treatment providers in anticipation of the approval of MHD. These referral agreements represent every lower level of care, including residential treatment, for providers located in every county in the Central Maryland Planning Region (and some extending outside of the region). They also represent the operational ability of MHD to complete warm handoffs to the lower levels of care. MHD has taken the steps to secure these providers as outgoing referral partners in its mission to increase access to detox services and facilitate treatment within the existing treatment system. The number of referral partners secured prior to approval speaks volumes about the recognition of the need of MHD to the treatment community. Once approved, the breadth and scope of these referral agreements will grow immediately to include partners in every county in the state to ensure that MHD will fulfill its mission.

MHD will provide a service environment with heightened emphasis on early identification of social crisis stabilization, occurring parallel and on day one, along with medical evaluation and stabilization with detoxification. MHD, through it's uniquely innovative, cutting edge treatment model will implement a highly personalized patient-driven recovery plan, an individualized flexible approach that will best serve to fit into patients' life circumstances.

Data Collection

The Commission rightfully recognized that data must be collected and analyzed in order make informed decisions on planning healthcare needs. When the Health Plan was written in 2002, the Alcohol and Drug Abuse Administration utilized an information management tool called SAMIS (Substance Abuse Management Information System). At the time, there was concern surrounding incomplete reporting throughout the treatment system. Treatment providers operate across many different settings and regulatory boards depending on levels of care offered, modality of treatment, and funding sources. These "gaps within the treatment system contribute to the difficulty of transferring patient-specific information from one system to another and of collecting comprehensive individual data" (SHP p. 13).

In an effort to centralize data reporting, the Commission developed Policy 4.0 which was designed to develop "a more comprehensive and integrated data collection and management system administered by the Alcohol and Drug Abuse Administration through the Substance Abuse Management Information System (SAMIS)." Following this policy, statewide efforts were made, as conditions of funding and licensure for alcohol and drug abuse treatment programs, to report on admission, discharges, length of stay in treatment, types and frequency of substances used at admission, patient demographic information, and social issues pertaining to employment, living conditions, and crime.

In 2007, ADAA adopted SMART (Statewide Maryland Automated Records Tracking) as the Management Information System to which programs were required to report data. All publically and privately funded programs were required to submit patient data monthly to this system. Unfortunately, because private facilities' ability to operate did not depend upon state funds, most facilities stopped reporting or reported incomplete data to this system. The 2009 and 2010 Outcomes and Outlook Report admits that there was erosion of reporting by programs that receive limited or no public dollars. The 2011 Annual Report is the first report to analyze data as only reported by state funded programs. The reports through 2014 continue this trend. Effective January 1, 2015 data reporting by substance-related disorder treatment programs to SAMIS/SMART was discontinued and directed to an Administrative Service Organization – in the state's case, this organization is Beacon Health Options (Value Options). This reporting system solely relies on entry from publically funded programs as well.

The current reporting system is an Outcome Measuring System that is designed to measure improvements in patients' substance use and health and social functionality during and after treatment. This system relies on self-reported data and is largely qualitative in nature. The areas targeted for measurement are:

- living situation;
- psychiatric symptoms;
- substance use;
- recovery and functioning;
- legal;
- employment;
- and general health;

The data from publically funded programs is largely intended to determine the effectiveness of treatment. Large portions of the treatment modalities that are measured are the lower levels of care that MHD intends to refer patients to.

While there are currently no requirements for privately funded providers to report data, MHD recognizes its' internal needs and the state's external need to evaluate quality and cost-benefit of specific types of care. The Commission developed Policy 4.1 in the State Health Plan "support[ing] efforts to require all public and private intermediate care facilities to report on a regular basis to SAMIS data required to support planning for services" (p. 13). Of particular importance to the Commission are:

- patient origin;
- payer source;
- readmissions,
- length of stay;
- and charge per admission.

Advances in Electronic Medical Records systems means that for MHD, the information that the Commission values will be automatically captured and measured. Standard admission information will include not only this data, but demographic, substance use, mental health, and treatment history data as well.

More recently in 2015, one the Heroin and Opioid Emergency Task Force Final Report recommendations is "Requiring and Publishing Performance Measures on Addiction Treatment Providers" (p.13). The Task Force identifies priority data targets as:

- Initiation and Engagement in Treatment
    - What percentages of patients who are given a SUD diagnosis actually begin treatment and remain in treatment.
- Treatment Completion Rates
    - There are variations in completion rates across providers that relate to the quality of care provided.
- Continuing Care Rates
    - The State can begin gathering data on the transition from withdrawal management to any treatment. The importance of this transition demands attention if withdrawal management is to have a useful role in the SUD continuum of care.

MHD believes that this type of data can be more useful to assess its mission and demonstrate its value. The rational behind creating MHD is overwhelming in many aspects – including its ability to transition patients from detox to treatment. The goal of MHD is to compliment the treatment system in Maryland by promoting entry into the range of available levels of care. In order to attain this goal, MHD plans to not only collect data on the patterns of its patients, but also evaluate its effectiveness at fostering successful entry and engagement in the larger treatment system.

In particular, MHD plans to track demographic, health, and referral information in line with Policy 4.1 of the Health Plan as well as the current OMS. MHD will collect data on:

- Initiation and Engagement in Treatment
    - Patients that voluntarily complete detox
- Treatment Completion Rates
    - Number of patients effectively detoxed
    - Number of days authorized by third party payers to complete detox

    - Difference in number of days authorized versus number of days needed to complete detox
- Continuing Care Rates
    - Number of patients successfully connected to lower levels of care
    - Number of patients connected to each of the lower levels of care
    - Patients successfully completing the subsequent level of care

By tracking this data, MHD will be able to make adjustments to its referral agreements and internal procedures to ensure that transitions result in continuously high rates of successful engagement in treatment. This data will be volunteered to the Commission and to BHA in order to help the state make decisions in creating an effective healthcare delivery system.

Continuum of Care

The State Health Plan was developed with intent and purpose as somewhat of a guide map for Maryland's future. It contains policy directives for adoption and creation of alternative approaches to meet the needs of the residents of this state. The same treatment gaps that existed in 2002 persist today. The Commission concedes that "there is limited capacity system-wide to provide treatment to addicted individuals. The development of additional intensive, rehabilitative, and other outpatient services may provide alternatives to families to receive care near their homes and assist family members in the process of recovering together from addiction" (p. 14). MHCC recognized the overwhelming need for the addition of services that offer alternatives within existing treatment providers and systems. The creation of MHD provides a new addition, an entry point for detoxification and access into the substance abuse treatment system (specifically outpatient) and directly satisfies the plan's needs.

For far too long, the state of our treatment system has been stagnant – as evidenced by the lack of CD CON applications discussed earlier. This stagnation has created a system in which the only way to enter medically monitored detox is through a long-term residential facility. The State Health Plan calls for "providers within the system [to] keep abreast of current trends, new and more effective treatments methods, and changing public priorities and policies" and encourages "public agencies and both public and private payers to monitor the development of the treatment system to assure that, as treatment modalities change, programs incorporate these changes" (p.14). Unfortunately for the residents of Maryland, there is no evidence of CON approvals for programs or providers planning to offer new treatment modalities, subsequent to when the SHP was written in 2002.

In fact, Policy 5.0 developed in the State Health Plan demands that "Each jurisdiction or region should have a balanced service system with increased capacity for intensive, rehabilitative and other kinds of outpatient and community based services, where needed." Approval of MHD would be a gesture towards satisfying this policy. MHD not only provides a new intensive treatment option, but also facilitates entry into community based services.

The Commission's findings further support the anecdotal evidence suggested by MHD regarding real-world access to care for affected individuals. The SHP agrees that in one form or another, "all acute general hospital emergency rooms provide substance abuse-related services" (p. 14). MHD contends that as a result of systemic inflexibility and deficient status of available ICF beds in the current treatment system, many out of desperation seek help and access to detox by going to the emergency rooms at hospitals, often overstating their need for help. The commission furthers MHD's argument that "due to intensified utilization review by third party payers, and the inability of many acutely addicted patients to pay for hospital care, there

are few hospitals that specialize in addiction care[3]" (p. 14). Because hospitals, by and large, are not being reimbursed for detox services, many of them have greatly reduced, downsized or eliminated addiction treatment services all together.

MHD has discussed its planned project with Emergency and Psychiatric leadership at Baltimore Washington Medical Center, which operates one of the state's busiest Emergency Departments. BWMC echoed the concerns expressed in the Health Plan and acknowledges that crisis substance use admissions to its Emergency Department represent an area of patient care that needs dire attention. Its experience reflects long wait lists with the current III.7.D providers, the social barriers previously discussed, and simply not enough options for individuals to enter detox. BWMC has indicated its strong support for MHD's approval, as evidenced by an executed agreement for patients to be referred to MHD (Exhibit 5) and an executed agreement for MHD to refer patients experiencing a medical emergency to BWMC (Exhibit 6). MHD and BWMC plan to create actionable procedures for the referral process to and from MHD, including the continuance of withdrawal management medications and transportation. The experience of BWMC is not an isolated case for hospitals, but is now the new normal for the hospitals across our state.

The commission continues the discussion towards a possible solution for the juxtaposition posed by the inability of hospitals to care for individuals needing detox. Because "individual hospitals have reduced the availability of detoxification services, regionalization of services may assure continued access to hospitals for those who require this level of care" (p.14). The final policy adopted by MHCC in the state health plan, Policy 5.1, states:

> The Commission, in cooperation with the Alcohol and Drug Abuse Administration, should support the development of regionalized acute detoxification units.

The scope, breadth, and design of these regionalized detoxification units are not defined or discussed in the plan. To this date, Maryland has yet to create a single regional detoxification unit, work towards compliance with this policy. MHD is in the position to serve as a regionalized detoxification unit, and Policy 5.1 states that the Commission should support its development.

The issues highlighted in 2002 that affected delivery of efficient and effective care still continue to plague our system – and are not limited to hospital admissions. As discussed earlier, all III.7.D. beds are located within the auspices of a treatment facility. Most long term residential treatment centers prioritize offering admission (an open bed) to an individual seeking both the initial detoxification phase and the subsequent long term treatment period through extended residential care. This cannot remain the only entry into detox. MHD will assist the chemically dependent individual who also, may not otherwise (and for a myriad of reasons), enter treatment due to the various social barriers that exist.

Unfortunately, there are many individuals who do meet the ASAM criteria for inpatient detox and subsequent treatment but may not be able to enter the detoxification level treatment setting if they are required to stay inpatient for the proposed 28 days or longer. These individuals often present in crisis, overwhelmed by numerous families, financial and social commitments. Real time evidence of phone inquiries to all existing residential treatment III.7.D providers, requesting only detoxification services, revealed there are no track one providers within the state that will solely provide the detox level of treatment. MHD will also serve to fill that gap, for those waiting

or needing to enter treatment urgently, and a solution for those that need an inpatient level of care but cannot commit to long term residential treatment.

MHD will provide an intensive needs analysis and focus discharge to the most appropriate level of care. "Fostering the patient's entry into treatment involves preparing the patient for entry into substance abuse treatment by stressing the importance of following through with the complete substance abuse treatment continuum of care" (TIP 45 p. 8). Collaboration with the primary aftercare provider will require an "executed" primary handoff for all discharges. In other words, identification of and actual connection with the intended primary referral for subsequent treatment at the next appropriate level of care is to occur as early as within the first 48 hours but no less than one full 24 hour day prior to the actual day set for discharge for an uninterrupted and seamless transition into the next level of care.

MHD has developed 7 referral agreements prior to approval, and will continue to develop referral service agreements with local service providers. If any impact arises, it should prove favorable to existing residential treatment programs, in part due to the shortened length of stay expected for the average patient at MHD in comparison to the average length of stay for those receiving long-term treatment. It is expected that all patients completing detoxification at MHD will require and receive a warm handoff, in accordance with ASAM criteria, for subsequent continuation of treatment at the residential, partial hospitalization or intensive outpatient level of care. Thus, the bottleneck in the treatment system will eventually but assuredly lessen. We know that "successfully linking detoxification with substance abuse treatment reduces the 'revolving door' phenomenon of repeated withdrawals, saves money in the medium and long run, and delivers the sound and humane level of care patients need" (TIP 45 p. 8).

Cost of Services to Society

While MHD has shown there is a deficiency in the number of Track One ICF beds, the regulations we follow do not exist in a vacuum. Considering only the need determination methodology set forth by the state, MHD should be granted 16 ICF beds. When considering the circumstances surrounding the state of substance use in the state and across the nation, the need for more treatment options becomes even greater. On February 24, 2015, Governor Hogan issued Executive Order 01.01.2015.12, which created the Heroin and Opioid Emergency Task Force. The Task Force is composed of 11 members with expertise in addiction treatment, law enforcement, education, and prevention. The Task Force was charged with advising and assisting Governor Hogan in establishing a coordinated statewide and multi-jurisdictional effort to prevent, treat, and significantly reduce heroin and opioid abuse.

The Task Force's findings confirm a trend of escalating substance use and the need for additional services.

> "For the past eight years, Maryland has seen rising rates of d
> related overdose death
> 387 there were 464 h
> heroin homicides and 482 motor
> Force Report p. 1). Since 2010, there has overdose dea
> of fatal drug- and alcohol-related overdoses been a 60 perc
> deaths in 2014 (Task Force Report p. 1). in Maryland, fro

The most recently available data tells us the number of deaths continued to increase in 2015. There were 599 drug- and alcohol-related deaths in the first half of 2015 (January to June), almost double the number of deaths that occurred in the same period in 2010 (Task Force p. 1).

According to the 2014 annual report on Drug and Alcohol-Related Intoxication Deaths in Maryland released by the Maryland Department of Health and Mental Hygiene in May 2015, the number of specifically opioid-related deaths increased by 22% between 2013 and 2014, and by 76% between 2010 and 2014 (p.5).

The first recommendation made by the Task Force is to improve and expand access to treatment. In its own words, the Task Force admits "there is a growing need across the State for treatment services for individuals with heroin and opioid addiction. Unfortunately, barriers to accessing treatment in a timely manner for some populations remains a significant problem. The key to improving access to high-quality treatment lies in creating a delivery system that provides a full continuum of substance use services and care" (Heroin and Opioid Emergency Task Force p. 4). MHD can help fill void in the full continuum of substance abuse services in the state.

At a State Task Force meeting, Anne Arundel County Executive Schuh stated that one component of the county's three-pronged approach to tackling the crisis is to add more treatment options in the county. Mr. Schuh also submitted comments on statements made at the Anne Arundel Town Hall meeting when residents inquired as to why there weren't more treatment beds available. The Task Force officially acknowledges that "access to treatment is extremely sensitive to delays in intake and first appointment time" (Final Report, p. 13).

When individuals cannot access treatment in a timely manner, our entire society suffers through increased medical and social costs (crime, incarceration, unemployment, and death).
MHD will serve as an access point to a treatment system that finds demand exceeding supply. It will play a role in helping to solve the need for additional treatment options as well as breaking down the traditional barriers to treatment in the state.

The addition of MHD to the treatment landscape will ultimately address other factors that are barriers to accessing treatment such as child care, family obligations, employment issues, financial and/or legal obligations and responsibilities; a myriad of issues that may ultimately delay, prohibit or impede people, from accessing treatment services they seek. Often, this type of individual, if able to initially access short term detox for stabilization, find they can successfully maintain abstinence in a subsequent outpatient setting.

The Task Force recognizes that "offering crisis services will relieve pressure on hospital acute-care systems" (Heroin and Opioid Emergency Task Force p. 4). The stakeholders involved in examining the substance use crisis and developing solutions acknowledge that oftentimes in the real world, individuals effected by substance abuse turn to hospitals for care in times of crisis. These crises are caused by the lack of resources for medically monitored inpatient detox coupled with the often extremely high barriers to enter the level of care that is needed.

SAMHSA reinforces the need for alternatives to hospital settings – "A study (Mark et al. 2002) conducted for the Substance Abuse and Mental Health Services Administration highlights the pitfalls of the service delivery system. According to the authors, each year at least 300,000 patients with substance use disorders or acute intoxication obtain inpatient detoxification in general hospitals while additional numbers obtain detoxification in other settings. Only about one-fifth of people discharged from acute care hospitals for detoxification receive substance

abuse treatment during that hospitalization. Moreover, only 15 percent of people who are admitted through an emergency room for detoxification and then discharged receive any substance abuse treatment" (TIP 45 p. 8).

We know that "effective detoxification includes not only the medical stabilization of the patient and the safe and humane withdrawal from drugs, including alcohol, but also entry into treatment" (TIP 45 p. 8). At it's core, MHD functions to break down barriers and foster entry into the treatment system. Each year the Maryland Department of Health and Mental Hygiene publishes the Outlook and Outcomes report detailing data surrounding the patients, circumstances, and outcomes of substance abuse treatment in the state. In every year from 2007 to 2014, the state was able to provide evidence-based conclusions for the outcomes that we anecdotally know to be true about treatment. Data supports the conclusions that entry into the treatment system reduces substance use, increases employment, improves living conditions, reduces crime, and promotes mental health referrals. These are the outcomes that drive providers to operate under the highest standards, continuously improve quality of care, and create innovative solutions to address our society's healthcare needs.

While MHD does not contend that its approval and subsequent operations will solve all of the issues afflicting our state or our state's treatment delivery system, it does contend that it can help: recovery leads to a better quality of life for everyone. It is evident that the massive costs to society of persistently operating the treatment system without progress far outweigh the privately incurred costs to develop and operate Maryland House Detox.

Complete Tables 1 and/or 2 below, as applies.

[(INSTRUCTION: Complete Table 1 for the Entire Facility, including the proposed project, and Table 2 for the proposed project only using the space provided on the following pages. Only existing facility applicants should complete Table 1. All Applicants should complete Table 2. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY)]

TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT
(INSTRUCTION: All applicants should complete this table.)

	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	2016	2017	2018	20___
1. Admissions				
a. ICF-MR				
b. RTC-Residents				
Day Students				
c. ICF-C/D	0	720	960	
d. Other (Specify)				
e. TOTAL	0	720	960	
2. Patient Days				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D	0	4320	5760	
d. Other (Specify)				
e. TOTAL	0	4320	5760	
3. Average Length of Stay				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D	0 days	6 days	6 days	
d. Other (Specify)				
e. TOTAL	0 days	6 days	6 days	
4. Occupancy Percentage*				

a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D	0%	75%	100%	
d. Other (Specify)				
e. TOTAL	0%	75%	100%	

Table 2 Cont.	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	2016	2017	2018	20___
5. Number of Licensed Beds				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D	0	16	16	
d. Other (Specify)				
e. TOTAL	0	16	16	
6. Home Health Agencies				
a. SN Visits				
b. Home Health Aide				
c.				
d.				
e. Total patients served				
7. Hospice Programs				
a. SN Visits				
b. Social work visits				
c. Other staff visits				
d. Total patients served				
8. Ambulatory Surgical Facilities				
a. Number of operating rooms (ORs)				
● Total Procedures in ORs				
● Total Cases in ORs				
● Total Surgical Minutes in				

ORs**				
b. Number of Procedure Rooms (PRs)				
● Total Procedures in PRs				
● Total Cases in PRs				
● Total Minutes in PRs**				

*Do no include turnover time

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

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

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

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

Problem Identification

Maryland House Detox aims to provide an additional avenue to entry into the treatment system by providing detoxification services. Detox is the first point of contact with the treatment system for the majority of addicted individuals seeking treatment. In providing additional III.7.D beds in the state, MHD seeks to address the problem of a lack of inventory of III.7.D as required by the State Health Plan.

By operating as a stand-alone detox facility, MHD will assist in alleviating some of the traditional barriers to entering the treatment system, as discussed thoroughly in previous sections. The shorter length of stay for patients treated at MHD translates into a more efficient use of the number of licensed beds, allowing MHD to create exponentially more opportunities for patients to enter the treatment system than the existing (and proposed) detox beds that are inevitably tied to lower levels of care. Because its beds are not tied to a larger project involving the costs associated with developing and maintaining a contained treatment environment, the MHD project is a cost effective approach to addressing the deficiency of Track One ICF beds in the Central Maryland Planning Region and the entire state of Maryland.

Below is a summary of the existing beds in the state compared to the number of beds that are required by the State Health Plan:

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

	Base Year 2015	MHCC Projected 2020	Addition of MHD Beds
(h) **Existing Track One Inventory ICF/CD beds**[4]	132	132	148
(**i) Net Private ICF/CD Bed Need**			
Minimum (g1-h)	137	145	148
Maximum (g2-h)	182	192	182

Table 6 Summary: Projected Bed Need for Alcoholism and Drug Abuse ICF Beds in State of Maryland
Serving Adults (18 years and older)

Total State	Base Year 2015	MHCC Projected 2020	Addition of MHD Beds
(h) Existing Track One Inventory ICF/CD beds(4)	157	157	173
(**i) Net Private ICF/CD Bed Need**			
(i) Net Private ICF/CD Bed Need			
Minimum (Sum of All Regions)	418	442	173
Maximum (Sum of All Regions)	524	553	524

Identification of Alternative Approaches

In its design, MHD is the alternative approach to the existing landscape of providing Medically Monitored Inpatient Detoxification services. To identify the alternative approaches to solving the problems that were considered during the project planning process, MHD must examine the services being provided by existing facilities and the services being proposed by new facilities.

The State Health Plan developed methodology examining the population, demographics, prevalence rates, discharges, and treatment rates to determine the number of individuals who need to be served in an ICF bed and the number of beds required to serve these individuals. According to the SHP, below is a summary of the updated bed-need projections conducted by MHCC in 2015.

Table 6 Summary: Projected Bed Need for Alcoholism and Drug Abuse ICF Beds in State of Maryland

Serving Adults (18 years and older)

Central Maryland	**Base Year 2015**	**MHCC Projected 2020**
(f) Range of Adults **Requiring ICF/CD Care**		
Minimum (d1+e1+out of state)	5,254	5,440
Maximum (d2+e2+out of state)	6,255	6,476
(h) **Existing Track One Inventory ICF/CD beds**[4]	132	132
(**i) Net Private ICF/CD Bed Need**		
Minimum (g1-h)	137	145
Maximum (g2-h)	182	192
Total State	**Base Year 2015**	**MHCC Projected 2020**
(f) Range of Adults **Requiring ICF/CD Care**		
Minimum (d1+e1+out of state)	12,048	12,573
Maximum (d2+e2+out of state)	14,408	15,036
(h) Existing Track One Inventory ICF/CD beds(4)	157	157
(i) Net Private ICF/CD Bed Need		
Minimum (Sum of All Regions)	418	442
Maximum (Sum of All Regions)	524	553

As discussed previously, the number of adults needing to enter an ICF bed in the region is far greater than the existing bed capacity. In examining the operational nature of these beds, MHD illustrates that while these beds are licensed for detox, they are utilized for extended services and levels of care subsequent to completion of detoxification. This means that "detox" bed remains occupied and becomes a "residential" bed for the completion of Level III.5 and beyond.

Based on the treatment modality and average length of stay in these facilities, the existing 132 beds in the MHD region allow for approximately 132 patients to enter detox every month. Spread out over the course of a year, this equates to 1,584 patients. MHD does acknowledge that because not every patient entering one of these beds will complete the entire course of subsequent treatment, so this number may be somewhat higher. Even if this number were to increase by 50% to 2,250 to account for early discharges or additional admissions, the existing number of beds for admissions is not sufficient to serve the number of patients that need to utilize a detox bed. The SHP estimates that between 5,000 and 6,000 individuals will need to enter a track one detox bed in the region every year. Because the existing detox beds are all tied to lower levels of care, they are not made available for a successive detox patient immediately after the prior detox is complete. They only become available once a patient has completed the entire course of treatment.

The existing approach of treating patients in ICF beds is not sustainable. The bottleneck to enter treatment begins at the detox level. In proposing the MHD project, DBHG and DCX Group seek to alleviate the lack of required ICF beds in the region and the state.

The fact remains that additional beds are needed to meet the state's requirements and serve the affected individuals.

Effectiveness and the Costs of Each Alternative

It has been suggested that every person's treatment course is as varied as his or her substance use and addiction patterns. Likewise, their treatment course should provide options to ensure its effectiveness in engaging patients in a meaningful way. It is important to note that the Commission recently approved a CON application for one of the existing alternatives to MHD's detox beds. While the Commission did approve the addition of 15 beds, it substantiates the notion that the traditional admission into treatment is tied to a subsequent residential length of stay. It went on to question the cost-effectiveness of this approach and even provided evidence that it may not be the most cost effective approach to treatment:

> Beyond the limited perspective of the project itself and the costs and effectiveness of various approaches to modernizing FMA's facilities for the purposes to which they are used, the review required for this project does present the Commission with an opportunity to examine the larger question of costs and effectiveness in substance abuse treatment. FMA is philosophically wedded to a single basic treatment modality, involving admission of patients for a 28-day stay on its campus. The applicant was not able to provide and staff was unable to find, in the literature, support for the idea that this approach to treatment is the most cost effective approach to treating alcohol or drug dependency or an approach that is the most cost-effective for a majority of persons in need of such treatment. This is not a treatment modality that third-party payers are universally willing to fund, at full cost, under most plans with benefit coverage for addictions treatment and this fact has shaped the way in which FMA operates and markets it program. It appears to be a major factor in the limited number of such programs in operation. In fairness, FMA is not claiming that its program is the best option for all patients in need of addictions treatment but believes it is the most effective approach for some types of patient. It has not attempted to systematically evaluate its level of effectiveness in comparison with similar 28-day programs in other states.
>
> The most recent research identified by staff comparing treatment modalities was published in 2003. This research compared the cost and effectiveness of four modes: inpatient, residential, outpatient detox/methadone, and outpatient drug-free. It found cost-effectiveness, when compared to other health interventions, for all four modes and found that outpatient drug- free settings were the most cost-effective, in terms of cost per successfully treated abstinent case. It noted that, although variations in settings, modalities, and outcomes makes comparisons of cost-effectiveness estimates across studies difficult, its findings were, in general, consistent with the results of most prior cost-effectiveness studies of alcohol and substance abuse treatment. While this study did not conclude that different modalities might not be more cost-effective for particular types of patients, it noted that no evidence was found in its study that patients could be "selected" into programs for improved effectiveness and cited the "mixed" evidence in the literature that matching clients and client-problems to the "right kinds" of programs to maximize or optimize effectiveness can be successfully implemented (FMA response, pp. 25-26).

The Commission's discussion centered around the titled "Effectiveness and Cost-effectiveness of Four Treatment Modalities for Substance Disorders: A Propensity Score Analysis" encourage the flexibility of MHD's model:

- **"This is not a treatment modality that third-party payers are universally willing to fund, at full cost, under most plans with benefit coverage for addictions treatment."** The Commission points out that most insurance plans do not pay for this entire course of treatment in full. 100 of the 132 licensed beds in the Central Maryland Planning Region are located within the auspices of this program. If insurance companies will not pay for this entire course of treatment, then cost is passed to patients and families, making the out of pocket expenses for treatment exponentially higher while at the same time exacerbating the barriers to entry. If insurance companies do pay for this course of treatment in full, then the payment amounts may be much higher than an alternative setting.

- **"It found cost-effectiveness, when compared to other health interventions, for all four modes and found that outpatient drug- free settings were the most cost-effective, in terms of cost per successfully treated abstinent case."** The study and the Commission both agree that outpatient settings are more cost-effective setting for treatment. MHD does not contend that every patient that is stabilized and referred into the treatment system will enter an outpatient level of care – but in its design MHD is flexible. In fact, some of its patients will enter a residential level of care. The most important distinction that MHD makes in operations regarding cost-effectiveness of treatment is that patients will be referred to providers based on ASAM placement criteria, social factors, and the ability to successfully engage in treatment. The existing alternatives to MHD do not make this distinction, as all patients are required to remain within the facility for higher levels of care. By simple logic, a portion of MHD patients will be referred directly from detox to outpatient settings.

- **"It noted that no evidence was found in its study that patients could be "selected" into programs for improved effectiveness and cited the "mixed" evidence in the literature that matching clients and client-problems to the "right kinds" of programs to maximize or optimize effectiveness can be successfully implemented."** The Commission noted from the study the author's findings that no evidence exists to support the idea that clients can be matched into treatment levels to improve effectiveness. When these statements are taken in full context, the authors express that client-matching treatment has produced some effective results – i.e. the mixed results mentioned here, but that the actual practice of this process is not easily applied. **"It is also noteworthy that attempts at client–problem matching in the past have produced mixed results. Commenting on these studies, 'This idea of 'matching' the right types of clients to the right kinds of programs has been as attractive to clinicians and administrators as it has been elusive to those who have tried to accomplish it'. Furthermore, as these authors note, matching clients with treatments is often not feasible in the real world'" (p. 254).** The authors do not explicitly mean that the effects of matching clients with specific treatment modalities not justified, only that the real-world application of this practice tends to be unfeasible. MHD agrees that since an industry-wide model of binding detox beds to residential beds has become widely accepted, oftentimes matching

clients outside of a facility is extremely difficult or impossible. Clinicians and administrators traditionally have not had the luxury of being able to refer to an effective level of care because detox has been tied to residential treatment. This is especially the case for the alternative existing providers in the state and is the premise of what MHD is built upon.

- Another conclusion the authors of this study stated is that **"the outpatient drug-free treatment modality, however, appears to be most cost-effective, even for clients who are more likely to choose (or be referred to) treatment in other modalities."** This means that the cost of patients who choose to stay in residential treatment after detox, or are referred by the facility providing detox to any level other than outpatient, is higher than patients who either choose or are referred to outpatient treatment. MHD has the flexibility to refer patients to outpatient treatment after detox, whereas the system of existing providers does not.

When a patient enters MHD for assistance, instituting a detoxification service will be in direct result to a needs assessment. The ASAM reference guidelines will further guide and delineate the patient's proper progression through treatment, again, based upon the patients' assessment. Because MHD will offer level III.7.D only, an objective review for determining the most appropriate subsequent level of care can then be determined. The most appropriate subsequent placement will be to either residential, partial hospitalization, intensive outpatient, outpatient, or to see a specialty provider for co-morbidities. As the acuity level of the patient decreases, the placement will as well. In MHD, the cost of unique treatment for this individual will be limited to detoxification services and therefore cost contained.

To consider the next likely question from administrators – is outpatient detox a cost-effective alternative approach? The answer to this question is an unequivocal "no". To make this comparison would be to compare "apples to oranges". Healthcare providers are bound to place patients in levels of care based on ASAM criteria, so the discussion of this point is bound to the parameters of patients requiring a III.7.D level of care. MHD does not hold outpatient services to be an alternative for comparison for this application. Inadvertent risk for patient harm exponentially increases when the patient, who may have just undergone induction of a stabilizing medication, leaves the outpatient center as it closes for the day. The request for MHD's beds can only be considered within the context of Medically Monitored Inpatient Detoxification beds. The only consideration for cost-effective alternatives should be an "apples to apples" comparison to these beds.

Development Costs

In 2013, The Commission approved a CON project with a cost of $18,563,000 that effectively added 15 ICF beds to the current inventory. The project involved the construction and modernization of an entirely new building and extension of a program. The costs of this project were not contained to simply add to the number of beds, the majority of the costs of this project were related to the ongoing operations of the larger residential treatment program. Included in these costs were the additions of 20 private patient rooms and a wellness/fitness center as a part of the larger treatment program.

Currently, there are 3 CON applications under review by the Commission for projects similar to the one that the Commission approved in 2013. The total cost of the projects

is over $59 million. The costs for each facility include the development of entire residential treatment programs related to new construction and renovation of large buildings. Each project costs $17,370,227, $21,193,277, and $21,019,435 and request the addition of 21, 64, and 55 detox beds respectively.

When considering how to address the problem of the lack of ICF beds in the state, MHD is a cost-effective project to implement. A cost per-bed development rate of recent projects is below:

Project	Project Cost	ICF Beds	Cost Per Bed
FMA	$18,563,000	15	$1,237,533.33
RCA Earleville	$17,370,227	21	$827,156.05
RCA Waldorf	$21,193,277	64	$331,144,95
RCA Upper Marlboro	$21,019,435	55	$382,171.55
MHD	$1,936,275	16	$121,017.19

To address the current deficiency in ICF beds, MHD per-bed development costs are the most cost-effective.

It is important to highlight that MHD does not wish to discredit the traditional model of tying detox beds to residential treatment programs as a clinically effective treatment modality. It only makes these comparisons in regards to costs. MHD seeks to establish an alternative to the status quo and increase access to detox beds in the state. This alternative is more concise in its operations, will cost less to develop, and will be more cost-effective in its per treatment episode interaction with the larger system.

Life Cycle Costs

MHD costs are restricted to detoxification level of care only and therefore cost-contained. The traditional models require residential and partial hospitalization levels, which are more expensive to the health care system and to the individuals – both in explicit costs (billing to insurance and to individuals) and implicit costs – (opportunity costs of missing work, paying for child care, travel and lodging expenses, etc.).

The costs to maintain facilities that house detox and lower levels of care are substantially higher than the costs to maintain MHD as a detox-only facility. Staffing requirements, building maintenance, marketing budgets, and ancillary costs all factor into life cycle costs for facilities. The efficiency in which MHD will continuously utilize its beds for detox services (as previously discussed) can be considered a form of cost containment as well.

MHD will consistently implement 100% impartial consideration to the ASAM criteria guided both through the admission and discharge processes. It will support patients as they participate in the admission planning, treatment level and decision-making process for their discharge referral options and destinations. MHD will operate as a facility that has 100% opportunity to implement the ASAM criteria in a fair, impartial and objective manner because it is not attached or “wedded to a traditional 28-day” program. The flexibility to refer a patient to any other (lower) level of care such as Residential, a Partial Hospitalization Program, Day Program or Outpatient Program, comes without any fiscal

repercussions whatsoever. From this perspective and viewpoint alone, overall costs associated with detoxification level of addiction treatment services will indicate a decline when considered within the overall treatment system.

MHD also raises the premise that the consideration of cost-effectiveness of treatment may not lie entirely within the tenets of the programs, but also within the burden placed upon the patients. Such is the case if a comparison of the costs associated with a Maryland resident attending an out of state facility to the costs of the same resident attending a local facility that provides comparable Level III.7.D services. Towards this end, Maryland House Detox has developed a local, patient centric program tailored to fit into Maryland residents' life circumstances. As with any life decisions an individual would navigate, a prudent person would likely determine "what works best" for them, while remaining in a Maryland facility.

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

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

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

- Complete Tables 3 and/or 4 below, as applicable. Attach additional pages as necessary detailing assumptions with respect to each revenue and expense line item.

- Complete Table L (Workforce) from the Hospital CON Application Table Package.

- Audited financial statements for the past two years should be provided by all applicant entities and parent companies to demonstrate the financial condition of the entities involved and the availability of the equity contribution. If audited financial statements are not available for the entity or individuals that will provide the equity contribution, submit documentation of the financial condition of the entities and/or individuals providing the funds and the availability of such funds. Acceptable documentation is a letter signed by an independent Certified Public Accountant. Such letter shall detail the financial information considered by the CPA in reaching the conclusion that adequate funds are available.

- If debt financing is required and/or grants or fund raising is proposed, detail the experience of the entities and/or individuals involved in obtaining such financing and grants and in raising funds for similar projects. If grant funding is proposed, identify the grant that has been or will be pursued and document the eligibility of the proposed project for the grant.

- Describe and document relevant community support for the proposed project.

- Identify the performance requirements applicable to the proposed project (see question 12, “Project Schedule”) and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, obtaining State and local land use, environmental, and design approvals, contracting and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame(s).

Company History

Delphi Behavioral Health Group ("DBHG" or the "Company") is a recently organized entity that brought together a strong independent team of multiple treatment facilities throughout Florida and California. The reorganization of the entities included within DBHG include (a) Ocean Breeze Recovery (b) Las Olas Recovery d/b/a Pathway to Hope (c) Delphi Health Group and (d) Ocean Breeze Detox. The Company recognized early on that most treatment centers, striving to achieve high bed counts and drive revenue growth, severely hindered quality of clinical care and resultant patient outcomes. Core to the Company's treatment philosophy was individualized care predicated on three basic tenants: (i) high clinician-to-patient ratio; (ii) low bed counts ranging from 30 to 60 beds per facility; and (iii) comprehensive, tailored treatment solutions including cognitive and behavioral therapies, aftercare services and relapse prevention. The Company believed this "boutique" model would enable staff to focus on the development of tailored treatment solutions for each patient and provide the requisite one-on-one counseling necessary to combat subsequent relapse and improve clinical outcomes.

Ocean Breeze Recovery ("OBR") is a 65-bed drug and alcohol addiction treatment center located in Pompano Beach, FL. Today, OBR serves as DBHG's flagship treatment center and is highly regarded for its individualized treatment programs and intimate clinical care. OBR offers eating disorder and Christian tracks as part of its care model, as well as specializes in trauma treatment, leveraging Eye Movement Desensitization and Reprocessing (EMDR) and other effective treatments. OBR alumni have the opportunity to attend OBR's nationally accredited (DOE & NAADAC) Certified Addiction Professional School, where they are educated and trained to meet all the standards and qualifications necessary to apply for state certification as a Certified Addiction Specialist.

As patient count continued to rise and OBR reached maximum capacity, the Company remained committed to the boutique model philosophy. In April 2012, the Company developed their first de novo facility, Pathway to Hope ("PTH"), a treatment center focused on chronic and dual diagnosis (trauma, eating disorder) treatment.

OBR transferred patient inquiries into PTH, which had capacity for new residents. PTH, located in Fort Lauderdale, Florida, offers RTC, PHP, IOP and OP in a 45-bed facility. Applying the same principles of high quality care administered at OBR, PTH successfully increased patient census.

Throughout 2013 and 2014, Management saw strong returns on its initial developments. Patient census at both OBR and PTH remained at or close to capacity and brand awareness began to extend to the northern and western parts of the country creating potential for further expansion through de novo site developments.

The Company saw a tremendous opportunity to replicate the key components of success developed at OBR and PTH across new entities. In May 2014, Delphi Health Group, (DHG) was formed with an aim to replicate the boutique model through a series of treatment centers throughout the country. DHG's formation was predicated on drawing from Management's successful track record of identifying suitable de novo sites, securing properties, overseeing zoning, licensure and development of facilities and integrating de novo centers into its treatment facility network where centers share a

common service platform (i.e., bookkeeping, accounting, admissions processing and marketing). Delphi's strategy is to target facilities with 16-60 bed potential and high clinician-to-patient ratios. Importantly, the Company seeks highly qualified and committed operators that share Management's philosophy of patient treatment.

Executing on this expansion strategy, DHG completed the following de novo projects since inception:

- A 25-bed treatment center located in Orange, California offering the full continuum of care, including detox.
- A 12-bed treatment center based in Fort Lauderdale, FL offering PHP and IOP services.
- A 23-bed treatment center in Orange, CA offering PHP and IOP services.
- A 17-bed treatment center in Banning CA offering the full continuum of care, including detox.
- A 16-bed detox center located in Pembroke Pines, FL expecting to begin treating patients in early 2016.
- A 16-bed detox center in Linthicum Heights, MD expecting to begin treating patients in the first quarter of 2017

Treatment Overview

Delphi offers treatment services across the full continuum of care, delivering comprehensive, high quality and effective care that addresses all stages of a patient's addiction. Delphi's 28-day residential treatment program is premised on holistic health, offering trauma resolution in attempts to get to the root of the problem rather than treatment only through medications. Delphi takes a multi-disciplinary approach to recovery leveraging medical services, ASAM best practices, 12-step recovery programs and customized treatment referrals and aftercare. Within each approach, the Company provides a number of different treatment services such as assessment, detoxification and medication assisted treatment, counseling, education, lectures and group therapy. A mix of treatment programming is available at the Company's facilities, including (from most to least acute): detoxification ("DTX"), residential treatment ("RTC"), partial hospitalization ("PHP"), intensive outpatient ("IOP") and outpatient ("OP"). It is common for patients to begin treatment in detoxification, and then progress through lower acuity treatment programs, with each subsequent program providing an incrementally higher level of reintegration into society.

Each patient receives a customized treatment program specific to his or her needs. Typical programs include a mix of individual psychological treatment from a psychiatrist or masters-level therapist to address any underlying mental health problems, individual therapy with a substance abuse counselor, numerous group counseling sessions, and treatment from medical doctors for the physical ailments that often manifest from heavy substance abuse. Due to the complexity of their cases, patients with co-occurring mental health disorders often require more intensive treatment, increasing lengths of stay. The ability to address these complex conditions enhances Delphi's reputation with patients and their families.

Delphi's clinicians are trained to advise patients on managing their substance addictions as well as their familial relationships, employment status and overall life skills. Helping

patients establish a strong outside support network serves as a means for patients to cope with problems as they arise after completing treatment. Delphi's clinicians form strong professional relationships with patients resulting from their role in facilitating a life-changing treatment.

Maryland House Detox Project

DBHG identified Maryland House Detox as a project that advances its mission of providing high quality individualized care in low bed-count facilities. The viability of the project was determined based on its knowledge of the existing treatment landscape in Maryland and the operational experience of the DCX Group leadership.

DCX Group leadership is exceptionally qualified perform the core clinical functions of a successful healthcare operation at the highest level. The DCX Leadership Team is comprised of exceptional talent whose collective behavioral health expertise and extensive knowledge base crosses multiple industries and funding sources, amongst public, private, not-for-profit, governmental, federal/state/local agencies and the Department of Defense/Health Affairs including a special emphasis on:

- Health care business systems development for operations and start-ups
- Behavioral health, clinical and medical case management incorporating utilization review and third party collaboration
- Regulatory compliance in health policy and federal, state, and local agencies
- Emergency preparedness and response management
- Risk management, patient safety, and infection control
- Development and management of the environment of care
- Electronic health records and Health Information Technology
- Staff development and performance improvement

DCX leadership will guide the development and execution of MHD's long term strategy and ensure high standards of corporate citizenship and social responsibility are upheld.

As the Chief Executive, David Stup, BS, oversees the design, marketing promotion, and delivery and quality of programs while ensuring that MHD performs the business functions necessary to sustain successful operations. In 2009 as Director of Business Development, Mr. Stup developed a robust referral base of healthcare providers in Maryland, Washington, and Virginia for American Addiction Centers, the country's first publically traded national addiction treatment provider. The success of these referral relationships lead to the development of a Mid-Atlantic regional team of business development and community outreach consultants. In working with an array of healthcare providers and stakeholders, Mr. Stup specifically identified hospitals as a subset of these referral partners that required immediate attention, education, and engagement. Collaboration with emergency, psychiatric, and medical clinicians encompassed education on substance use disorders, identification of candidates for substance abuse treatment, the development of a system of on-demand referrals, and successful completion of patient transfers into treatment directly from hospitals. As Director of Staff Development, this approach was replicated for the eventual development and training of a national team of consultants to educate and promote collaboration across the healthcare spectrum.

In working with healthcare providers to connect patients to treatment, Mr. Stup discovered a gap in the substance use and mental health treatment services provided in Baltimore and Harford Counties. In 2012, he developed a Co-Occurring Intensive Outpatient treatment program in Baltimore County alongside two of Maryland's most experienced addiction medicine MD's. The Bergand Group operates a long-term, high-focus treatment program in which every patient is treated by a multi-disciplinary team of clinicians focused on medical, psychiatric, therapeutic, and recovery-oriented interventions. Mr. Stup helped to successfully develop the program, obtain licensure from Maryland DHMH, develop partnerships in healthcare communities, and expand operations by opening a second site in Harford County in 2015.

MHD's program and relationship development will continue to expand while providing local crisis detox services, with transportation from hospitals, treatment centers, outpatient providers, and other referral sources. As evidenced by the referral agreements and letters of support contained in this application, MHD will begin its operations with successful referral relationships with many of the state's existing addiction treatment and healthcare providers. Outreach efforts will not be limited to healthcare providers, as a program of Community Outreach has started to work with local stakeholders to engage business, residential, judicial, and faith-based communities to ensure that MHD is able to provide services to patients seeking help through an array of likely sources.

As President and Chief Operations Officer, Cynthia Curtis RN, CITRMS, LNC oversees the conceptual design and process structure, program development, and health systems management at MHD. As a Nurse Executive and Health Care Management and Business Systems Analyst, Ms. Curtis has over 30 years performance in the echelon of executive level leadership. Since early in the 1990's, Ms. Curtis had assumed management positions that span across the medical industry for executive level administrative leadership in regulatory compliance, infection control, patient safety, risk management, disaster management, education and training, utilization management, research and development, health information management, and accreditation preparation consulting. Never far from extending a hand to comfort a patient, her clinical expertise crosses all age groups as a Maternal-Child Health and Pediatric nurse for 25 years, and as a nurse educator and certified case manager while working with the pediatric, adolescent and adult HIV population.

The excellence that Ms. Curtis demands began in her early clinical experiences as a nurse, when in 1985, on the heels of a 2 year per diem position at the DC General Hospital Detox, she was recruited for a permanent position to the Alcohol and Drug Abuse Services Administration (ADASA), District of Columbia Government, Bureau of Drug Treatment Services, Central Intake Division. Direct patient care coupled with program development lead to recruitment by the Department of Defense/Health Affairs (DoD/HA) Defense Contractors for national corporate executive level positions in 1998.

Ms. Curtis lead a dual managed care organization(s) start-up for the DoD, being appointed as the national Corporate Director of Utilization Management, Model Region 1, intended as the Model Region design for additional 11 national Regions yet to come. With international development and reach, Ms. Curtis encouraged the widespread adoption of tele-medicine, internationally equipping surgeons to save the lives of surgical candidates deployed to the theatre of war. Working next to the CEO and VP of Medical Management, the executive leadership Ms. Curtis assumed allowed her to command the

successful orchestration of the development of the Catastrophic Case Management Division within the Utilization Management Division. This achievement occurred within the 3-month lead-time for complete transition from CHAMPUS to TRICARE. This was to include the highly sensitive beneficiaries in Washington with top secret clearances including members at the White House, in Congress and high ranking Generals deployed at war. As primary lead contact with direct bi-weekly face to face report to the Joint Chiefs' of Staff at the Pentagon, the greatest responsibility and achievement consisted of planning implementation for what was to be a "seamless and uninterrupted transition" in provision of health care services and products to 10-12 million military services beneficiaries in the United States and internationally.

Requested to return in 2005 as a Subject Matter Expert (SME), Ms. Curtis was again recruited to analyze, design, develop and integrate military managed care practices with civilian managed care industry concepts and standards, while aiming to infuse health care systems medical management evidence-based practices, benchmark standards, space and budget allocation policies and practices into daily provision of health services.

Ms. Curtis continues to give in her primary nurse role where she has served for almost 2 decades at Johns Hopkins Bayview Medical Center, in the Department of Psychiatry, Addiction Treatment Services (ATS), Center for Addiction & Pregnancy (CAP). The culmination of over three decades direct care expertise in specifically the detoxification treatment area, but also obtained by direct care to patients in the entire Psychiatry and Substance Abuse field, leaves undoubtedly no question as to the astute medical health care knowledge base, diverse skill sets and executive leadership Ms. Curtis provides to the creative development of Maryland House Detox project and the nurturing care to the populations she has served for over 35 years.

Financial Overview

DBHG has developed a strong financial profile with substantial free cash flow generation. The Company has continued to add to its bed count while containing costs and delivering year over year sequential top and bottom line growth, as illustrated below.

REVENUES				
Entity	**2012**	**2013**	**2014**	**2015**
Ocean Breeze	$ 13,987,978	$ 23,421,678	$ 27,964,306	$ 30,821,409
Las Olas Recovery	$ 2,106,105	$ 10,745,990	$ 13,903,989	$ 13,257,642
Delphi Health	$ -	$ -	$ 2,708,931	$ 16,707,960
Total	**$ 16,094,083**	**$ 34,167,668**	**$ 44,577,226**	**$ 60,787,011**

As depicted in the chart below, DBHG's management has been successful in turning the top line revenue growth into substantial free cash flow from operations.

FREE CASH FLOW GENERATED FROM OPERATIONS				
Entity	**2012**	**2013**	**2014**	**2015**
Ocean Breeze	$ 4,904,218	$ 10,470,569	$ 12,328,608	$ 10,410,483
Las Olas Recovery		$ 3,696,638	$ 5,451,138	$ 5,012,721
Delphi Health			$ (729,548)	$ 4,612,105
Total	**$ 4,904,218**	**$ 14,167,207**	**$ 17,050,198**	**$ 20,035,309**

For years 2012, 2013 and 2014, the Company had its annual financial statements reviewed by Goldstein Schechter Koch, P.A., a well recognized firm based out of Coral Gables, FL. A copy of these reviewed financial statements have been enclosed for your reference in Exhibit 9.

In addition, the Company has retained the services of an independent CPA to review the documentation provided and opine as to the availability of working capital to fund the project. A copy of that letter has also been enclosed for your reference in Exhibit 9.

The Company has currently engaged BDO, LLP to audit the 2015 financial statements and can make those available to the commission upon completion.

Specific Project Financing for MHD

As illustrated above, the Company expects cash flow from operations to be the primary source of funds in funding the working capital needs of the project.

Additionally, as of March 1, 2015, the Company has approximately $2.1 million in unrestricted cash on its balance sheet. Moreover, DBHG has access to a $5,000,000 revolving credit facility with its 3rd party lender. On March 2, 2016, DBHG entered into a three-year, $26.0 million senior secured credit facility with KeyBank, N.A., as administrative agent for the lenders party thereto, which consists of a $5.0 million revolver and a $20.0 million term loan. DHBG used the proceeds from the $20.0 million term loan to re-purchase membership units in the Company and a portion of the revolver to fund expenses associated with the financing transaction and to de novo development projects. As of the date of this Application, the Company has approximately $2.5 million of revolving credit available for use.

DBHG believes it has adequate cash flow from operations and access to capital to fund the project to completion. Therefore, we believe there is no financing risk associated with this project.

Community Support for the Project

While still in its planning and pre-approval stage, MHD has garnered the widespread support of many of the stakeholders involved in addiction treatment in the state. MHD will open as a viable project and continue its success through its operational phases.

Support from the existing treatment community for MHD is robust. Treatment providers have lauded the possibility that MHD's model may exist in Maryland soon. Conversations with providers of outpatient, partial hospitalization, and residential levels of care have produced a collective desire and echoed the rationale for MHD. Evidence of this support can be found in Exhibits 5,6, and 7 in the form of referral agreements and letters of support.

In order to adapt to the regulations of the state, pressure from third-party payers, and high development costs, a relatively new trend has developed within the treatment landscape. The state (and the rest of the country) has experienced tremendous growth of "residential" treatment programs providing all of the levels of care required for a long-term treatment program – except for the detox level. While indicated by a need for

treatment services, these programs operate successfully through the residential, partial, and outpatient treatment levels – but due to the costs, time, and regulations associated with the CON process in Maryland have chosen to forgo applying for a detox license. Five of these facilities exist within the Central Maryland Planning Region that could be considered track one (if applying the same standards). Three of the five facilities began operations within the past two years. These programs accept patients seeking treatment and (as discussed thoroughly in previous sections) oftentimes need to first refer these patients to the appropriate level of detox care for stabilization before they can effectively treat the patients. Many of these providers utilize detox facilities outside of the state of Maryland or are forced to turn to emergency rooms and psychiatric units to perform this stabilization since no such standalone option exists in Maryland. Additionally, the existing III.7.D providers do not accept these patients for detox if the patient is going to continue treatment at a different treatment program. MHD has secured referral agreements with 3 of these programs in the planning region to perform the necessary stabilization followed by entry into the treatment system.

In discussing the Continuum of Care, The State Health Plan states that "public agencies and both public and private payers need to monitor the development of the treatment system to assure that, as treatment modalities change, programs incorporate these changes" (SHP p. 14). The trend to offer more treatment is alive and well within the current system. The singular modality that has not changed in 14 years since the SHP was written is the III.7.D level of care. MHD will provide an avenue for these successful treatment programs to detox patients in the state, outside of an acute care hospital. In doing so, patient transfer and retention through the levels of care increases substantially.

MHD has strong support from its local healthcare community. Baltimore Washington Medical Center has indicated its support for MHD's approval, as evidenced by an executed agreement for patients to be referred to MHD (Exhibit 6) and an executed agreement for MHD to refer patients experiencing a medical emergency to BWMC (Exhibit 5). MHD and BWMC have discussed plans to create actionable procedures for the referral process to and from MHD, including the continuance of withdrawal management medications and transportation directly from the Emergency Department into MHD for detox. These plans can be replicated with emergency departments across the state.

Local agencies also recognize the bottleneck of treatment services at the detox level. MHD has conducted meetings with the local health, drug and alcohol abuse, and mental agencies in its county of operation. The leadership of the Anne Arundel County Health Department, the Anne Arundel County Behavioral Health Agency, and the Anne Arundel County Mental Health Agency all widely support the addition of detox beds to the county, as well as MHD as the specific project to provide these beds. Anne Arundel County Health Officer, Jinlene Chan MD, MPH and Anne Arundel County Mental Health Agency Executive Director Adrienne Mickler MS, CPA both have written letters of support for MHD. These agencies will have the ability to refer patients, providers, and community members to MHD for services. The letters of support can be found in Exhibit 7.

Performance Requirements to Complete Project

The specific performance requirements for MHD, as a new healthcare facility, are set forth in COMAR 10.24.01.12(c):

> Except as provided in this subsection, a proposed new health care facility has up to 18 months to obligate 51 percent of the approved capital expenditure, and up to 18 months after the effective date of a binding construction contract to complete the project.

All funds necessary for the completion of the MHD project have been approved by DHBG and will be obligated immediately upon CON approval (see Question 12). The project design for MHD is complete and construction documents will be finalized once approved. A comprehensive description of the project outlining the details of the construction, permitting, and approval processes can be found in Part I, Question 8.B. Once approved by MHCC, MHD expects approval of use and construction permits to take approximately 60 days. Construction will begin immediately. The construction of the project is expected to take approximately 5 months to complete, including finishes, furniture, and IT. MHD will be able to meet the performance requirements of obligating funds within 18 months and completion of the project within 18 months of a binding construction contract required in COMAR 10.24.01.12(c).

This project schedule represents the target schedule for MHD. Acknowledging the approval process may take longer than outlined in the original schedule, MHD has planned for an alternative project schedule. The times to needed to obligate 51 percent of the capital and to complete the project do not change. The alternative project schedule only accounts for delays in starting the process. Alternative cost and revenue projections can be found in Exhibit 10.

Both the target schedule and the alternative schedule will meet the requirements of capital obligation with 18 months of approval and project completion within 18 months of a construction contract.

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project)

(INSTRUCTION: ALL EXISTING FACILITY APPLICANTS MUST SUBMIT AUDITED FINANCIAL STATEMENTS)

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	2016	2017	2018	20___	20-___
1. Revenue							
a. Inpatient services			0	$7,200,000	$9,600,000		
b. Outpatient services			0	0	0		
c. Gross Patient Service Revenue			0	$7,200,000	$9,600,000		
d. Allowance for Bad Debt			0	$2,400,000	$3,360,000		
e. Contractual Allowance							
f. Charity Care				$1,200,000	$1,200,000		
g. Net Patient Services Revenue			0	$3,600,000	$5,040,000		
h. Other Operating Revenues (Specify)							
i. Net Operating Revenue			0	$3,600,000	$5,040,000		

Table 3 Cont.	Two Most	Current	Projected Years

	Actual Ended Recent Years		Year Projected	(ending with first full year at full utilization)			
CY or FY (Circle	20__ _	20__ _	2016	2017	2018	20 __ _	20 __ _
2. Expenses							
a. Salaries, Wages, and Professional Fees, (including fringe benefits)			$477,025	$2,293,760	$2,293,760		
b. Contractual Services			$10,000	$60,000	$60,000		
c. Interest on Current Debt			N/A	N/A	N/A		
d. Interest on Project Debt			N/A	N/A	N/A		
e. Current Depreciation			N/A	N/A	N/A		
f. Project Depreciation							
g. Current Amortization			N/A	N/A	N/A		
h. Project Amortization							
i. Supplies			$49,000	$25,000	$25,000		
j. Other Expenses (Specify)			$205,450	$325,060	$327,560		
k. Total Operating Expenses			$741,475	$2,703,820	$2,706,320		
3. Income			($741,475)	$896,180	$2,333,680		
a. Income from Operation			($741,475)	$896,180	$2,333,680		
b. Non-							

Operating Income							
c. Subtotal			($741,475)	$896,180	$2,333,680		
d. Income Taxes				($61,882)	($933,472)		
e. Net Income (Loss)			($741,475)	$834,298	$1,400,208		

Table 3 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	2016	2017	2018	20___	20-___
4. Patient Mix: A. Percent of Total Revenue							
1. Medicare							
2. Medicaid							
3. Blue Cross				20%	20%		
4. Commercial Insurance				62.5%	62.5%		
5. Self-Pay				5%	5%		
6. Other (Charity)				12.5%	12.5%		
7. TOTAL	100%	100%	100%	100%	100%	100%	100%
B. Percent of Patient Days/Visits/Procedures (as applicable)							
1. Medicare							
2. Medicaid							
3. Blue Cross				20%	20%		
4. Commercial Insurance				62.5%	62.5%		
5. Self-Pay				5%	5%		
6. Other (Charity)				12.5%	12.5%		
7. TOTAL	100%	100%	100%	100%	100%	100%	100%

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

(INSTRUCTION: Each applicant should complete this table for the proposed project only)

	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	2016	2017	2018	20___
1. Revenues				
a. Inpatient Services	0	$7,200,000	$9,600,000	
b. Outpatient Services	0	0	0	
c. Gross Patient Services Revenue	0	$7,200,000	$9,600,000	
d. Allowance for Bad Debt	0	$2,400,000	$3,360,000	
e. Contractual Allowance				
f. Charity Care	0	$1,200,000	$1,200,000	
g. Net Patient Care Service Revenues	0	$3,600,000	$5,040,000	
h. Total Net Operating Revenue	0	$3,600,000	$5,040,000	
2. Expenses				
a. Salaries, Wages, and Professional Fees, (including fringe benefits)	$477,025	$2,293,760	$2,293,760	
b. Contractual Services	$10,000	$60,000	$60,000	
c. Interest on Current Debt	N/A	N/A	N/A	
d. Interest on Project Debt	N/A	N/A	N/A	
e. Current Depreciation	N/A	N/A	N/A	
f. Project Depreciation				
g. Current Amortization	N/A	N/A	N/A	
h. Project Amortization				
i. Supplies	$49,000	$25,000	$25,000	
j. Other Expenses (Specify)	$205,450	$325,060	$327,560	
k. Total Operating Expenses	$741,475	$2,703,820	$2,706,320	

STATEMENT OF ASSUMPTIONS

General: The Applicant assumes the 16-bed facility will begin treating patients on January 1, 2017. The Applicant also assumes that in 2017, the census of the facility will remain constant at 75% utilization from initial treatment and be at 100% utilization beginning with January 1, 2018 remaining static throughout 2018. The Applicant also assumes that approximately 12.5% of its beds, or 2 out of the 16, will be for charity, which do not fluctuate with utilization of overall bed count.

General – Revenue: The Applicant performed a comprehensive analysis of charge and collection data as it relates to detoxification services across entities under its control as well as collaborate with its third party billing company as to expected reimbursement rates. Based on the information reviewed, historical experience and future expected fluctuations in billings and collections, the Applicant believes gross billings for detoxification services will average approximately $1,667 per day, which includes a blended mix of out-of-network and in-network payers. The chart below illustrates the historical findings of the average reimbursement rate, net of allowance for doubtful accounts and contractual allowances, of the Applicant across other entities under common control in which detoxification services are provided:

	Facility #1	Facility #2	Facility #3
Description	**Out-of-network**	**Out-of-network**	**In-network**
Average Reimbursement Rate	$ 1,451	$ 2,239	$ 818
No. of Insurance Carriers Analyzed	34	3	10

The Applicant expects to operate as an out-of-network facility until such time that contracts can be entered into with commercial payers. For purposes of the Application, the Applicant has assumed that the average reimbursement rate would be based primarily on 80% of reimbursements coming from in-network policies and the remaining 20% from out-of-network policies. Assuming continued collections for detoxification services remains comparable for future periods as has historically been true, the Applicant expects to collect a rate of $1,023 per day, net of allowance for doubtful accounts and contractual allowances, as illustrated in the chart below.

	Facility #1	Facility #2	Facility #3
Description	**Out-of-network**	**Out-of-network**	**In-network**
Average	**10.00%**	**10.00%**	**80.00%**
Average Reimbursement Rate	$ 1,451	$ 2,239	$ 818
No. of Insurance Carriers Analyzed	34	3	10
Weighted Average Total	$ 145.10	$ 223.90	$ 654.40
Weighted Average Reimbursement Rate			**$ 1,023**

For purposes of the assumptions and tables, the Applicant has utilized a 360 day year and rounded the expected reimbursement down to $1,000 per day.

Table 3 – Line 1a – Inpatient Services: The table assumes that 12 beds will be utilized for the entire calendar year 2017, with an average gross billing rate of $1,667 and a 360-day year. Beginning in 2018, the table assumes the facility will be at a 100% utilization rate. The revenues can be calculated as follows:

2017: 12 (beds utilized) x $1,667 x 30 (days in month) x 12 (months in year) = $7,201,400 (rounded in table)

2018: 16 (beds utilized) x $1,667 x 30 (days in month) x 12 (months in year) = $9,601,920 (rounded in table)

Table 3 – Line 1d – Allowance for bad debt: The allowance for bad debt is based upon a historical analysis of reconciling gross billed amounts to average collected amounts whether via 3rd party insurance reimbursement or patient co-pays and deductibles. Historically, the Company has experienced an approximate allowance amount of 40% of gross charges for detoxification services provided. The table assumes that of the number of beds utilized, that 2 will be directly allocated to charity usage. The remaining beds will be subject to an allowance for bad debt of 40%. The total gross billings allocable to charity usage are $1,200,000 and are further described in their applicable section. The allowance can be calculated as follows:

2017: 7,200,000 (gross billings) – 1,200,000 (charity usage) = 6,000,000 (gross billings to non-charity patients)

6,000,000 (gross billings to non-charity patients) x 40% = $2,400,000 (allowance)

2018: 9,600,000 (gross billings) – 1,200,000 (charity usage) = 8,400,000 (gross billings to non-charity patients)

8,400,000 (gross billings to non-charity patients) x 40% = $3,360,000 (allowance)

Table 3 – Line 1f – Charity Care: The Applicant has designated 2 beds, or 12% of total bed count, to directly account for charity care. The total charity care in both 2017 and 2018 can be calculated as follows:

2 (beds utilized) x 1,667 (gross billing rate) x 30 (days in month) x 12 (months) = $1,200,000 (rounded in table)

Table 3 – Line 2a – Salaries and wages: For all amounts included within this category, all applicable taxes and benefits estimated to be 12% of compensation have been included in this category.

2016: During the start-up phase of the project, the Applicant has assumed that key employees will be required to start prior to treating patients. The Applicant has assumed that the President will be required to begin employment on April 1, 2016, the public relations staff will begin work on July 1, 2016, and the remainder of the staff beginning employment on November 1, 2016.

2017 and 2018: As of January 1, 2017, the facility is expecting to be fully staffed to treat 16 patients at all times throughout these years.

Table 3 – Line 2b – Contractual services: The Applicant expects to incur expenses related to marketing efforts of 3rd party contractors and expects to pay $5,000 per month beginning November 1, 2016.

Table 3 – Line 2c and 2d – Interest on debt: Since the Applicant plans to use cash from operations from other operating facilities as the primary source of funding working capital, no amount for interest on current or expected debt has been recorded.

Table 3 – Line 2i – Supplies:

2016: In 2016, the Applicant expects to incur costs of approximately $1,500 per patient bed to furnish with beds, nightstands, armoires and bedding. In addition, the Company intends to expend $25,000 to furnish the administrative offices (including office supplies), lounges, laboratory, and other miscellaneous expenditures.

2017 and 2018: Once the Applicant makes the initial furnishings in 2016, it is expected that costs will be minimal. The Applicant has assumed annual costs of $25,000 per year in 2017 and 2018.

Table 3 – Line 2i – Other Expenses: The Applicant used the following information to determine the other expenses associated with the facility:

OTHER EXPENSES			
Description	**2016**	**2017**	**2018**
Rent	$ 162,750	$ 186,000	$ 186,000
Property Management	$ 15,000	$ 15,000	$ 15,000
Utilities	$ 13,200	$ 25,200	$ 25,200
Food costs	$ -	$ 54,860	$ 54,860
Insurance	$ 10,000	$ 15,000	$ 15,000
Electronic medical records	$ -	$ 5,000	$ 7,500
Automobile	$ 1,500	$ 6,000	$ 6,000
Support costs	$ 3,000	$ 18,000	$ 18,000
Total	**$ 205,450**	**$ 325,060**	**$ 327,560**

- *Rent*: For 2016, rent is $7,750 per month in the first 3 months of the year. Beginning on April 1, 2016, rent expense is increased to $15,500 per month and remains at that rate until the end of 2018.
- *Property Management*: The Applicant uses a property management for services rendered to the commercial building. The expense is set at $1,250 per month and is expected to remain static for 2016, 2017 and 2018.
- *Utilities*: In 2016, utilities are expected to be $1,100 per month, inclusive of electricity and gas. Beginning in 2017, these costs are expected to increase to $2,100 per month.
- *Food costs*: The Applicant has received quotes from 3rd party vendors as

it relates to food costs. The expected cost is $1,055 per week.

- *Insurance*: Insurance costs are expected to cover general liability, professional liability, and auto insurance and has been estimated at $10,000 for 2016 and $15,000 for 2017 and 2018.
- *Electronic medical records*: This cost has been estimated at $0 in 2016, $5,000 in 2017, and $7,500 in 2018 as census is expected to grow.
- *Automobile*: The Applicant expects to spend $500 per month on an automobile beginning October 1, 2016. This expense is expected to continue throughout 2017 and 2018.
- *Support costs*: The Applicant expects to incur support costs (book keeping, miscellaneous labor, unexpected expenses) of approximately $1,500 per month beginning on November 1, 2016 and continuing throughout 2018.

Table 3 – Line 3d – Income Taxes: Although the Applicant is an LLC which will taxed as a partnership with the ultimate taxes paid by the partners, for illustrative purposes, the Applicant has included an estimated income tax expense as if it were to be paid by the entity. No income tax expense was recognized in 2016 as the Applicant expects to incur loss. In 2017, the Applicant expects to incur income tax expense at an effective rate of 40% of the 2017 income offset by the expected carry forward loss from 2016. The 2017 income tax expense can be calculated as follows:

> $896,180 (2017 income) - $741,475 (2016 loss) x 40% = $61,882 (income tax expense)

In 2018, the income tax expense is expected to be 40% of income.

Table 4 Assumptions – Since the Applicant does not have any other services other than the ones proposed in this project, all assumptions used in Table 4 are identical to the assumptions used in Table 3. No variations between the Tables exist.

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

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

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

N/A – No Maryland Certificate of Needs have been issued to the project applicant, its parent, or its affiliates or subsidiaries over the prior 15 years.

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

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

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

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project;

b) On the payer mix of all other existing health care providers that are likely to experience some impact on payer mix as a result of this project. If an applicant for a new nursing home claims no impact on payer mix, the applicant must identify the likely source of any expected increase in patients by payer.

c) On access to health care services for the service area population that will be served by the project. (State and support the assumptions used in this analysis of the impact on access);

d) On costs to the health care delivery system.

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

Positive Impact to Volume of Services for Existing Providers

As discussed throughout this application, MHD expects to have a positive impact on the health care delivery system as whole. This includes a positive impact on the volume of service provided by existing residential and outpatient treatment providers, existing providers of ICF beds, and existing providers of medical services. MHD will increase the volume of services within the treatment system through its discharges, while increasing ability of emergency, medical, and psychiatric providers to perform essential non-substance related services to additional patients.

MHD will operate 16 beds specifically designed for the detoxification and stabilization of the chemically depend patient. The table below enumerates the expected discharges from MHD per month and year.

Length of Stay	Discharges Per Month	Discharges Per Year
5-6 days	80-96 patients	960-1,152 patients

These figures represent the number of patients that MHD will foster into the existing treatment system. MHD will discharge to each of the levels of care, the percentage of which entering each level is not yet known.

For treatment providers operating at levels lower than III.7, this represents a positive impact on the potential volume of services they may provide. A portion of the patients treated by MHD every month will be patients that are entering the treatment system for the first time, who otherwise may not have been able to access treatment otherwise. MHD will foster these patients into the treatment system – specifically into the residential and outpatient levels of care discussed throughout this application.

MHD expects to treat patients that have been referred from within the treatment system as well. These referrals represent patients that may be engaged in outpatient treatment services, but continue to struggle with abstinence. Another portion of these referrals represent patients who have contacted residential or partial hospitalization providers, but need to be successfully stabilized prior to beginning a meaningful treatment episode. Even though MHD may not have acquired these patients prior to some contact with the treatment system, by stabilizing them and referring back to their existing provider, MHD has increased the ability of these providers to retain these patients in treatment. This has the positive effect of steadying the volume of services provided.

In order to consider the needs of the existing providers and examine how the addition of MHD's beds could possibly impact them, MHD conducted a careful investigation of the providers' own recently written impact concerns and considered each to their full merit. During its CON request for additional beds, FMA reported to the Commission that only 48% of its admissions are procured from the State of Maryland, and 26% are procured from the Central Region (FMA p.22). When considering this fact within the context of the volume of services, more than half of FMA's admissions are not affected by additional ICF services operating within Maryland. More so, ICF beds in the central region do not affect three-quarters of the services provided by FMA. The Commission reported its occupancy rate "for the past two years has been between 93% and 95% [and] FMA pointed to the level of interest in its program as evidenced by an average of 55 inquiries per week over the 30 months prior to submission of the CON application" (FMA p. 22). The addition of MHD's beds will not appear to have any negative impact to this provider's volume of services.

Pathways recently provided some insight on how they may be impacted by new programs in its Interested Party Comments to a CON application currently under review (November 2015). MHD is not a replica of the program in question, and will not affect existing providers the same manner by accepting patients for the entire treatment course. Existing providers rely on providing all of the treatment services, not solely on the detox level. In its response, Pathways agrees "there may be a need for some level of additional ICF beds in the state" (Pathways, p. 2). It "is a regionally recognized resource dedicated to preventing and educating the community about addiction and substance use" that "receives a score of 94% in 'likelihood to recommend to others.'"(pp. 4 - 5). While Pathways operates within the central region, "its extended service area includes the Eastern Shore, Prince George's County and Southern Maryland" (p. 5). Pathways ICF beds are integrated with its residential treatment program, so it may only

need to admit approximately 32 patients per month to occupy its ICF beds at full capacity. The addition of MHD's 16 beds to the central region would not appear to have any negative impact on the ICF beds of Pathways. In fact, because Pathways successfully operates lower levels of care – including outpatient – MHD expects to have a positive impact on the volume of lower level treatment services that it offers. MHD has the ability to refer patients into Pathways' outpatient programs and increase the overall volume of services it provides. Pathways reports that its "residential volume during the first three calendar quarters of 2015 is approximately 18% less than it was during the first three calendar quarters of 2014" (Pathways, pp. 4-5). MHD will be able to refer patients to Pathways residential level of care after completing detox, and may positively impact on its volume of services that have recently decreased.

Acute care and emergency providers also stand to have a positive outcome on the volume of services they provide as a result of MHD's operations. MHD's meetings with BWMC indicate that the implications of substance users seeking crisis medical care tend to have a negative impact on hospitals' ability to quickly refer patients out of emergency departments, medical floors, and psychiatric units. In practice, a substance user in crisis may occupy one of these beds until an appropriate referral can be made, or until the patient is stable enough to be discharged. MHD will help to alleviate the occupied bed by accepting these patients into a more appropriate setting. In doing so, the providers make way for additional volumes of patients they can appropriately serve.

Positive Impact to Payer Mix

MHD does not expect to affect the payer mix of existing providers in any negative way. In fact, it expects to have a positive impact on both the private and public providers in the state by treating and referring both public and private patients.

By definition, MHD is a Track One facility; meaning more than 70% of its patient population will be commercially insured. In reality, MHD expects to treat 85% private and 15% public patients. The numbers of expected discharges for each population are below:

Population	Discharges Per Month	Discharges Per Year
Private	68-82	816-984
Public	12-14	144-168

These figures represent the number of patients that MHD will foster into the existing treatment system. MHD will discharge to each of the levels of care, the percentage of which entering each level is not yet known.

Existing private providers of all levels of care – residential, partial hospitalization, intensive outpatient, outpatient, and individual – all stand to benefit from the number of patients that will be transferred, or retained, in the treatment system in Maryland. When compared to public insurance, the nature of commercial insurance is that subscribers may travel out of their home state to receive substance abuse treatment services. FMA reported that 52% of its patients are procured from out of the state of Maryland (FMA p.22). To some extent, the same flow of patients from other states is true about patients leaving Maryland. This supports what treatment providers know to be anecdotally true – that many Maryland residents now seek treatment outside of the state. MHD will provide an avenue for these patients to stay in the state and be referred to existing private

providers. Maryland Recovery Partners, a provider or residential, partial hospitalization, and outpatient treatment services, confirms that it must send its patients across state lines for detox now (Letter of Support, Exhibit 7). MHD will have a positive impact on private providers by increasing the number of referrals, and retaining patients in the state during transfers from detox to lower levels of care.

The existing public providers and providers who accept both public and private funds may experience a positive impact on the mix of public patients they are able to serve. The SHP defines the "indigent population" as "those persons who qualify for services under the Maryland Medical Assistance Program, regardless of whether Medical Assistance will reimburse for alcohol and drug abuse treatment". In practice, MHD may accept these patients for detox as part of its charity care provision and then refer to existing providers for the lower levels of care. MHD will not be reimbursed for these services, but existing providers will be able to treat these patients at outpatient levels of care.

In its Interested Party comments, Pathways explains that a recent decision by the Maryland's Medicaid Managed Care Organization (Value Options/Beacon) has limited its ability to accept these patients for detox and residential care:

> Pathways has always accepted Medicaid. Effective January 1, 2015, however, Medicaid no longer covers residential or outpatient services provided to adults between the ages of 21 and 64 who are admitted to an ICF with more than 16 beds. This is a result of the federal "IMD" ("institution for mental diseases") exclusion under 42 CFR 435.1009(a)(2) that affected 4 10297664-v1 Medicaid reimbursement in Maryland beginning January 1, 2015 with the mental health carveout from the Health Choice program. **While Medicaid reimbursement is still available for outpatient services if the patient is not in need of residential care**, there has been a substantial reduction in Medicaid reimbursement beginning January 1, 2015 for those services. The impact of the IMD waiver on Pathways' payer mix has been significant. During calendar year 2014, Medicaid represented 36% percent of Pathways payer mix, whereas currently it represents 13%. At the same time, the commercial payer mix has increased from 62% prior in calendar year 2014 to 85% currently (Pathways pp. 4-5).

By referring Medicaid patients to public providers for outpatient services, including Pathways, MHD may help to diversify the payer mix of the providers. MHD may provide the detox under its charity care provision, and then transfer to providers who have recently experienced a decline in Medicaid services provided. The decline can be explained by the providers' inability to be reimbursed for detox and residential services. MHD can positively impact the payer mix of these providers by increasing public referrals to the lower levels of care that are being reimbursed.

Increased Access to Healthcare Services

One of the main tenets of the creation of MHD is to increase access to healthcare services. MHD will accept approximately 1000 patients into detox services each year. As thoroughly discussed in previous sections, these are individuals who may not have entered detox through existing providers and may not have the opportunity to access the array of treatment services that are readily available to them following stabilization. If

these patients are not able to access detox services in a timely manner, many will stop looking and lose the opportunity to access all of the treatment services that are available in the state.

The SHP has determined that approximately 12,000 to 14,000 individuals in the state will require ICF care each year. In the central region, the SHP estimates the number to be between 5,000 and 6,000. It is evident by the number of existing beds that the supply cannot meet the demand. An alternative summary of Table 6 is provided below to highlight only these figures again.

Condensed Table 6 Summary: Projected Bed Need for Alcoholism and Drug Abuse ICF Beds in State of Maryland

Serving Adults (18 years and older)

Central Maryland	**Base Year 2015**	**MHCC Projected 2020**
(f) Range of Adults **Requiring ICF/CD Care**		
Minimum (d1+e1+out of state)	5,254	5,440
Maximum (d2+e2+out of state)	6,255	6,476
Total State	**Base Year 2015**	**MHCC Projected 2020**
(f) Range of Adults **Requiring ICF/CD Care**		
Minimum (d1+e1+out of state)	12,048	12,573
Maximum (d2+e2+out of state)	14,408	15,036

In the previous section, **Positive Impact to Existing Providers**, MHD describes how accepting patients into detox paves the way for acute and emergency service providers to treat additional patients in need of those services. By providing a direct avenue to detox, MHD has indirectly increased access to emergency departments, medical floors, and psychiatric units. Beds that may be occupied by a substance user who is more appropriately cared for at MHD (or a similar ICF) will be open to treat individuals who may be waiting to receive services.

The same logic can be attributed to physicians who prescribe buprenorphine or other related opioid maintenance medications in conjunction with Medication Assisted Treatment. The Heroin and Opioid Task Force discusses the need to improve access to buprenorphine prescribers in the state – "There is still a shortage of buprenorphine providers. The Behavioral Health Administration estimates that there are currently less than 800 physicians actively prescribing in the state" (Task Force p.5). Many of the active prescribers in the state have met their limit of patients – whether it is 30 or 100 – and cannot accept any more patients. As these patients seek relief from withdrawal symptoms, MHD can accept them for detox, foster into the treatment system, and make way for an additional buprenorphine patient to enter a physician's roles. MHD may have the indirect effect of opening treatment slots with buprenorphine providers.

Access for all healthcare services directly and indirectly related to substance use and co-morbidities – detox services, treatment services, emergency care, psychiatric care, and

acute medical care – stand to benefit from the addition of MHD's ICF beds. As MHD's beds are free to operate solely as detox beds, the benefit increases exponentially compared to the actual number of licensed beds.

Decreased Costs to the Health Care Delivery System

Taking the steps to create an integrated, flexible healthcare system to treat substance users in the most appropriate settings will help to decrease system-wide costs. The appropriateness of these settings can be considered within the treatment system and within the larger healthcare system as a whole. We know that the most cost-effective course of treatment includes some portion of outpatient care after an initial stabilization. Additionally, the costs associated with substance users seeking medical attention in hospital settings in times of crisis – including emergency and psychiatric care – are higher than the costs of appropriate placement.

The operational nature of MHD as a standalone detox provides a greater level of flexibility in the transfer of patients to subsequent levels of care. This has been discussed at length throughout this application. The cost-effectiveness of outpatient treatment compared to residential treatment has also been previously discussed. By simple logic, MHD stands to reduce costs within the treatment system for patients entering a III.7.D level of care.

The figures below are meant to illustrate the difference in the costs for each level of care. An example of in-network and out-of-network reimbursement rates is provided. MHD can independently confirm the accuracy of its internal calculations. While the actual figures may vary slightly from provider to provider, the average percent decrease in each level of care's costs will not deviate far from these numbers.

Level of Care	Delphi Internal (In-Network Average)	Delphi Internal (Out-of-Network Average	Average Percent Decrease Through Level of Care
Residential	$762	$1,461.23	N/A
Partial Hosp	$650	$1,030.99	22.1%
Intensive Outpatient	$449	$733.97	29.9%
Outpatient	N/A	$222.27	60.3%

As the level of care decreases, the cost to treat decreases. Additionally, the percent that costs are reduced across the levels of care grows as the intensity of treatment declines. MHD has the ability to refer directly to lower levels of care while the traditional model ICF dictates that all patients are referred to residential or partial hospitalization after detox. Even if a portion of patients discharged from MHD enter PHP, IOP, or OP, then cost savings to the healthcare system will be immediately realized.

The real-world implications of sustained substance abuse indicate that if the symptoms are not addressed, lessened, or arrested, individual substance users may demand acute medical services in a hospital setting. This necessity may present in the form of crisis intervention i.e. withdrawal symptoms, conditional suicidality, and/or chemically induced

psychosis; or it may present in the form of medical co-morbidities caused or exacerbated by substance use – high blood pressure, infections, cirrhosis, accident induced trauma, etc. The utilization costs when substance users enter a hospital system for the treatment of addiction or co-morbidities surpass the costs associated with treating these individuals in the appropriate setting.

The table below utilizes data from Maryland's Health Services Cost Review for a selection of 2016 daily inpatient unit rates. The selection of services encompasses units that chemically dependent individuals are likely to end up on if admitted to a hospital. Medical/Surgical ICUs, Step Down (Observation), and Medical Surgical Units are utilized to detox alcohol dependent individuals and to treat individuals suffering from complications due to substance use. Acute psychiatric units unfortunately act as proxy detox units at many acute care hospitals and serve to stabilize patients with co-occurring mental illnesses and/or conditional psychiatric symptoms.

HSCRC Rates for Maryland Hospitals FY 2016

Hospital Service	Range	Average
MIS Medical Surgical ICU	$1,500 - $4,000	$2,377.48
DEF Definitive Observation	$695 -$1,749	$1,220.78
PSY Psychiatric Acute	$815 - $1,475	$1,142.20
MSG Medical Surgical Acute	$725 - $1,900	$1,115.31

These daily rates do not include the Emergency Department RVUs, services, and medications that are likely to be charged prior to admission. Once admitted, these daily rates do not include professional fees, medications, labs, and other ancillary expenses. Costs to treat substance users in hospital settings are not economical when compared to the costs of the appropriate setting. MHD estimates an average bill rate of $1,667 and average reimbursement rate of $1000 – both of which are inclusive rates of professional fees, medication, and lab services.

The costs of entering substance abuse treatment and preventing further utilization of hospital services undoubtedly serve to decrease costs across the healthcare system. There is a concerted effort with Maryland's HSCRC to reduce costs associated with readmissions in hospital settings. If substance users are not fostered into the treatment system upon an acute admission, the risk of readmission for the same crisis symptoms and/or the same and additional co-morbidities is intensified many times over. The costs may be repeated over an over again, steadily increasing as symptoms and conditions worsen. Healthcare costs across the entire system are strained when there is a lack access to appropriate treatment settings.

By increasing access to detox services and fostering patients into the treatment system, the MHD project will directly and indirectly have a positive impact on the volume of services delivered by existing providers across the healthcare system. Treatment providers stand to experience an increase in referrals to all levels of care and acute care medical providers will ultimately be able to provide more services to non-addicted patients. MHD will help to diversify the payer mix in the state by providing another avenue for commercially insured individuals stay in the state for treatment while promoting services for publically funded individuals throughout the treatment system. In

doing so, MHD effectively works to improve access to all services for an unprejudiced population of individuals and lower costs across the healthcare delivery system.

Exhibit 1

Organizational Chart

Maryland House Detox Organizational Chart

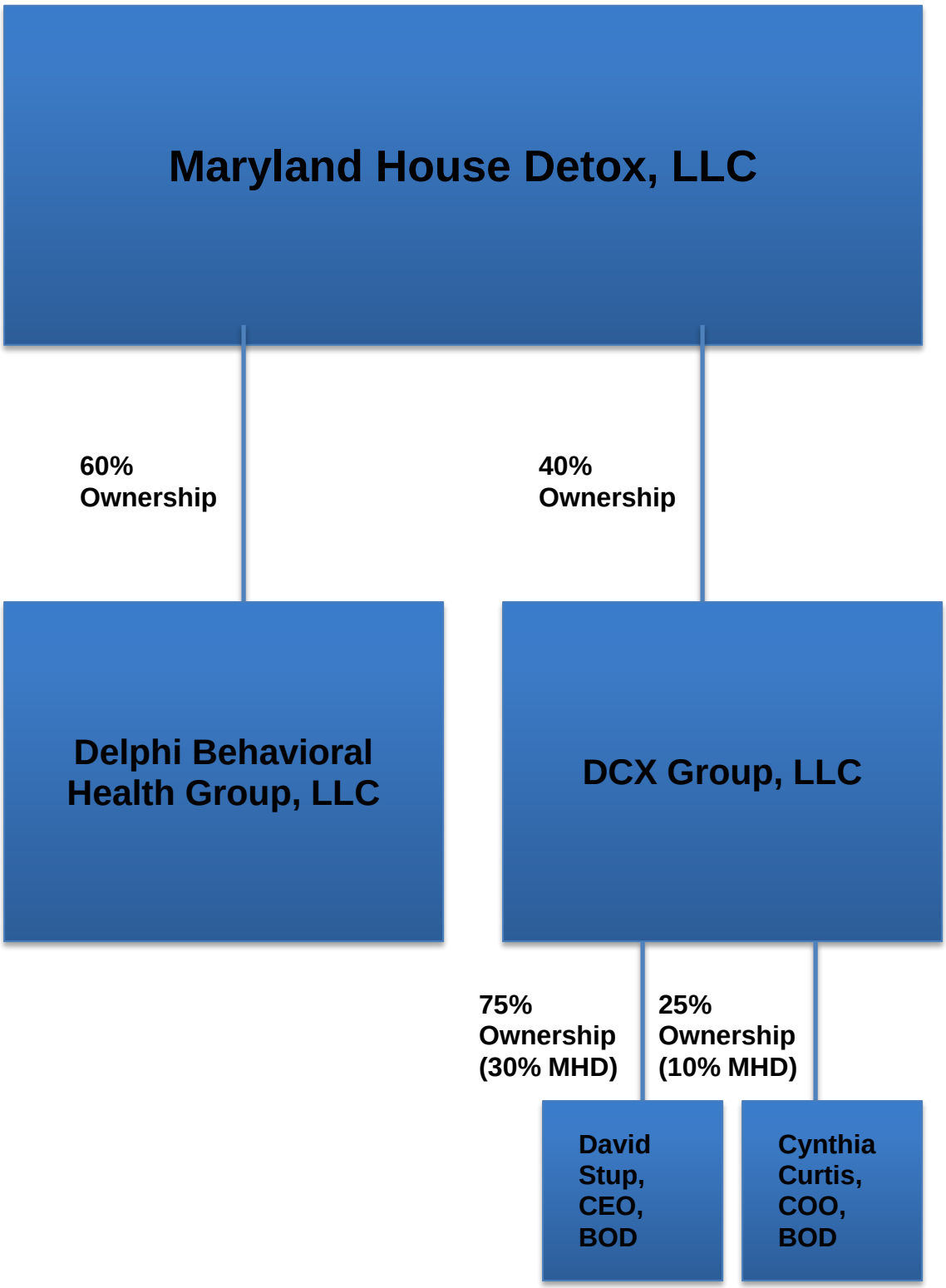

Exhibit 2

Lease Agreement

LEASE AGREEMENT

THIS LEASE AGREEMENT (this "Lease") is made this 1 day of November, 2015 (the "Effective Date") by and between Maryland Healthcare Real Estate, LLC, a Maryland limited liability company (the "Landlord"), and Maryland House Detox LLC, a Delaware limited liability company (the "Tenant").

WITNESSETH:

In consideration of the agreements set forth in this Lease, Landlord hereby leases to Tenant, and Tenant hereby leases from Landlord the Leased Premises described below.

1. **PRINCIPAL LEASE PROVISIONS.**

a. Landlord's Address.

Maryland Healthcare Real Estate LLC
5722 Flamingo Rd., Suite 412
Fort Lauderdale, FL 33330-3206
Attn: Ryan Collison

b. Tenant's Address.

Maryland House Detox LLC
817 S. Camp Meade Rd
Linthicum, MD 21090

Attn: David Stup

c. Leased Premises. The real property consisting of approximately 1.90 acres which is legally identified in the Official Records of Anne Arundel County, Maryland, as Tax Map 4, Grid 15, Parcel 600, and all improvements and facilities located on the land, including, but not limited to, the Building (as defined below). The Leased Premises is more particularly described on **Exhibit A,** which is attached hereto and made a part hereof (referred to herein as the "Leased Premises" or "Property").

d. Building. The one-story single-tenant building located within the Leased Premises with the street address of 817 S. Camp Meade Road, Linthicum, Anne Arundel County, Maryland 21090, containing approximately 6,175 square feet (the "Building").

e. Lease Term. The "Lease Term" shall commence on the Lease Commencement Date and shall be a period of five (5) years plus the part of the month, if any, from the Lease Commencement Date to the first day of the first full calendar month thereafter. The "Lease Term" shall include any properly exercised Extension Terms.

f. Extension Term. In addition to the original Lease Term, so long as Tenant has well and faithfully performed all of its obligations to be performed under this Lease, Tenant shall have the option to extend the Lease Term for two (2) consecutive extension terms of five (5) years each (each, an "Extension Term"). If Tenant desires to exercise its option to extend the Lease Term or to further extend the Lease after the first Extension Term, Tenant shall deliver to Landlord written notice at least ninety (90) days before the expiration of the original Lease Term or first Extension Term, as applicable. All of the terms, covenants and conditions of this Lease pertaining to the Lease Term also shall apply during each Extension Term (including the Base Rent set forth below), except that at the expiration of the second Extension Term, Tenant shall not have the further right to extend the Lease Term. If, for any reason, Tenant fails to exercise its option to extend within the time and in the manner described above, then this right and option shall terminate and be null and void without the necessity of any further act or documentation by Landlord or Tenant, and the Lease Term shall terminate in accordance with the provisions set forth elsewhere in this Lease.

g. Lease Commencement Date. The Lease Commencement Date shall be the later to occur of the following: (i) the Effective Date, or (ii) October 1, 2015, which shall be deemed by the parties to be the date upon which Landlord delivers possession of the Leased Premises to Tenant. Upon final determination of the Lease Commencement Date, Landlord may prepare a written instrument confirming the Lease Commencement Date and expiration date of the Lease Term. Tenant shall execute such instrument within five (5) days after receipt from Landlord.

h. Rent Commencement Date. The Rent Commencement Date shall be the same as the Lease Commencement Date.

i. Termination Option. Provided that (i) no Event of Default has occurred and is then continuing and no facts or circumstances exist, either at the time of Tenant's delivery of the Termination Notice (as defined below) to Landlord or on the date such termination would otherwise be effective, which, with the giving of notice or the passage of time, or both, would constitute an Event of Default; (ii) despite making commercially reasonable efforts, Tenant is unable to secure any necessary governmental certificates or permits related to zoning, occupancy or use of the property that are necessary for Tenant's use of the Property for the Permitted Use (as defined below); (iii) Tenant has provided Landlord with reasonable evidence of Tenant's efforts and inability to acquire the certificates or permits described in subsection (ii) above, and (iv) Tenant delivers to Landlord prior to the date of such early termination the Termination Fee (as defined below), then Tenant shall have the right to terminate this Lease in accordance with the terms herein, on the condition that the Termination Fee and Termination Notice are delivered to Landlord within twelve (12) months after the Effective Date of this Lease. In order to exercise such termination right, Tenant shall notify Landlord of such exercise and the selected date for such early termination in writing ("Termination Notice") at least thirty (30) days prior to the effective date of such termination (time being of the essence), and, within thirty (30) days of delivering the

Termination Notice, Tenant shall pay to Landlord via certified check or wire transfer the sum of Forty Six Thousand Five Hundred Dollars ($46,500) ("Termination Fee"), as an agreed upon termination payment. Rent shall be payable through and including the date of early termination, pro-rated for any partial months. In the event that Tenant timely gives the Termination Notice and pays the Termination Fee, this Lease shall expire on the date specified by Tenant in the Termination Notice just as though such date had been the original Expiration Date.

j. Base Rent.

Time Period	**Monthly Installment**
Months 1 - 3 of Lease Term	$0.00*
Months 4 - 6 of Lease Term	$7,750.00
Months 7 - 60 of Lease Term	$15,500.00
Months 1 - 60 of the First Extension Term	$16,895.00
Months 1 - 12 of the Second Extension Term	$17,401.85
Months 13 - 24 of the Second Extension Term	$17,923.91
Months 25 - 36 of the Second Extension Term	$18,461.62
Months 37 - 48 of the Second Extension Term	$19,015.47
Months 49 - 60 of the Second Extension Term	$19,585.94
* Landlord agrees to abate the initial three (3) successive installments of monthly Base Rent (which would otherwise be $7,750.00/month), provided that no Event of Default occurs with respect to Tenant under this Lease which is not cured within any applicable notice and cure period. If such Event of Default occurs, then the abated rent shall be paid to Landlord by Tenant as additional rent.	

k. Permitted Use. The "Permitted Use" is: Drug and alcohol detox treatment facility uses, including but not limited to drug, alcohol abuse, and mental health rehabilitation, education, and treatment, and for any lawful purpose incidental thereto.

l. Security Deposit. There is no Security Deposit.

m. Tenant's Proportionate Share. "Tenant's Proportionate Share" shall be 100% of the Building.

2. **DEFINITIONS**.

a. Operating Expenses. "Operating Expenses" shall mean expenses, costs and disbursements of every kind and nature incurred in connection with the ownership, management, maintenance, repair and operation of the Property, including but not limited to the following:

(1) all costs and expenses of operating, repairing, lighting, cleaning, and insuring the Property, including replacement of equipment and systems, and all costs incurred in removing snow, ice and debris therefrom and of policing and regulating traffic with respect thereto, and depreciation of all machinery and equipment used therein or thereon;

(2) cost of all supplies and materials used in the ordinary and customary operation, maintenance and repair of the Building and all other portions of the Property, including sales and uses taxes on the same;

(3) cost of all water and sewer (including surcharges) for the Property;

(4) costs incurred under all maintenance and service agreements for the Building, including but not limited to access control, energy management services, window cleaning, elevator maintenance, janitorial service and landscaping;

(5) cost of insurance relating to the Property, including but not limited to the cost of casualty and liability insurance;

(6) cost of ordinary and customary general maintenance to the Property which shall include necessary repairs and replacements but shall exclude any repairs and replacements of a capital nature;

(7) costs of any repairs, or replacements required or made necessary by law or changes in law arising after the date hereof;

(8) cost of any licenses or permits required by any public authority after completion of the construction;

(9) maintenance, repair and replacement of mechanical and electrical equipment including heating, ventilation and air conditioning equipment;

(10) window cleaning, janitorial service, trash removal service and pest control services, including, if applicable, the cost of necessary equipment, uniforms, supplies and sundries;

(11) maintenance and repair of elevators, stairways, rest rooms, lobbies, hallways and other facilities;

(12) repainting and redecoration of the Building;

(13) actual management fees incurred by Landlord;

(14) cost of wages and salaries of all employees engaged full time in the operation and maintenance of the Property, including but not limited to payroll taxes, insurance and benefits, and the prorated cost of wages and salaries of all employees engaged part time in the operation and maintenance of the Property, including but not limited to payroll taxes, insurance and benefits;

(15) legal, accounting and administrative fees and expenses;

(16) costs and expenses of grass cutting, fertilizing, planting, replanting and replacing flowers, shrubs or other exterior decorations within the Property;

(17) costs necessary for providing adequate security and/or security personnel to the Property, if such is deemed necessary by Landlord;

(18) Taxes (defined below);

(19) Utility Costs (defined below);

(20) all other expenses which would be considered an expense of owning, maintaining, operating or repairing the Property.

"Operating Expenses" shall **not** include the following:

(1) payments of principal and interest, points and fees on any mortgages, deeds of trust or other financing instruments relating to the financing of the Property and/or the Building; (2) leasing commissions; (3) brokerage fees; (4) any increase in real estate taxes based on a re-assessment of the Property resulting from the sale of the Property; (5) any ground lease rental; (6) costs incurred by Landlord for the repair of damage to the Building, to the extent the Landlord is reimbursed by insurance proceeds or to the extent that such damage is caused by Landlord's intentional misconduct; (7) any and all income tax paid by Landlord; (8) marketing costs, including leasing commissions, attorney's fees in connection with the negotiation and preparation of letters, deal memos, letters of intent, leases, subleases and/or assignments, space planning costs, and other costs and expenses incurred in connection with lease, sublease and/or assignment negotiations and transactions; (9) audits performed as required by Landlord's lenders or members or for Landlord's business; (10) any amounts paid by Landlord for materials, labor or equipment shall be limited to the amounts which would have been paid for the aforesaid based upon their procurement from an unaffiliated party in an arm's length transaction; (11) all items and services for which Tenant reimburses Landlord (other than through Tenant's Proportionate Share of Operating Expenses); (12) advertising of a non-employment nature and promotional expenditures, and procurement costs of signs in or on the Building identifying the owner of the Building; (13) fines and/or penalties incurred by Landlord as a result of violation of any laws, rules, orders, regulations, or ordinances applicable to Landlord or the Building or the Property (including all costs of remedying such violations, except for any violations resulting from Tenant's acts), provided any such violation is not caused by Tenant's actions; (14) tax penalties incurred as a result of

Landlord's negligence, inability or unwillingness to make payments when due; (15) costs arising from Landlord's charitable or political contributions; (16) costs arising from latent defects in the base, shell or core of the Building; and (17) attorney fees, costs and disbursements (including settlements) and other expenses incurred in connection with defense of Landlord's title to or interest in the Leased Premises, the Building or its appurtenances, or any part thereof.

Landlord may, from time to time and with prior notice to Tenant, and at Landlord's election in Landlord's sole and absolute discretion, require Tenant to pay for any Operating Costs directly to the applicable vendor, municipality, or other payee, or Landlord may instead pay for such costs directly and send Tenant periodic invoices seeking reimbursement of such costs. Tenant shall pay any such invoices within thirty (30) days after receipt of same.

b. Lease Year. A "Lease Year" shall be a calendar year from January 1 through December 31. If the Lease Commencement Date is a date other than January 1, then the first Lease Year shall include the portion of the calendar year following the Lease Commencement Date. The last Lease Year shall include the portion of the calendar year immediately preceding the expiration of the Lease Term.

c. Taxes. "Taxes" shall mean all present and future real estate taxes, assessments, and valorem charges, personal property taxes, front foot benefit charges and all other governmental impositions and/or levies, whether or not now customary or within the contemplation of the parties hereto and regardless of whether the same shall be extraordinary or ordinary, general or special, foreseen or unforeseen, or similar or dissimilar to any of the foregoing. "Taxes" shall further mean any advances or escrow deposits paid or made to any taxing authority or third party such as lender on account of any of the foregoing. If, during the Lease Term or any extension thereof, the method of taxation prevailing at the commencement of the Lease Term shall be altered or eliminated so as to cause all or any part of the items listed in the preceding sentences of this paragraph to be replaced or supplemented by a capital levy, tax, imposition or otherwise, on the rents or income received from the Property, (provided the tax on such income is not a tax levied on taxable income from all sources generally) then the charge to Landlord resulting from such modified or replaced method of taxation shall be deemed to be within the definition of "taxes". All reasonable expenses incurred by Landlord (including attorneys' fees and costs) in contesting, appealing and/or negotiating against any increase in taxes or any increase in the assessment of the Property shall be included as an item of taxes for purposes hereof.

d. Utility Costs. "Utility Costs" shall mean all costs of electricity, gas, steam and fuel used in lighting, heating, ventilating and air conditioning and all other electrical operations within the Property.

3. **BASE RENT; SECURITY DEPOSIT; LATE CHARGE.**

a. Base Rent. Tenant covenants and agrees to pay to Landlord, as rental for the Leased Premises, the Base Rent set forth in Section 1 of this Lease. Tenant shall pay the Base Rent in twelve (12) equal monthly installments in advance on the first day of each full calendar month during the Lease Term. All rental and other monetary obligations of Tenant set forth in this Lease (whether or not characterized as rent), except for Base Rent, shall be referred to as "Additional Rent". All Base Rent and Additional Rent are sometimes collectively referred to as "Rent" or "rent".

b. Guaranty of Lease. Tenant shall cause the Guaranty of Lease attached hereto as **Exhibit C** to be duly executed by Delphi Health Group LLC, a Delaware limited liability company ("Guarantor"), and delivered to Landlord concurrent with the execution and delivery of this Lease. This Lease such be deemed cancelled and of no further force and effect if such concurrent delivery is not made.

c. Rent Payment. All Rent payable by Tenant to Landlord under this Lease shall be paid to Landlord at Landlord's address set forth in Section 1 above. Tenant will promptly pay all Rent when and as the same shall become due and payable, without notice, demand, abatement, deduction or set-off.

d. Late Charge. In the event that Tenant makes any payment due hereunder more than five (5) days after the due date thereof, Tenant also shall pay a late charge to Landlord to cover the extra expense involved in handling delinquent payments; provided, however, that Tenant shall be entitled to one (1) five (5) day notice during each twelve (12) month period before the late charge shall be payable with respect to the late payment as to which such notice relates. The late charge shall be equal to five percent (5%) of the amount of the late payment.

4. **PERMITTED USE.**

Tenant shall use the Leased Premises solely for the Permitted Use and for no other purpose or purposes. No use shall be made or permitted to be made of the Leased Premises or acts done which will increase the existing rate of insurance on the Property or cause the cancellation of any insurance policy covering the Property or any part thereof, nor shall Tenant sell or permit to be kept, used or sold in or about the Leased Premises any article which may be prohibited by the standard form of fire insurance policies. Tenant shall not commit or suffer to be committed any waste upon the Leased Premises or any public or private nuisance. Tenant shall not use the Leased Premises or permit the same to be used in whole or in part for any purpose or use that is deemed to be in violation of any of the laws, ordinances, regulations or rules of any public authority or organization at any time.

5. **[INTENTIONALLY OMITTED.]**

6. **OPERATING EXPENSES.**

a. Commencing as of the Rent Commencement Date, for each calendar year or portion thereof during the Term, Tenant shall pay Landlord, without demand or offset, as

Additional Rent, an amount reasonably estimated by Landlord to reflect Tenant's Proportionate Share of Operating Expenses that are reimbursable to Landlord by Tenant.

b. Landlord will deliver to Tenant an annual reconciliation statement of the actual Operating Expenses incurred during each calendar year. Tenant shall pay, or Landlord shall refund, any underpayment or overpayment of Operating Expenses within thirty (30) days after the date of the annual reconciliation.

c. Tenant's obligation to pay any additional rent accruing during the Lease Term pursuant to this Section shall apply pro rata to the proportionate part of a calendar year in which the Lease Term begins or ends, for the portion of each such year during which this Lease is in effect. Such obligation to make payments of such additional rent shall survive the expiration or sooner termination of the Lease Term, whether or not this Lease is superseded by a subsequent lease of the Leased Premises or of any other space or Tenant leaves the Building; any such superseding lease shall not serve to supersede Tenant's obligation for any such additional rent unless it makes express reference thereto and recites that such additional rent is abated in consideration of the superseding lease.

7. **HVAC, SERVICES, AND UTILITIES**.

Landlord shall ensure that the following utilities are provided to the Leased Premises on the Commencement Date, but Tenant shall provide routine maintenance of all equipment necessary to supply the same after the Commencement Date: Heat or air conditioning ("HVAC"), hot and cold water, electricity, gas, sewer, and other standard utility services typically necessary for the Permitted Use. Landlord shall be responsible for any repairs or replacements of a capital nature to any plumbing or electrical systems, except to the extent that such repair or replacement is caused by the negligence or willful misconduct of Tenant or Tenant's agents, employees, contractors, guests or invitees, and Landlord may pass-through to Tenant as part of Operating Expenses, so long as such costs are amortized over the useful life of such repair or replacement on a straight-line basis in accordance with generally accepted accounting principles and only the portion allocable to the Lease Term shall be payable by Tenant.

8. **INTERRUPTION**:

a. Landlord shall have no liability to Tenant on account of any failure, modification or interruption of electricity, water or other utility or HVAC or other service, unless caused by Landlord's negligence or intentional misconduct. In the event of failure or interruption of such service, Landlord shall take reasonable steps to provide for the resumption of such service to the extent the same is within Landlord's control. There shall be no allowance to Tenant for any diminution of rental value of the Leased Premises.

b. Landlord shall have no liability to Tenant for any discontinuance of heat, air conditioning, and hot water unless directly due to Landlord's gross negligence or intentional misconduct and not covered by insurance carried or otherwise required to be carried by Tenant under this Lease. Landlord shall not be liable for any loss or damage to the Tenant caused by rain, snow, water or storms that may leak into or flow from any part of the premises through any

defects in the roof or plumbing or from any other source unless directly due to Landlord's negligence and not covered by insurance carried or otherwise required to be carried by Tenant under this Lease.

c. There shall be no allowance to Tenant for any diminution of rental value and no liability on the part of the Landlord by reason of inconvenience, annoyance or injury to business arising from the making by Landlord, Tenant or others of any repairs or improvements in or to the Building or the Leased Premises, or in or to the fixtures, appurtenances or equipment thereof which are made in the ordinary course of business.

d. Landlord shall have no liability to Tenant for any injury or damage resulting from acts or omissions of persons occupying property adjoining the Leased Premises, or for any injury or damage resulting to Tenant or its property from bursting, stoppage, or leaking of water, gas sewer or steam pipes, except where such loss or damage is caused by Landlord's gross negligence or intentional misconduct.

9. **INSURANCE BY TENANT.**

a. Throughout the Lease Term (including any extensions thereof), Tenant shall procure and maintain, at its expense, the following insurance policies for any claim, damage, liability, loss or expense (hereinafter, "Claims") caused by, resulting from, arising out of or in connection with the Tenant's use and occupancy of the Leased Premises and any portion of the Property, any construction or other work being performed by or on behalf of Tenant, and the operations and activities of Tenant, its employees, agents, contractors, guests and other invitees at the Leased Premises:

i. Commercial General Liability insurance with limits not less than $2,000,000 each occurrence and $2,000,000 in the aggregate. Such insurance shall include coverage for contractual liability, premises liability, products-completed operations, personal and advertising injury, tenant's legal liability, premises damage legal liability, medical payments, and third party property damage and bodily injury liability (including death).

ii. Automobile Liability insurance for claims arising out of Tenant's use, maintenance or operation of any vehicles (including service trucks) within the Property, with limits not less than $1,000,000 each accident combined single limit for bodily injury and property damage; and Auto Physical Damage providing coverage for Comprehensive and Collision related damages to such vehicles.

iii. Workers' Compensation insurance covering Tenant's employees with limits as required by statutory law, including Employer's Liability coverage with limits not less than $1,000,000 each accident, $1,000,000 disease-each employee and $1,000,000 disease-policy limit.

iv. Property insurance written on an "all risk" replacement cost basis with respect to all alterations, improvements, and other modifications made by or on behalf of Tenant at the Leased Premises, and any theft, loss or damage to Tenant's business personal property, including but not limited to, furniture, fixtures, equipment, Signage,

communication systems, computer systems, cable systems, microwaves, satellites or other antenna systems, supplies, contents and other property owned, leased, held or possessed by Tenant at the Building and/or the Leased Premises.

b. All insurance required to be maintained by Tenant pursuant to this Lease shall be maintained with responsible companies that are admitted to do business, and are in good standing, in the jurisdiction in which the Leased Premises are located and that have a financial strength rating of at least "A" and are within a financial size category of not less than "Class X" in the most current Best's Key Rating Guide or such similar rating as may be reasonably selected by Landlord.

c. To the fullest extent permitted by law, the commercial general liability and auto insurance carried by Tenant pursuant to this Lease shall name Landlord, Landlord's managing agent, and such other Persons as Landlord may reasonably request from time to time as additional insureds with respect to liability arising out of this Lease or the operations of Tenant by ISO form CG 20 11 or its equivalent (collectively "Additional Insureds"). Such insurance shall provide primary coverage without contribution from any other insurance carried by or for the benefit of Landlord, Landlord's managing agent, or other Additional Insureds. For the avoidance of doubt, each primary policy and each excess/umbrella policy through which Tenant satisfies its obligations under this section must provide coverage to the Additional Insureds that is primary and noncontributory.

d. On or before the earlier of (i) the date on which Tenant first enters the Leased Premises for any reason or (ii) the Commencement Date, Tenant shall furnish Landlord with certificates evidencing that all insurance requirements in this Lease have been met. Renewal certificates shall be furnished to Landlord annually thereafter (on the anniversary of the Commencement Date), and at least thirty (30) days prior to the expiration date of each policy for which a certificate was furnished. Failure by the Tenant to provide the certificates required by this section shall not be deemed to be a waiver of the requirements in this section. Upon request by Landlord, a true and complete copy of any insurance policy required by this Lease shall be delivered to Landlord within ten (10) days following Landlord's request.

e. All insurance required to be maintained by Tenant hereunder shall contain an endorsement prohibiting cancellation, failure to renew, reduction of amount of insurance, or change in coverage without the insurer first giving Landlord thirty (30) days' prior written notice (by certified or registered mail, return receipt requested, or by fax or email) of such proposed action. If the insurer fails to give such notice, Tenant shall give such notice to Landlord at least ten (10) days prior to such modification, cancellation, or non-renewal.

f. To the fullest extent permitted by law, Landlord and Tenant waive and release any and all rights of recovery against the other, and agree not to seek to recover from the other or to make any claim against the other, and in the case of Landlord, against all "Tenant Parties" (defined below in Section 17), and in the case of Tenant, against all "Landlord Parties" (defined below in Section 17), for any loss or damage incurred by the waiving/releasing party to the extent the party receives insurance proceeds for such loss or damage under any insurance policy required by this Lease, or to the extent the party would have received such insurance proceeds had the party carried the insurance it was required to carry hereunder. Tenant shall obtain from

its subtenants and other occupants of the Leased Premises a similar waiver and release of claims against all Tenant Parties and Landlord Parties. In addition, the parties hereto (and in the case of Tenant, its subtenants and other occupants of the Leased Premises) shall procure an appropriate clause in, or endorsement on, any insurance policy required by this Lease pursuant to which the insurance company waives subrogation against Tenant Parties and Landlord Parties. The insurance policies required by this Lease shall contain no provision that would invalidate or restrict the parties' waiver and release of the rights of recovery in this section. The parties hereto covenant that no insurer shall hold any right of subrogation against the parties hereto by virtue of such insurance policy.

g. In the event Tenant shall fail to obtain or maintain any insurance meeting the requirements of this Article, or to deliver such policies or certificates as required by this Article, Landlord may, at its option, on five (5) days' notice to Tenant, procure such policies for the account of Tenant, and the cost thereof shall be paid to Landlord within five (5) days after delivery to Tenant of bills therefor.

h. During such times that Tenant is performing work or having work or services performed in or to the Demised Premises, Tenant shall require that each contractor and subcontractor hired to perform such work or services maintain at such contractor's and/or subcontractor's expense, insurance as reasonably required by Landlord.

i. Landlord reserves the right to modify the insurance requirements under this Lease from time to time in its reasonable discretion.

10. **INSURANCE BY LANDLORD**.

Landlord shall maintain insurance against loss or damage to the Building with coverage for perils as set forth under the "Causes of Loss-Special Form" or equivalent property insurance policy in an amount equal to the full insurable replacement cost of the Building (excluding coverage of Tenant's personal property and any alterations by Tenant), and such other insurance, including rent loss coverage, as Landlord may reasonably deem appropriate or as any mortgagee may require.

11. **RULES AND REGULATIONS**.

Tenant shall comply with all rules and regulations (the "Rules of Regulations") established by Landlord which Rules and Regulations are attached hereto as **Exhibit B** and are hereby made a part of this Lease. Landlord shall have the right to make additions and amendments to the Rules and Regulations, which shall be as binding on Tenant as if set forth herein, provided such additions and amendments do not materially and adversely affect the Tenant's use of the Leased Premises and are not inconsistent with the terms of this Lease.

12. **MAINTENANCE**.

a. Except for the items specified as Landlord obligations pursuant to Section 12.b. below, Tenant shall at all times maintain the interior and exterior of the Leased Premises and all equipment, personal property and fixtures in good, clean, and safe repair and condition, ordinary wear and tear excepted. Tenant shall enter into and maintain a contract with a janitorial service

company and landscaping company reasonably approved by Landlord pursuant to which such company shall perform regularly scheduled cleaning and landscaping services, as applicable, at the Property.

b. Landlord shall furnish, supply and maintain in good order and repair, and replace, if necessary in Landlord's sole discretion, with costs for same to be passed through as Operating Expenses as provided elsewhere in this Lease: (a) the roof and other structural portions of the exterior of the Building, (b) the Building systems and facilities to the extent such repair or replacement is of a capital nature, including, but not limited to, plumbing, electrical and heating and air-conditioning facilities, and (c) the façade of the Building.

c. Alterations, repairs and replacements to the Property, including the Leased Premises, made necessary because of Tenant's alterations or installations, any use or circumstances special or particular to Tenant, or any act or omission of Tenant or its agents shall be made at the sole expense of Tenant. Tenant shall be responsible for the cost incurred by Landlord in connection with the maintenance, repair and replacement of hardware and locks on the exterior entrance doors of the Leased Premises.

13. **HAZARDOUS AND INFECTIOUS WASTE.**

a. Prohibitions. Tenant, its employees, licensees, invitees, agents and contractors shall not use, manufacture, release, store or dispose of on, under or about the Leased Premises, the Property, any medical waste, biohazards, explosives, flammable substances, radioactive materials, asbestos in any form, paint containing lead, materials containing urea formaldehyde, polychlorinated biphenyls, or any other hazardous, toxic or dangerous substances, wastes or materials, whether having such characteristics in fact or defined as such under federal, state or local laws or regulations and any amendments thereto (all such materials and substances being hereinafter referred to as "Hazardous Materials"), except such Hazardous Materials routinely used in connection with Tenant's permitted use under this Lease and then only in such quantities reasonably required in connection with Tenant's operations and in compliance with all applicable laws.

b. Inspection. After notice to Tenant, Landlord, in addition to its other rights under this Lease, may enter upon the Leased Premises for the purposes of inspecting to determine whether the Leased Premises, the Building, the Property or the environment have become contaminated with Hazardous Materials. In the event Landlord discovers the existence of any such Hazardous Materials due to fault or other act of Tenant or its agents, employees, invitees or licensees, Tenant shall reimburse Landlord upon demand for the costs of such inspection, sampling and analysis.

c. Cleaning and Removal. At Tenant's sole cost, Tenant promptly shall remove the following from the Leased Premises and sanitize the affected area: bodily fluids and blood-borne pathogens. In the event that any of the foregoing are introduced to the Property by Tenant, its agents, employees, guests or invitees, then Tenant promptly shall remove the same and cause the area to be sanitized.

d. Indemnification. Without limiting the above, Tenant shall indemnify and hold harmless Landlord from and against any and all claims, losses, liabilities, damages, costs and expenses, including without limitation attorneys' fees and the costs of any required or necessary repair, cleanup or detoxification, arising out of or in any way connected with the existence, use, manufacture, storage or disposal of Hazardous Materials by Tenant or its employees, agents, invitees, licensees or contractors on, under or about the Leased Premises, the Building or the Property. The indemnity obligations of Tenant under this clause shall survive any termination of this Lease.

14. **ALTERATIONS BY TENANT.**

Landlord shall deliver the Premises to Tenant and Tenant shall accept the Premises in the "as-is" condition existing on the Effective Date. Tenant shall be responsible for all costs and expenses necessary to convert the Building into a drug and alcohol detox and rehabilitation facility. Subject to the prior written consent of Landlord, Tenant at Tenant's expense, may make alterations, additions or improvements which are non-structural and which do not affect utility services or plumbing and electric lines, in or to the interior of the Leased Premises. All alternations, improvements or additions shall become the property of Landlord upon their installation and shall remain upon the Leased Premises at the expiration of this Lease Term. Notwithstanding the foregoing, Landlord may elect to require that Tenant remove any alterations or improvements by delivering written notice to Tenant at least thirty (30) days before the expiration or early termination of this Lease. In such event Tenant shall at its expense immediately remove such alterations, improvements and additions. Tenant may remove any of its trade fixtures installed at its expense. Upon removal of any trade fixtures from the Leased Premises or upon removal of any alterations, additions or improvements as may be required by Landlord, Tenant shall immediately and at its expense, repair and restore the Leased Premises to the condition existing prior to installation and repair any damage to the Leased Premises or the Building due to such removal. Tenant shall be responsible to pay all costs associated with any alteration, construction or reconstruction of the Leased Premises required by any governmental authority in order to comply with the provisions of the Americans with Disabilities Act of 1990. All property permitted or required to be removed by Tenant at the end of the term remaining in the Leased Premises after Tenant's removal shall be deemed abandoned and may, at the election of Landlord, either be retained as Landlord's property or may be removed from the premises by Landlord at Tenant's expense. If any mechanic's lien is filed against the Leased Premises, the Property for work claimed to have been done for, or materials furnished to Tenant whether or not pursuant to this Section, the same shall be discharged by Tenant within ten (10) days thereafter. Failure to timely discharge any such lien shall constitute an Event of Default hereunder.

15. **SURRENDER OF PREMISES.**

a. At the expiration or earlier termination of the Lease Term, (i) Tenant will surrender the Leased Premises to Landlord broom clean and in as good condition as when received, excepting depreciation caused by ordinary wear and tear, and (ii) in addition to any alterations and improvements required to be removed by Tenant from the Leased Premises pursuant to other provisions of this Lease, Tenant shall remove all wiring and cabling installed by or on behalf of Tenant.

b. This Lease and the tenancy hereby created shall cease and terminate at the end of the Lease Term, without the necessity of any notice of termination from either Landlord or Tenant. Tenant hereby waives any notice of termination or to surrender the Leased Premises. Tenant agrees that Landlord shall be entitled to the benefit of all laws respecting summary recovery of possession of premises from a tenant holding over to the same extent as if statutory notice was given. If Tenant shall occupy the Leased Premises after such expiration or termination, either due to a failure to timely exercise an option for an Extension Term or otherwise, Tenant shall hold the Leased Premises as a tenancy at sufferance, subject to all the other terms and conditions of this Lease, at an amount equal to two hundred percent (200%) of the monthly Base Rent in effect immediately preceding such holdover for the first (1st) partial and full calendar month of such holdover, with such amount to increase by an additional ten percent (10%) each successive month of such holdover until the last calendar day of the month in which Tenant eventually vacates and surrenders the Leased Premises to Landlord in the condition required under this Lease. There shall be no pro-ration of Base Rent in the event that Tenant vacates and surrenders the Leased Premises in the condition required under this Lease prior to the last day in a calendar month and such occupancy shall be deemed to extend through, and Base Rent shall be owed for the period extending through, the last day of such calendar month.

16. **SIGNS**.

a. Tenant shall not display any sign, picture, advertisement, awning, merchandise, or notice on the outside or roof of the Building; or on the exterior of the Leased Premises; or in the interior of the Leased Premises if visible from the exterior of the Leased Premises, unless approved by Landlord in writing, such approval not to be unreasonably withheld. Tenant shall not display any advertising or informational material, merchandise, place vending machines or show cases or other obstructions on the outside of the Building.

17. **INDEMNITY**.

a. Indemnity. To the fullest extent permitted by law, Tenant waives any right to contribution against the Landlord Parties (as hereinafter defined) and agrees to indemnify and save harmless the Landlord Parties from and against all claims of whatever nature by a third party arising from or claimed to have arisen from (i) any intentional misconduct or negligence of the Tenant Parties (as hereinafter defined); (ii) any accident, injury or damage whatsoever caused to any person, or to the property of any person, occurring in or about the Leased Premises from the Commencement Date, and thereafter throughout and until the end of the Lease Term, and after the end of the Lease Term for so long after the end of the Lease Term as any property of Tenant remains on the Leased Premises, or anyone acting by, through or under Tenant may use, be in occupancy of any part of, or have access to the Leased Premises or any portion thereof, except to the extent caused by Landlord's negligence or willful misconduct; (iii) any accident, injury or damage whatsoever occurring outside the Leased Premises, where such accident, injury or damage results, or is claimed to have resulted, from any intentional misconduct or negligence on the part of any of the Tenant Parties; (iv) any breach of this Lease by Tenant. Tenant shall pay such indemnified amounts as they are incurred by the Landlord Parties. This indemnification shall not be construed to deny or reduce any other rights or obligations of indemnity that Landlord Parties may have under this Lease or the common law.

b. Breach. In the event that Tenant breaches any of its indemnity obligations hereunder or under any other contractual or common law indemnity: (i) Tenant shall pay to the Landlord Parties all liabilities, loss, cost, or expense (including attorney's fees) incurred as a result of said breach, and the reasonable value of time expended by the Landlord Parties as a result of said breach; and (ii) the Landlord Parties may deduct and offset from any amounts due to Tenant under this Lease any amounts owed by Tenant pursuant to this section.

c. No limitation. The indemnification obligations under this section shall not be limited in any way by any limitation on the amount or type of damages, compensation or benefits payable by or for Tenant or any subtenant under workers' compensation acts, disability benefit acts, or other employee benefit acts. Tenant waives any immunity from or limitation on its indemnity or contribution liability to the Landlord Parties based upon such acts.

d. Subtenants. Tenant shall require its subtenants to provide similar indemnities to the Landlord Parties in a form acceptable to Landlord.

e. Survival. The terms of this section shall survive any termination or expiration of this Lease.

f. Costs. The foregoing indemnity and hold harmless agreement shall include indemnity for all costs, expenses and liabilities (including, without limitation, attorneys' fees and disbursements) incurred by the Landlord Parties in connection with any such claim or any action or proceeding brought thereon, and the defense thereof. In addition, in the event that any action or proceeding shall be brought against one or more Landlord Parties by reason of any such claim, Tenant, upon request from the Landlord Party, shall resist and defend such action or proceeding on behalf of the Landlord Party by counsel appointed by Tenant's insurer (if such claim is covered by insurance without reservation) or otherwise by counsel reasonably satisfactory to the Landlord Party. The Landlord Parties shall not be bound by any compromise or settlement of any such claim, action or proceeding without the prior written consent of such Landlord Parties.

g. Landlord Parties and Tenant Parties. The term "Landlord Party" or "Landlord Parties" shall mean Landlord, any affiliate of Landlord, Landlord's managing agents for the Building, each mortgagee, and each of their respective direct or indirect partners, officers, shareholders, directors, members, trustees, beneficiaries, servants, employees, principals, contractors, licensees, agents or representatives. The term "Tenant Party" or "Tenant Parties" shall mean Tenant, any affiliate of Tenant, any permitted subtenant of the Leased Premises, and each of their respective direct or indirect partners, officers, shareholders, directors, members, trustees, beneficiaries, servants, employees, principals, contractors, licensees, agents, invitees or representatives.

18. LIMITATION ON LANDLORD'S LIABILITY.

Landlord is a limited liability company. Tenant agrees that in the event of the entry of any judgment against Landlord, as it is now or may hereafter be constituted, arising out of or in connection with this Lease, neither Landlord, nor any manager, member, principal, officer, or employee of Landlord, shall have any personal liability whatsoever with regard to such judgment. Tenant shall look solely to Landlord's interest in the Property to satisfy or pay such

judgment and Tenant shall have no right to recover against any partner, member, manager, principal, officer or employee of Landlord or against any of Landlord's other assets. Upon the transfer of the Property by Landlord, Landlord shall be released from any and all obligations hereunder from and after the date of such transfer. This Section shall inure to the benefit of Landlord's successors and assigns.

19. **CASUALTY**.

a. If the Leased Premises or any portion thereof, shall, through no fault of Tenant or Tenant's agents, servants, employees, customers, contractors, visitors or licensees, be damaged by fire, the elements, unavoidable accident or other casualty (any, a "Casualty"), but the Leased Premises are not thereby rendered untenantable in whole or in part, Landlord shall promptly at its own expense cause such damage to be repaired, and the rent shall not be abated. If by reason of the Casualty, the Building shall be rendered untenantable only in part, Landlord shall promptly at its own expense cause the damage to be repaired, and the rent meanwhile shall be abated proportionately as to the portion of the Building rendered untenantable. If by reason of the Casualty (a) the Building shall be rendered wholly untenantable, or (b) Landlord's insurance is not sufficient to repair the damage, or (c) twenty-five percent (25%) or more of the square footage of the Building is damaged, then Landlord may elect not to reconstruct the damaged area. In such event, Landlord shall deliver written notice to Tenant within one hundred twenty (120) days after the occurrence of the Casualty that this Lease and the tenancy hereby created shall terminate as of the date of the Casualty and all rent due hereunder shall be adjusted as of such date. If Landlord elects to repair the Casualty, then the rent shall be abated proportionally to the portion of the Building rendered untenantable.

b. Notwithstanding the foregoing, within a reasonable period of time after any Casualty, Landlord may elect, in its sole and absolute discretion, to demolish, rebuild or reconstruct the Building. In such event, Landlord shall deliver written notice to Tenant that this Lease and the tenancy hereby created shall terminate as of the date set forth in such notice and all rent due hereunder shall be adjusted as of such date.

c. If the Building is rendered untenantable by a Casualty and either (i) the repairs are reasonably estimated to take more than one hundred eighty (180) days to complete, or (ii) the repairs are reasonably estimated to take more than thirty (30) days to complete and less than twelve (12) months remain in the Lease Term, then Tenant may elect to terminate this Lease by providing Landlord with written notice of such election within thirty (30) days of Tenant being provided with the estimate on how long the repairs will take to complete.

20. **CONDEMNATION**.

In the event the whole or any part of the Leased Premises shall be taken under the power of eminent domain, or sold under threat thereof, or taken in any manner for public use, the Landlord, at its option, may terminate this Lease. In such event, this Lease shall then terminate on the effective date of the condemnation or sale. The compensation awarded or paid for such taking, both as to Landlord's reversionary interest and Tenant's interest under this Lease, is hereby assigned by Tenant to Landlord and shall belong to and be the sole property of Landlord. Tenant shall have no claim against the Landlord or be entitled to any award or damages other

than an abatement of the rent beyond the period of termination date of this Lease and any compensation paid by the condemning authority directly to Tenant for moving expenses and/or cost of removal of stock and/or trade fixtures or improvements made to the Leased Premises and paid for entirely by Tenant, if allowable by the condemning authority.

21. **INSPECTION AND ENTRY BY LANDLORD.**

a. At any time during the Lease Term, with at least twenty-four (24) hours prior notice to Tenant, Tenant shall permit inspection of the Leased Premises during reasonable hours by Landlord and Landlord's agents and representatives, and by or on behalf of prospective purchasers and lenders. During the six (6) months preceding the expiration of the Lease Term, Tenant shall permit the inspection of the Leased Premises by or on behalf of prospective tenants and the posting of signs and notices indicating that the Leased Premises are 'for lease,' 'to let' or 'for sale'. Landlord and Landlord's agents and representatives also may enter the Leased Premises to the extent necessary for the protection of the Property or any part thereof, and for performing any repair, maintenance, replacement or decoration.

b. If Landlord is required by any law, ordinance, regulation or order to make any structural alteration, change or addition in the building of which the Leased Premises are part, and to carry out which it is reasonably necessary to take some portion of the Leased Premises, Landlord shall have the right to do so and the rent herein reserved shall thereafter be proportionately reduced and Tenant shall not be entitled to any damages which may be occasioned thereby. If such structural alteration, change or addition shall so affect the Leased Premises as to make them substantially unusable for the purpose herein set forth, either Landlord or Tenant, may terminate this Lease on thirty (30) days' written notice and effective upon the date set forth in such notice this Lease shall then cease and expire as if such date were the date herein fixed for the expiration of the term hereof.

22. **ASSIGNMENT AND SUBLETTING.**

Tenant shall not assign or transfer or encumber all or any portion of its interest in this Lease or in the Leased Premises, nor sublet all or any portion of the Leased Premises, without the prior written consent of Landlord which Landlord shall not unreasonably withhold, condition, or delay. Any assignment, sublease or other such transfer without Landlord's prior written consent shall be void, and, at Landlord's election, shall constitute a default of Tenant hereunder. Consent by Landlord to one or more assignment or sublease shall not constitute a waiver of Landlord's rights with respect to any subsequent assignment or sublease. If Tenant is a partnership or limited liability company, a withdrawal or change (voluntary, involuntary, or by operation of law) of any partner or member owning fifty-one percent (51%) or more of the entity, or the dissolution or liquidation of the entity, shall be deemed an assignment of this Lease. If Tenant is a corporation, any dissolution, merger, consolidation, or other reorganization of Tenant, or the sale or other transfer of the controlling percentage of the capital stock of Tenant, or the sale of fifty-one percent (51%) of the value of the assets of Tenant, shall be deemed an assignment of this Lease. If Tenant consists of more than one person, a purported assignment (voluntary, involuntary, or by operation of law) from any of such persons to any other person or entity shall be deemed an assignment of this Lease. Notwithstanding any assignment or subletting, Tenant and any guarantor of Tenant's obligations under this Lease shall at all times

remain fully liable for the payment of all rent and other obligations under this Lease. Landlord shall have the right at any time to assign this Lease, in whole or in part, to any third party.

It shall not be deemed an assignment or sublease for Tenant to provide treatment services to resident patients and to license to such patients revocable occupancy rights on a short-term and non-exclusive basis.

23 **NOTICE OF NAME CHANGE.**

In the event that Tenant changes or modifies its entity name or trade name, Tenant shall notify Landlord in writing.

24 **NOTICE OF DEFAULT TO LANDLORD AND MORTGAGEE AND RIGHT TO CURE.**

If Landlord shall fail to perform any covenant, term or condition of this Lease required to be performed by Landlord, Tenant shall deliver written notice of such default to Landlord by certified mail return receipt requested. Such notice shall specifically set forth the nature of the default by Landlord. Landlord shall have thirty (30) days within which to cure the default. Such notice of default shall be a condition precedent to the institution by Tenant of any judicial proceedings for non-performance or default against Landlord. Tenant agrees to deliver a copy of any such notice to any mortgagee or other lien holder, also by certified mail return receipt requested, provided that Tenant has been notified in writing of the address of such mortgagee and lien holder. Tenant further agrees that if Landlord fails to cure such default within such thirty-day period, then the mortgagee and lien holder shall have an additional thirty (30) days within which to cure such default or, if such default cannot be cured within that time, then such additional time as may be necessary if within such thirty (30) days, any mortgagee or lien holder has commenced and is diligently pursuing the remedies necessary to cure such default (including but not limited to commencement of foreclosure proceedings, if necessary to effect such cure), in which event this Lease shall not be terminated while such remedies are being so diligently pursued.

25. **PERFORMANCE BY TENANT.**

Tenant covenants and agrees that it will perform all covenants and agreements herein expressed on its part to be performed, and that it will promptly upon receipt of written notice specifying action desired by Landlord in connection with any such covenant or agreement, commence to comply with such notice. If Tenant shall not commence and proceed diligently to comply with such notice to the satisfaction of Landlord within ten (10) days after delivery thereof, then Landlord may, at its option, enter upon the Leased Premises and perform the action specified in said notice. In such event, Landlord shall not be liable to Tenant for any loss or damage resulting in any way from such action by Landlord, and Tenant agrees to pay as additional rent, promptly upon demand, any expense incurred by Landlord in taking such action.

26. **DEFAULT AND REMEDIES.**

a. As used in this Lease, each of the following events shall constitute and is hereinafter referred to as an "Event of Default" or "Default," without notice from Landlord to

Tenant and without any right to cure: (i) if Tenant (A) fails to pay any rent or any other sum which it is obligated to pay under this Lease and such failure continues beyond five (5) days after notice to Tenant that such payment is overdue, (B) fails to perform any of its other obligations under this Lease where such failure continues beyond thirty (30) days after notice to Tenant of such failure, or (C) breaches any of its covenants, representations, warranties or agreements under this Lease where such breach continues beyond thirty (30) days after notice to Tenant of such breach; or (ii) if Tenant fails to occupy and assume possession of the Leased Premises on or before the thirtieth (30th) day after the Commencement Date; or (iii) a default occurs under any assignment of this Lease or any sublease of all or a portion of the Leased Premises; or (iv) if Tenant shall abandon the Leased Premises and permit the same to remain unoccupied and unattended, or shall remove or attempt to remove or manifest an intent to remove, not in the ordinary course of business, substantially all of Tenant's goods and property from or out of the Leased Premises; or (v) if the business operated by Tenant shall be permanently closed for any other reason.

b. Upon the occurrence of an Event of Default, Landlord shall have the option, in addition to and not in limitation of any other remedy permitted by law or by this Lease, to exercise any or all of the following remedies; (i) terminate this Lease, in which event Tenant shall immediately surrender the Leased Premises to Landlord, but if Tenant shall fail to so do, Landlord may, without further notice and without prejudice to any other remedy Landlord may have for possession or arrearages in rent, or damages for breach of contract, enter upon the Leased Premises and remove Tenant, any other person occupying the Leased Premises and their effects without being liable to prosecution or any claim for damages; (ii) enter the Leased Premises as the agent of Tenant, without being liable to prosecution of any claim for damages and relet the Leased Premises as the agent of Tenant and receive the rent therefor, and Tenant shall pay Landlord any deficiency that may arise by reason of such reletting on demand; (iii) receive the rents from any subtenants of Tenant in the Leased Premises; (iv) perform any act Tenant is obligated to perform under the terms of this Lease (and enter upon the Leased Premises in connection therewith if necessary) in Tenant's name and on Tenant's behalf, without being liable for prosecution or any claim for damages therefor, and Tenant agrees to reimburse Landlord on demand for any expenses which Landlord may incur in thus effecting compliance with Tenant's obligations under this Lease (including, but not limited to, collection costs and legal expenses), plus interest thereon at the maximum rate permitted by law, and Tenant further agrees that Landlord shall not be liable for any damages resulting to Tenant from such action; (v) alter all locks and other security devices at the Leased Premises; (iv) exercise the provisions of applicable laws respecting the speedy recovery of tenements held over by tenants of proceedings in forcible entry and detainer; (vii) restrain any default or violation, or attempted or threatened default or violation of any of the terms, covenants, conditions or other provisions of this Lease, by injunction, order of specific performance or other appropriate equitable relief; (ix) declare the entire amount of Rent which would become due and payable hereunder for the remainder of the Term of this Lease to be immediately due and payable, in which event Tenant agrees to pay at once the entire amount of such Rent for the remainder of the Term of this Lease, together with all other sums then due and owing to Landlord. The payment of such Rent shall not constitute a penalty or forfeiture or liquidated damages, but shall constitute payment of Rent for the remainder of the Term. Upon the payment by Tenant of the entire amount of the Rent for the remainder of the Term together with all other sums then due and owing Landlord, Tenant shall be entitled to receive from Landlord all rents received by Landlord from other tenants on account

of the Leased Premises during the remainder of the Term of this Lease, if any; provided, however, that the monies to which Tenant shall become so entitled shall in no event exceed the entire amount payable by Tenant to Landlord as Rent. Any such claim for Rent by Landlord shall not preclude Landlord from collecting the Additional Rent due under this Lease or exercising any other remedy permitted by law, equity or by this Lease.

c. Following the occurrence of any Event of Default, Tenant shall also be liable for and shall pay to Landlord as Additional Rent all costs and expenses incurred by Landlord in enforcing or defending Landlord's rights and/or remedies at law, equity or hereunder, including reasonable attorneys' fees, litigation expenses, court costs and other necessary disbursements.

27. **REMEDIES CUMULATIVE; NO WAIVER.**

No mention in this Lease of any specific right or remedy shall preclude Landlord from exercising any other right or from having any other remedy, or from maintaining any action to which it may otherwise be entitled either at law or equity. The failure of Landlord to insist in any one or more instances upon a strict performance of any covenant of this Lease or to exercise any option or right herein contained shall not be construed as a waiver of relinquishment for the future of such covenant, right or option, but the same shall remain in full force and effect. The receipt by Landlord of rent, with knowledge of the breach of any covenant hereof, shall not be deemed a waiver of such breach, and no waiver by Landlord of any provision hereof shall be deemed to have been made unless expressed in writing and signed by Landlord.

28. **SUCCESSORS AND ASSIGNS.**

This Lease and the covenants and conditions set forth herein shall inure to the benefit of and be binding upon Landlord, and its successors and assigns, and Tenant, and its permitted successors and assigns.

29. **NOTICES.**

All notices, demands and requests required under this Lease shall be in writing. All such notices, demands and requests shall be deemed to have been properly given upon receipt or refusal of delivery when sent by nationally recognized overnight courier or by United States registered or certified mail, return receipt requested, postage prepaid, addressed to the parties at the addresses set forth in Section 1 of this Lease. Either party may designate a change of address by written notice to the other party, and thereafter all notices to such parties shall be sent by registered or certified mail to such substitute address.

30. **[INTENTIONALLY OMITTED].**

31. **APPLICABLE LAW.**

This Lease shall be construed and enforced under the laws of the State of Maryland.

32. **SUBORDINATION AND ATTORNMENT.**

a. Tenant accepts this Lease, and the tenancy created hereunder, subject and subordinate to the lien, operation and effect of each and every ground lease and existing or future mortgage, deed of trust or other security instrument constituting a lien upon or affecting the Property, or any part thereof and to any renewals, extensions, consolidations, modifications or refinancings thereof.

b. In the event of any foreclosure sale or sales pursuant to the terms of any mortgages or deeds of trust or other security instruments now or hereafter constituting a lien upon or affecting the Property of any part thereof, by virtue of judicial proceedings or otherwise, this Lease shall, at the option of the mortgagee or beneficiary under the deed of trust or other security instrument or the foreclosure purchaser continue in full force and effect and Tenant will, upon request, attorn to and acknowledge the foreclosure purchaser or purchasers at such sale, as landlord hereunder.

c. Tenant shall, at any time hereafter, within ten (10) days after written demand by Landlord, execute any instrument, releases or other documents that may be required by any mortgagee or mortgagor or over landlord for the purpose of confirming such subordination and attornment. The failure of Tenant to timely execute, acknowledge, and deliver any such instruments, releases or documents, shall constitute an Event of Default hereunder.

33. **ESTOPPEL CERTIFICATES.**

Tenant agrees at any time hereafter upon not less than ten (10) days prior notice by Landlord, to execute, acknowledge and deliver to Landlord a statement in writing certifying that this Lease is unmodified and in full force and effect (or if there have been modifications, that the same is in full force and effect as modified and stating the modifications). Such certificate shall state the dates to which the rent and other charges have been paid in advance, if any, and whether or not to the best knowledge of the signer of such certificate Landlord is in default in performance of any covenant, agreement or condition contained in this Lease; and if applicable, specifying each such default of which the signer may have knowledge, it being intended that any such statement delivered hereunder may be relied upon by third parties not a party to this Lease. The failure of Tenant to timely execute and deliver any such estoppel, shall constitute an Event of Default hereunder.

34. **QUIET ENJOYMENT.**

If and so long as Tenant pays rent and additional rent reserved by this Lease, and is not in default hereunder, Tenant shall quietly enjoy the Leased Premises, subject, however, to the terms and provisions hereof.

35. **TERMINATION.**

This Lease and the tenancy hereby created shall cease and determine at the end of the Lease Term, or any extension or renewal thereof, without the necessity of any notice from either Landlord or Tenant to terminate the same, and Tenant hereby waives notice to vacate the Leased Premises and agrees that Landlord shall be entitled to the benefit of all provisions of law

respecting the summary recovery of possession of premises from a tenant holding over to the same extent as if statutory notice had been given.

36. **ENTIRE AGREEMENT**.

This writing is intended by the parties as a final expression of their agreement and as a complete and exclusive statement of the terms thereof, all negotiations, considerations and representations between the parties having been incorporated herein. No course of prior dealings between the parties or their affiliates shall be relevant or admissible to supplement, explain or vary any of the terms of the Lease. Acceptance of, or acquiescence in, a course of performance rendered under this or any prior agreement between the parties or their affiliates shall not be relevant or admissible to determine the meaning of any of the terms of this Lease. No representations, understandings or agreements have been made or relied upon in the making of this Lease other than those specifically set forth herein. This Lease can only be modified by a writing signed by all of the parties hereto or their duly authorized agents.

37. **ZONING AND LICENSING APPROVALS**.

Anything herein elsewhere contained to the contrary, this Lease and all the terms, covenants, and conditions hereof are in all respects subject and subordinate to all zoning restrictions affecting the Leased Premises, and the Building in which they are located, and Tenant agrees to be bound by such restrictions. Landlord further does not warrant that any license or licenses, permit or permits, which may be required for the business to be conducted by Tenant on the Leased Premises will be granted, or, if granted, will be continued in effect or renewed, and any failure to obtain such license or licenses, permit or permits, or any revocation thereof or failure to renew the same, shall not release Tenant from its obligations under this Lease.

38. **BROKERS**.

Landlord and Tenant warrant and represent to the other that neither has dealt with any finder or real estate broker in connection with the consummation of this Lease. In the event that any broker successfully maintains that at the request of either Landlord or Tenant such broker was the procuring cause of this Lease and is entitled to a commission resulting in any way from the consummation of this Lease, then the party which has been found to have retained such broker shall indemnify and hold the other harmless from and against all costs, fees (including without limitation reasonable attorney's fees) expenses, liabilities and claims incurred or suffered by the other as a result of any such allegation.

39. **SEVERABILITY**.

If any term, provision, condition or covenant set forth in this Lease, or the application thereof to any person or circumstance shall, to any extent, be invalid or unenforceable, or be held to be invalid or unenforceable by any court of competent jurisdiction, the remainder of the Lease, the application of such term, provision, condition or covenant to persons or circumstances other than those to which it is held invalid or unenforceable, shall not be affected thereby, and all such remaining terms, provisions, conditions and covenants in this Lease shall be deemed to be valid and enforceable.

40. **TRIAL BY JURY**.

LANDLORD AND TENANT DO HEREBY WAIVE TRIAL BY JURY IN ANY ACTION, PROCEEDING OR COUNTER CLAIM BROUGHT BY EITHER OF THE PARTIES HERETO AGAINST THE OTHER ON ANY MATTERS WHATSOEVER ARISING OUT OF OR IN ANY WAY CONNECTED WITH THIS LEASE, THE RELATIONSHIP OF LANDLORD AND TENANT, TENANT'S USE OR OCCUPANCY OF THE DEMISED PREMISES, AND/OR ANY CLAIM OF INJURY OR DAMAGE, AND ANY EMERGENCY STATUTORY OR ANY OTHER STATUTORY REMEDY.

In the event of any suit, action, or other proceeding at law or in equity, by either party hereto against the other, by reason of any matter arising out of this Lease, the prevailing party shall recover, not only its legal costs, but also reasonable attorneys' fees (to be fixed by the Court) for the maintenance or defense of said suit, action or other proceeding, as the case may be.

41. **COUNTERPARTS**.

This Lease may be executed in multiple counterparts, and each counterpart, when fully executed and delivered, shall constitute an original instrument, and all such multiple counterparts shall constitute but one and the same instrument.

42. **DISCLOSURE OF RELATED ENTITIES/PERSONS**.

Landlord and Tenant acknowledge that Ryan Collison, an individual, has ownership, management, fiduciary, and/or other business and personal interests and relationships with one or more Landlord and Tenant parties and/or affiliates, including Guarantor. The parties acknowledge that such interests and relationships have been disclosed and that the parties have had ample opportunity to investigate such interests and relationships and hereby waive any conflicts of interest which may arise by virtue of such interests and relationships.

43. **EXHIBITS AND ADDENDA**.

The following exhibits and addenda are attached to this Lease and made a part hereof:

Exhibit A	Description of Leased Premises
Exhibit B	Rules and Regulations
Exhibit C	Guaranty of Lease

[remainder of page intentionally blank]

IN WITNESS WHEREOF, the parties hereto have executed this Lease under seal as of the day and year first written above.

WITNESS:

LANDLORD

Maryland Healthcare Real Estate LLC,
a Maryland limited liability company

_____

By: _____ (Seal)
Name: Ryan Collison
Title: Manager

WITNESS:

TENANT

Maryland House Detox LLC,
a Delaware limited liability company

_____

By: _____ (Seal)
Name: David Stup
Title: Manager

EXHIBIT A

LEASED PREMISES

all that lot of ground situate in the Fifth Election District of Anne Arundel County, in the State of Maryland, and more fully described as follows, that is to say:

BEGINNING FOR THE SAME at a point in the easternmost right of way line of Camp Meade Road (Maryland Route 170) said being located, as now surveyed, and referring the courses to the meridian of the Maryland State Place Coordinate System, South 35 degrees 21 minutes 07 seconds W 152.39 feet from Boundary Stone No. 2 on the outline of the entire property of the Mayor and City Council of Baltimore, known as Friendship International Airport, and running thence the following 9 courses and distances:

(1) With the said easternmost right of way line of Camp Meade Road south 35 degrees 21 minutes 07 seconds W 347.61 feet to a point, thence leaving the easternmost right of way line of Camp Meade Road,

(2) South 54 degrees 38 minutes 53 seconds E 220.00 feet to a point, thence

(3) North 35 degrees 21 minutes 07 seconds E 472.56 feet to a point, said point also being on the future right of way line of proposed Hammonds Ferry Road, thence with the said right of way, the following six courses and distances

(4) North 76 degrees 42 minutes 45 seconds W 60.18 feet to a point, thence

(5) South 86 degrees 35 minutes 04 seconds W 52.20 feet to a point, thence

(6) North 76 degrees 42 minutes 45 seconds W 20.00 feet to a point, thence

(7) North 50 degrees 10 minutes 47 seconds W 33.53 feet to a point, thence

(8) South 80 degrees 42 minutes 30 seconds W 92.16 feet to a point, thence

(9) North 54 degrees 38 minutes 53 seconds W 6.00 feet to the point of beginning.

Containing 2.1069 acres, more or less.

Being a part of that parcel of land which was conveyed to the Mayor and City Council of Baltimore, by Charles E. Hammond, unmarried, et al., by Deed dated November 10, 1947 and recorded among the Land Records of Anne Arundel County in Liber J.H.H. No. 477, at folio 449.

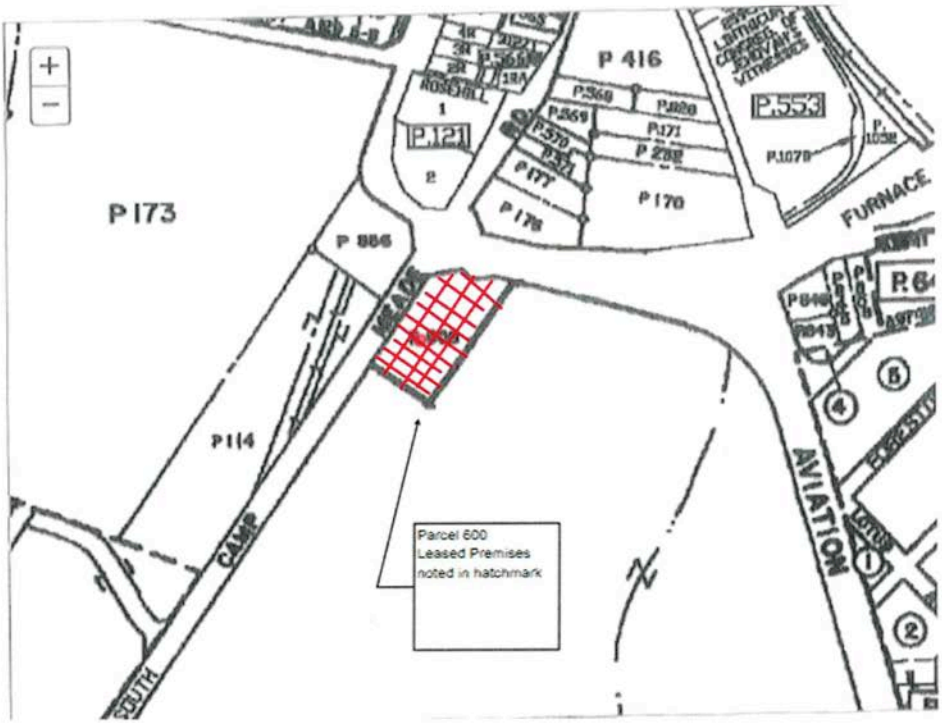

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EXHIBIT B

RULES AND REGULATIONS

1. Tenant will comply with all laws, rules and regulations issued by any and all governmental agencies, federal, state and local municipalities whose jurisdiction affects all or any portion of the Property.

2. When electric wiring of any kind is introduced, it must be connected as directed by Landlord, and no stringing or cutting of wires will be allowed, except with the prior written consent of Landlord, and shall be performed only by contractors approved in advance in writing by Landlord. The number and location of telephones, electric appliances, and equipment shall be subject to Landlord's approval.

4. No awning or other projections shall be attached to the outside walls of the Building. No curtains, blinds, shades or screens shall be attached to or hung in, or used in connections with, any window or door of the Leased Premises, without the prior written consent of Landlord. Such curtains, blinds or shades must be of a quality, type, design, and color, and attached in a manner approved by Landlord.

5. The sidewalks, halls, passages, exits, entrances, elevators and stairways shall not be obstructed by Tenant or used for any purpose other than for ingress to and egress. Unless making repairs required to be made under the terms of the Lease to heating, ventilation or air conditioning located thereon, neither Tenant nor any employees or invitees of Tenant shall have access to or go upon the roof of the Building without the prior approval of Landlord.

6. Tenant, its agents, servants, employees and invitees, shall abide by such security rules and regulations as Landlord may promulgate.

7. Water closets and urinals shall not be used for any other purpose other than those for which they were constructed; and no sweepings, rubbish, ashes, newspaper or any other substances of any kind shall be thrown into them. Waste and excessive or unusual use of electricity or water is prohibited.

8. Trash or garbage generated by Tenant's occupancy of the Leased Premises shall be removed by Tenant at its sole cost or expense.

9. Tenant shall not make or permit to be made any loud or offensive noises, keep any foul or noxious gas or substance or other disturbances of any kind in the Leased Premises or within the Building.

10. No additional lock or locks shall be placed by Tenant on any door in the Building, without prior written consent of Landlord.

11. Tenant shall not use any other method of heating or air conditioning than via the equipment existing in the Property on the Effective Date, without first obtaining the written consent of Landlord.

12. No animals or birds of any kind shall be kept in or permitted on or about the Leased Premises or any other part of the Building.

13. The Leased Premises shall not be used for any improper, objectionable or immoral purposes.

14. Tenant shall not be permitted to use or keep explosives, kerosene, cleaning fluid or any other illuminating, combustible or explosive material or substance of any kind in the Building or the Leased Premises excepting those products which are generally accepted for everyday cleaning, and excepting those used in the operation of Tenant's business and used, stored and disposed of in accordance with applicable laws.

15. Tenant shall not be permitted to keep food upon the Leased Premises except in proper containers, cabinets and refrigerators and in strict accordance with all applicable rules, regulations and ordinances of all local health and sanitation authorities.

16. Tenant shall comply with all requirements issued and mandated by insurance companies insuring the Building.

17. Landlord reserves the right to institute energy management procedures when applicable.

18. No vending, video, amusement machine or machines of any other description shall be installed, maintained or operated upon the Leased Premises or the Building without the prior written consent of Landlord.

19. Tenant shall not lay linoleum, tile, carpet or other similar floor covering so that the same shall be affixed to the floor of the Leased Premises or the Building in any manner except as approved by Landlord. The expense of repairing any damage resulting from violation of this Rule or of removing any floor covering shall be borne and paid for by Tenant who violated, either by its own actions or the actions of its contractors of employers, this Rule.

21. No contract of any kind with any supplier of towels, water, ice, toilet articles, waxing, rug shampooing, venetian blind washing, furniture polishing, lamp servicing, cleaning of electrical fixtures, removal of waste paper, rubbish or garbage, or other like service shall be entered into by Tenant for the Leased Premises or any other portion of the Leased Premises without the prior written approval of Landlord.

22. Canvassing, soliciting and peddling in the Building are prohibited, and Tenant shall cooperate with Landlord to prevent these practices.

23. There shall not be used in the Leased Premised or in the Building, either by Tenant or by others in the delivery or receipt of merchandise, any hand trucks except those equipped with rubber tires and side guards.

11. Tenant shall not use any other method of heating or air conditioning than via the equipment existing in the Property on the Effective Date, without first obtaining the written consent of Landlord.

12. No animals or birds of any kind shall be kept in or permitted on or about the Leased Premises or any other part of the Building.

13. The Leased Premises shall not be used for any improper, objectionable or immoral purposes.

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22. Canvassing, soliciting and peddling in the Building are prohibited, and Tenant shall cooperate with Landlord to prevent these practices.

23. There shall not be used in the Leased Premised or in the Building, either by Tenant or by others in the delivery or receipt of merchandise, any hand trucks except those equipped with rubber tires and side guards.

24. Landlord reserves the right at any time to rescind any one or more of these Rules and Regulations, or to make such other and further reasonable Rules and Regulations as in Landlord's judgement may, from time to time, be necessary for the safety, care and cleanliness of the Property or any part thereof, and for the preservation of other herein.

EXHIBIT C

GUARANTY OF LEASE

This Guaranty of Lease (the "Guaranty") is attached to and made a part of that certain real estate Lease Agreement (the "Lease") dated NOV 1 2015, between Maryland Healthcare Real Estate LLC, a Maryland limited liability company (the "Landlord"), and Maryland House Detox LLC, a Delaware limited liability company (the "Tenant"). The terms used in this Guaranty shall have the same definitions as set-forth in the Lease.

In order to induce Landlord to enter into the Lease with Tenant, Delphi Health Group LLC, a Delaware limited liability company, with the address of 5722 Flamingo Rd., Suite 412, Fort Lauderdale, FL 33330-3206 ("Guarantor"), has agreed to execute and deliver this Guaranty to Landlord. Guarantor acknowledges that Landlord would not enter into the Lease if each Guarantor did execute and deliver this Guaranty to Landlord.

1. **Guaranty**: In consideration of the execution of the lease by Landlord and as a material inducement to Landlord to execute the Lease, Guarantor hereby irrevocable, unconditionally, jointly and severally guarantees the full, timely and complete (a) payment of all rent and other sums payable by Tenant to Landlord under the Lease, and any amendments or modifications thereto by agreement or course of conduct, and (b) performance of all covenants, representations and warranties made by Tenant and all obligations to be performed by Tenant pursuant to the Lease, and any amendments or modifications thereto by agreement or course of conduct. The payment of those amounts and performance of those obligations shall be conducted in accordance with all terms, covenants and conditions set-forth in the Lease, without deduction, offset or excuse of any nature and without regard to the enforceability or validity of the Lease, or any part thereof, or any disability of Tenant.

2. **Landlord's Rights**. Landlord may perform any of the following acts at any time during the Lease Term, without notice to or assent of Guarantor and without in any way releasing, affecting or impairing any of Guarantor's obligations or liabilities under this Guaranty: (a) alter, modify or amend the Lease by agreement or course of conduct, (b) grant extensions or renewals of the lease, (c) assign or otherwise transfer its interest under the lease, (e) release Guarantor, or amend or modify this guaranty with respect to Guarantor, without releasing or discharging Guarantor from any of Guarantor's obligations or liabilities under this Guaranty, (f) take and hold security for the payment of this Guaranty and exchange, enforce, waive and release any such security, (g) apply such security and direct the order or manner of sale thereof as landlord, in its sole discretion deems appropriate, and (h) foreclose upon' any such security by judicial or non-judicial sale, without affecting or impairing in any way the liability of Guarantor under this Guaranty, except to the extent the indebtedness has been paid.

3. **Tenant's Default**. This Guaranty is a guaranty of payment and performance, and not of collection. Upon any breach or default by Tenant under the Lease, Landlord may proceed immediately against Tenant and/or Guarantor to enforce any of Landlords rights or remedies against Tenant or Guarantor pursuant to this Guaranty, the Lease, or at law or in equity without notice to or demand upon either Tenant or Guarantor. This Guaranty shall not be released,

modified or affected by any failure or delay by Landlord to enforce any of its rights or this Guaranty, or at law or in equity.

4. Guarantor's Waivers. Guarantor hereby waives (a) presentment, demand for payment and protest of non-performance under the Lease, (b) notice of any kind including, without limitation, notice of acceptance of this Guaranty, protest, presentment, demand for payment, default, nonpayment, or the creation or incurring of new or additional obligations of Tenant to Landlord, (c) any right to require Landlord to enforce its rights or remedies against Tenant under the Lease, or otherwise, or against any other party, (d) any right to require Landlord to proceed against any security held from Tenant or any other party, (e) any right of subrogation and (f) any defense arising out of the absence, impairment or loss of any right of reimbursement of subrogation or other right or remedy of guarantors against Landlord or any such security, whether resulting from an election by Landlord, or otherwise. Any part payment by Tenant or other circumstance, which operates to toll any statute of limitations as to Tenant, shall operate to toll the statute of limitations as to Guarantor.

5. Separate and Distinct Obligations. Guarantor acknowledges and agrees that Guarantor's obligations to Landlord under this Guaranty are separate and distinct from Tenant's obligations to Landlord under the Lease. The occurrence of any of the following events shall not have any effect whatsoever on Guarantor's obligations to Landlord hereunder, each of which obligations shall continue in full force or effect as though such event had not occurred: (a) the commencement by Tenant of a voluntary case under the federal bankruptcy laws, as now constituted or hereafter amended or replaced, or any other applicable federal or state bankruptcy, insolvency or other similar law (collectively, the "Bankruptcy Laws"), (b)the consent by Tenant to the appointment of or taking possession by a receiver, liquidator, assignee, trustee, custodian, sequestrator or similar official of Tenant or for any substantial part of its property, (c) any assignment by Tenant for the benefit of creditors, (d) the failure of Tenant generally to pay its debts as such debts become due, (e) the taking of corporate action by Tenant in the furtherance of any of the foregoing: or (f) the entry of a decree or order for relief by a court having jurisdiction in respect of Tenant in any involuntary case under the Bankruptcy Laws, or appointing a receiver, liquidator, assignee, custodian, trustee, sequestrator (or similar official) of Tenant or for any substantial part of its property, or ordering the winding-up or liquidation of any of its affairs and the continuance of any such decree or order unstayed and in effect for a period of sixty (60) consecutive days. The liability of Guarantor under this Guaranty is not and shall not be affected or impaired by any payment made to the landlord under or related to the Lease for which Landlord is required to reimburse Tenant pursuant to any court order or in settlement of any dispute, controversy or litigation in any bankruptcy, reorganization, arrangement, moratorium or other federal or state debtor relief proceeding, if, during any such proceeding, the Lease is assumed by Tenant or any trustee, or thereafter assigned by the Tenant or any trustee to a third party, this Guaranty shall remain full force and effect with respect to the full performance of Tenant, any such trustee or any such third party's obligations under the Lease. If the Lease is terminated or rejected during any such proceeding, or any of the events described in Subparagraphs (a) through (f) of this paragraph 5 occur, as between Landlord and Guarantor, Landlord shall have the right to accelerate all of 'Tenant's obligations under the Lease and Guarantor's obligations under this Guaranty. In such event, all such obligations shall become immediately due and payable by Guarantor to the Landlord. Guarantor waives any defense of Tenant or by reason of the cessation from any cause whatsoever of the liability of the Tenant.

6. **Subordination**. All existing and future advances by the Guarantor to Tenant, and all existing and future debts of Tenant to any Guarantor, shall be subordinated to all obligations owed to Landlord under the Lease and this Guaranty.

7. **Successors and Assigns**. This Guaranty binds Guarantor's personal representatives, successors and assigns.

8. **Corporate Authority**. If Guarantor is an entity, each individual signing this Guaranty on behalf of Guarantor represents and warrants that he is duly authorized to execute and deliver this Guaranty on behalf of the entity, and that this Guaranty is binding on Guarantor in accordance with its terms. Guarantor shall, at Landlord's request, deliver a certified copy of a resolution of its governing board or the equivalent authorizing such execution.

9. **Disclosure of Related Entities/Persons**. Guarantor acknowledges that its Manager, Ryan Collison, an individual, has ownership, management, fiduciary, and/or other business and personal interests and relationships with one or more Landlord and Tenant parties. Guarantor acknowledges that such interests and relationships have been disclosed and that Guarantor has had ample opportunity to investigate such interests and relationships and hereby waives any conflicts of interest which may arise by virtue of such interests and relationships.

10. **Attorneys' Fees**. In the event of any suit, action, or other proceeding at law or in equity, by either party hereto against the other, by reason of any matter arising out of this Guaranty, the prevailing party shall recover, not only its legal costs, but also reasonable attorneys' fees (to be fixed by the Court) for the maintenance or defense of said suit, action or other proceeding, as the case may be.

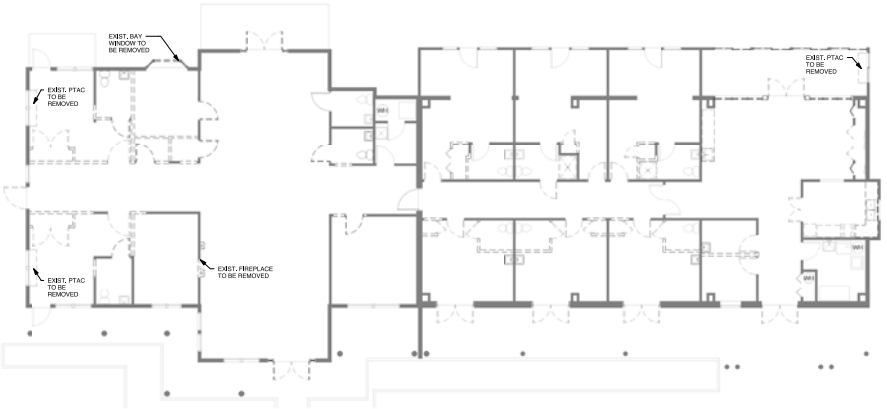
GUARANTOR:

Delphi Health Group LLC,
a Delaware limited liability company

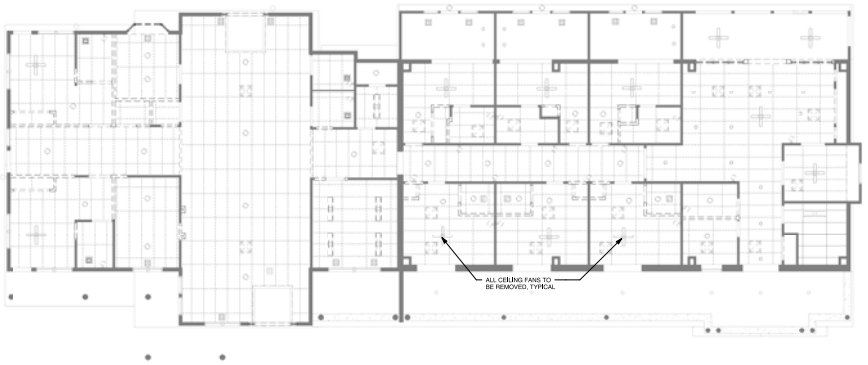
By:_____
Name: Ryan Collison
Its: Manager

Exhibit 3

Project Drawings



1 FIRST FLOOR DEMOLITION PLAN
1/8" = 1'-0"



2 DEMOLITION REFLECTED CEILING PLAN
1/8" = 1'-0"

TO BE REMOVED
TO REMAIN

ELPHI HEALTH GROUP

817 S. CAMP MEADE RD
LINTHICUM, MD

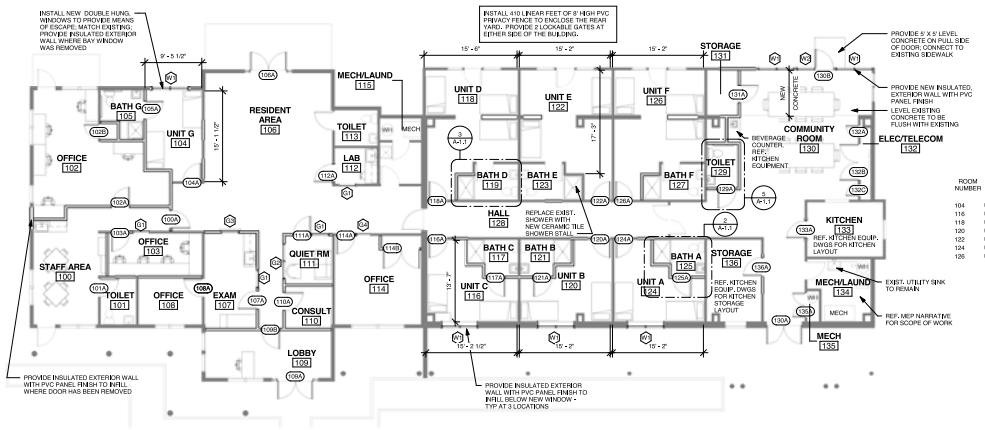
NO.	DESCRIPTION	DATE

3/21/16

SUBMISSION SET

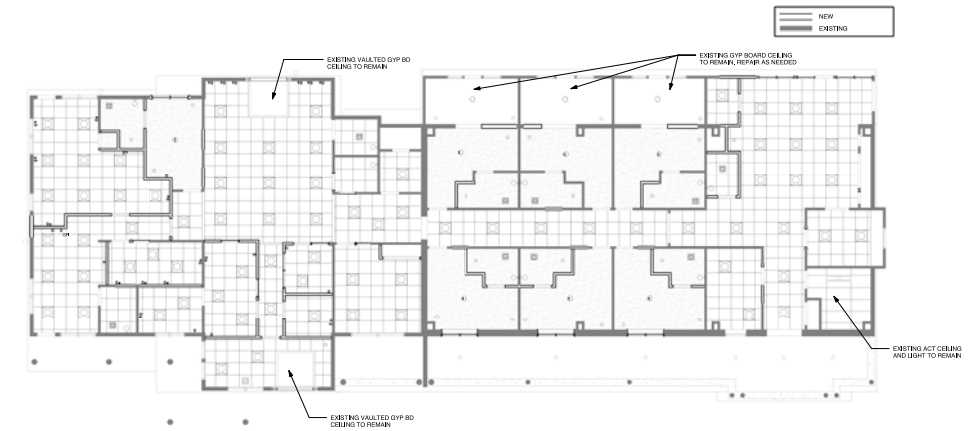
DEMOLITION PLANS

15043



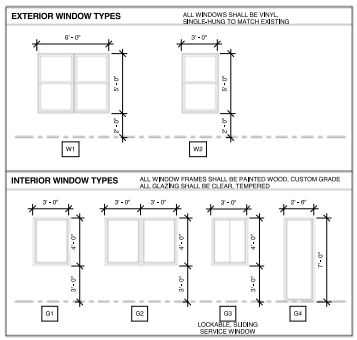
M SCHEDULE

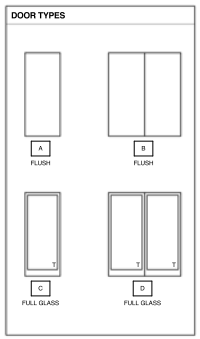
ROOM NUMBER	ROOM NAME	AREA	PATIENT BEDS
104	UNIT G	134 SF	2
116	UNIT C	151 SF	2
118	UNIT D	261 SF	3
120	UNIT B	153 SF	2
122	UNIT E	259 SF	2
124	UNIT A	155 SF	2
126	UNIT F	260 SF	3
			16

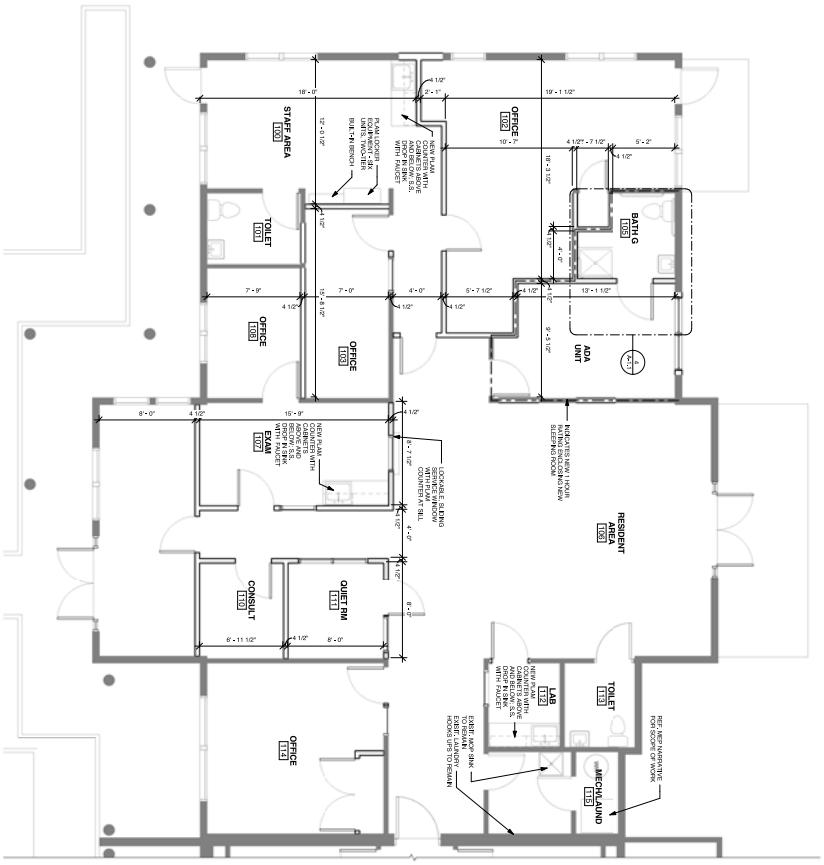


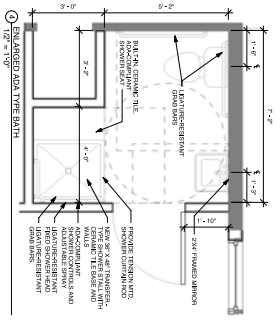
RCP LEGEND

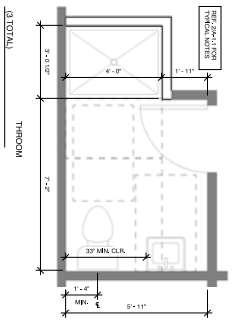
- DUPLEX OUTLET
- GFI DUPLEX OUTLET
- DATA OUTLET
- 24" X 24" RECESSED LIGHT
- SURFACE MOUNTED FIXTURE
- 6" RECESSED CAN LIGHT
- WALL MOUNTED LIGHT BAR
- EXHAUST FAN
- 24" ACT CEILING
- NEW GYPSUM BOARD CEILING

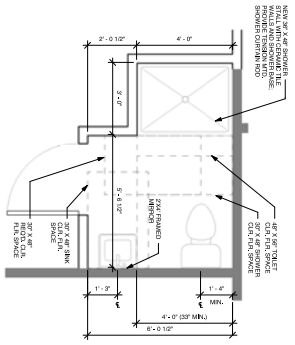


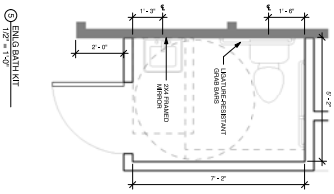




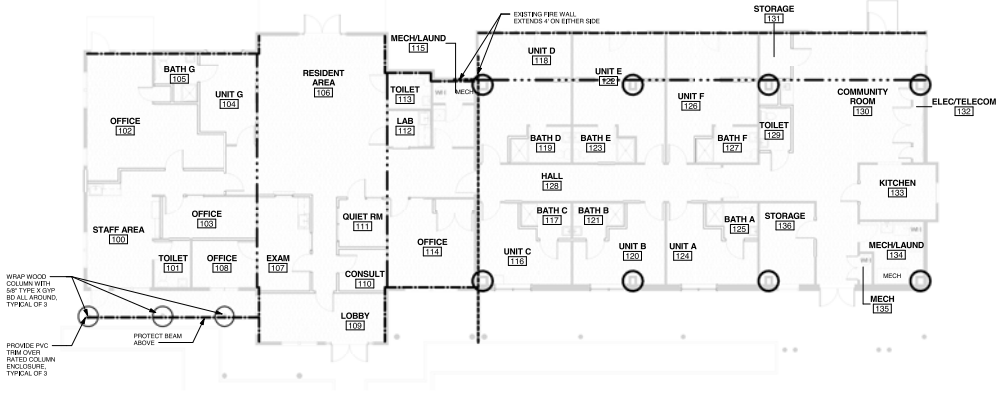




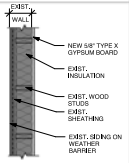
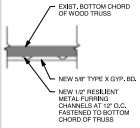
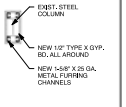


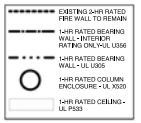


NO.	DESCRIPTION	DATE



FLOOR PLAN

EXTERIOR BEARING WALL	INTERIOR BEARING WALL	ROOF STRUCTURE PROTECTION	COLUMN PROTECTION
			
WOOD STUDS WITH SIDING UL-U356(1 HR BEARING) EXPOSED TO FIRE ON INTERIOR FACE ONLY	WOOD STUDS WITH GYP BD UL-U305 (1 HR RATED)	GYP BD ON METAL CHANNELS UL-P533 (1 HR RATED)	GYP BD ON METAL CHANNELS UL-X520 (1 HR RATED MIN.)



NO.	DESCRIPTION	DATE

Exhibit 4

Hospital CON Application Table Package
Cover Sheet
Table A
Table B
Table C
Table D
Table E
Table I
Table J
Table K
Table L
Project Budget

CON TABLE PACKAGE FOR HOSPITAL APPLICATIONS

Name of Applicant: Maryland House Detox

Date of Submission: 21-Mar-16

Applicants should follow additional instructions included at the top of each of the following worksheets. Please ensure all green fields (see above) are filled.

Table	Table Title	Instructions
Table A	Physical Bed Capacity Before and After Project	All applicants whose project impacts any nursing unit, regardless of project type or scope, must complete Table A.
Table B	Departmental Gross Square Feet	All applicants, regardless of project type or scope, must complete Table B for all departments and functional areas affected by the proposed project.
Table C	Construction Characteristics	All applicants proposing new construction or renovation must complete Table C.
Table D	Site and Offsite Costs Included and Excluded in Marshall Valuation Costs	All applicants proposing new construction or renovation must complete Table D.
Table E	Project Budget	All applicants, regardless of project type or scope, must complete Table E.
Table F	Statistical Projections - Entire Facility	Existing facility applicants must complete Table F. All applicants who complete this table must also complete Tables G and H.
Table G	Revenues & Expenses, Uninflated - Entire Facility	Existing facility applicants must complete Table G. The projected revenues and expenses in Table G should be consistent with the volume projections in Table F.
Table H	Revenues & Expenses, Inflated - Entire Facility	Existing facility applicants must complete Table H. The projected revenues and expenses in H should be consistent with the projections in Tables F and G.
Table I	Statistical Projections - New Facility or Service	Applicants who propose to establish a new facility, existing facility applicants who propose a new service, and applicants who are directed by MHCC staff must complete Table I. All applicants who complete this table must also complete Tables J and K.
Table J	Revenues & Expenses, Uninflated - New Facility or Service	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant who completes a Table I must complete Table J. The projected revenues and expenses in Table J should be consistent with the volume projections in Table I.
Table K	Revenues & Expenses, Inflated - New Facility or Service	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant that completes a Table I must complete Table K. The projected revenues and expenses in Table K should be consistent with the projections in Tables I and J.
Table L	Work Force Information	All applicants, regardless of project type or scope, must complete Table L.

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

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

NOTE: Physical capacity is the total number of beds that could be physically set up in space without significant renovations. This should be the maximum operating capacity under normal, non-emergency circumstances and is a physical count of bed capacity, rather than a measure of staffing capacity. A room with two headwalls and two sets of gasses should be counted as having capacity for two beds, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough from a square footage perspective to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain no headwalls or a single headwall, but are normally used to accommodate one or more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms should be counted as they are currently used.

Before the Project								After Project Completion								Additional Instruction
Hospital Service	Location (Floor/Wing)*	Licensed Beds: 7/1/201_	Based on Physical Capacity					Hospital Service	Location (Floor/Wing)*	Based on Physical Capacity						
			Room Count			Bed Count				Room Count			Bed Count			
			Private	Semi-Private	Total Rooms	Physical Capacity				Private	Semi-Private	Total Rooms	Physical Capacity			
ACUTE CARE								ACUTE CARE								
General Medical/Surgical*					0	0		General Medical/Surgical*				0	0			
					0	0						0	0			
					0	0						0	0			
					0	0						0	0			
					0	0						0	0			
SUBTOTAL Gen. Med/Surg*								SUBTOTAL Gen. Med/Surg*								*Calculate the sum of all General Medical/Surgical rows*
ICU/CCU					0	0		ICU/CCU				0	0			
Other *(Specify/add rows as needed)*					0	0						0	0			
TOTAL MSGA								TOTAL MSGA								*Calculate the sum of Med/Surg Subtotal, ICU/CCU, and other physical capacity*
Obstetrics					0	0		Obstetrics				0	0			
Pediatrics					0	0		Pediatrics				0	0			
Psychiatric					0	0		Psychiatric				0	0			
TOTAL ACUTE		0	0	0	0	0		TOTAL ACUTE		0	0	0	0			*Ensure that Total includes Total MSGA and Obstetrics, Pediatrics, and Psych rows*
NON-ACUTE CARE								NON-ACUTE CARE								
Dedicated Observation**					0	0		Dedicated Observation**				0	0			
Rehabilitation					0	0		Rehabilitation				0	0			
Comprehensive Care					0	0		Comprehensive Care				0	0			
Other O/D	First Floor - Entire Facility	0	0	8	8	16		Other O/D	First Floor - Entire Facility	0	7	7	16			
TOTAL NON-ACUTE								TOTAL NON-ACUTE								*Calculate the sum of all Non-Acute Care rows*
HOSPITAL TOTAL		0	0	0	0	0		HOSPITAL TOTAL		0	7	7	16			*Ensure that Hospital Total includes Total Acute and Total Non-acute rows*

* Include beds dedicated to gynecology and addictions, if unit(s) is separate for acute psychiatric unit

** Include services included in the reporting of the "Observation Center". Service 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, which are reasonable and necessary to determine the need for a possible admission to the hospital as an inpatient. Must be ordered and documented in writing, given by a medical practitioner.

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

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

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
Entrance/Waiting			172		172
Staff			1,410		1,410
Patient Areas			3,660		3,660
Commercial Kitchen			252		252
Common bathroom/utility			357		357
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
Total					5,851

TABLE C. CONSTRUCTION CHARACTERISTICS

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.

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

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Basement		
First Floor		6,127
Second Floor		
Third Floor		
Fourth Floor		
Average Square Feet		6,127
Perimeter in Linear Feet	**Linear Feet**	
Basement		
First Floor		421
Second Floor		
Third Floor		
Fourth Floor		
Total Linear Feet		421
Average Linear Feet		421
Wall Height (floor to eaves)	**Feet**	
Basement		
First Floor		9'-0"
Second Floor		
Third Floor		
Fourth Floor		
Average Wall Height		9'-0"
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger		
Freight		
Sprinklers	**Square Feet Covered**	
Wet System		6,127
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project		
Type of Exterior Walls for proposed project		

TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS

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

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
SITE PREPARATION COSTS		
Normal Site Preparation		$0
Utilities from Structure to Lot Line		$0
Subtotal included in Marshall Valuation Costs		$0
Site Demolition Costs		$0
Storm Drains		$0
Rough Grading		$0
Hillside Foundation		$0
Paving		$0
Exterior Signs		$0
Landscaping		$0
Walls		$0
Yard Lighting		$0
Other *(Specify/add rows if needed)*		$0
Subtotal On-Site excluded from Marshall Valuation Costs		$0
OFFSITE COSTS		
Roads		$0
Utilities		$0
Jurisdictional Hook-up Fees		$0
Other *(Specify/add rows if needed)*		$0
Subtotal Off-Site excluded from Marshall Valuation Costs		$0
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	$0	$0
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	$0	$0

*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

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

	Hospital Building	Other Structure	Total	Additional instruction for cost categories
A. USE OF FUNDS				
1. CAPITAL COSTS				
a. Land Purchase:			$0	
b. New Construction				
(1) Building			$0	
(2) Fixed Equipment			$0	*These costs should be consistent with the Marshall Valuation Service definition of Group 1 equipment: Permanent equipment, installed on or attached to the building, part of a general contract, and included in calculator costs.*
(3) Site and Infrastructure			$0	
(4) Architect/Engineering Fees			$0	
(5) Permits (Building, Utilities, Etc.)			$0	
SUBTOTAL	$0	$0	$0	*Ensure that SUBTOTAL includes all categories under 1.b.*
c. Renovations				
(1) Building			$0	
General conditions		$144,862	$144,862	
Site construction / Select demolition		$76,104	$76,104	
Concrete		$19,575	$19,575	
Masonry		$2,125	$2,125	
Metals		$5,000	$5,000	
Woods and plastics		$18,460	$18,460	
Thermal and moisture protection		$31,200	$31,200	
Doors and windows		$56,755	$56,755	
Finishes		$145,814	$145,814	
Specialties		$6,500	$6,500	
Equipment		$71,237	$71,237	
Furnishings		$3,979	$3,979	
Special constructions		$37,198	$37,198	
Mechanical Plumbing, HVAC		$170,050	$170,050	
Electrical		$144,225	$144,225	
General excess, umbrella insurance		$8,398	$8,398	
5% overhead		$47,074	$47,074	
5% profit		$49,428	$49,428	
(2) Fixed Equipment (not included in construction)			$0	
(3) Architect/Engineering Fees		$53,018	$53,018	
(4) Permits (Building, Utilities, Etc.)			$0	
SUBTOTAL	$0	$1,091,002	$1,091,002	*Ensure that SUBTOTAL includes all categories under 1.c.*
d. Other Capital Costs				
(1) Movable Equipment			$0	
(2) Contingency Allowance		$103,798	$103,798	
(3) Gross interest during construction period			$0	
(4) Other *(Specify/add rows if needed)*			$0	
SUBTOTAL		*$103,798*	$103,798	*Calculate sum of all categories under 1.d.*
TOTAL CURRENT CAPITAL COSTS	$0	$1,194,800	$1,194,800	*Ensure that TOTAL CURRENT CAPITAL COSTS includes all SUBTOTALS above*
e. Inflation Allowance			$0	*Inflation should only be included in this category*
TOTAL CAPITAL COSTS	$0	$1,194,800	$1,194,800	*Ensure that TOTAL CAPITAL COSTS includes TOTAL CURRENT CAPITAL COSTS and Inflation Allowance*
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. Other *(Specify/add rows if needed)*			$0	
SUBTOTAL			$0	*Calculate sum of all categories under 2.*
3. Working Capital Startup Costs			$0	*Start up costs are costs incurred before opening a facility or new service that under generally accepted accounting principles are not chargeable as operating expense or maintenance.*
TOTAL USES OF FUNDS	*$0*	*$1,194,800*	*$1,194,800*	*Ensure that TOTAL USES OF FUNDS includes TOTAL CAPITAL COSTS, SUBTOTAL under A.2., and Working Capital Startup Costs*
B. Sources of Funds				
1. Cash		**$1,194,800**	$1,194,800	
2. Philanthropy (to date and expected)			$0	*Identify and explain the sources, plans, and the hospital's experience regarding fundraising goals under the response to the Viability standard in Section XX of the CON application.*
3. Authorized Bonds			$0	
4. Interest Income from bond proceeds listed in #3			$0	
5. Mortgage			$0	
6. Working Capital Loans			$0	
7. Grants or Appropriations				
a. Federal			$0	
b. State			$0	
c. Local			$0	
8. Other *(Specify/add rows if needed)*			$0	*Include the value of any donated land for the project in this category*
TOTAL SOURCES OF FUNDS		*$1,194,800*	$1,194,800	*Calculate sum of all categories under B; Note that TOTAL SOURCES OF FUNDS should match TOTAL USES OF FUNDS*
Annual Lease Costs (if applicable)				
1. Land			$0	
2. Building		**$162,750**	$162,750	
3. Major Movable Equipment			$0	
4. Minor Movable Equipment			$0	
5. Other *(Specify/add rows if needed)*			$0	

The lease agreement for the building is for 5 years and is effective as of October 1, 2015. The first 3 months require a $0 payment, months 4-6 require a $7,750 monthly installment and months 7-60 require a monthly installment of $15,500. The amount shown above is 3 months at $7,750 per month and 9 months at $15,500 per month. We have assumed that the facility will be operational on January 1, 2017.

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (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.

	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 J and K.						
Indicate CY or FY	2016	2017	2018	2019			
1. DISCHARGES							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	0	0	0	0	0	0	0
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	*0*	*0*	*0*	*0*	*0*	*0*	*0*
f. Rehabilitation							
g. Comprehensive Care							
h. Other (J/D	0	960	960	960			
TOTAL DISCHARGES	*0*	*960*	*960*	*960*	*0*	*0*	*0*
2. PATIENT DAYS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	0	0	0	0	0	0	0
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	*0*	*0*	*0*	*0*	*0*	*0*	*0*
f. Rehabilitation							
g. Comprehensive Care							
h. Other (J/D	0	5760	5760	5760			
TOTAL PATIENT DAYS	*0*	*5,760*	*5,760*	*5,760*	*0*	*0*	*0*
3. AVERAGE LENGTH OF STAY							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA							
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute							
f. Rehabilitation							
g. Comprehensive Care							
h. Other (J/D	0.0	6.0	6.0	6.0			
TOTAL AVERAGE LENGTH OF STAY	0.0	6.0	6.0	6.0			
4. NUMBER OF LICENSED BEDS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	0	0	0	0	0	0	0
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	*0*	*0*	*0*	*0*	*0*	*0*	*0*
f. Rehabilitation							
g. Comprehensive Care							
h. Other (J/D	0	16	16	16			
TOTAL LICENSED BEDS	*0*	*16*	*16*	*16*			
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA							
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute							
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)	0.0%	98.6%	98.6%	98.6%			
TOTAL OCCUPANCY %	0.0%	98.6%	98.6%	98.6%			
6. OUTPATIENT VISITS							
a. Emergency Department							
b. Same-day Surgery							
c. Laboratory							
d. Imaging							
e. Other (Specify/add rows of needed)							
TOTAL OUTPATIENT VISITS	*0*	*0*	*0*	*0*	*0*	*0*	*0*
7. OBSERVATION S**							
a. Number of Patients							
b. Hours							

*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 hospital 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 defined area of the hospital.

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

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.							Additional Instruction
Indicate CY or FY	**CY 2016**	**CY 2017**	**CY 2018**	**CY 2019**				*Indicate CY or FY*
1. REVENUE								
a. Inpatient Services	$ -	$ 7,200,000	$ 9,600,000	$ 9,600,000				
b. Outpatient Services								
Gross Patient Service Revenues	*$ -*	*$ 7,200,000*	*$ 9,600,000*	*$ 9,600,000*	*$ -*	*$ -*	*$ -*	*Ensure that Gross Patient Service Revenue includes 1 a-b.*
c. Allowance For Bad Debt	$ -	$ 2,400,000	$ 3,360,000	$ 3,360,000				
d. Contractual Allowance								
e. Charity Care	$ -	$ 1,200,000	$ 1,200,000	$ 1,200,000				
Net Patient Services Revenue	*$ -*	*$ 3,600,000*	*$ 5,040,000*	*$ 5,040,000*	*$ -*	*$ -*	*$ -*	*Ensure that Net Patient Services Revenue includes Gross Patients Service Revenue minus 1 c-e.*
f. Other Operating Revenues (Specify)								
NET OPERATING REVENUE	*$ -*	*$ 3,600,000*	*$ 5,040,000*	*$ 5,040,000*	*$ -*	*$ -*	*$ -*	*Ensure that Net Operating Revenue reflects the sum of Net Patient Services Revenue and all Other Operating Revenue rows.*
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 477,825	$ 2,293,760	$ 2,293,760	$ 2,293,760				
b. Contractual Services	$ 10,000	$ 60,000	$ 60,000	$ 60,000				
c. Interest on Current Debt								
d. Interest on Project Debt								
e. Current Depreciation								
f. Project Depreciation								
g. Current Amortization								
h. Project Amortization								
i. Supplies	49,000	25,000	25,000	25,000				
j. Other Expenses (Specify)	205,450	325,060	327,560	327,560				Specified in Assumptions
TOTAL OPERATING EXPENSES	*$ 741,475*	*$ 2,703,820*	*$ 2,706,320*	*$ 2,706,320*	*$ -*	*$ -*	*$ -*	*Ensure that Total Operating Expenses includes any added Other rows.*
3. INCOME								
a. Income From Operation	$ (741,475)	$ 896,180	$ 2,333,680	$ 2,333,680	$ -	$ -	$ -	*Ensure that Income from Operation includes Net Operating Revenue minus Total Operating Expenses.*
b. Non Operating Income								
SUBTOTAL	*$ (741,475)*	*$ 896,180*	*$ 2,333,680*	*$ 2,333,680*	*$ -*	*$ -*	*$ -*	*Ensure that Subtotal includes 3 a-b*
c. Income Taxes		$ 61,882	$ 933,472	$ 933,472				
NET INCOME (LOSS)	*$ (741,475)*	*$ 834,298*	*$ 1,400,208*	*$ 1,400,208*	*$ -*	*$ -*	*$ -*	*Ensure that the Net Income (Loss) includes Subtotal and Income Taxes.*
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare								
2) Medicaid								
3) Blue Cross	0.0%	20.0%	20.0%	20.0%				
4) Commercial Insurance	0.0%	62.5%	62.5%	62.5%				
5) Self-pay	0.0%	5.0%	5.0%	5.0%				
6) Other	0.0%	12.5%	12.5%	12.5%				
TOTAL	*0.0%*	*100.0%*	*100.0%*	*100.0%*	*0.0%*	*0.0%*	*0.0%*	*Ensure that 4a captures 100% of patients*
b. Percent of Equivalent Inpatient Days								
Total MSGA								
1) Medicare								
2) Medicaid								
3) Blue Cross	0.0%	20.0%	20.0%	20.0%				
4) Commercial Insurance	0.0%	62.5%	62.5%	62.5%				
5) Self-pay	0.0%	5.0%	5.0%	5.0%				
6) Other	0.0%	12.5%	12.5%	12.5%				
TOTAL	*0.0%*	*100.0%*	*100.0%*	*100.0%*	*0.0%*	*0.0%*	*0.0%*	*Ensure that 4b captures 100% of patients*

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

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.							Additional Instruction
Indicate CY or FY	CY 2016	CY 2017	CY 2018	CY 2019				*Indicate CY or FY*
1. REVENUE								
a. Inpatient Services	$ -	$ 7,200,000	$ 9,888,000	$ 10,184,640				
b. Outpatient Services								
Gross Patient Service Revenues	*$ -*	*$ 7,200,000*	*$ 9,888,000*	*$ 10,184,640*	*$ -*	*$ -*	*$ -*	*Ensure that Gross Patient Service Revenue includes 1 a-b.*
c. Allowance For Bad Debt	$ -	$ 2,400,000	$ 3,460,800	$ 3,564,624				
d. Contractual Allowance								
e. Charity Care	$ -	$ 1,200,000	$ 1,236,000	$ 1,273,080				
Net Patient Services Revenue	*$ -*	*$ 3,600,000*	*$ 5,191,200*	*$ 5,346,936*	*$ -*	*$ -*	*$ -*	*Ensure that Net Patient Services Revenue includes Gross Patients Service Revenue minus 1 c-e.*
f. Other Operating Revenues (Specify/add rows of needed)								
NET OPERATING REVENUE	*$ -*	*$ 3,600,000*	*$ 5,191,200*	*$ 5,346,936*	*$ -*	*$ -*	*$ -*	*Ensure that Net Operating Revenue reflects the sum of Net Patient Services Revenue and all Other Operating Revenue rows.*
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 477,025	$ 2,293,760	$ 2,362,573	$ 2,433,450				
b. Contractual Services	$ 10,000	$ 60,000	$ 61,800	$ 63,654				
c. Interest on Current Debt								
d. Interest on Project Debt								
e. Current Depreciation								
f. Project Depreciation								
g. Current Amortization								
h. Project Amortization								
i. Supplies	$ 49,000	$ 25,000	$ 25,750	$ 26,523				
j. Other Expenses (Specify/add rows of needed)	$ 205,450	$ 325,060	$ 337,387	$ 347,500				
TOTAL OPERATING EXPENSES	$ 741,475	$ 2,703,820	$ 2,787,510	$ 2,871,135	$ -	$ -	$ -	*Ensure that Total Operating Expenses includes any added Other rows.*
3. INCOME								
a. Income From Operation	$ (741,475)	$ 896,180	$ 2,403,690	$ 2,475,801	$ -	$ -	$ -	*Ensure that Income from Operation includes Net Operating Revenue minus Total Operating Expenses.*
b. Non-Operating Income								
SUBTOTAL	*$ (741,475)*	*$ 896,180*	*$ 2,403,690*	*$ 2,475,801*	*$ -*	*$ -*	*$ -*	*Ensure that Subtotal includes 3 a-b.*
c. Income Taxes		$ 61,882	$ 961,476	$ 990,320				
NET INCOME (LOSS)	*$ (741,475)*	*$ 834,298*	*$ 1,442,214*	*$ 1,485,481*	*$ -*	*$ -*	*$ -*	*Ensure that the Net Income (Loss) includes Subtotal and Income Taxes*
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare								
2) Medicaid								
3) Blue Cross	0.0%	20.0%	20.0%	20.0%				
4) Commercial Insurance	0.0%	62.5%	62.5%	62.5%				
5) Self-pay	0.0%	5.0%	5.0%	5.0%				
6) Other	0.0%	12.5%	12.5%	12.5%				
TOTAL	*0.0%*	*100.0%*	*100.0%*	*100.0%*	*0.0%*	*0.0%*	*0.0%*	*Ensure that 4a captures 100% of patients*
b. Percent of Equivalent Inpatient Days								
1) Medicare								
2) Medicaid								
3) Blue Cross	0.0%	20.0%	20.0%	20.0%				
4) Commercial Insurance	0.0%	62.5%	62.5%	62.5%				
5) Self-pay	0.0%	5.0%	5.0%	5.0%				
6) Other	0.0%	12.5%	12.5%	12.5%				
TOTAL	*0.0%*	*100.0%*	*100.0%*	*100.0%*	*0.0%*	*0.0%*	*0.0%*	*Ensure that 4b captures 100% of patients*

TABLE L: WORKFORCE INFORMATION

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) *		Additional Instruction
	Current Year FTEs	Average Salary per FTE	Current Year Total Cost	FTEs	Average Salary per FTE	Total 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)												
Medical Director			$0	1.0	$252,000	$252,000			$0	1.0	$252,000	
Clinical Supervisor			$0	1.0	$75,000	$84,000			$0	1.0	$84,000	
Case Manager				2.0	$75,000	$168,000				2.0	$84,000	
Admissions Coordinator				1.0	$85,000	$96,000				1.0	$96,000	
Office Manager/HR/Accounting			$0	1.0	$65,000	$72,800			$0	1.0	$72,800	
Executive Assistant				1.0	$40,000	$44,800				1.0	$44,800	
Receptionist				1.0	$28,000	$31,360				1.0	$31,360	
President/COO				1.0	$145,000	$162,400				1.0	$162,400	
CMO				1.0	$150,000	$168,000				1.0	$168,000	
Marketing				1.0	$65,000	$97,200				1.0	$97,200	
Public Relations				1.0	$75,000	$84,000				1.0	$84,000	
			$0			$0			$0		$0	
Total Administration			$0	12.0		$1,190,560			$0	12.0	$1,190,560	Calculate the sum of Administration
Direct Care Staff (List general categories, add rows if needed)												
CRNP/PA			$0	1.8	$85,000	$151,200			$0	1.8	$151,200	
Social Worker			$0	2.0	$65,000	$146,600			$0	2.0	$146,600	
Nursing Supervisor (Charge)			$0	1.0	$80,000	$100,800			$0	1.0	$100,800	
Nurse (Day)				1.0	$80,000	$89,600				1.0	$89,600	
Nurse/LPN (Evening)				2.0	$65,000	$134,400				2.0	$134,400	
Nurse/LPN (Night)				1.0	$85,000	$97,200				1.0	$97,200	
Behavioral Health Techs/Medicine Aide				3.0	$35,000	$120,960				3.0	$120,960	
			$0			$0			$0	0.0	$0	
Total Direct Care			$0	11.5		$809,760			$0	11.5	$809,760	Calculate the sum of Direct Care
Support Staff (List general categories, add rows if needed)												
Line Cook			$0	2.0	$48,000	$100,800			$0	2.0	$100,800	
Chef/Food Service Manager			$0	1.0	$65,000	$91,600			$0	1.0	$91,600	
Dietician			$0	0.25	$100,000	$28,000			$0	0.3	$28,000	
Janitorial Staff				2.00	$32,000	$71,680						
Driver				1.00	$28,000	$31,360						
			$0			$0			$0	0.0	$0	
Total Support			$0			$293,440			$0	0.0	$293,440	Calculate the sum of Administration, Support staff
REGULAR EMPLOYEES TOTAL			$0	6.3		$2,293,760			$0	6.3	$2,293,760	Calculate the sum of Administration, Direct Care, and Support staff
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			$0	0.0	$0	Calculate the sum of Administration
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			$0	0.0	$0	Calculate the sum of Direct Care
Support 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 Support Staff			$0			$0			$0	0.0	$0	Calculate the sum of Administration, Support staff
CONTRACTUAL EMPLOYEES TOTAL			$0			$0			$0	0.0	$0	Calculate the sum of Administration, Direct Care, and Support staff
Benefits (State method of calculating benefits below):												
For all amounts included within this category, all applicable taxes and benefits estimated to be 12% of compensation have been included in this category.												Indicate the method of calculating benefits given related errors
TOTAL COST	0.0		$0	29.8		$2,293,760	0.0		$0		$2,293,760	Enter the total sum of Total Costs of Regular Employees Total and Contractor Employees above

* 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.

Preliminary
NOT FOR CONSTRUCTION

Owner Rep Consulting Conceptual Estimate

PROJECT: Delphi Health Group

LOCATION: Linthicum Heights, MD | NOTES: Approximate Square Footage (SF): 6,050

DATE: March 16, 2016 | SUMMARY: Preliminary Budget; Not for Construction

DIV	DESCRIPTION	NOTES	$ CONST.	$/SF

	Budget (Order of Magnitude)*	Qualifications	Costs	$/SF	Comment
0	Soft Costs	None Figured	$ -	$ -	
1	General Conditions		$ 144,862	$ 23.94	Lump Sum, Conceptual Budget
2	Site Construction (Select) / Select Demolition		$ 76,104	$ 12.58	Lump Sum, Conceptual Budget
3	Concrete		$ 19,575	$ 3.24	Lump Sum, Conceptual Budget
4	Masonry		$ 2,125	$ 0.35	Lump Sum, Conceptual Budget
5	Metals		$ 5,000	$ 0.83	Lump Sum, Conceptual Budget
6	Woods and Plastics		$ 18,460	$ 3.05	Lump Sum, Conceptual Budget
7	Thermal and Moisture Protection		$ 31,200	$ 5.16	Lump Sum, Conceptual Budget
8	Doors and Windows		$ 56,755	$ 9.38	Lump Sum, Conceptual Budget
9	Finishes		$ 145,814	$ 24.10	Lump Sum, Conceptual Budget
10	Specialties		$ 6,500	$ 1.07	Lump Sum, Conceptual Budget
11	Equipment		$ 71,237	$ 11.77	Lump Sum, Conceptual Budget
12	Furnishings		$ 3,979	$ 0.66	Lump Sum, Conceptual Budget
13	Special Construction		$ 37,198	$ 6.15	Lump Sum, Conceptual Budget
14	Conveying Systems-Elevator	Not Applicable	$ -	$ -	
15	Mechanical-Plumbing, HVAC		$ 170,050	$ 28.11	Lump Sum, Conceptual Budget
16	Electrical		$ 144,225	$ 23.84	Lump Sum, Conceptual Budget
	SUBTOTAL		$ 933,084	$ 154.23	Lump Sum, Conceptual Budget
	General & Excess, Umbrella Insurance		$ 8,398	$ 1.39	Lump Sum, Conceptual Budget
	Builders Risk Insurance	BY Developer/Borrower	$ -	$ -	Lump Sum, Conceptual Budget
	SUBTOTAL (INCL. INSURANCES)		$ 941,481	$ 155.62	Lump Sum, Conceptual Budget
	5% OVERHEAD		$ 47,074	$ 7.78	Lump Sum, Conceptual Budget
	SUBTOTAL (INCL. OVERHEAD)		$ 988,555	$ 163.40	Lump Sum, Conceptual Budget
	5% PROFIT		$ 49,428	$ 8.17	Lump Sum, Conceptual Budget
	GRAND TOTAL (EXCLUDING CONTINGENCY)		$ 1,037,983	$ 171.57	Lump Sum, Conceptual Budget
	10% CONTINGENCY		$ 103,798	$ 17.16	Recommended for unforeseen conditions
	GRAND TOTAL (INCLUDING CONTINGENCY)		$ 1,141,781	$ 188.72	Lump Sum, Conceptual Budget
	GRAND TOTAL (INCL. CONTINGENCY)	3/16/16 2:21 PM	$ 1,141,781	$ 188.72	Project Budget: Order of Magnitude

CONFIDENTIAL

Exhibit 5

Transfer and Outgoing Referral Agreements

Outgoing Referral Agreement

Maryland House Detox will be operating a III.7.D Medically Monitored Inpatient Detoxification Intermediate Care Facility located at 817 S Camp Meade Rd Linthicum, MD. MHD plans to accept patients from the Central Maryland Planning Region and across the state to detox and stabilize, assess and evaluate, and foster entry into the substance use treatment system. During assessment, admission, and/or treatment, patients may experience acute medical or psychiatric emergencies. If an emergency of this nature occurs, this agreement represents a possible transfer to UM Baltimore Washington Medical Center for emergency care.

In accordance to COMAR 10.24.14.05(J), UM Baltimore Washington Medical Center agrees to establish a referral agreement and process with Maryland House Detox to accept cases that exceed, extend, or complement MHD's capabilities.

The referral process includes telephone contact with the Emergency Department Charge Nurse and physician (410-787-4567) and the possible transportation to UM Baltimore Washington Medical Center Emergency Department for further evaluation and treatment.

Accepting Provider:

Karen E. Olsen

UM BWMC

Name and Title

President & CEO

Date 3/21/16

Maryland House Detox:

David Stup, CEO

Name and Title

3/21/16

Date

Outgoing Referral Agreement

Maryland House Detox will be operating a III.7.D Medically Monitored Inpatient Detoxification Intermediate Care Facility located at 817 S Camp Meade Rd Linthicum, MD. MHD plans to accept patients from the Central Maryland Planning Region and across the state to detox and stabilize, assess and evaluate, and foster entry into the substance use treatment system. Upon assessment and stabilization, MHD will determine the most appropriate level of care for its patients and complete a warm referral process with its continued care partners.

In accordance to COMAR 10.24.14.05(J), Tranquility Woods LLC **agrees to establish a referral agreement and process with Maryland House Detox to accept cases that exceed, extend, or complement MHD's capabilities and foster continued treatment for its patients.**

The referral process includes telephone contact with Tranquility Woods LLC **and the possible transportation to** Tranquility Woods LLC **for further evaluation and treatment.**

The accepting program provides the following levels of care:

Residential	**Individual Care**	**Location(s):**
Partial Hospitalization/Housing	**Halfway House**	**Anne Arundel Co**
Intensive Outpatient	**Other:**	**Baltimore Co**
Outpatient	_____	**Baltimore City**
		Harford Co
		Howard Co

Accepting Provider:

Ellen M Kulp

Ellen M. Kulp

Name and Title

Director of Wellness

Date 3/10/2016

Maryland House Detox:

David Stup, CEO

Name and Title

3/10/16

Date

Outgoing Referral Agreement

Maryland House Detox will be operating a III.7.D Medically Monitored Inpatient Detoxification Intermediate Care Facility located at 817 S Camp Meade Rd Linthicum, MD. MHD plans to accept patients from the Central Maryland Planning Region and across the state to detox and stabilize, assess and evaluate, and foster entry into the substance use treatment system. Upon assessment and stabilization, MHD will determine the most appropriate level of care for its patients and complete a warm referral process with its continued care partners.

In accordance to COMAR 10.24.14.05(J), Congruent Counseling Services, Mark Donovan **agrees to establish a referral agreement and process with Maryland House Detox to accept cases that exceed, extend, or complement MHD's capabilities and foster continued treatment for its patients.**

The referral process includes telephone contact with CCS **and the possible transportation to** CCS Columbia **for further evaluation and treatment.**

The accepting program provides the following levels of care:

Residential	**Individual Care**	**Location(s):**
Partial Hospitalization/Housing	**Halfway House**	**Anne Arundel Co**
Intensive Outpatient	**Other:**	**Baltimore Co**
Outpatient	- MH & addictions	**Baltimore City**
	Individual	**Harford Co**
	- psychiatry	**Howard Co**
	- Anger	Carroll County
	- DBT	Montgomery County
	- Family	

Accepting Provider:

Congruent Counseling Services
10630 Little Patuxent Pkwy
Suite 209, Columbia, MD
Name and Title

Mark Donovan, LCPC

Date 3/8/16

Maryland House Detox:

Maryland House Detox

David Stup, CEO
Name and Title

Date 3/8/16

Outgoing Referral Agreement

Maryland House Detox will be operating a III.7.D Medically Monitored Inpatient Detoxification Intermediate Care Facility located at 817 S Camp Meade Rd Linthicum, MD. MHD plans to accept patients from the Central Maryland Planning Region and across the state to detox and stabilize, assess and evaluate, and foster entry into the substance use treatment system. Upon assessment and stabilization, MHD will determine the most appropriate level of care for its patients and complete a warm referral process with its continued care partners.

In accordance to COMAR 10.24.14.05(J), __Maryland Recovery__ agrees to establish a referral agreement and process with Maryland House Detox to accept cases that exceed, extend, or complement MHD's capabilities and foster continued treatment for its patients.

The referral process includes telephone contact with Maryland Recovery and the possible transportation to _21 W Courtland Street, Bel Air MD 21014_ for further evaluation and treatment.

The accepting program provides the following levels of care:

✓ **Residential**	**Individual Care**	**Location(s):**
✓ **Partial Hospitalization/Housing**	**Halfway House**	**Anne Arundel Co**
✓ **Intensive Outpatient**	**Other:**	**Baltimore Co**
Outpatient	_____	**Baltimore City**
		Harford Co
		Howard Co

Accepting Provider:

_ **Maryland Recovery Programs** __

James Haggerty, CEO

Name and Title

3/7/16

Date

Maryland House Detox:

David Stup, CEO

Name and Title

3/7/16

Date

JM

Outgoing Referral Agreement

Maryland House Detox will be operating a III.7.D Medically Monitored Inpatient Detoxification Intermediate Care Facility located at 817 S Camp Meade Rd Linthicum, MD. MHD plans to accept patients from the Central Maryland Planning Region and across the state to detox and stabilize, assess and evaluate, and foster entry into the substance use treatment system. Upon assessment and stabilization, MHD will determine the most appropriate level of care for its patients and complete a warm referral process with its continued care partners.

In accordance to COMAR 10.24.14.05(J), Bergand Group agrees to establish a referral agreement and process with Maryland House Detox to accept cases that exceed, extend, or complement MHD's capabilities and foster continued treatment for its patients.

The referral process includes telephone contact with ~~MHD~~ Bergand Group and the possible transportation to ~~MHD~~ B.C. for further evaluation and treatment.

The accepting program provides the following levels of care:

Residential	**Individual Care**	**Location(s):**
Partial Hospitalization/Housing	**Halfway House**	**Anne Arundel Co**
Intensive Outpatient	**Other:**	**Baltimore Co**
Outpatient	_____	**Baltimore City**
		Harford Co
		Howard Co

Accepting Provider:

Bergand Group

Name and Title

John A. Kleinberg MD

Date 3/14/16

MEDICAL DIRECTOR

Maryland House Detox:

David Step, CEO

Name and Title

3/14/16

Date

Outgoing Referral Agreement

Maryland House Detox will be operating a III.7.D Medically Monitored Inpatient Detoxification Intermediate Care Facility located at 817 S Camp Meade Rd Linthicum, MD. MHD plans to accept patients from the Central Maryland Planning Region and across the state to detox and stabilize, assess and evaluate, and foster entry into the substance use treatment system. Upon assessment and stabilization, MHD will determine the most appropriate level of care for its patients and complete a warm referral process with its continued care partners.

In accordance to COMAR 10.24.14.05(J), New Life Addictions **agrees to establish a referral agreement and process with Maryland House Detox to accept cases that exceed, extend, or complement MHD's capabilities and foster continued treatment for its patients.**

The referral process includes telephone contact with New Life Addictions **and the possible transportation to** New Life Addictions **for further evaluation and treatment.**

The accepting program provides the following levels of care:

Residential	**Individual Care**	**Location(s):**
Partial Hospitalization/Housing	**Halfway House**	**(Anne Arundel Co)**
(Intensive Outpatient)	**Other:**	**Baltimore Co**
Outpatient	COC	**Baltimore City**
		Harford Co
		Howard Co

Accepting Provider:

NEW LIFE ADDICTION COUNSELING SERVICES, INC.

Name and Title

Beverly Herrin, CEO

Date 3/14/16

Maryland House Detox:

David Stup, CEO

Name and Title

3/14/16

Date

Outgoing Referral Agreement

Maryland House Detox will be operating a III.7.D Medically Monitored Inpatient Detoxification Intermediate Care Facility located at 817 S Camp Meade Rd Linthicum, MD. MHD plans to accept patients from the Central Maryland Planning Region and across the state to detox and stabilize, assess and evaluate, and foster entry into the substance use treatment system. Upon assessment and stabilization, MHD will determine the most appropriate level of care for its patients and complete a warm referral process with its continued care partners.

In accordance to COMAR 10.24.14.05(J), Hope House Treatment Centers agrees to establish a referral agreement and process with Maryland House Detox to accept cases that exceed, extend, or complement MHD's capabilities and foster continued treatment for its patients.

The referral process includes telephone contact with Peter D'Souza. and the possible transportation to Hope House for further evaluation and treatment.

The accepting program provides the following levels of care:

Residential	**Individual Care**	**Location(s):**
Partial Hospitalization/Housing	**Halfway House**	**Anne Arundel Co**
Intensive Outpatient	**Other:**	**Baltimore Co**
Outpatient	_____	**Baltimore City**
		Harford Co
		Howard Co

Accepting Provider:

D'Souza

Peter D'Souza, CEO

Name and Title

March 17th, 16.

Date

Maryland House Detox:

David Stup, CEO

Name and Title

3/17/16

Date

Outgoing Referral Agreement

Maryland House Detox will be operating a III.7.D Medically Monitored Inpatient Detoxification Intermediate Care Facility located at 817 S Camp Meade Rd Linthicum, MD. MHD plans to accept patients from the Central Maryland Planning Region and across the state to detox and stabilize, assess and evaluate, and foster entry into the substance use treatment system. Upon assessment and stabilization, MHD will determine the most appropriate level of care for its patients and complete a warm referral process with its continued care partners.

In accordance to COMAR 10.24.14.05(J), Harbor of Grace Recovery Ctr. agrees to establish a referral agreement and process with Maryland House Detox to accept cases that exceed, extend, or complement MHD's capabilities and foster continued treatment for its patients.

The referral process includes telephone contact with the Admissions Dept. and the possible transportation to Harbor of Grace Recovery for further evaluation and treatment.

The accepting program provides the following levels of care:

Residential	**Individual Care**	**Location(s):**
Partial Hospitalization/Housing	**Halfway House**	**Anne Arundel Co**
Intensive Outpatient	**Other:**	**Baltimore Co**
Outpatient	_____	**Baltimore City**
		Harford Co
		Howard Co

Accepting Provider:

Harbor of Grace Enhanced Recovery Ctr, LLC
Havre de Grace, Md.

Name and Title

D. Kenneth Beyea - CEO

Date Mar. 17, 2016

Maryland House Detox:

David Sharp, CEO

Name and Title

3/17/16

Date

Outgoing Referral Agreement

Maryland House Detox will be operating a III.7.D Medically Monitored Inpatient Detoxification Intermediate Care Facility located at 817 S Camp Meade Rd Linthicum, MD. MHD plans to accept patients from the Central Maryland Planning Region and across the state to detox and stabilize, assess and evaluate, and foster entry into the substance use treatment system. Upon assessment and stabilization, MHD will determine the most appropriate level of care for its patients and complete a warm referral process with its continued care partners.

In accordance to COMAR 10.24.14.05(J), Epoch Counseling agrees to establish a referral agreement and process with Maryland House Detox to accept cases that exceed, extend, or complement MHD's capabilities and foster continued treatment for its patients.

The referral process includes telephone contact with Epoch Counseling and the possible transportation to Epoch Counseling for further evaluation and treatment.

The accepting program provides the following levels of care:

Residential	**Individual Care**	**Location(s):**
Partial Hospitalization/Housing	**Halfway House**	**Anne Arundel Co**
Intensive Outpatient	**Other:**	**Baltimore Co** (Catonsville, Dundalk, Essex)
Outpatient	_____	**Baltimore City**
		Harford Co
		Howard Co

Accepting Provider: Epoch Counseling Center

Maryland House Detox:

Name and Title: Manette Mapa, LCPC (Clinical Coordinator Epoch-Catonsville)

Date: 3/18/16

Name and Title: David Stup, CEO

Date: 3/18/16

Exhibit 6

Incoming Referral Agreements

Incoming Referral Agreement

Maryland House Detox will be operating a III.7.D Medically Monitored Inpatient Detoxification Intermediate Care Facility located at 817 S Camp Meade Rd Linthicum, MD. MHD plans to accept patients from the Central Maryland Planning Region and across the state to detox and stabilize, assess and evaluate, and foster entry into the substance use treatment system. The facility will be considered Track One, meaning that more than 50% of its funding will come from private sources. Conversely, Maryland House Detox will also be providing 12.5% of its patient treatment days to indigent and gray area populations. A portion of these charity days will be dedicated to serving Anne Arundel County residents. This agreement demonstrates that your organization has been informed of the planned project, are aware of the ability for MHD to accept private and a portion of public patients, and if approved, develop a process to refer patients for MHD for detoxification, evaluation, and referral to treatment services.

In accordance to COMAR 10.24.14.05(J)(K) Maryland House Detox agrees to establish a referral agreement and process with UM Baltimore Washington Medical Center to accept patients that do not meet criteria for hospital admission for detoxification, evaluation, and referral to treatment services.

The referral process includes telephone contact with MHD, the scheduling of an assessment, and admission into detox based on ASAM criteria and availability of services.

Referring Provider:

Karen E. Alm

UM BWMC

Name and Title

President & CEO

Date 3/21/16

Maryland House Detox:

David Step, CEO

Name and Title

3/21/16

Date

Incoming Referral Agreement

Maryland House Detox plans to operate a III.7.D Medically Monitored Inpatient Detoxification Intermediate Care Facility located at 817 S Camp Meade Rd Linthicum, MD. Maryland House Detox will be providing 12.5% of its patient treatment days to indigent and gray area populations. A portion of these charity days (at least half) will be dedicated to serving Anne Arundel County residents. We would like to demonstrate that we have spoken to your agency regarding our planned project, informed you of our intentions to dedicate a portion of our days to these patients, and if approved, develop a referral process for patients that you identify as needing this level of care so that we may accept these patients in MHD for detoxification, evaluation, and referral to treatment services. This does not bind or commit the Anne Arundel County Mental Health Agency (AACMHA) to refer patients to MHD.

In accordance to COMAR 10.24.14.05(K), Maryland House Detox agrees to establish a referral agreement and process with the Anne Arundel Mental Health Agency to accept indigent and gray area patients for detoxification, evaluation, and referral to treatment services.

The referral process includes telephone contact with MHD, the scheduling of an assessment, and admission into detox based on ASAM criteria and availability of services.

Referring Agency:

Anne Arundel Mental Health Agency (AACMHA)

Adrienne Mickler, Executive Director Date: 3/1/16

Maryland House Detox

(name and title)
David Stup, CEO Date: 3/1/16

Incoming Referral Agreement

Maryland House Detox will be operating a III.7.D Medically Monitored Inpatient Detoxification Intermediate Care Facility located at 817 S Camp Meade Rd Linthicum, MD. MHD plans to accept patients from the Central Maryland Planning Region and across the state to detox and stabilize, assess and evaluate, and foster entry into the substance use treatment system. The facility will be considered Track One, meaning that more than 50% of its funding will come from private sources. Conversely, Maryland House Detox will also be providing 12.5% of its patient treatment days to indigent and gray area populations. A portion of these charity days will be dedicated to serving Anne Arundel County residents. We would like to demonstrate that we have spoken to your organization regarding our planned project, informed you of our intentions to accept private and a portion of public patients, and if approved, develop a referral process for patients that you serve so that we may accept these patients in MHD for detoxification, evaluation, and referral to treatment services.

In accordance to COMAR 10.24.14.05(J)(K) Maryland House Detox agrees to establish a referral agreement and process with Tranquility Woods LLC **to accept patients that do not meet criteria for hospital admission for detoxification, evaluation, and referral to treatment services.**

The referral process includes telephone contact with MHD, the scheduling of an assessment, and admission into detox based on ASAM criteria and availability of services.

Referring Provider:

Ellen M Kulp

Ellen M. Kulp

Name and Title

Director of Wellness

Date 3/10/2016

Maryland House Detox:

David Stup, CEO

Name and Title

3/10/16

Date

Incoming Referral Agreement

Maryland House Detox will be operating a III.7.D Medically Monitored Inpatient Detoxification Intermediate Care Facility located at 817 S Camp Meade Rd Linthicum, MD. MHD plans to accept patients from the Central Maryland Planning Region and across the state to detox and stabilize, assess and evaluate, and foster entry into the substance use treatment system. Maryland House Detox will be donating 12.5% of its patient treatment days to indigent and gray area populations. This agreement demonstrates that your agency has been informed of our planned project and of our intentions to dedicate a portion of our days to these patients. MHD will develop a referral process for patients that are identified as indigent or gray area so that we may accept these patients in MHD for detoxification, evaluation, and referral to treatment services.

In accordance to COMAR 10.24.14.05(K), Maryland House Detox agrees to establish a referral agreement and process with Maryland Recovery Programs to accept indigent and gray area patients for detoxification, evaluation, and referral to treatment services.

The referral process includes telephone contact with MHD, the scheduling of an assessment, and admission into detox based on ASAM criteria and availability of services.

Referring Provider:

Maryland Recovery

James Haggerty, CEO

Name and Title

3/7/16

Date

Maryland House Detox:

David Stup, CEO

Name and Title

3/7/16

Date

Incoming Referral Agreement

Maryland House Detox will be operating a III.7.D Medically Monitored Inpatient Detoxification Intermediate Care Facility located at 817 S Camp Meade Rd Linthicum, MD. MHD plans to accept patients from the Central Maryland Planning Region and across the state to detox and stabilize, assess and evaluate, and foster entry into the substance use treatment system. The facility will be considered Track One, meaning that more than 50% of its funding will come from private sources. Conversely, Maryland House Detox will also be providing 12.5% of its patient treatment days to indigent and gray area populations. A portion of these charity days will be dedicated to serving Anne Arundel County residents. We would like to demonstrate that we have spoken to your organization regarding our planned project, informed you of our intentions to accept private and a portion of public patients, and if approved, develop a referral process for patients that you serve so that we may accept these patients in MHD for detoxification, evaluation, and referral to treatment services.

In accordance to COMAR 10.24.14.05(J)(K) Maryland House Detox agrees to establish a referral agreement and process with Berland Group **to accept patients that do not meet criteria for hospital admission for detoxification, evaluation, and referral to treatment services.**

The referral process includes telephone contact with MHD, the scheduling of an assessment, and admission into detox based on ASAM criteria and availability of services.

Referring Provider:

BERLAND GROUP
JOHN A. STEINBERG, MD
MEDICAL DIRECTOR

Name and Title

John M. Steinberg

Date 3/14/16

Maryland House Detox:

DAVID SHUP, CEO

Name and Title

3/14/16

Date

Incoming Referral Agreement

Maryland House Detox will be operating a III.7.D Medically Monitored Inpatient Detoxification Intermediate Care Facility located at 817 S Camp Meade Rd Linthicum, MD. MHD plans to accept patients from the Central Maryland Planning Region and across the state to detox and stabilize, assess and evaluate, and foster entry into the substance use treatment system. The facility will be considered Track One, meaning that more than 50% of its funding will come from private sources. Conversely, Maryland House Detox will also be providing 12.5% of its patient treatment days to indigent and gray area populations. A portion of these charity days will be dedicated to serving Anne Arundel County residents. We would like to demonstrate that we have spoken to your organization regarding our planned project, informed you of our intentions to accept private and a portion of public patients, and if approved, develop a referral process for patients that you serve so that we may accept these patients in MHD for detoxification, evaluation, and referral to treatment services.

In accordance to COMAR 10.24.14.05(J)(K) Maryland House Detox agrees to establish a referral agreement and process with Hope House **to accept patients that do not meet criteria for hospital admission for detoxification, evaluation, and referral to treatment services.**

The referral process includes telephone contact with MHD, the scheduling of an assessment, and admission into detox based on ASAM criteria and availability of services.

Referring Provider:

D'Sanga

Peter D'Sanga, CEO

Name and Title

March 17th 16.

Date

Maryland House Detox:

David Stup, CEO

Name and Title

3/17/16

Date

Incoming Referral Agreement

Maryland House Detox will be operating a III.7.D Medically Monitored Inpatient Detoxification Intermediate Care Facility located at 817 S Camp Meade Rd Linthicum, MD. MHD plans to accept patients from the Central Maryland Planning Region and across the state to detox and stabilize, assess and evaluate, and foster entry into the substance use treatment system. Maryland House Detox will be donating 12.5% of its patient treatment days to indigent and gray area populations. This agreement demonstrates that your agency has been informed of our planned project and of our intentions to dedicate a portion of our days to these patients. MHD will develop a referral process for patients that are identified as indigent or gray area so that we may accept these patients in MHD for detoxification, evaluation, and referral to treatment services.

In accordance to COMAR 10.24.14.05(K), Maryland House Detox agrees to establish a referral agreement and process with Harbor of Grace Recovery Center **to accept indigent and gray area patients for detoxification, evaluation, and referral to treatment services.**

The referral process includes telephone contact with MHD, the scheduling of an assessment, and admission into detox based on ASAM criteria and availability of services.

Referring Provider:

Harbor of Grace Enhanced Recovery Ctr.
Havre de Grace, Md. 21078

Name and Title

D. Kenneth Beyer - CEO

Date MAR. 17, 2016

Maryland House Detox:

David Stup, CEO

Name and Title

3/17/16

Date

Exhibit 7

Letters of Support

ANNE ARUNDEL COUNTY
MARYLAND

Department of Health
J. Howard Beard Health Services Building
3 Harry S. Truman Parkway
Annapolis, Maryland 21401
Phone: 410-222-7375 Fax: 410-222-4436
Maryland Relay (TTY): 1-800-735-2258
www.aahealth.org

Jinlene Chan, M.D., M.P.H.
Health Officer

March 9, 2016

David Stup
CEO, Maryland House Detox
3107 Stirling Road #308
Fort Lauderdale, FL 33312

Dear Mr. Stup:

The Anne Arundel County Department of Health recognizes the need for additional high-quality substance use treatment services to serve the residents of Anne Arundel County and the Baltimore metropolitan region. Timely access to appropriate treatment is the cornerstone of combatting Maryland's opioid overdose epidemic, and there are currently too few providers to meet the need that exists.

Delphi Group's Maryland House application to open Maryland House Detox is designed to provide medically monitored detoxification services for individuals suffering from chemical dependency. This 16 bed 3.7 Medically Monitored Inpatient Detoxification program to be located at 817 S Camp Meade Rd Linthicum MD 21090 will add another treatment avenue for County residents in need of substance use treatment. We are pleased to learn about your plans to offer to offer extensive case management and aftercare planning to assure that individuals leaving your short term detoxification program will be connected with ongoing treatment and recovery services.

We look forward to working with you in the future.

Sincerely,

Jinlene Chan, M.D., M.P.H.
Health Officer

CC: William Rufenacht, MA, LCADC

Anne Arundel County Mental Health Agency, Inc

PO Box 6675, MS 3230
1 Truman Parkway, Suite 101
Annapolis, MD 21401
Adrienne Mickler, CPA, MS, Executive Director
Frank Sullivan, LCSW-C, Executive Director, Emeritus

Sponsor of Anne Arundel County's information website: www.networkofcare.org

Web Site: www.aamentalhealth.org
Email: mhaaac@aol.com
Phone: 410-222-7858
Fax: 410-222-7881

January 14, 2015

David Stup
3107 Stirling Road #308
Ft. Lauderdate, FL 33312

Subject: Letter of Support - Delphi Health Group,

To Whom It May Concern:

Anne Arundel County Mental Health Agency supports the Delphi Health Group opening a treatment facility in Linthicum, Maryland. The program plans to provide medically monitored detoxification services for individuals suffering from chemical dependency. This 16 bed Intermediate Care Facility will offer 24 hour medically supervised evaluation and withdrawal management by medical professionals. This service is very much needed in Anne Arundel County as we continue our efforts to treat individuals who need this level of care.

It is my understanding that a site has been identified and the Delphi Health Group is underway with regard to both certification and the certificate of need process. Please do not hesitate to contact me if there is any further clarification that I can offer as this program continues.

Sincerely,

Adrienne J Mickler

Adrienne Mickler
Executive Director

Maryland RECOVERY

March 7, 2016

To Whom It May Concern:

Maryland Recovery supports Maryland House Detox opening a medically monitored inpatient treatment facility in Linthicum, MD. The program plans to provide detoxification services for individuals suffering from chemical dependency. This 16-bed facility will provide 24-hour hospital level medically supervised evaluation and withdrawal management by licensed medical professionals. Maryland House Detox is designed to act as a first point of crisis entry into treatment for individuals seeking treatment. After stabilization occurs, the program will facilitate a warm hand-off to ensure admission into treatment programs that may not have been previously possible. The facility will be a much-needed addition to the treatment options available to the residents and treatment providers in the state.

As a treatment provider in the state, we provide a 90 day residential Out Patient treatment model....we are licensed at PHP, IOP, OP and assessments.

It is common practice for Maryland Recovery to refer incoming patients out of state to PA, VA, or NJ to receive detox service.

Residential Treatment centers nor hospitals in Maryland DO NOT accept our patients for detox only. We are in need of a detox only facility to stabilize patients that have relapsed in our program or prior to them being medically stabilized for entry into our program.

Thank you for your consideration.

Sincerely,

Jim Haggerty, CEO
Maryland Recovery

Exhibit 8

Identified Policies and Procedures Requested Documentation

CLINICAL
POLICY AND PROCEDURE MANUAL

TABLE OF CONTENTS

TITLE **ADMISSION PROCESS**	NUMBER **CL-1:001**
SUBJECT **NURSING**	EFFECTIVE DATE
REVIEW AND APPROVAL	PAGE(S) **1 of 7**
REVIEW DATES	REVISION DATES

PURPOSE:
The purpose of this policy is to delineate the criteria and process for an admission requiring stabilization detoxification services.

SCOPE:
This policy applies to all staff of Maryland House Detox.

RESPONSIBILITY:
It is the responsibility of the CEO and/or Director of Nursing to implement this policy and procedure and to disseminate this information to all licensed medical staff and employees under his/her direction. The Medical Director is responsible to provide final determination of the pending admission and if individual meets admission criteria.

POLICY:
It is the policy of MHD to refer to the American Society of Addiction Medicine (ASAM) Patient Placement Criteria in order to determine the appropriate level of services warranted for the individual who is requesting services.

TITLE **ADMISSION PROCESS**	NUMBER **CL-1:001**
SUBJECT **NURSING**	PAGES(S) **2 of 7**

Admission Intake Guidelines

Individuals must be 18 years of age or older.

An individual must meet the guidelines of the American Society of Addiction Medicine Individual Placement Criteria (ASAM) for medically monitored individual stabilization detoxification.

The individual has a recent history of substance use which may have withdrawal syndromes and acknowledges that treatment response can be variable, potentially life threatening or cause serious physical harm.

Individuals with comorbid medical conditions deemed unstable that would create increased medical risk will be referred appropriately.

Individuals appropriate for this level of treatment are intoxicated or exhibit physical signs of withdrawal, or both.

Individuals that experience withdrawal signs and/or symptoms while in substance use disorder treatment at/below level III.5, or in a non-medical setting such as a recovery house, halfway house, or in individual's personal home environment - would be considered unsafe and therefore contraindicated, as evidenced by one of the following but not limited to:

1. Signs and symptoms that support anticipation of an impending acute withdrawal syndrome that based upon the reported history and patterns of use, has the potential to be life threatening or may preempt serious complications that can lead to an unstable condition or irreversible harm.
2. A history of seizure disorder, seizures associated with alcohol or chemical dependency withdrawal, delirium tremens, or other signs of neurological involvement.
3. Presence of comorbid medical conditions that may quickly complicate the expected management of withdrawal, becoming potentially life threatening.
4. Signs and/or symptoms of cardiac instability, high blood pressure and dehydration.

TITLE **ADMISSION PROCESS**	NUMBER **CL-1:001**
SUBJECT **NURSING**	PAGES(S) **3 of 7**

PROCEDURE:

Admission Intake

1. A face-to-face or telephone screening interview will be conducted with all potential individuals, prior to admission. During the intake process, a comprehensive medical assessment will be conducted. The clinical findings are then applied to ASAM placement criteria, an evidence-based decision tool which serves to guide placement of the individual into the most appropriate treatment level necessary, and within the least restrictive environment.
2. The prospective individual must have a BAL or toxicology screen indicating presence of substance use of the following including their derivative forms, but not limited to: Opiates; alcohol; cocaine; amphetamines; sedatives; tranquilizers; anxiolytics; hallucinogens, cannabinoids and/or other mood altering substances within the previous 24-48 hours and/or have indications of:
    a. Long term and/or multiple-substance use history, recent account of multiple substance use, or increased frequency in substance use of which may be known or associated with delayed or slow onset of withdrawal syndromes or that may become potentially life threatening or cause serious injury or harm.
    b. Signs and symptoms of an impending withdrawal syndrome that has the imminent potential to be life threatening or produce serious irreversible harm.
    c. A history of a seizure disorder, seizures associated with withdrawal, delirium tremens, or other life threatening complications experienced during withdrawal from substances.
    d. The individual presents with co morbid medical conditions that in the absence of medically supervised treatment during detoxification, the underlying conditions may likely complicate the management of withdrawal to the degree that the individual’s life may be endangered.
    e. An external agency has provided sufficient history to substantiate that the individual has an active substance use disorder that now requires evaluation for detoxification.
    f. The individual exhibits cognitive capacity and mental health stability to engage services at an expected level and benefit from admission into the detoxification level of treatment.

3. Additional consultation with the Medical Director may be required for the individual presenting with increased symptoms within an otherwise stable co-occurring mental health disorder, a history of comorbid conditions that may currently present as primary in nature and/or significant or unstable medical conditions.

TITLE **ADMISSION PROCESS**	NUMBER **CL-1:001**
SUBJECT **NURSING**	PAGES(S) **4 of 7**

4. If upon evaluation, the licensed medical provider individual determine the medical and psychiatric status is unstable the individual will be transferred to an appropriate facility.
5. If transferred to MHD from a hospital or other facility, the following shall apply:
    a. The discharge RN shall provide verbal report to the MHD Admissions RN
    b. The hospital shall fax to MHD, a signed release of information and the following information for MHD medical provider to review to establish potential clearance for admission:
        - History and Physical
        - Psychiatric evaluation (if appropriate)
        - All lab reports including pathology and cultures results, if indicated
        - Any diagnostic imaging test result, including scans and ultrasound
        - PPD results
        - Nursing Assessment
        - List of medications upon discharge
        - Discharge summary and patient instruction sheet
        - All progress notes
        - Documentation of CIWA/COWS on the medications administration record, including withdrawal protocol taper, if initiated.
        - Physician Statement of Medical Clearance- will indicate the medical and/or psychiatric status is stable and individual's request for detoxification.

*The prospective individual must arrive with copies of all medical reports in a properly sealed package (if not previously received by fax). At minimum, a Physician Statement of Medical Clearance provided by discharging Physician must be obtained until additional medical reports are available.

6. The individual with history of positive PPD must provide approved diagnostic imaging results occurring within prior six (6) months or a documented statement of treatment/clearance from TB medical provider.
7. If the presenting individual is currently on low dose Methadone of less than 20mg/day, special consideration and evaluation will be provided for the individual to include and consider all medical circumstances presented. If Medical Director determines minimal risk for protracted withdrawal, the individual may be converted

to an alternate medication and tapered according to the MHD Medical Director recommendation/orders.

TITLE **ADMISSION PROCESS**	NUMBER **CL-1:001**
SUBJECT **NURSING**	PAGES(S) **5 of 7**

8. The individual must be able to independently demonstrate that they are able to perform all personal care needs and the following activities of daily living but not limited to:
    a. Feed self
    b. Bath self
    c. Toilet self
    d. Transfer self

    *If using a mobility device, the individual is required to demonstrate ability to perform transfer of their own weight from the bed to the chair, or from chair to the shower, etc. independent of staff or family assistance.

Admission contraindicated pending specialty medical clearance

Individuals may be deemed currently inappropriate for admission on intake assessment day for the following medical conditions and/or objective findings, but not limited to:

- Questionable or presumed presence of an undiagnosed or untreated communicable disease
- Unstable physical or psychiatric comorbidities that will increase medical risk, compromise and/or interfere with the ability to engage in treatment, or may negatively impact environmental safety parameters for any or all individuals currently receiving MHD detox treatment services.
- Upper or lower GI bleeding (blood in stool or in vomit)
- Neurological warning signs such as: change in responsiveness of pupils to light; history of Delirium Tremens; Epilepsy; primary seizure disorder; warning signs of increased risk for seizures: ankle clonus; heightened deep tendon reflex
- Psychosis, hallucinations, increasing confusion and/or altered level of consciousness
- Chest pains and/or recent abnormal EKG; unstable resting heart rate; uncontrolled blood pressure
- Previous or recent head injury, meningitis, encephalitis or current fever of >100.6 F.

An individual may return to MHD for admission review following receipt of recommended medical care providing they have obtained the follow-up care. The individual will be required to provide to MHD, documentation of obtaining necessary follow-up in the medical clearance by the specific provider formerly identified in the referral, for any potential future admission.

TITLE **ADMISSION PROCESS**	NUMBER **CL-1:001**
SUBJECT **NURSING**	PAGES(S) **6 of 7**

Admission Review for Medical Clearance

The MHD Medical Director/Physician/NP will utilize all applicable medical information available to him or her at that time, in the consideration for individual admission into detoxification services.

Decision to admit will be based on the comprehensive assessment of the full medical history, physical examination and current objective findings during the intake admission process.

Admission Intake

The Medical Director will provide final decision regarding the level of safety and medical necessity for admission, as individuals may have been unaware of the presence of any underlying conditions, which can increase the risk for an adverse response to treatment.

1. Upon establishing the primary admission diagnosis(s) the ordering provider will determine the initial withdrawal management plan to stabilize the individual, which includes
    - Parameters for nursing assessment and interventions,
    - Medications and/or withdrawal protocol,
    - Activity restrictions,
    - And/or identified safety concerns, if warranted.
2. The admissions coordinator or case manager will contact the representative third party payer for authorization of individual level detoxification services and will provide the individual information, assessment diagnosis, CIWA / COWS indicator, appropriate level of treatment recommendations per ASAM placement criteria, with scheduled reviews as indicated.
3. An individual is assigned to an open bed in a gender specific room. Staff will guide the individual and provide assistance as necessary to help the individual get cleaned up as much as possible immediately after entering the individual area, and bathed thoroughly as soon as medically stabilized.
4. The medical staff will observe and assess for trauma, bruises, lacerations or open wounds, continue to monitor for altered or decreased level of consciousness and observe for head injuries, as a subdural hematoma may not be immediately evident.
5. When individual has stabilized, staff will provide a program and facility orientation based on the individual's capacity to acknowledge comprehension of the information and instructions.

TITLE **ADMISSION PROCESS**	NUMBER **CL-1:001**
SUBJECT **NURSING**	PAGES(S) **7 of 7**

During the initial 24 hours of admission, the individual will be reassessed and monitored closely for response(s) to treatment, safety & comfort and capacity for engagement.
At Maryland House Detox, a licensed medical provider is on-site 24 hours a day to provide the ongoing withdrawal management supervision and care for individuals in detoxification services.
The Admission period concludes after the initial 24 hours.
The Maryland House Detox Admission Department will provide Intake Screening for Admission on a 24-hour basis. When census has reached full capacity, and where appropriate, MHDAD will engage the individual in their search to access treatment and services from existing licensed providers.

Maryland House Detox
ADMISSION PHYSICIAN'S ORDER SHEET
ALCOHOL LIBRIUM PROTOCOL

PATIENT NAME: _____

MR#: _____

ADMISSION DATE: _____

ADMITTING DIAGNOSIS: _____

ALLERGIES: _____

ADMITTING NURSE: _____

DATE ORDERED	TIME ORDERED	DAY	TREATMENT
			OBTAIN INITIAL CIWA UPON ADMISSION
		1	LIBRIUM 50MG PO QID; HOLD LIBRIUM IF CIWA IS LESS THAN 8
		2	LIBRIUM 50MG PO TID
		3	LIBRIUM 50MG PO BID
		4	LIBRIUM 25MG PO TID
		5	LIBRIUM 25MG PO BID
		6	LIBRIUM 25MG PO 0800 then Stop
			SEIZURE PRECAUTIONS- ALERT
			THIAMINE 100MG PO DAILY x 8 DAYS
			FOLIC ACID 1MG PO DAILY x 8 DAYS
			MAGNESIUM GLUCONATE 500MG PO BID x 8 DAYS, HOLD IF LOOSE STOOLS
			NOTIFY MD FOR ANY ACUTE MENTAL STATUS CHANGES
			HOLD MEDICATION IF PATIENT BECOMES OR APPEARS SEDATED

NURSE SIGNATURE/CREDENTIALS: _____DATE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

Maryland House Detox
ADMISSION PHYSICIAN'S ORDER SHEET
SUBUTEX 12MG PROTOCOL

PATIENT NAME:

_____

MR#:

_____

_

ADMISSION DATE:

_____

ADMITTING DIAGNOSIS:

_____

ALLERGIES:_____

_____

ADMITTING

NURSE:_____

Date Ordered	Time Ordered	DAY	Treatment
		1	SUBUTEX 8MG AFTER COW REACHES 13, THEN 4MG WITHIN 8 HOURS IF WITHDRAWAL SYMPTOMS CONTINUE
		2	SUBUTEX 4MG SL AT 0800, 4MG SL AT 1400, AND 2MG SL AT 2100
		3	SUBUTEX 4MG SL AT 0800 AND 4MG SL AT 1800
		4	SUBUTEX 4MG SL AT 0800, AND 2MG SL AT 1800
		5	SUBUTEX 2MG SL AT 0800 AND 2MG SL AT 1800
		6	SUBUTEX 2MG SL AT 0800 THEN STOP

NURSE SIGNATURE/CREDENTIALS: _____DATE: _____

PHYSICIAN SIGNATURE: _____DATE: _____

Maryland House Detox
ADMISSION PHYSICIAN'S ORDER SHEET
ALCOHOL LIBRIUM PROTOCOL LOW LEVEL

PATIENT NAME: _____

MR#: _____

ADMISSION DATE: _____

ADMITTING DIAGNOSIS: _____

ALLERGIES: _____

ADMITTING NURSE: _____

DATE ORDERED	TIME ORDERED	DAY	TREATMENT
			OBTAIN INITIAL CIWA UPON ADMISSION
		1	LOADING DOSE LIBRIUM 25MG PO Q4 PRN FOR CIWA GREATER THAN 8 FOR SIGNS AND SYMPTOMS OF WITHDRAWAL X 24 HRS
			HOLD MEDICATION IF PATIENT BECOMES OR APPEARS SEDATED
		2	LIBRIUM 50MG PO TID
		3	LIBRIUM 25MG PO QID
		4	LIBRIUM 25MG PO TID
		5	LIBRIUM 25MG PO BID
		6	LIBRIUM 25MG PO 0800 THEN STOP

			SEIZURE PRECAUTIONS- HIGH ALERT
			THIAMINE 100MG PO DAILY x 8 DAYS
			FOLIC ACID 1MG PO DAILY x8 DAYS
			MANESIUM GLUCONATE 500MG PO BID x 8 DAYS, HOLD IF LOOSE STOOLS
			NOTIFY MD FOR ANY ACUTE MENTAL STATUS CHANGES
			HOLD MEDICATION IF PATIENT BECOMES OR APPEARS SEDATED

NURSE SIGNATURE/CREDENTIALS: _____DATE:_____

PHYSICIAN SIGNATURE: _____DATE:_____

Maryland House Detox
ADMISSION PHYSICIAN'S ORDER SHEET
BENZODIAZEPINE PROTOCOL LOW LEVEL

Patient Name:

_____

MR#:

_____

Admission Date:

_____

Admitting Diagnosis:

_____

Allergies:

_____

Admitting Nurse:

_____

Date Ordered	Time Ordered	DAY	Treatment
			OBTAIN INITIAL CIWA SCORE

		1	LOADING DOSE LIBRIUM 25MG PO Q4 PRN FOR CIWA GREATERTHAN 8 FOR SIGNS AND SYMPTOMS OF WITHDRAWAL X 24 HRS
			HOLD MEDICATION IF PATIENT BECOMES OR APPEARS SEDATED
		2	LIBRIUM 50MG PO TID
		3	LIBRIUM 25MG PO QID
		4	LIBRIUM 25MG PO TID
		5	LIBRIUM 25MG PO BID
		6	LIBRIUM 25MG PO 0800 THEN STOP
			SEIZURE PRECAUTIONS- HIGH ALERT
			NOTIFY MD FOR ANY ACUTE MENTAL STATUS CHANGES

NURSE SIGNATURE/CREDENTIALS: _____DATE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

Maryland House Detox
ADMISSION PHYSICIAN'S ORDER SHEET
SUBUTEX 16MG PROTOCOL

PATIENT NAME:

_____

MR#: _____

ADMISSION DATE: _____

ADMITTING DIAGNOSIS:

_____

ALLERGIES:

_____

ADMITTING NURSE:

_____

DATE ORDERED	TIME ORDERED	DAY	TREATMENT
		1	SUBUTEX 8MG AFTER COW REACHES 13, THEN 8MG WITHIN 8 HOURS IF WITHDRAWAL SYMPTOMS CONTINUE
		2	SUBUTEX 6MG SL AT 0800, 4MG SL AT 1400, AND 4MG SL AT 2100
		3	SUBUTEX 4MG SL AT 0800, 4MG SL AT 1400, AND 4MG SL AT 2100
		4	SUBUTEX 4MG SL AT 0800, SUBUTEX 4MG SL AT 1400 AND SUBUTEX 2MG SL AT 2100
		5	SUBUTEX 4MG SL AT 0800 AND 4MG SL AT 2100
		6	SUBUTEX 2MG SL AT 0800 AND 2MG AT 1800 THEN STOP

NURSE SIGNATURE/CREDENTIALS: _____DATE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

ADMISSION PHYSICIAN'S ORDER SHEET
SUBUTEX 12MG PROTOCOL

PATIENT NAME:

_____

MR#:

_____

_

ADMISSION DATE:

_____

ADMITTING DIAGNOSIS:

_____

ALLERGIES:_____

_____

ADMITTING

NURSE:_____

Date Ordered	Time Ordered	DAY	Treatment
		1	SUBUTEX 8MG AFTER COW REACHES 13, THEN 4MG WITHIN 8 HOURS IF WITHDRAWAL SYMPTOMS CONTINUE
		2	SUBUTEX 4MG SL AT 0800, 4MG SL AT 1400, AND 2MG SL AT 2100
		3	SUBUTEX 4MG SL AT 0800 AND 4MG SL AT 1800
		4	SUBUTEX 4MG SL AT 0800, AND 2MG SL AT 1800
		5	SUBUTEX 2MG SL AT 0800 AND 2MG SL AT 1800
		6	SUBUTEX 2MG SL AT 0800 THEN STOP

NURSE SIGNATURE/CREDENTIALS: _____DATE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

TITLE **LENGTH OF STAY**	NUMBER **CL-1:002**
SUBJECT **CLINICAL**	EFFECTIVE DATE
REVIEW AND APPROVAL	PAGE(S) **1 of 2**
REVIEW DATES	REVISION DATES

PURPOSE:
The purpose of this policy is to determine decision-making process regarding individual length of stay for each patient.

SCOPE:
This policy applies to all patients.

RESPONSIBILITY:
It is the responsibility of the CEO and/or designee to implement this policy. It is the responsibility of the Program Manager and/or designee to disseminate this information to each employee under his or her direction.

POLICY:
It is the policy of MHD that patients will be safely detoxed before moving onto the next treatment modality.

TITLE **LENGTH OF STAY**	NUMBER **CL-1:002**
SUBJECT **CLINICAL**	EFFECTIVE DATE
REVIEW AND APPROVAL	PAGE(S) **2 of 2**
REVIEW DATES	REVISION DATES

PROCEDURE:

1. Patients admitted to MHD will be provided detoxification services on an individual basis. During the admission intake process, the medical provider will determine admission diagnosis and objectively ascertain the severity of withdrawal that is present.
2. In addition, the provider will determine the presence of appropriate medical necessity for an inpatient environment for provision of safety related to the management of withdrawal.
3. The case manager will utilize the admission medical assessment and apply the American Society of Addiction Medicine patient placement criteria to determine the recommended treatment level for the patient.
4. The case manager will remain in contact with the third party payer to discuss the admission intake information based son ASAM guidelines and request authorization as necessary and document the number of treatment days authorized.
5. The case manager will contact the insurance provider to provide update information regarding the patient's progress in treatment at this level.
6. All contacts made and authorizations obtained will be documented in the patients Individualized Treatment Plan and discussed with patient and their family.
7. Each individual's length of stay will be determined by his/her medical treatment needs. Detox may take between 3 and 7 days, and is widely variable based on abused substance type.
8. While in treatment for detox, the case manager will assist the patient to identify individual extenuating circumstances, medical needs and social situation to support transition for referral discharge to next level in the continuum of care.
9. The length of time that it takes each individual to detox can affect the length of time for addiction treatment that is need. The case manager and the medical team will collaborate to monitor and determine when the patient is stabilized to continue onto the next treatment modality.

TITLE **CASE MANAGEMENT STANDARDS OF PRACTICE**	NUMBER **CL-1:003**
SUBJECT **CLINICAL**	EFFECTIVE DATE
REVIEW AND APPROVAL	PAGE(S) **1 OF 6**
REVIEW DATES	REVISION DATES

Purpose
The purpose of this policy is to define the Case Management Global Standards of Practice at Maryland House Detox.

Scope
This policy applies to all Case Management staff at MHD.

Responsibility
It is responsibility of the CEO to implement this policy and procedure. It is the responsibility of the Clinical Director and/or designee to disseminate this information to staff under their direction. It is the ultimately the responsibility of the Clinical Director to assure the case management process and operations impartially identify and address the bio psychosocial needs of the patient for promotion of holistic wellbeing and continued sobriety.

TITLE	NUMBER
CASE MANAGEMENT STANDARDS OF PRACTICE	**CL-1:003**
SUBJECT	**PAGES(S)**
CLINICAL	**2 OF 6**

Policy

It is the policy of MHD to provide case management service by a licensed professional who works collaboratively with patients, nurses, social workers, physicians, other practitioners, caregivers and community resources and agency partners.
Case managers will provide support for the individual during the intake admission process, work with third party payers for authorizations appropriate to ASAM guideline, Through the entire course of detoxification treatment, the case manager will identify referral resources implementing a warm hand off referral to subsequent level of treatment, thereby assuring a seamless transition to the subsequent level in the continuum of care. The outcomes will reflect patient preferences and value.

Global Standards of Practice

The case manager utilizes care management practices that are evidence-based to collaborate with a team of providers as they support the access into treatment, current withdrawal management care needs and provide facilitation for ongoing communication toward that effort.
The role is vast and complex and the actions and resources coordinated on behalf of the patient may look different from patient to patient. Following the initial screening, the case manager involvement is required. The communication is the supporting thread that will weave a myriad of actionable steps and functions in the pursuit to identify and mange the care needs for the patient.
Following Admission Intake, the case manager meets with all members of the treatment team to orchestrate procurement of authorization for the treatment stay, to review the patient's progress with the authorizing financial provider and to coordinate the culmination of all resources necessary to help the patient progress through treatment and into the next phase of care.

TITLE **CASE MANAGEMENT STANDARDS OF PRACTICE**	NUMBER **CL-1:003**
SUBJECT **CLINICAL**	PAGES(S) **3 OF 6**

The types of actions listed help to organize the case manager efforts to avoid duplication or inefficient services while ascribing to the most effective placement level of treatment for the patient in the most appropriate environment and in the least restrictive environment. The service needs are discussed with the patient, the medical and clinical team and all funding sources for continued stay, based on ASAM criteria and patient progress.

Collaboration

1. A case manager will meet with and collaborate with patients, nurses, social workers, therapists, physicians, other practitioners, family members, community partners, resources and external agencies to identify patient preferred needs and goals.
2. The case manager will support the unique qualities training, skill sets, interests and abilities of each person involved and works to eliminate duplication of efforts.
3. Actively meets and communicates with patient/family and all members of the healthcare team the case manager directs the treatment plan to progress towards goals.
4. Works to ensure all stakeholders contribute to developing an effective plan of care.
5. Creates safe and effective plans that are based on patient needs and preferences.
6. Negotiates with payers regarding available options.

Communication

1. Communicates timely, relevant and accurate information to all parties involved with a patient’s care.
2. Communicates in a manner appropriate to the stated preference, level of education and comprehension of the patient or other party.
3. Assures all communication is nonjudgmental and sensitive to cultural differences.
4. Meets with patient /family and validates understanding of information.
5. Assures informed decision-making through explanation of choices, risks and benefits to the patient, caregiver or other healthcare team involved.
6. Provides education that enhances patient/family competence and capacity to participate in decision-making.

TITLE **CASE MANAGEMENT STANDARDS OF PRACTICE**	NUMBER **CL-1:003**
SUBJECT **CLINICAL**	PAGES(S) **4 OF 6**

7. Communicates in a judicious manner consistent with professional ethics, and with respect for patient/family privacy and confidentiality.
8. Chooses the appropriate time, venue and participants for optimal communication.
9. Reveals any conflict of interest of his or her own or other parties' that could influence the decision-making process.
10. Chooses a tone, style and presentation to diffuse potential conflict or misunderstanding.
11. Maintains self-awareness regarding the influence of one's own cultural background, values, and beliefs on working relationships.

Facilitation

1. A case manager facilitates the progression of care by advancing the plan of care to achieve desired outcomes.
2. Facilitates the development of a safe and effective plan of care through early identification at admission and through assessment of the patient's needs, preferences and goals and identifies available resources for the referral discharge.
3. The case manager meets with the patient by 48-72 hours to specifically meet with the patient to initiate arrangements for the patient referral to the next level of care.
4. Assures the designation of primary responsibility among the team members for each aspect of the plan, avoiding duplication and fragmentation.
5. Carries out individual responsibilities according to the treatment plan, to include coordinating authorizations with insurance providers for transfer into the and to
6. Monitors progress toward the goals of the plan and makes revisions in response to changes inpatient needs and conditions.
7. Proactively identifies and removes barriers that impede the progression of care coordination.
8. Refers facets of the plan beyond the control or influence of the team to the appropriate level of authority.
9. Fosters the team's ability to work together and achieve desired outcomes.
10. May identify need to utilize an Ethics Committee and other resources to resolve conflict or challenges regarding treatment decisions, if they occur.

TITLE **CASE MANAGEMENT STANDARDS OF PRACTICE**	NUMBER **CL-1:003**
SUBJECT **CLINICAL**	PAGES(S) **4 OF 6**

Coordination

1. A case manager integrates the work of the healthcare team by coordinating resources and services necessary to accomplish patient-centered agreed-upon goals.
2. Evaluates the patient's level of understanding and comfort with the progress towards goals.
3. Utilizes the strengths and expertise of all team members to develop and implement the plan.
4. Integrates services among community agencies, physicians, insurers, and other behavioral health care treatment providers and all others involved in the plan of care with the patient.
5. Assures appropriate sequencing of all interventions for optimal results and a smooth and seamless transition at discharge. A "warm hand-off" referral procedure initiated shortly after admission will assure uninterrupted provision of services into the identified subsequent level of treatment along the continuum of care.
6. Identifies multidimensional (physiological, psychological, social and spiritual) factors and integrates them into an individualized and holistic treatment plan of care that both promote the successful attainment of expected outcomes and fit into their current life circumstances.
7. Elicits and incorporates the expectations of patients, all internal providers, community referral healthcare associates and payers in the planning process.

Advocacy

1. A case manager advocates on behalf of patients and their families for services access or creation, and for the protection of the patient's health, safety and rights.
2. Promotes the patient's self-determination in all decisions, honoring that right even when decisions differ from recommendations of the healthcare team, and assists the healthcare team's understanding of and respect for the patient's decisions.
3. Assures patient receives information on benefits, risks, costs and treatment alternatives including the option of no detoxification treatment.

TITLE **CASE MANAGEMENT STANDARDS OF PRACTICE**	NUMBER **CL-1:003**
SUBJECT **CLINICAL**	PAGES(S) **5 OF 6**

4. Advocates for culturally competent care.
5. Supports optimal health for at-risk individuals through prevention, health promotion and education for populations with specific and unique health needs.
6. Partners with community agencies and providers to address and refer to for unmet needs.
7. Provides patient caregiver education regarding the payment denial and appeals process, if necessary.
8. Recognizes the limitations of a patient's autonomy, preventing imminent danger to the patient or others.
9. Promotes participation in standardized satisfaction surveys and/or other methods for evaluation of continued abstinence after discharge referral and monitoring of the quality and effectiveness of both detoxification treatment services provided at MHD and/or services received through the referral community providers.
10. Engages in legislative and professional activities.

Resource Management

1. A case manager assures prudent utilization of all resources (fiscal, human, environmental, equipment and services) by evaluating the options available and balancing cost and quality to assure the optimal clinical and financial outcomes.
2. Evaluates cost of care with the benefits of patient safety, clinical quality, risk, and patient satisfaction to provide recommendations and decisions that assure optimal outcomes.
3. Educates patients/families on the economic impact of their healthcare choices.
4. Assures timely progression to appropriate levels of care.
5. Collects, analyzes and interprets data to identify practice patterns that may require modification.
6. Maintains current knowledge of healthcare economics, trends and reimbursement methodologies and applies this knowledge to daily practice.
7. Identifies and interprets strategies for avoiding and/or managing unnecessary costs.
8. Recognizes situations that require referral to Quality or Risk management and makes a timely referral.
9. Manages patient and family expectations for goals based on health status, prognosis, and available treatment and community resources.

TITLE **CASE MANAGEMENT STANDARDS OF PRACTICE**	NUMBER **CL-1:003**
SUBJECT **CLINICAL**	PAGES(S) **6 OF 6**

Accountability

1. A case manager accepts responsibility and accountability for achievement of optimal outcomes within their scope of practice.
2. Recognizes and respects that joint responsibility and joint accountability is inherent in collaborative practice.
3. Follows through on his/her own commitments and expects others to follow through on their commitments.
4. Utilizes best practice methodologies to improve care delivery.
5. Contributes to decision-making and decision support as a member of the interdisciplinary team.
6. Assures timely follow-up and evaluation of the plan of care and implements changes as indicated.
7. Maintains on ongoing awareness of his or her own competencies, seeking consultation and collaboration as needed.

Professionalism

1. A case manager acquires and maintains knowledge and competence related to the expectations of their position and practices within their scope.
2. Aligns practice with the mission, vision and goals of their employer.
3. Maintains appropriate licensure and certifications.
4. Commits to continuous learning and strives to improve competence in all areas of practice.
5. Advances knowledge of the profession through research and application of best practice.
6. Participates in patient safety and quality improvement activities.
7. Participates in the orientation and training of students, interns and new department members.
8. Adheres to professional standards of practice and his or her professional code of ethics.
9. Demonstrates commitment, initiative integrity and flexibility.
10. Regularly evaluates his or her own performance and sets goals for personal and professional development.

TITLE **INDIVIDIUALIZED TREATMENT PLAN**	NUMBER **CL-1:004**
SUBJECT **CLINICAL**	EFFECTIVE DATE
REVIEW AND APPROVAL	PAGE(S) **1 of 5**
REVIEW DATES	REVISION DATES

PURPOSE:
The purpose of this policy is to provide an individual plan of care that addresses the patient's bio- psychosocial, education and discharge needs. The treatment plan allows care to be delivered in a logical, organized, goal-directed, patient centered manner. This is achieved through the prioritizing of patient's problems, establishing patient-centered goals/outcomes and stating specific interventions for each problem.

SCOPE:
This policy applies to all clinical staffs of MHD

RESPONSIBILITY:
It is the responsibility of the CEO and/or designee to implement this policy. It is the responsibility of the Clinical Director and/or designee to disseminate this information to each staff under his/her direction.

POLICY:
It is the policy of MHD that in order to insure the delivery of effective, efficient, patient centered care, in accordance with state and federal laws, to provide each patient with an individualized multidisciplinary treatment plan of care.

TITLE **INDIVIDUALIZED TREATMENT PLAN**	NUMBER **CL-1:004**
SUBJECT **CLINICAL**	PAGES(S) **2 of 5**

DISCUSSION

Developments of an Individualized Treatment Plan is the primary component, which drives the patient, preferred care management processes with focused activities, and facilitate the appropriate delivery of health care services on behalf of the patient and their family. It involves the marshaling of numerous personnel and other resources, to address all required activities and components. It is often managed by the exchange of information among the various participants, each responsible for different aspects of the current care, treatment and/or referral discharge planning process.

It is a patient and family centered, team-based activity designed to assess and meet the needs of patients, while helping them navigate effectively and efficiently through the continuum of care and the larger health care system. Clinical coordination involves determining where to send the patient next (e.g., sequencing among treatment levels/providers/specialists), what information about the patient is necessary to transfer among health care entities, and how accountability and responsibility is managed among all health care professionals (doctors, nurses, social workers, therapists, counselors, case managers, supporting staff, etc.) as well as the patient and/or their family. Care coordination addresses potential gaps in meeting patients' interrelated medical, social, developmental, behavioral, educational, informal support system, and financial needs in order to achieve optimal health and wellness according to patient preferences, needs, and goals.

The optimal goal of care coordination is to facilitate appropriate and efficient delivery of health care services both within and across systems. The coordinated effort to identify and address the unique needs of an individual is further defined and is the basis for constructing a treatment plan, developed with the patient, for the patient.

Components of a Client-Centered Treatment Plan

Acute Safety Needs: Determines the need for immediate stabilization to establish safety prior to routine assessment

Severity of Mental and Substance Use Disorders: Guides the choice of the most appropriate setting for treatment

Appropriate Care Setting: Determines the appropriate program or level placement for individuals (per ASAM)

Diagnosis: Determines the recommended treatment.

TITLE **INDIVIDUALIZED TREATMENT PLAN**	NUMBER **CL-1:004**
SUBJECT **CLINICAL**	PAGES(S) **3 of 5**

Disability: Determines case management needs and whether an enhanced level of intervention is needed
Strength and Skills: Determines areas of prior success around which to organize future treatment interventions and areas of skill building needed for management of either disorder
Availability and Continuity of Recovery Support: Determines whether continuing relationships need to be established and availability of existing relationships to provide contingencies to promote learning and support
Cultural Context: Determines the most culturally appropriate treatment interventions and settings
Problem Priorities: Determines problems to be solved specifically, and opportunities for contingencies to promote treatment participation
State of Recovery-Individuals Readiness to Change Behaviors Relating to Each Problem: Determines appropriate treatment interventions and outcomes for a client at a given stage of recovery or readiness for change (TIP 35).
Entering treatment for substance abuse is difficult whether it's by personal choice, if it's being recommended or required by an outside source such as the court system, family, or employer. The first step in establishing a treatment plan for a substance abuse disorder is assuring an environment of safety, privacy and confidentiality during the full intake assessment and evaluation.
Complete comprehensive and detailed assessments of the individuals may include a variety of information-gathering methods including the administration of actual assessment instruments, an in-depth clinical interview which may include a bio-psychosocial, a social history, a treatment history, interviews with family/other(s) after receipt of appropriate client authorization(s), a review of medical and psychiatric records, a physical examination and laboratory tests (toxicology screens, tests for infectious diseases and organ system damage, etc.).
Detailed focus of substance use patterns should include current and prior substances of use and their patterns of combined use, medications prescribed, OTC medication, supplements, vitamins, and prescribed medications. It is equally vital to capture current or prior interruptions in utilization patterns of use such as an increase or decrease in frequency, amount, substance abstinence, combination use and method of administration and alterations. It is useful to establish trends or cycles in patterns based upon reported history, which may assist in the later identification of self-intervention efforts.

TITLE **INDIVIDUALIZED TREATMENT PLAN**	NUMBER **CL-1:004**
SUBJECT **CLINICAL**	PAGES(S) **4 of 5**

PROCEDURE:
Intake Admission:

1. Initial Screening and Comprehensive Assessment

During the first 24 hours or at admission, for patients who meet the ASAM Criteria for level 3.7D, the patient will meet with their primary therapist and a bio-psychosocial assessment will be completed identifying preliminary treatment goals and objectives.

2. Treatment Plan

The Treatment Plan will be based on the assessment findings that will be reviewed and updated with each goal or objective achieved, problem resolved and/or significant change in patient status.
The Individualized Treatment Plan (ITP) will be appropriate to a short term detoxification treatment regimen.
The ITP will include the patient's individualized needs, including

- Monitoring for the decreasing amount of substances in the body, as the patient progresses in their detoxification treatment
- Medically monitored services including but not limited to nursing services, medication administration, physician/PA/NP services, medical examination, response to withdrawal management
- Substance use and/or dependence
- Physical health

The following patient's needs shall also be identified:

- Psychological
- Family
- Legal
- Vocational
- Educational

All individualized needs identified will include:

- Long range/short range treatment plan goals and objectives;
- Strategies for implementation of treatment plan goals and objectives;
- Target dates for completion of treatment plan goals and objectives

TITLE **INDIVIDUALIZED TREATMENT PLAN**	NUMBER **CL-1:004**
SUBJECT **CLINICAL**	PAGES(S) **5 of 5**

Each patient will have an individual schedule of clinical services, identifying:

- Criteria for successful completion of treatment;
- Individualized counseling;
- Alcohol and drug education;
- Family sessions
- Nutrition education

Length of stay for each patient is based on level of severity index and response to treatment.

Additional areas included on the ITP:

- Individualized case management needs
- Referral services, as applicable
    - Division of Rehabilitation services;
    - Vocational assistance;
    - Mental health providers;
    - Legal assistance;
    - Social services

DISCHARGE COORDINATION:

The ITP will include an agreement for at least one year of aftercare following discharge from the facility.

Warm Hand-Off Follow Up:

- MHD will obtain consent from the patient for follow up within the first 14 days and again at 30 days post discharge with referral provider to ensure patient's engagement in treatment.
- If patient has not engaged with treatment at referral provider, MHD will contact patient and offer assistance in locating additional resources and treatment sources for patient.

Aftercare Follow Up:

MHD will obtain prior consent to provide follow up survey calls at 90, 180 and 365 days to determine status of sobriety, recovery and continued engagement in follow up substance abuse aftercare treatment

MHD will document discharge referral provisions identified for at least one year of aftercare following MHD discharge.

TITLE DISCHARGE OF PATIENTS-PLANNED	NUMBER CL-1:005
SUBJECT CLINICAL	EFFECTIVE DATE
REVIEW AND APPROVAL	PAGE(S) 1 OF 4
REVIEW DATES	REVISION DATES

PURPOSE:
The purpose of this policy is to ensure that a patient scheduled for discharge is comprehensively prepared and provided with appropriate discharge instructions. Discharge planning can be a varied complex process involving multi-discipline input. Inclusion of a patient-centered framework built upon the identified needs, preferences and goals provide the cornerstone for a positive treatment experience and outcome.

SCOPE:
This policy applies to all clinical staff of MHD

RESPONSIBILITY:
It is the responsibility of the CEO and/or designee to implement this policy. It is the responsibility of the Program Manager and/or designee to disseminate this information to each staff under his/her direction.

POLICY:
It is the policy of MHD that the discharge planning process will begin at the time of admission or within 24 hours of admission to ensure a seamless and uninterrupted transition to a subsequent level of treatment in accordance with ASAM placement criteria guidelines. The case manager will collaborate with all providers to help determine and select the next level of care.

TITLE DISCHARGE OF PATIENTS-PLANNED	NUMBER CL : 5-001
SUBJECT CLINICAL	PAGES(S) 2 OF 4

PROCEDURE:

1. During the intake assessment or within first 24 hours of admission, patients will be informed of the discharge planning process.
2. The case manager or primary therapist will identify and determine the most appropriate level of care using American Society of Addiction Medicine (ASAM) patient placement criteria and engage patient in discussions regarding particular providers of this level of care.
3. The patient will be informed of the recommendations and provided an opportunity to discuss their questions with the case manager to increase understanding of the process.
4. Patients will participate in the process of selecting a high quality treatment care provider for the primary discharge referral.
5. As appropriate, the case manager will facilitate a family meeting to confirm and/or facilitate the referral.
6. At the time of referral to an outside agency or practitioner the case manager shall complete a release of information and consent shall be obtained from the individual.
7. Final identification of referral destination and/or provider will be determined before but no less than 48 hours prior to actual discharge date.
8. Within 48 hours of the planned discharge, the case manager will implement the referral discharge process that incorporates a “warm hand-off” referral procedure that will assure uninterrupted provision of services into the identified subsequent level of treatment along the continuum of care, further ensuring continued abstinence and social stability.

MHD’s WARM HAND OFF REFERRAL PROCEDURES:

1. MHD will initiate communication and arrange teleconferencing with the referral provider for the patient to meet and therefore augment communication efforts and maximize patient desire and willingness. The contact will occur 48 hours prior to discharge prior to discharge.
2. In the event the chosen referral provider maintains a reasonably accessible geographical location, and/or is unable to teleconference with the patient, MHD may deem it appropriate to transport the patient to the location for the face-to-face component of the warm hand-off process.

TITLE DISCHARGE OF PATIENTS-PLANNED	NUMBER CL : 5-001
SUBJECT CLINICAL	PAGES(S) 3 OF 4

3. Whenever possible, MHD will provide transportation and accompany patient to their intake appointment with the referral provider.
4. The case manager will clarify the discharge referral plans and continuing discharge instructions with patient and family, which includes agreement to receive follow-up survey calls at 90-180-365 days
5. MHD will obtain additional consent from the patient for follow up within the first 14 days and again at 30 days post discharge with referral provider to ensure patient's engagement in treatment.
6. If patient has not engaged in treatment with the referral provider, MHD will contact patient and offer assistance in locating additional resources and treatment sources for patient.

Aftercare Follow Up:
MHD will obtain prior signed consent for release of information to provide follow up survey calls at 90, 180 and 365 days to determine status of sobriety, recovery and continued engagement in follow up substance abuse aftercare treatment
MHD will document discharge referral provisions identified for at least one year of aftercare following MHD discharge

DISCHARGE SUMMARY AND DOCUMENTS:
The case manager and patient will complete discharge-planning documents, which will contain patient's signature indicating understanding of instructions.
The patient's discharge referral provider will be contacted for verbal referral confirmation with confirmatory fax and in turn MHD will fax discharge information per standard referral agreement and regulatory standards.

TITLE DISCHARGE OF PATIENTS-PLANNED	NUMBER CL : 5-001
SUBJECT CLINICAL	PAGES(S) 3 OF 4

The referral provider will be provided with appropriate discharge information and summary, which will include but not be limited to:

- Bio-psychosocial assessment,
- History and Physical
- Treatment Plan
- Discharge Plan Detoxification protocols
- MAR
- Progress notes
- Case management records
- Insurance records
- Pertinent comorbid medical information

Patient and case manager will sign and date the confirmation discharge summary. The original signed discharge summary documents will be placed in the chart, a copy provided to referral provider and a copy will be given to patient.
The case manager or primary therapist will request patient complete the Patient Satisfaction Survey and conduct an exit interview, if applicable at discharge.

SURVEILLANCE, PREVENTION, AND CONTROL OF INFECTION
POLICY AND PROCEDURE MANUAL

TABLE OF CONTENTS

TITLE **INFECTION SURVIELLANCE, PREVENTION, AND CONTROL PROGRAM**	NUMBER **INF-1:001**
SUBJECT **INFECTION CONTROL**	EFFECTIVE DATE

REVIEW AND APPROVAL	PAGE(S) **1 of 3**
REVIEW DATES	REVISION DATES

PURPOSE:
The purpose of this policy is to establish a protocol to monitor and prevent transmission of infection(s) at Maryland House Detox.

SCOPE:
This policy applies to all employees Maryland House Detox.

RESPONSIBILITY:
It is the responsibility of the Director of Nursing and/or designee to implement this policy and procedure. It is the responsibility of the Infection Control Designee to disseminate this information to each employee under their direction.

POLICY:
It is the policy of The MHD to establish infection control guidelines to assist in the surveillance, prevention, and control of infections.

TITLE	NUMBER
INFECTION SURVEILLANCE, PREVENTION AND CONTROL PROGRAM	**INF-1:001**
SUBJECT	**PAGES(S)**
INFECTION CONTROL	**2 of 3**

PROCEDURE:

1. All employees of Maryland House Detox will follow Standard Precautions as the standard of practice at all times. Standard Precautions shall include the following:
    A. OSHA Bloodborne Standards
        1. Who is Covered
        2. The Exposure Control Plan
        3. Who Has Occupational Exposure
        4. Communicating the Hazards to Employees
        5. Preventive Measurers
        6. Hepatitis B Vaccination
        7. Universal Precautions
        8. Methods of Control
        9. Engineering and Work Practice Controls
        10. Personal Protective Equipment
    B. Housekeeping Procedures
        1. Equipment
        2. Waste
    C. Standard Precautions
        1. Hand washing
        2. Mask, Eye Protection, Face Shield
        3. Patient-Care Equipment
        4. Environmental Control
        5. Occupational Health and Bloodborne Pathogens
        6. What To Do If An Exposure Incident Occurs
        7. Training
        8. Record Keeping

TITLE	NUMBER
INFECTION SURVEILLANCE, PREVENTION AND CONTROL PROGRAM	**INF-1:001**
SUBJECT	**PAGES(S)**
INFECTION CONTROL	**3 of 3**

2. Any potential or identified infection will be reported immediately to the Infection Control Designee. The Infection Control Designee is responsible to perform any follow-up; for maintaining records of reported infections; and for reporting infectious processes to local authorities as required by Federal, State and County regulations and requirements, and to the appropriate Supervisor.

3. The Infection Control Designee will report all pertinent infection control information, and/or the need for educational in-services to the Management Team.

4. The Performance Improvement Committee will be responsible, as one of its functions, for trending and providing appropriate follow-up as needed at Maryland House Detox.

TITLE **INFECTION CONTROL: PERFORMANCE IMPROVEMENT COMMITTEE**	NUMBER **INF – 1:002**
SUBJECT **INFECTION CONTROL**	EFFECTIVE DATE
REVIEW AND APPROVAL	PAGE(S) **1 of 2**
REVIEW DATES	REVISION DATES

PURPOSE:
The purpose of this policy is to outline the specific responsibilities of the Infection Control Function.

SCOPE:
This policy and procedure applies to all employees of The MHD.

RESPONSIBILITY:
It is the responsibility of the Executive Director and/or designee to implement this policy and procedure. It is the responsibility of the Management Team to disseminate this information to each employee under their direction.

POLICY:
It is the policy of The MHD to maintain a Function of the Performance Improvement Committee, which functions in the area of Infection Control. The Center's Infection Control Designee will be assigned to collect data and perform infection control activities under the guidance of the Performance Improvement Committee. It will be the responsibility of the Infection Control Designee to trend the data and report it to the Performance Improvement Committee, who will provide a corrective action plan if necessary.

TITLE	NUMBER
INFECTION CONTROL: PERFORMANCE IMPROVEMENT COMMITTEE	**INF – 1:002**
SUBJECT	**PAGES(S)**
INFECTION CONTROL	**2 of 2**

PROCEDURE:

1. The Infection Control Designee completes the responsibilities set forth in the Infection Control Plan. All reports are forwarded to the Management Team for trending and performance improvement recommendations

2. The Management Team will consult with local and state Health Departments as necessary; and utilize consultants as necessary for the topics under review.

3. Specific duties and responsibilities of the Performance Improvement Committee's Infection Control Function include, but not limited to:

A. To develop, establish, and monitor Infection Control Plan.
B. To make recommendations concerning surveillance methods related to unusual epidemics, infection clusters, and infection trend.
C. To review and approve, at least annually, all policies and procedures related to infection surveillance, prevention and control.

TITLE **REPORTING FOR INFECTION CONTROL MONITORING**	NUMBER **INF – 1:003**
SUBJECT **INFECTION CONTROL**	EFFECTIVE DATE
REVIEW AND APPROVAL	PAGE(S) **1 of 2**
REVIEW DATES	REVISION DATES

PURPOSE:
The purpose of this policy is to delineate a specific protocol to follow when an infection is detected and/or identified.

SCOPE:
This policy applies to all employees of Maryland House Detox.

RESPONSIBILITY:
It is the responsibility of the Executive Director and/or designee to implement this policy and procedure. It is the responsibility of the Infection Control Designee to disseminate this information to each employee under their direction.

POLICY:
It is the policy of Maryland House Detox that due to the potential transmission of infection, that the safety of clients, visitors and staff members will be ensured through on-going collection and analysis of data. Results of this analysis will lead to corrective action as necessary.

TITLE	NUMBER
REPORTING FOR INFECTION CONTROL MONITORING	**INF – 1:003**
SUBJECT	**PAGES(S)**
INFECTION CONTROL	**2 of 2**

PROCEDURE:

1. The Performance Improvement Committee will evaluate trends and corrective action as indicated by data analysis.

2. Infections will be monitored by the Infection Control/Safety Officer to determine the progress or resolution of the infection utilizing employee return to work documentation, clinical symptoms or other applicable data.

3. The Infection Control Designee, on an as needed basis, will analyze staff reports of infections.

4. The infection rate and the action taken will be reported in the Infection Control Report and reported to the Management Team.

5. Communicable diseases which are required to be reported to state and local health departments will be reported via telephone by a member of the management team. Any supporting documentation of such a communicable disease will also be forwarded to the appropriate local agencies.

6. Reporting of employee illnesses will follow the same protocol, and if the employee is deemed infectious, a physician's note of medical clearance will be required to resume working.

TITLE **INFECTION CONTROL REGARDING SAFETY**	NUMBER **INF – 1:004**
SUBJECT **INFECTION CONTROL**	EFFECTIVE DATE
REVIEW AND APPROVAL	PAGE(S) **2 of 2**
REVIEW DATES	REVISION DATES

PURPOSE:
The purpose of this policy is to delineate a specific protocol to follow when an infection is detected and/or identified.

SCOPE:
This policy applies to all employees of Maryland House Detox.

RESPONSIBILITY:
It is the responsibility of the Executive Director and/or designee to implement this policy and procedure. It is the responsibility of the Infection Control Safety Officer to disseminate this information to each employee under their direction.

POLICY:
It is the policy of Maryland House Detox to ensure that a specific protocol is followed when an infection is detected and / or identified.

TITLE **INFECTION CONTROL REGARDING SAFETY**	NUMBER **INF – 1:004**
SUBJECT **INFECTION CONTROL**	PAGES(S) **2 of 2**

PROCEDURE:

1. Through the assessment process, client complaints or observations of physical ill health will be referred to the Infection Control Safety Officer.

2. Referral will be implemented if the client's infection so warrants this action. The Medical Director in consultation with the Infection Control Designee will make this decision.

3. Client’s communicable diseases which are required to be reported to state and local health departments.
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TITLE **STANDARD PRECAUTIONS**	NUMBER **INF – 1:005**
SUBJECT **INFECTION CONTROL**	EFFECTIVE DATE
REVIEW AND APPROVAL	PAGE(S) **1 of 3**
REVIEW DATES	REVISION DATES

PURPOSE:
The purpose of this policy is to establish guidelines to utilize Standard Precautions to prevent, and/or minimize the transmission of infections.

SCOPE:
This policy applies to all employees of Maryland House Detox

RESPONSIBILITY:
It is the responsibility of the Executive Director and/or designee to implement this policy and procedure. It is the responsibility of the Infection Control Safety Officer to disseminate this information to each employee under their direction.

POLICY:
It is the policy of Maryland House Detox to require and enforce Standard Precautions to prevent infection among clients, staff and visitors. It shall require practices and procedures that minimize the risk of the development and/or spread of communicable illness. It is also required that all body fluids/substances shall be considered Bio-hazardous and are handled in accordance with Standard Precautions.

TITLE **STANDARD PRECAUTIONS**	NUMBER **INF- 1:005**
SUBJECT **INFECTION CONTROL**	PAGES(S) **2 of 3**

PROCEDURE:

1. All employees shall follow the Standard Precautions (Universal Precautions) in which there is potential exposure to blood, body fluids, or any potentially infectious tissues.
2. All employees shall handle the materials noted above “as if” they were infectious regardless of the materials or any prior information about their source or relative seriousness of the potential infection.
3. All potentially exposed material shall be treated as if it has been exposed to infections.
4. Education of staff regarding infection control practices shall be provided annually and during the orientation of new staff.
5. Infection control techniques associated with Standard Precautions shall be routinely and continuously implemented without exception by ALL PERSONNEL IN ALL CATEGORIES AND CLASSIFICATIONS.
6. Staff shall be prepared to spontaneously state why and how Standard Precautions are utilized if questioned by a client, family member, supervisor, or others.
7. Hands should always be washed before and after contact with clients, even when gloves have been used. When hands come into contact with blood, body fluids, excrement or human tissue they must be immediately washed. Soap and water is sufficient for this purpose provided the hands are washed using friction for at least 15 seconds.
8. Gloves should be worn when contact with blood, body fluids, or contaminated surfaces are anticipated, including venipuncture, obtaining culture specimens, and handling of urine specimens. Gloves can be obtained at the Nursing Station or the Lab.

TITLE **STANDARD PRECAUTIONS**	NUMBER **INF- 1:005**
SUBJECT **INFECTION CONTROL**	PAGES(S) **3 of 3**

9. All mucosal splashes, exposure/contamination of open wounds with blood or other body fluids or exposure during venipuncture should be reported immediately to your Supervisor and the Director of Nursing/Infection Control Safety Officer or within 1 hour.
10. An Incident Report should be completed by the staff member observing the incident and submitted to the Program Director within 4 hours of the incident but no later than 24 hours of the occurrence.
11. Blood and body fluid spills should be cleaned with a solution of sodium hypochlorite (household bleach) diluted 1:10 with water.
12. Articles contaminated with blood, body fluids or other excrement should be double bagged with red biohazard bags and discarded in appropriate receptacles or and sent for cleaning and decontamination.
13. Standard precautions eliminate the need for other categories of isolation procedures unless an airborne disease is suspected or diagnosed (e.g. TB or Chicken Pox). If that occurs the involved person will be segregated by the Nursing Supervisor or the Infection Control Safety Officer where they will remain under observation until sent home or to another health care agency for diagnosis and/or indicated treatment.
14. Orientation/Education: All new employees shall receive detailed instructions regarding Standard Precautions as part of orientation prior to being assigned to a workstation. Continuing education regarding Infection Control practices, including Universal Precautions, shall be conducted no less than annually for all staff. Documentation of the completion of these educational experiences shall be retained in each employee's personnel folder.

TITLE **HANDWASHING**	NUMBER **INF – 1:006**
SUBJECT **INFECTION CONTROL**	EFFECTIVE DATE
REVIEW AND APPROVAL	PAGE(S) **1 of 4**
REVIEW DATES	REVISION DATES

PURPOSE:
The purpose of this policy is to outline employee responsibilities focusing on preventing and/or minimizing the transmission of infections through appropriate hand washing.

SCOPE:
This policy applies to all employees of Maryland House Detox.

RESPONSIBILITY:
It is the responsibility of the Executive Director and/or designee to implement this policy and procedure. It is the responsibility of the Infection Control Safety Officer to disseminate this information to each employee under their direction.

POLICY:
It is the policy of Maryland House Detox to ensure proper hand washing by its employees in order to prevent the transmission of pathogenic organisms among clients, employees, and visitors. This policy will be in accordance with the Centers for Disease Control and Prevention Hand Washing Guidelines.

TITLE **HANDWASHING**	NUMBER **INF – 1:006**
SUBJECT **INFECTION CONTROL**	PAGES(S) **2 of 4**

PROCEDURE:

1. All the restrooms will have running water, dispensable soap and disposable towels.
2. All employees will wash their hands with soap and water before and after eating, each use of the restroom, each physical contact and/or as needed.
3. All employees must also wash with soap and water any skin area that has come in contact with a patient's body fluid.
4. The total required time for hand washing is one (1) to two (2) minutes.
5. All employees will wash hands in the following manner:
   A. Turn on water and adjust to a comfortable temperature, standing away from the sink to avoid splashing.
   B. Moisten the hands, apply enough soap to make lather, cover the hands with soap going beyond the area of contamination (forearm area).
   C. Use friction, one hand upon the other with fingers interlaced, for at least fifteen (15) seconds.
   D. Rinse hands and forearms thoroughly under running water, holding elbows slightly higher than hands, allowing water to run through fingertips.
   E. Repeat Steps #B, C and D.
   F. Dry the hands and arms with a paper towel; turn off the faucet with the same towel before discarding.

TITLE **HANDWASHING**	NUMBER **INF – 1:006**
SUBJECT **INFECTION CONTROL**	PAGES(S) **3 of 4**

6. All employees shall follow the following CDC Hand Hygiene Guidelines:
Improved adherence to hand hygiene (i.e. hand washing or use of alcohol-based (or non-alcohol based) hand rubs) has been shown to terminate outbreaks in health care facilities, to reduce transmission of antimicrobial resistant organisms (e.g. methicillin resistant staphylococcus aureus) and reduce overall infection rates.
CDC is releasing guidelines to improve adherence to hand hygiene in health care settings. In addition to traditional hand washing with soap and water, CDC is recommending the use of alcohol-based (or non-alcohol based) hand rubs by health care personnel for patient care because they address some of the obstacles that health care professionals face when taking care of patients.
Hand washing with soap and water remains a sensible strategy for hand hygiene in non-health care settings and is recommended by CDC and other experts.
When health care personnel's hands are visibly soiled, they should wash with soap and water.
The use of gloves does not eliminate the need for hand hygiene. Likewise, the use of hand hygiene does not eliminate the need for gloves. Gloves reduce hand contamination by 70% to 80%, prevent cross-contamination and protect patients and health care personnel from infection. Hand rubs should be used before and after each patient just as gloves should be changed before and after each patient.
When using an alcohol-based (or non-alcohol based) hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. Note that the volume needed to reduce the number of bacteria on hands varies by product.
Alcohol-based (and non-alcohol based) hand rubs significantly reduce the number of microorganisms on skin, are fast acting and cause less skin irritation.
Health care personnel should avoid wearing artificial nails and keep natural nails less than one quarter of an inch longer than the tip of the finger if they care for patients that are immunocompromised and at high risk of acquiring infections.

TITLE **HANDWASHING**	NUMBER **INF – 1:006**
SUBJECT **INFECTION CONTROL**	PAGES(S) **4 of 4**

When evaluating hand hygiene products for potential use in health care facilities, administrators or product selection committees should consider the relative efficacy of antiseptic agents against various pathogens and the acceptability of hand hygiene products by personnel. Characteristics of a product that can affect acceptance and therefore usage include its smell, consistency, color and the effect of dryness on hands. As part of these recommendations, CDC is asking health care facilities to develop and implement a system for measuring improvements in adherence to these hand hygiene recommendations. Some of the suggested performance indicators include: periodic monitoring of hand hygiene adherence and providing feedback to personnel regarding their performance, monitoring the volume of alcohol-based hand rub used/1000 patient days, monitoring adherence to policies dealing with wearing artificial nails and focused assessment of the adequacy of health care personnel hand hygiene when outbreaks of infection occur.
Allergic contact dermatitis due to alcohol hand rubs is very uncommon. However, with increasing use of such products by health care personnel, it is likely that true allergic reactions to such products will occasionally be encountered.
Alcohol-based (and non-alcohol based) hand rubs take less time to use than traditional hand washing. In an eight-hour shift, an estimated one hour of a nurse's time will be saved by using an alcohol-based (or non-alcohol based) hand rub.
These guidelines should not be construed to legalize products that are not approved by FDA's Over-the-Counter Drug Review. The recommendations are not intended to apply to consumer use of the products discussed.

- Due to the nature of the services provided at Maryland House Detox, the facility utilizes non-alcohol based hand sanitizer located throughout the facility.

Any alcohol based hand sanitizers are kept out of the reach of any patients and stored appropriately in either the supply closet or nursing station.

TITLE **EXPOSURE PLAN FOR TUBERCULOSIS**	NUMBER **INF – 1:007**
SUBJECT **INFECTION CONTROL**	EFFECTIVE DATE
REVIEW AND APPROVAL	PAGE(S) **1 of 5**
REVIEW DATES	REVISION DATES

PURPOSE:
The purpose of this policy is to identify persons at risk so that progression of infection can be prevented and to provide provisions and safeguard the confidentiality and civil rights of individuals with Tuberculosis under applicable State and Federal Laws.

SCOPE:
This policy applies to all employees of Maryland House Detox

RESPONSIBILITY:
It is the responsibility of the Executive Director and/or designee to implement this policy and procedure. It is the responsibility of the Infection Control Safety Officer to disseminate this information to each employee under their direction.

POLICY:
It is the policy of Maryland House Detox to have a defined Exposure Control Plan for Tuberculosis to ensure that potential transmission of Tuberculosis minimized.

TITLE	NUMBER
EXPOSURE PLAN FOR TUBERCULOSIS	**INF – 1:007**
SUBJECT	**PAGES(S)**
INFECTION CONTROL	**2 of 5**

PROCEDURE:

Employees:

1. No applicant with active Tuberculosis may be hired at the facility until certified by the Anne Arundel County Health Department as non-contagious or cured.
2. An employee with inactive Pulmonary Tuberculosis may continue to work at the facility if he/she has been correctly treated or is on chemoprophylaxis, and the latest chest x-ray shows no changes.
3. Compliance with this procedure is a condition of employment at the facility.

Initial Screening:
All new employees are required to have Mantoux (intra-cutaneous) (PPD) test with 0.1 ml of PPD Tuberculin containing and/or a chest x-ray prior to the completion of their probationary period.
If the PPD is positive, or if the chest x-ray shows some abnormality suspicious of Tuberculosis, they will be referred to the Anne Arundel County Health Department and the employee will be counseled regarding the increased risk of progression from latent Tuberculosis to active Tuberculosis.
When the PPD is contraindicated, the employee will have a chest x-ray only. The PPD skin test must be read by a licensed medical provider between 48 and 72 hours after administration.

TITLE	NUMBER
EXPOSURE PLAN FOR TUBERCULOSIS	**INF – 1:007**
SUBJECT	**PAGES(S)**
INFECTION CONTROL	**3 of 5**

Screening for Health Care Workers Latent Tuberculosis Infection:

Health care workers with a documented history of vaccination with Bacillus of Calmette and Guerin (BCG), history of a positive PPD test, adequate treatment for disease, or adequate preventative therapy for infection, should be exempt from further PPD screening unless they develop signs or symptoms suggestive of Tuberculosis.
Health care workers with a history of a positive PPD, will require a pre-employment chest X-ray with a normal result

Summary of Interpretation of Skin test:

I. A reaction of > or = to 5mm is classified as positive (a) in persons with HIV infection or risk for HIV infection with unknown HIV status, (b) in persons who have had recent close contact with persons with active Tuberculosis, and (c) in persons who have an abnormal chest x-ray consistent with old healed Tuberculosis.

2. A reaction of > or = I0mm is classified as positive in persons who do not meet any of the criteria above but who have other risk factors for Tuberculosis, including:

A. High Risk Groups -- intravenous drug users known to be HIV seropositive; persons with other medical conditions that have been reported to increase the risk of progressing from latent Tuberculosis infection to active Tuberculosis, including silicosis, gastrostomy, bypass surgery; being 10% or more below ideal body weight; chronic renal failure; diabetes mellitus; high dose corticosteroid and other immunosuppressive therapy; some hematologic disorders (e.g. leukemia and lymphomas); and other malignancies.
B. High Prevalence Groups - foreign born persons from high prevalence countries in Asia, Africa, and Latin America, persons from medically under - served, low income populations, residents of long term care facilities (e.g. correctional institutions, nursing homes), persons from high risk communities as determined by local public health authorities.

TITLE **EXPOSURE PLAN FOR TUBERCULOSIS**	NUMBER **INF – 1:007**
SUBJECT **INFECTION CONTROL**	PAGES(S) **4 of 5**

3. Induration of > or = l5mm is classified as positive for persons who do not meet any of the above criteria.
4. Recent converters are defined on the basis of both induration and age > or = 10 mm increase within a two year period is classified as positive for persons> or = 35 years of age, > or = 5mm increase under certain circumstances (41 above).

- NOTE: Recent close contact implies household contact or unprotected occupational exposure similar in intensity and duration to household contact.

Annual:
A Tuberculosis evaluation be encouraged to all employees on an annual basis.

Repeat Screening Of Personnel With Significant Reactions:
Persons with known significant reactions to Tuberculosis have no need for additional Tuberculin tests. Radiographs shall be indicated for first time reactions and personnel reporting one or more symptoms as specified on the Tuberculosis Screening Form. The x-ray will be taken and sent to the County Health Contract.

Management of Personnel and/or Patients after Exposure:
If personnel or clients are exposed to an infected person with active pulmonary Tuberculosis and proper precautions were not used, skin testing of these persons will be done as soon as possible to obtain a baseline and then 10 weeks after exposure. The same procedure as outlined previous for interpretation of skin rest will be followed for clients and staff.

TITLE	NUMBER
EXPOSURE PLAN FOR TUBERCULOSIS	**INF – 1:007**
SUBJECT	**PAGES(S)**
INFECTION CONTROL	**5 of 5**

Education and Training:
1. The Infection Control Designee will conduct annual in-service education programs on the epidemiology, pathogenesis, transmission, and occupation risk of tuberculosis.
2. New employees will be offered a similar program during the orientation process.
3. An inventory of employee infection control practices will be carried out prior to each in-service in order that any apparent area of weakness may be specifically addressed in an educational setting.

Counseling and Screening:
Increased risk of immunocompromised employees who have converted will be evaluated for possible Tuberculosis transmission. All Tuberculosis infections, positive Tuberculosis Mantoux Skin test and Tuberculosis disease in employees will be reported on the OSHA 200 log and maintained for 5 years.

TITLE **EMPLOYEE TRAINING EDUCATION INFECTION CONTROL**	NUMBER **INF – 1:008**
SUBJECT **INFECTION CONTROL**	EFFECTIVE DATE
REVIEW AND APPROVAL	PAGE(S) **1 of 2**
REVIEW DATES	REVISION DATES

PURPOSE:
The purpose of this policy is to ensure all Maryland House Detox employees are equipped with the knowledge to comply with the infection control policies by being provided training and education in surveillance, prevention and the control of infection.

SCOPE:
This policy applies to all employees of Maryland House Detox.

RESPONSIBILITY:
It is the responsibility of the Executive Director to implement this policy and procedure. It is the responsibility of the Infection Control Safety Officer to disseminate this information to each employee under their direction.

POLICY:
It is the policy of Maryland House Detox to ensure that all employees will be provided training and education at the time of hire and on an annual basis. The Instruction will include the importance of adherence to infection control policies, personal hygiene, and their responsibilities as employees of Maryland House Detox.

TITLE **EMPLOYEE TRAINING EDUCATION INFECTION CONTROL**	NUMBER **INF – 1:008**
SUBJECT **INFECTION CONTROL**	PAGES(S) **2 of 2**

PROCEDURE:

1. The Infection Control Officer will facilitate all new employee Infection Control orientations.
2. The following topics will be addressed in orientation and in-service classes:
    a. Infection Control Program
    b. Bloodborne Pathogens/Exposure Control Plan
    c. Hand washing
    d. TB Exposure Control Plan
    e. Standard Precautions
    f. Hepatitis
    g. Employee Health
    h. AIDS vs. HIV

3. Failure to follow the infection control procedures will result in counseling and a notation entered in the staff member's personnel file.
4. Documentation of all in-service programs is maintained in the HR Office for three years.
5. All full time employees will attend one (1) in-service program on infection control annually.

TITLE **PREVENTION AND SPREAD OF INFECTION**	NUMBER **INF – 1:009**
SUBJECT **INFECTION CONTROL**	EFFECTIVE DATE
REVIEW AND APPROVAL	PAGE(S) **1 of 2**
REVIEW DATES	REVISION DATES

PURPOSE:
The purpose of this policy is to ensure Maryland House Detox provides preventative infection control procedures to maintain a pathogen-free environment.

SCOPE:
This policy applies to all employees of Maryland House Detox

RESPONSIBILITY:
It is the responsibility of the Executive Director to implement this policy and procedure. It is the responsibility of the Infection Control Designee to disseminate this information to each employee under their direction.

POLICY:
It is the policy of Maryland House Detox to have preventative infection control procedures designed to maintain a pathogen-free environment and prevent the spread of infection among clients and employees.

TITLE **PREVENTION AND SPREAD OF INFECTION**	NUMBER **INF – 1:009**
SUBJECT **INFECTION CONTROL**	PAGES(S) **2 of 2**

PROCEDURE:

1. It is the responsibility of the designated staff to:
    A. Perform and provide the following janitorial service:
        a. Cleans building daily.
        b. Disposes of all trash from lined covered containers in group and dining areas and lined wastebaskets (all other rooms) into dumpster at rear of building.
        c. Cleanse floors daily in accordance with specific manufacturer's recommendations.

2. It is the responsibility of the Infection Control/Safety Officer that all surveillance and prevention activities are carried out as scheduled.
3. It is the responsibility of all staff to:
    - Wash hands regularly throughout the day, including before and after working with food or medication and as specified in the Hand Washing Policy.
    - Encourage all clients to wash hands regularly, especially before and after handling food.
    - Ensure that tables are wiped with antiseptic cleaner before and after meals.
    - Ensure that all paper and other waste products are properly disposed of into covered, lined containers or wastebaskets at the end of each workday.

Infection Control Plan

The purpose of the ICP is to quantify and organize the procedures to be used to minimize and contain the possible transmission of potentially infectious organisms to patients, employees and others related to our practice/facility. Information collected from surveillance of activities At Maryland House Detox, may be used to improve processes and outcomes related to infection prevention and control.
THE PLAN HAS BEEN PREPARED IN ACCORDANCE WITH OSHA GUIDELINES FOR THE HANDLING OF BLOOD BORNE PATHOGENS AND OTHER POTENTIALLY INFECTIOUS BODILY SUBSTANCES AND ADDRESSES PROCEDURES TO BE USED SHOULD EXPOSURE, THROUGH REMOTE, TO THESE HAZARDS OCCUR DURING THE DAY TO DAY ACTIVITIES.
It is our policy that all blood and bodily fluids be regarded as infectious and potentially hazardous in nature. These fluids include: blood, saliva, secretions, tissue, excrement and other drainage of any kind.
Universal precautions will be practiced for all patient contact and will be practiced by all staff and members of the facility. In compliance of OSHA Blood Borne Pathogens Standard (29 CFR 1910.1030) plan is comprised of:

1. Staff Training
2. Work practice controls
3. Emergency procedures
4. Incident reporting/ infection control reporting
5. Annual flu shots for employees
6. Laundry, housekeeping and sanitation
7. Lab collection procedures
8. Communicable disease surveillance

Section 1- Training.
Policy: IC training will be conducted for all personnel on an annual basis. It will include but will not be limited to the following: Universal precautions, Procedures for cleaning, disinfection and handling. This will occur for each new hire and annually thereafter.

Infection Control Plan

Section 2- Work Place Controls.
Policy: Work place controls will be utilized to minimize and/ or eliminate exposure to potentially infectious materials. This includes:
General area/Patients bedrooms
Hazardous materials
Protective gear
Gloves and proper disposal
Eye protection where needed
Waterless hand cleaner and hand washing procedures

Spill kits

Section 3- Emergency Procedures

Policy: All personnel will follow emergency procedures. Should a patient or employee be exposed to a potential infection due to an accident or procedure, the incident must be reported and evaluated immediately. Respondents must use appropriate safety equipment and determine what procedures are deemed necessary.

Section 4- Incident Reporting and Infection Control Reporting

Policy: All personnel will follow procedures for appropriate reporting of exposures to blood, body fluids, excrement, or needle point injuries. Infection control is monitored and reported in the QI meetings.

Section 5- Annual Flu Shots for Employees

Policy: The facility will develop an annual Influenza Vaccination Program that will offer the annual Influenza vaccination.

Section 6- Laundry, Housekeeping and Sanitation

Policy: All staff will receive annual training regarding procedures for cleaning, disinfection and general housekeeping in the facility and of patient's laundry. All personnel will be trained to implement standard precautions in handling and washing of laundry.

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Infection Control Plan

Section 7- Urine Cup Procedures

Policy: All appropriate staff will be trained on handling and technique of obtaining urine drug screens from patients and/or staff. Proper sanitation techniques using gloves and hand washing will be maintained to prevent contamination or infection. Specimens will be handled in accordance with universal precautions

Section 8 – Communicable Disease Surveillance

Policy: All facility staff will be trained in accordance on evidenced-based practices regarding reduction and prevention measures for seasonal flu or flu-like illness or symptoms of flu-like illness. All patients will be encouraged to receive testing for HIV, Hepatitis and for any visible symptoms of a bacterial or viral nature. MHD will report to the AACHD, incidence of suspected or active infection. Patients will also be screened for their recent exposure to international endemic viral infections.

TITLE **EDUCATION & TRAINING, STAFF**	NUMBER **ED-1:001**
SUBJECT **HUMAN RESOURCE DEVELOPMENT**	EFFECTIVE DATE
REVIEW AND APPROVAL	PAGE(S) **1 of 4**
REVIEW DATES	REVISION DATES

PURPOSE:
The purpose of this policy is to establish education, certification licensure and training requirements for staff employment and/or non-paid support staff volunteers at Maryland House Detox.

SCOPE:
This policy applies to all types of staff paid or non-paid employee staff at Maryland House Detox

RESPONSIBILITY:
It is the responsibility of the CEO and/or Director of Human Resources to manage and implement this policy and to disseminate this information to all staff and employees under his/her direction. The Program Director is responsible to arrange and/or provide education and training with the essential Onboarding components for new hires and ensure annual competency and proficiency training is conducted for all personnel. The credentialed employee will be responsible to procure the proper education, training or recertification examinations in order to maintain their credentials in active status.

TITLE **EDUCATION & TRAINING, STAFF**	NUMBER **ED-1:001**
HUMAN RESOURCE DEVELOPMENT	PAGES(S) **2 OF 4**

POLICY:

Maryland House Detox Department of Human Resources will ensure that the mission of the organization is met by providing appropriately trained and qualified staff to deliver services to patients and by ensuring that ongoing education and training needs are identified and provided. MHD will manage the ongoing educational and training needs specific to various roles, positions and tasks to assure the highest level of competence and compliance with all federal, state licensure and certification level requirements are maintained. Auxiliary training across complementary disciplines will grant greater flexibility in patient service provision.

PROCEDURE:

The Human Resources Department will:

1. Manage all activities related to new staff participation in New Hire Onboarding – Orientation and training requirements to assure new staff readiness.
2. Provide ongoing annual competency, training and development opportunities for non-licensed and non-credentialed staff.

The Director of Human Resources will:

1. Provide talent recruitment
2. Process employment applications and agreements
3. Conduct initial interview
4. Obtain applicable background checks
5. Maintain employee records.

TITLE **EDUCATION & TRAINING, STAFF**	NUMBER **ED-1:001**
HUMAN RESOURCE DEVELOPMENT	PAGES(S) **3 OF 4**

The Program Director will, in collaboration with HR:

1. Oversee New Hire Onboarding Orientation.
2. Evaluate for new hire readiness.
3. Assist in recruitment and retention efforts.
4. Provide specific core trainings opportunities for licensed and credentialed staff
5. Partner with the HR Department to implement the mandatory annual trainings to all staff, in compliance with federal /state regulations such as COMAR, OSHA & HIPAA.

The Clinical Program Director will work with the HR Department to integrate opportunities for crossover trainings when possible to reduce requirements for time away from performance of primary role functions in order to meet competency standards.

NEW HIRE Onboarding Orientation & Annual Competency / Proficiency Training:

*All NEW HIRE staff will receive a 5-day Onboarding orientation and training. Each employee will be introduced to the Leadership and provided a tour. The New Hire participants will attend the weeklong orientation to the facility, in addition to attending the education and training sessions together with the regular staff in attendance for compliance with annual training requirements.

The various department supervisors within the facility at MHD will participate and provide various sessions content as assigned. The education and training learning sessions will be dynamic and engaging, and will be coordinated by both the Director of Human Resources and the Program Director, interchangeably. The NEW HIRE Onboarding orientation is as follows:

DAY 1 Maryland House Detox- Mission, Vision and Philosophy; Leadership is Stewardship; Tour of Facility, Introductions and Department Integration; Customer Service;

DAY 2 Patient Rights; Confidentiality & HIPAA; Security; Privacy; Ethics; Sexual Harassment; Diversity/Cultural Awareness;

DAY 3 Patient or Employee Accident/Injury; Employee Personal Safety; Infection Control; Blood borne Pathogens & Accidental Exposure Incident and Reporting; Use of Hazardous Chemicals.

TITLE **EDUCATION & TRAINING, STAFF**	NUMBER **ED-1:001**
HUMAN RESOURCE DEVELOPMENT	PAGES(S) **4 OF 4**

DAY 4 Patient Safety; Suicide Precautions; Crisis De-escalation; Incident Reporting;

DAY 5 Fire Safety & Prevention; Disaster & Response Management; Emergency Management & Evacuation Procedures; Medication Management; Ancillary Therapy; CPR

MHD Program Director will also manage various **core** trainings for licensed health care providers: clinical supervisors; social workers; primary therapists; addiction counselors; case managers; nurses; in addition to non-licensed staff such as mental health technicians and recovery support staff, when and where applicable.

The Program Director will ensure ongoing recertification, licensure status, competency reviews and proficiency trainings as necessary. A sample of the core elements curriculum for the licensed health provider includes but is not limited to:

Licensed Provider Core Curriculum:

Co-occurring Disorders; Motivational Interviewing; Language of Caring; Group Facilitation; ADHD & ADD; Compulsive Disorders; Personality Disorders; Mood Disorders; Anxiety Disorders; PTSD & Trauma; Cognitive Behavioral Therapy; Relapse Prevention; Medication Management; Withdrawal Management; Relapse Prevention; Dual Detox; Crisis De-escalation & Management; No Harm Intended-The patient with SIB; EHR Documentation

Staff is encouraged to attend additional training and attend educational opportunities offered in the community.

Maryland House Detox

ADMISSION PHYSICIAN'S ORDER SHEET
ALCOHOL LIBRIUM PROTOCOL

PATIENT NAME: _____

DATE OF BIRTH:_____

MR#: _____

ADMISSION DATE: _____

ADMITTING DIAGNOSIS: _____

ALLERGIES: _____

ADMITTING NURSE: _____

DATE ORDERED	TIME ORDERED	DAY	TREATMENT
			OBTAIN INITIAL CIWA UPON ADMISSION
		1	LIBRIUM 50MG PO 2-4HR; HOLD LIBRIUM IF CIWA IS LESS THAN 8 MAXIMUM DAY IS 300MG
		2	LIBRIUM 50MG PO TID
		3	LIBRIUM 50MG PO BID
		4	LIBRIUM 50MG PO QD
		5	LIBRIUM 25MG PO 0800 then Stop
			SEIZURE PRECAUTIONS- ALERT
			THIAMINE 100MG PO DAILY x 3 DAYS
			FOLIC ACID 1MG PO DAILY x 3 DAYS
			NOTIFY MD FOR INCREASE IN SYMPTOMS
			NOTIFY MD FOR ANY ACUTE MENTAL STATUS CHANGES
			HOLD MEDICATION IF PATIENT BECOMES OR APPEARS SEDATED

NURSE SIGNATURE/CREDENTIALS: _____DATE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

Maryland House Detox
ADMISSION PHYSICIAN'S ORDER SHEET
SUBUTEX 12MG PROTOCOL

PATIENT NAME:

_____

DATE OF

BIRTH:_____

MR#:

_____

_

ADMISSION DATE:

_____

ADMITTING DIAGNOSIS:

_____

ALLERGIES:_____

_____

ADMITTING

NURSE:_____

Date Ordered	Time Ordered	DAY	Treatment
		1	SUBUTEX 8MG AFTER COW REACHES 13, THEN 4MG WITHIN 8 HOURS IF WITHDRAWAL SYMPTOMS CONTINUE
		2	SUBUTEX 4MG SL AT 0800, 6MG SL AT 1800
		3	SUBUTEX 4MG SL AT 0800 AND 4MG SL AT 1800
		4	SUBUTEX 2MG SL AT 0800, AND 4MG SL AT 1800

		5	SUBUTEX 2MG SL AT 0800 AND 2MG SL AT 1800
		6	SUBUTEX 2MG SL AT 0800 THEN STOP

NURSE SIGNATURE/CREDENTIALS: _____DATE: _____

PHYSICIAN SIGNATURE: _____DATE: _____

Maryland House Detox
ADMISSION PHYSICIAN'S ORDER SHEET
ALCOHOL LIBRIUM PROTOCOL LOW LEVEL

PATIENT NAME: _____

DATE OF BIRTH_____

MR#: _____

ADMISSION DATE: _____

ADMITTING DIAGNOSIS: _____

ALLERGIES: _____

ADMITTING NURSE: _____

DATE ORDERED	TIME ORDERED	DAY	TREATMENT
			OBTAIN INITIAL CIWA UPON ADMISSION
		1	LOADING DOSE LIBRIUM 25MG PO Q4 PRN FOR CIWA GREATER THAN 8 FOR SIGNS AND SYMPTOMS OF WITHDRAWAL X 24 HRS
			HOLD MEDICATION IF PATIENT BECOMES OR APPEARS SEDATED
		2	LIBRIUM 50MG PO TID

		3	LIBRIUM 50MG PO BID
		4	LIBRIUM 25MG PO BID
		5	LIBRIUM 25MG PO 0800 THEN STOP
			SEIZURE PRECAUTIONS- HIGH ALERT
			THIAMINE 100MG PO DAILY x 3 DAYS
			FOLIC ACID 1MG PO DAILY x 3DAYS
			NOTIFY MD FOR ANY ACUTE MENTAL STATUS CHANGES
			HOLD MEDICATION IF PATIENT BECOMES OR APPEARS SEDATED

NURSE SIGNATURE/CREDENTIALS: _____DATE:_____

PHYSICIAN SIGNATURE: _____DATE:_____

Maryland House Detox
ADMISSION PHYSICIAN'S ORDER SHEET
BENZODIAZEPINE PROTOCOL LOW LEVEL

PATIENT NAME:

_____

DATE OF

BIRTH:_____

MR#:

_____

_

ADMISSION DATE:

_____

ADMITTING DIAGNOSIS:

_____

ALLERGIES:

_____

ADMITTING NURSE:

_____

Date Ordered	Time Ordered	DAY	Treatment
			OBTAIN INITIAL CIWA SCORE
		1	LOADING DOSE LIBRIUM 25MG PO Q4 PRN FOR CIWA GREATERTHAN 8 FOR SIGNS AND SYMPTOMS OF WITHDRAWAL X 24 HRS
			HOLD MEDICATION IF PATIENT BECOMES OR APPEARS SEDATED
		2	LIBRIUM 50MG PO TID
		3	LIBRIUM 25MG PO QID
		4	LIBRIUM 25MG PO TID
		5	LIBRIUM 25MG PO BID
		6	LIBRIUM 25MG PO 0800 THEN STOP
			SEIZURE PRECAUTIONS- HIGH ALERT
			NOTIFY MD FOR ANY ACUTE MENTAL STATUS CHANGES

NURSE SIGNATURE/CREDENTIALS: _____DATE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

Maryland House Detox
ADMISSION PHYSICIAN'S ORDER SHEET
SUBUTEX 16MG PROTOCOL

PATIENT NAME:

_____

DAE OF

BIRTH_____

MR#:

_____

ADMISSION DATE:

_____

ADMITTING DIAGNOSIS:

_____

ALLERGIES:

_____

ADMITTING NURSE:

_____

DATE ORDERED	TIME ORDERED	DAY	TREATMENT
		1	SUBUTEX 8MG AFTER COW REACHES 13, THEN 8MG WITHIN 8 HOURS IF WITHDRAWAL SYMPTOMS CONTINUE
		2	SUBUTEX 6MG SL AT 0800, 4MG SL AT 1400, AND 4MG SL AT 2100
		3	SUBUTEX 4MG SL AT 0800, 4MG SL AT 1400, AND 4MG SL AT 2100
		4	SUBUTEX 4MG SL AT 0800, SUBUTEX 4MG SL AT 1400 AND SUBUTEX 2MG SL AT 2100
		5	SUBUTEX 4MG SL AT 0800 AND 4MG SL AT 2100
		6	SUBUTEX 2MG SL AT 0800 AND 2MG AT 1800 THEN STOP

NURSE SIGNATURE/CREDENTIALS: _____DATE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

Maryland House Detox
ADMISSION PHYSICIAN'S ORDER SHEET
SUBUTEX 12MG PROTOCOL

PATIENT NAME:

_____

DATE OF BIRTH_____

MR#:

_____

ADMISSION DATE:

_____

ADMITTING DIAGNOSIS:

_____

ALLERGIES:_____

_____

ADMITTING NURSE:_____

Date Ordered	Time Ordered	DAY	Treatment
		1	SUBUTEX 8MG AFTER COW REACHES 13, THEN 4MG WITHIN 8 HOURS IF WITHDRAWAL SYMPTOMS CONTINUE

		2	SUBUTEX 4MG SL AT 0800, 4MG SL AT 1400, AND 2MG SL AT 2100
		3	SUBUTEX 4MG SL AT 0800 AND 4MG SL AT 1800
		4	SUBUTEX 4MG SL AT 0800, AND 2MG SL AT 1800
		5	SUBUTEX 2MG SL AT 0800 AND 2MG SL AT 1800
		6	SUBUTEX 2MG SL AT 0800 THEN STOP

NURSE SIGNATURE/CREDENTIALS: _____DATE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

Exhibit 9

Available Reviewed Financial Statements and Documentation for Delphi Health Group Subsidiaries and MHD Project

David S. Greenblatt, CPA
413 E. 81st Street
Apt 1A
New York, NY 10028
561-859-9760
Dgreeny317@hotmail.com

March 18, 2016

Maryland House Detox, LLC
Attn: David Stup, CEO
817 S. Camp Meade Road
Linthicum, MD 21093

Re: Viability of Proposal for Maryland Health Care Commission

Dear Mr. Stup,

I have been engaged to review certain documents provided to me by Maryland House Detox, LLC ("MHD") and Delphi Behavioral Health Group, LLC and subsidiaries ("DBHG") in order to make a determination as to the viability of MHD's proposal to the Maryland Health Care Commission with respect to a 16-bed detoxification facility located in Linthicum, Maryland.

I am independent with respect to MHD, DBHG and any of their officer's directors and have no financial interest in the determination by the Commission as it relates to the proposal. During my engagement, I have reviewed and analyzed documents in order to arrive at my conclusion, including, but not limited to:

- Reviewed Financial Statements for Ocean Breeze Recovery, LLC, including the Balance Sheet, Profit and Loss, and Statement of Cash Flows for the years ended 2012, 2013, and 2014.
- Reviewed Financial Statements for Las Olas Recovery, LLC, including the Balance Sheet, Profit and Loss, and Statement of Cash Flows for the years ended 2013 and 2014.
- Reviewed Financial Statements for Delphi Health Group, LLC, including the Balance Sheet, Profit and Loss, and Statement of Cash Flows for the year 2014.
- Consolidated financial statements for the year ended 2015
- 3 year projections for DBHG

- Projected revenue and expenses, including statement of assumptions included within MHD's application
- Estimated construction budget
- Information pertaining to DBHG's current credit facility and capacity

In addition to analyzing the above documents, I have also conferred with management as to their assumptions and believe that the assumptions included within the Application are achievable.

It is my conclusion based upon the information made available to me, that (a) MHD and DBHG generate sufficient free cash flow from continuing operations to fund the necessary working capital identified throughout their proposal and (b) DBHG currently has enough credit on their revolving facility with Key Bank to fund the working capital independent of the cash flow from operations.

Sincerely,

David Greenblatt, CPA (FL License # AC48483)

Ocean Breeze Recovery, LLC

Financial Statements
For The Years Ended December 31, 2014, 2013 and 2012

Ocean Breeze Recovery, LLC
Table of Contents

Independent Accountants' Review Report

To the Members of
Ocean Breeze Recovery, LLC
Pompano Beach, Florida

We have reviewed the accompanying balance sheets of Ocean Breeze Recovery, LLC (the "Company") as of December 31, 2014, 2013 and 2012, and the related statements of income and changes in members' equity and cash flows for the years then ended. A review includes primarily applying analytical procedures to management's financial data and making inquiries of Company management. A review is substantially less in scope than an audit, the objective of which is the expression of an opinion regarding the financial statements as a whole. Accordingly, we do not express such an opinion.

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America and for designing, implementing, and maintaining internal control relevant to the preparation and fair presentation of the financial statements.

Our responsibility is to conduct the review in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants. Those standards require us to perform procedures to obtain limited assurance that there are no material modifications that should be made to the financial statements. We believe that the results of our procedures provide a reasonable basis for our report.

Based on our reviews, we are not aware of any material modifications that should be made to the accompanying financial statements in order for them to be in conformity with accounting principles generally accepted in the United States of America.

Goldstein Schechter Koch, P.A.

Coral Gables, Florida
April 24, 2015

Ocean Breeze Recovery, LLC
Balance Sheets
December 31, 2014, 2013 and 2012

	2014	2013	2012
Assets			
Current assets:			
Cash and cash equivalents	$ 6,083,977	$ 6,541,447	$ 4,071,702
Accounts receivable	3,821,008	4,208,413	2,446,300
Due from related parties	117,746	59,563	751,615
Prepaid expenses and other current assets	73,497	138,838	183,651
Total current assets	10,096,228	10,948,261	7,453,268
Equipment and leasehold improvements, net	476,572	517,639	525,610
Goodwill	1,150,333	1,150,333	1,150,333
Investment in Las Olas Recovery, LLC	832,482	1,069,775	405,664
Other assets	334,649	148,646	200,355
Total assets	$ 12,890,264	$ 13,834,654	$ 9,735,230
Liabilities and Members' Equity			
Current liabilities:			
Accounts payable and accrued expenses	$ 492,755	$ 244,322	$ 140,044
Due to member	988,214	990,154	990,154
Note payable to member, current portion	421,118	407,515	391,614
Total current liabilities	1,902,087	1,641,991	1,521,812
Long-term liabilities:			
Note payable to member, net of current portion	971,791	1,324,538	1,732,053
Total liabilities	2,873,878	2,966,529	3,253,865
Members' equity	10,016,386	10,868,125	6,481,365
Total liabilities and members' equity	$ 12,890,264	$ 13,834,654	$ 9,735,230

See accompanying notes and independent accountants' review report.

Ocean Breeze Recovery, LLC
Statements of Income and Changes in Members' Equity
For the Years Ended December 31, 2014, 2013 and 2012

	2014	2013	2012
Net service fees	**$ 27,964,306**	$ 23,421,678	$ 13,987,978
Operating expenses:			
Salaries and wages	**5,982,314**	4,038,861	2,477,388
Advertising	**4,050,232**	2,093,020	1,468,192
Facility and occupancy costs	**2,763,284**	2,527,124	1,849,547
General and administrative	**1,401,350**	1,137,233	997,441
Professional fees	**1,247,343**	1,056,885	731,364
Insurance	**389,905**	258,629	184,348
Travel and entertainment	**170,309**	143,234	80,270
Depreciation and amortization	**166,923**	129,101	66,696
Repairs and maintenance	**140,436**	67,396	93,090
Total operating expenses	**16,312,096**	11,451,483	7,948,336
Income before other income (expenses)	**11,652,210**	11,970,195	6,039,642
Other income (expenses):			
Interest income	**10,821**	15,429	9,453
Other income	**51,000**	-	-
Income from investment in Las Olas Recovery, LLC	**2,112,707**	1,844,111	405,664
Loss on disposal of assets	**(104,801)**	(16,159)	-
Interest expense	**(60,855)**	(76,176)	(114,667)
Total other income (expenses)	**2,008,872**	1,767,205	300,450
Net income	**13,661,082**	13,737,400	6,340,092
Members' equity - beginning of year	**10,868,125**	6,481,365	-
Issuance of equity for purchase agreement	-	-	141,273
Distributions to members	**(14,512,821)**	(9,350,640)	-
Members' equity - end of year	**$ 10,016,386**	$ 10,868,125	$ 6,481,365

See accompanying notes and independent accountants' review report.

Ocean Breeze Recovery, LLC
Statements of Cash Flows
For the Years Ended December 31, 2014, 2013 and 2012

	2014	2013	2012
Cash flows from operating activities:			
Net income	**$ 13,661,082**	$ 13,737,400	$ 6,340,092
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	**166,923**	129,101	66,696
Loss on disposal of assets	**104,801**	16,159	-
Income from investment in Las Olas Recovery, LLC	**(2,112,707)**	(1,844,111)	(405,664)
Changes in operating assets and liabilities:			
Accounts receivable	**387,405**	(1,762,113)	(859,063)
Prepaid expenses and other current assets	**65,341**	44,813	(183,651)
Other assets	**(192,670)**	45,042	(184,772)
Accounts payable and accrued expenses	**248,433**	104,278	130,580
Net cash provided by operating activities	**12,328,608**	10,470,569	4,904,218
Cash flows from investing activities:			
(Advances to) repayments from related parties	**(58,183)**	692,052	(751,615)
Distributions received from Las Olas Recovery, LLC	**2,350,000**	1,180,000	-
Purchase of equipment and leasehold improvements	**(223,990)**	(130,622)	(519,997)
Net cash provided by (used in) investing activities	**2,067,827**	1,741,430	(1,271,612)
Cash flows from financing activities:			
(Repayments to) advances from member	**(1,940)**	-	815,429
Repayments on note payable to member	**(339,144)**	(391,614)	(376,333)
Distributions to members	**(14,512,821)**	(9,350,640)	-
Net cash (used in) provided by financing activities	**(14,853,905)**	(9,742,254)	439,096
Net (decrease) increase in cash and cash equivalents	**(457,470)**	2,469,745	4,071,702
Cash and cash equivalents - beginning of year	**6,541,447**	4,071,702	-
Cash and cash equivalents - end of year	**$ 6,083,977**	$ 6,541,447	$ 4,071,702
Supplemental disclosure of cash flow information:			
Interest paid	**$ 27,442**	$ 76,176	$ 114,667
Supplemental schedule of non-cash investing and financing activities:			
Purchase of net assets of BRT Counseling, Inc. financed through note payable	**$ -**	$ -	$ 2,500,000
Issuance of equity for purchase agreement of BRT Counseling, Inc.	**$ -**	$ -	$ 141,273

See accompanying notes and independent accountants' review report.

Note 1 – Description of Business and Summary of Significant Accounting Policies

Description of Business

Ocean Breeze Recovery, LLC, a Florida limited liability company (the "Company"), was formed on August 22, 2011 and commenced operations on January 1, 2012. The Company is headquartered in Pompano Beach, Florida, and provides substance abuse and addiction treatment services for individuals with drug and alcohol dependency.

Basis of Presentation and Estimates

The Company prepares its financial statements using accounting principles generally accepted in the United States of America ("GAAP"). The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents includes highly liquid investments with an original maturity at the time of purchase of ninety days or less. Deposits held with banks may exceed the amount of federally insured limits. The Company maintains its cash and cash equivalents with what management believes are high credit quality financial institutions. Therefore, management believes that no significant credit risk exists on its cash balances.

Revenue Recognition, Credit Risks and Concentrations

The Company provides services to its clients primarily in an inpatient treatment setting. Net service fees are recognized when services are performed at estimated net realizable value from clients, third-party payors and others for services provided. The Company receives the vast majority of payments from commercial payors at out-of-network rates.

Client service revenues are recorded at established billing rates less adjustments to estimate net realizable value. Adjustments are recorded to state client service revenues at the amount expected to be collected for the service provided based on historic adjustments for out-of-network services not under contract. Each client's insurance is verified prior to admission and the client self-pay amount is determined. The client self-pay portion is generally collected upon admission.

For the year ended December 31, 2014, approximately 85% of the Company's revenues were reimbursed by five insurance companies. No other payor accounted for 10% or more of revenue reimbursements for the year ended December 31, 2014.

For the year ended December 31, 2013, approximately 84% of the Company's revenues were reimbursed by five insurance companies. No other payor accounted for 10% or more of revenue reimbursements for the year ended December 31, 2013.

Note 1 – Description of Business and Summary of Significant Accounting Policies - continued

Revenue Recognition, Credit Risks and Concentrations - continued

For the year ended December 31, 2012, approximately 82% of the Company's revenues were reimbursed by four insurance companies. No other payor accounted for 10% or more of revenue reimbursements for the year ended December 31, 2012.

The Company derives the vast majority of its revenues from commercial payors at out-of-network rates. Management estimates the allowance for contractual and other discounts based on its historical collection experience. The services authorized and provided and related reimbursement are often subject to interpretation and negotiation that could result in payments that differ from the Company's estimates.

Accounts receivable primarily consists of amounts due from third-party payors (non-governmental) and private pay clients and is recorded net of contractual discounts. The Company's ability to collect outstanding receivables is critical to its results of operations and cash flows.

The Company's primary collection risks are (i) the risk of overestimating net revenues at the time of billing that may result in the Company receiving less than the recorded receivable, (ii) the risk of non-payment as a result of commercial insurance companies denying claims, (iii) the risk that clients will fail to remit insurance payments to the Company when the commercial insurance company pays out-of-network claims directly to the client, (iv) resource and capacity constraints that may prevent the Company from handling the volume of billing and collection issues in a timely manner, (v) the risk that clients do not pay the Company for their self-pay balance (including co-pays, deductibles and any portion of the claim not covered by insurance) and (vi) the risk of non-payment from uninsured clients. Based on the information available, the Company believes that no allowance for doubtful accounts as of December 31, 2014, 2013 and 2012 is necessary.

Equipment and Leasehold Improvements, net

Equipment and leasehold improvements are stated at cost, less accumulated depreciation and amortization. Expenditures for maintenance and repairs are charged to expense as incurred. Depreciation and amortization are provided using the straight-line method over the estimated lives of the related asset (shorter of economic life or lease term for leasehold improvements) which range from three to seven years.

Income Taxes

The Company, with the consent of its members, has elected to be taxed under the sections of the federal income tax laws, which provide that in lieu of corporate income taxes, the members separately account for their share of items of income, deductions, losses and credits. As a result of the elections, no income taxes have been recognized for this entity in the accompanying financial statements.

The Company's Federal tax status as a pass-through entity is based on its election to be treated as an S Corporation. The Company is required to file and does file tax returns with the Internal Revenue Service. The Company has no tax positions that must be considered for disclosures. The Federal income tax return of the Company is subject to examination by the Internal Revenue Service, generally for three years after they are filed.

Note 1 – Description of Business and Summary of Significant Accounting Policies - continued

Advertising Costs

Advertising costs are charged to operations as incurred. Advertising expense amounted to $4,050,232, $2,093,020 and $1,468,192 for the years ended December 31, 2014, 2013 and 2012, respectively.

Others Assets

Other assets include intangible assets which are the unamortized portions of costs assigned to a purchased trade name and non-compete agreement, all of which are amortized over a three year period, using the straight-line method. On an on-going basis, management reviews the valuation of intangible assets to determine possible impairment. Amortization expense totaled $6,667 for each of the years ended December 31, 2014, 2013 and 2012.

Goodwill

In accordance with Accounting Standard Codification ("ASC") 350 – Intangibles - Goodwill and Other, goodwill and indefinite-lived intangible assets are not amortized, but are subject to annual impairment testing unless circumstances dictate more frequent assessments. With the adoption of ASC 350, the Company determined that there was a single reporting unit for the purpose of goodwill impairment tests. The analysis of potential impairment of goodwill requires a two-step process. The first step is the estimation of fair value. If the carrying value of the Company's net assets is greater than fair value, the second step is performed to measure the amount of impairment, if any. Goodwill impairment exists when the estimated implied fair value of goodwill is less than its carrying value.

The Company performed its annual impairment assessment as of December 31, 2014, 2013 and 2012. Based on the step one analysis performed, the Company determined that the fair value of its reporting unit exceeded the carrying amount and there was no impairment of goodwill as of December 31, 2014, 2013 and 2012.

Subsequent Events

Management has evaluated subsequent events through April 24, 2015, the date which the financial statements were available for issue.

Note 2 – Business Combination

Effective January 1, 2012, the Company completed the purchase from BRT Counseling, Inc. of substantially all of the assets relating to the addiction treatment and recovery business. The Company also assumed certain specified liabilities associated with the assets being acquired. The aggregate purchase price was $2,500,000, the assumption of certain liabilities and a 5% membership interest in the Company valued at $141,273 on the date of purchase. The $2,500,000 will be paid through a note payable (see further details in note 5).

Note 2 – Business Combination - continued

The following is a condensed balance sheet at fair value of the assets acquired and the liabilities assumed as of the date of acquisition.

Accounts receivable	$ 1,587,237
Goodwill	1,150,333
Equipment	65,642
Other non-current assets	22,250
Current liabilities assumed	(184,189)
Net assets acquired	$ 2,641,273

Note 3 – Investment in Las Olas Recovery, LLC

During 2012, the Company acquired a 40% interest in Las Olas Recovery, LLC ("Las Olas"). The Company accounts for its investment in Las Olas on the equity method. The Company records its share of such earnings or losses in the accompanying statements of income and changes in members' equity and the carrying value of the Company's investment is recorded in the accompanying balance sheets as "Investment in Las Olas Recovery, LLC." During 2012, the Company advanced Las Olas $550,000 for start-up assistance and the advance was repaid in full during 2013.

During 2014, the members of Las Olas entered into an agreement with one of its members to buyback the member's equity interest. As a result of this agreement, the Company's interest in Las Olas increased to 45%.

The carrying value of the Company's investment at December 31, 2014, 2013 and 2012 approximates the Company's underlying equity in the net assets of Las Olas. Las Olas's assets, liabilities and net income totaled the following at December 31:

	2014	2013	2012
Assets	$ 3,235,120	$ 2,893,904	$ 1,763,628
Liabilities	$ 1,726,881	$ 219,468	$ 749,469
Net income	$ 6,078,183	$ 4,610,277	$ 1,014,159

Note 4 – Equipment and Leasehold Improvements, net

Equipment and leasehold improvements consisted of the following at December 31:

	2014	2013	2012
Vehicles	$ 488,342	$ 346,507	$ 239,183
Furniture and fixtures	166,560	161,321	161,321
Office equipment	9,090	137,402	135,203
Leasehold improvements	49,932	49,932	49,932
	713,924	695,162	585,639
Less accumulated depreciation and amortization	(237,352)	(177,523)	(60,029)
Equipment and leasehold improvements, net	$ 476,572	$ 517,639	$ 525,610

Depreciation and amortization expense totaled $160,256, $122,434 and $60,029 for the years ended December 31, 2014, 2013 and 2012, respectively.

Note 5 – Note Payable to Member

On January 1, 2012, the Company entered into an agreement to purchase substantially all of the assets relating to the addiction treatment and recovery business from BRT Counseling, Inc. in exchange for a note payable for $2,500,000, the assumption of certain liabilities and a 5% membership interest in the Company (see further details in note 2). The note payable bears interest at 4% and requires quarterly payments of $117,684 including interest and principal which commenced on April 1, 2012. The note payable matures on December 31, 2017.

As of December 31, 2014, future minimum principal payments required under the note payable to member are as follows:

Year ending December 31,	Amount
2015	$ 421,118
2016	438,275
2017	533,516
Total	$ 1,392,909

On March 19, 2015, the Company paid the full amount outstanding on the note payable to member.

Note 6 – Related Party Transactions

Due from Related Parties

Pursuant to the start-up assistance the Company provided to Las Olas, the Company advanced working capital of $550,000 during 2012. In return, the Company received Class B voting-only interests in Las Olas which were to be outstanding until the loan was repaid. During 2013, the loan was repaid in full and the Class B voting interests were retired.

At December 31, 2014, 2013 and 2012, the Company was owed $106,806, $49,563, and $201,615 respectively, from a member of the Company. This advance is non-interest bearing. There are no terms specified for repayment of this advance and, for financial reporting purposes, it has been reflected as a current asset as it is anticipated that it will be repaid within one year.

At December 31, 2014, the Company was owed $10,940, from a company that is a related party through common ownership. This advance is non-interest bearing. There are no terms specified for repayment of this advance and, for financial reporting purposes, it has been reflected as a current asset as it is anticipated that it will be repaid within one year.

Transactions with BRT Counseling, Inc.

At December 31, 2014 2013 and 2012, the Company owed $988,214, $990,154 and $990,154, respectively, to a member of the Company. This advance is non-interest bearing. There are no terms specified for repayment of this advance and, for financial reporting purposes, they have been reflected as a current liability as it is anticipated that it will be repaid within one year. On April 6, 2015, the Company paid the outstanding balance in full to the member.

Note 6 – Related Party Transactions - continued

Transactions with BRT Counseling, Inc. - continued

On January 1, 2012, the Company entered into an agreement to purchase substantially all of the assets relating to the addiction treatment and recovery business from BRT Counseling, Inc. in exchange for a note payable for $2,500,000, the assumption of certain liabilities and a 5% membership interest in the Company (see further details in note 2 and note 5). As a result of this transaction, BRT Counseling, Inc. became a member of the Company.

For the years ended December 31, 2014, 2013 and 2012, the Company received a total of $825,000, $474,370 and $491,000, respectively, from a member of the Company that is a non-profit organization and are included within net service fees in the accompanying statements of income and changes in members' equity. These payments are made on behalf of patients who require financial assistance in paying for the services provided by the Company. There are no terms specified for these scholarship funds and they are fully dependent on the discretion of the member.

Services Provided by Related Parties

For the years ended December 31, 2014, 2013 and 2012, the Company incurred a total of $1,073,379, $917,945 and $599,444, respectively, for billing services performed by a company related through common ownership. The amounts are included in the accompanying statements of income and changes in members' equity within professional fees. At December 31, 2014, the Company owed $82,458 to the related company for these services and is included in accounts payable and accrued expenses within the accompanying balance sheet. As of December 31, 2013 and 2012, the Company had no balance due to the related party.

Note 7 – Commitments and Contingencies

Leases

The Company leases certain facilities under various leases. These leases are classified as operating leases and expire at various dates during 2015 and 2017. The leases required the Company to pay for sales tax, real estate taxes, and insurance premiums. The Company recognizes rental expense for scheduled rent increases on a straight-line basis over the term of the lease. The difference between rent expense recorded and the amount paid is charged to "deferred rent" included within accounts payable and accrued expenses in the accompanying balance sheets.

The future minimum payments under these agreements are as follows at December 31, 2014:

2015	$	277,035
2016		31,460
2017		12,043
Total	$	320,538

Rent expense for the years ended December 31, 2014, 2013 and 2012 was approximately $660,000, $543,000 and $586,000, respectively, and is included within facility and occupancy costs in the accompanying statements of income and changes in members' equity.

Note 7 – Commitments and Contingencies - continued

Litigation

From time to time, the Company is exposed to claims and legal actions in the normal course of business, some of which are initiated by the Company. In management's opinion, the outcome of such matters, if any, will not have a material impact upon the Company's financial position and results of operations. As of December 31, 2014, 2013 and 2012, the Company is not aware of any litigation that would materially impact the financial statements.

Note 8 – Settlement

During 2014, the Company entered into a settlement agreement with an insurance company as a result of billing disputes. During the year ended December 31, 2014, the Company settled for a total of $230,000 of net service revenues to be returned and this amount is included as a reduction of net service revenues in the accompanying statements of income and changes in members' equity. At December 31, 2014, the Company owes $86,667 related to this settlement and is included within accounts payable and accrued expenses in the accompanying balance sheets.

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Las Olas Recovery, LLC
d/b/a Pathway to Hope

Financial Statements
For The Years Ended December 31, 2014 and 2013

Las Olas Recovery, LLC d/b/a Pathway to Hope
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CPAs & CONSULTANTS
GOLDSTEIN SCHECHTER KOCH

A.

Coral Gables, Florida
April 23, 2015

Las Olas Recovery, LLC d/b/a Pathway to Hope
Balance Sheets
December 31, 2014 and 2013

	2014	2013
Assets		
Current assets:		
Cash and cash equivalents	$ 27,675	$ 82,949
Accounts receivable	2,397,952	1,664,066
Due from members	397	289,989
Prepaid expenses and other current assets	3,425	40,644
Total current assets	2,429,449	2,077,648
Furniture and equipment, net	270,671	281,256
Security deposits	535,000	535,000
Total assets	$ 3,235,120	$ 2,893,904
Liabilities and Members' Equity		
Current liabilities:		
Accounts payable and accrued expenses	$ 127,125	$ 103,691
Deferred rent	73,596	115,777
Note payable, current portion	252,835	-
Total current liabilities	453,556	219,468
Long-term liabilities:		
Note payable, net of current portion	1,273,325	-
Total liabilities	1,726,881	219,468
Members' equity	1,508,239	2,674,436
Total liabilities and members' equity	$ 3,235,120	$ 2,893,904

See accompanying notes and independent accountants' review report.

Las Olas Recovery, LLC d/b/a Pathway to Hope
Statements of Income and Changes in Members' Equity
For the Years Ended December 31, 2014 and 2013

	2014	2013
Net service fees	**$ 13,903,989**	$ 10,745,990
Operating expenses:		
Salaries and wages	**2,583,221**	2,282,094
Facility and occupancy costs	**2,181,714**	1,540,889
General and administrative	**894,819**	818,397
Medical billing services	**501,156**	435,852
Advertising	**518,552**	342,666
Professional fees	**513,272**	271,363
Travel and entertainment	**280,705**	279,738
Insurance	**114,576**	106,074
Depreciation	**88,369**	63,985
Total operating expenses	**7,676,384**	6,141,058
Income before other income (expenses)	**6,227,605**	4,604,932
Other income (expenses):		
Guaranteed payments	**(155,652)**	-
Interest income	**9,366**	5,345
Interest expense	**(3,136)**	-
Total other income (expenses)	**(149,422)**	5,345
Net income	**6,078,183**	4,610,277
Members' equity - beginning of year	**2,674,436**	1,014,159
Distributions to members	**(5,550,000)**	(2,950,000)
Issuance of note payable in exchange for a member's equity interest	**(1,694,380)**	-
Members' equity - end of year	**$ 1,508,239**	$ 2,674,436

See accompanying notes and independent accountants' review report.

Las Olas Recovery, LLC d/b/a Pathway to Hope

Statements of Cash Flows

For the Years Ended December 31, 2014 and 2013

	2014	2013
Cash flows from operating activities:		
Net income	$ 6,078,183	$ 4,610,277
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation	88,369	63,985
Changes in operating assets and liabilities:		
Accounts receivable	(733,886)	(469,386)
Prepaid expenses and other current assets	37,219	(28,237)
Security deposits	-	(500,000)
Accounts payable and accrued expenses	23,434	1,908
Deferred rent	(42,181)	18,091
Net cash provided by operating activities	5,451,138	3,696,638
Cash flows from investing activities:		
Repayments from (advances to) members	289,592	(289,439)
Purchase of furniture and equipment	(77,784)	(192,697)
Net cash provided by (used in) investing activities	211,808	(482,136)
Cash flows from financing activities:		
Repayments on note payable	(168,220)	-
Repayments on advance from member	-	(550,000)
Distributions to members	(5,550,000)	(2,950,000)
Net cash used in financing activities	(5,718,220)	(3,500,000)
Net decrease in cash and cash equivalents	(55,274)	(285,498)
Cash and cash equivalents - beginning of year	82,949	368,447
Cash and cash equivalents - end of year	$ 27,675	$ 82,949
Supplemental disclosure of cash flow information:		
Interest paid	$ 2,647	$ -
Supplemental schedule of non-cash financing activities:		
Issuance of note payable in exchange for purchase of member's equity interest	$ 1,694,380	$ -

See accompanying notes and independent accountants' review report.

Note 1 – Description of Business and Summary of Significant Accounting Policies

Description of Business

Las Olas Recovery, LLC, d/b/a Pathway to Hope a Florida limited liability company (the "Company" or "LOR"), was formed on April 17, 2012 for the purpose of providing substance abuse and addiction treatment services for individuals with drug and alcohol dependency issues. The Company is headquartered in Broward county, Florida.

Basis of Presentation and Estimates

The Company prepares its financial statements using accounting principles generally accepted in the United States of America ("GAAP"). The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents includes highly liquid investments with an original maturity at the time of purchase of ninety days or less. Deposits held with banks may exceed the amount of federally insured limits. The Company believes that no significant credit risk exists in its cash balances.

Revenue Recognition, Credit Risks and Concentrations

The Company provides services to its clients primarily in an inpatient treatment setting. Net service fees are recognized when services are performed at estimated net realizable value from clients, third-party payors and others for services provided. The Company receives the vast majority of payments from commercial payors at out-of-network rates.

Client service revenues are recorded at established billing rates less adjustments to estimate net realizable value. Adjustments are recorded to state client service revenues at the amount expected to be collected for the service provided based on historic adjustments for out-of-network services not under contract. Each client's insurance is verified prior to admission and the client self-pay amount is determined. The client self-pay portion is generally collected upon admission.

For the year ended December 31, 2014, approximately 86% of the Company's revenues were reimbursed by five insurance companies. No other payor accounted for 10% or more of revenue reimbursements for the year ended December 31, 2014.

For the year ended December 31, 2013, approximately 91% of the Company's revenues were reimbursed by five insurance companies. No other payor accounted for 10% or more of revenue reimbursements for the year ended December 31, 2013.

Note 1 – Description of Business and Summary of Significant Accounting Policies - continued

Revenue Recognition, Credit Risks and Concentrations - continued

The Company derives the vast majority of its revenues from commercial payors at out-of-network rates. Management estimates the allowance for contractual and other discounts based on its historical collection experience. The services authorized and provided and related reimbursement are often subject to interpretation and negotiation that could result in payments that differ from the Company's estimates.

Accounts receivable primarily consists of amounts due from third-party payors (non-governmental) and private pay clients and is recorded net of contractual discounts. The Company's ability to collect outstanding receivables is critical to its results of operations and cash flows.

The Company's primary collection risks are (i) the risk of overestimating net revenues at the time of billing that may result in the Company receiving less than the recorded receivable, (ii) the risk of non-payment as a result of commercial insurance companies denying claims, (iii) the risk that clients will fail to remit insurance payments to the Company when the commercial insurance company pays out-of-network claims directly to the client, (iv) resource and capacity constraints that may prevent the Company from handling the volume of billing and collection issues in a timely manner, (v) the risk that clients do not pay the Company for their self-pay balance (including co-pays, deductibles and any portion of the claim not covered by insurance) and (vi) the risk of non-payment from uninsured clients. Based on the information available, the Company believes that no allowance for doubtful accounts as of December 31, 2014 and 2013 is necessary.

Furniture and Equipment, net

Furniture and equipment are stated at cost, net of accumulated depreciation. Expenditures for maintenance and repairs are charged to expense as incurred. Depreciation is calculated using the straight-line method over the estimated economic useful lives of the related asset which range from three to seven years.

Income Taxes

The Company, with the consent of its limited liability company members, has elected under the provisions of the Internal Revenue Code to be taxed as a partnership. The owners of an LLC taxed as a partnership are taxed on their proportionate share of the Company's taxable income. Therefore, no provision or liability for federal or state income taxes has been included in the accompanying financial statements.

The Company assesses its income tax positions, including its continuing tax status as a partnership, based on management's evaluation of the facts, circumstances and information available at the reporting date.

The Company uses a more likely than not threshold when making its assessment as to financial statement recognition and measurement of a tax position. The Company has not accrued any tax, interest expense, or penalties related to tax positions. There are no open federal or state tax years under audit. The Company is generally subject to tax examinations for all tax years since its formation.

Note 1 – Description of Business and Summary of Significant Accounting Policies - continued

Advertising Costs

Advertising costs are charged to operations as incurred. Advertising expense amounted to $518,552 and $342,666 for the years ended December 31, 2014 and 2013, respectively.

Subsequent Events

Management has evaluated subsequent events through April 23, 2015, the date which the financial statements were available for issue.

Note 2 – Furniture and Equipment

Furniture and equipment consists of the following at December 31:

	2014	2013
Furniture and fixtures	$ 227,719	$ 190,217
Vehicles	95,165	72,697
Computers	64,946	47,132
Office equipment	47,291	47,291
	435,121	357,337
Less accumulated depreciation	(164,450)	(76,081)
Furniture and equipment, net	$ 270,671	$ 281,256

Depreciation expense for the years ended December 31, 2014 and 2013 was $88,369 and $63,985, respectively.

Note 3 – Note Payable

On June 24, 2014, the Company entered into an agreement to purchase a member's 14% interest in exchange for a note payable for $1,694,380. The Company has recorded this note payable with a corresponding charge to members' equity in the amount of $1,694,380. The note payable bears interest at 0.32% and requires twenty quarterly payments of $85,433 including interest and principal which commenced on August 22, 2014.

As of December 31, 2014, future minimum principal payments required under the note payable are as follows:

Year ending December 31,	Amount
2015	$ 252,835
2016	338,060
2017	339,144
2018	340,232
2019	255,889
Total	$ 1,526,160

Note 4 – Related Party Transactions

Advance from Member

Pursuant to the start-up assistance the Company received from one of its members a working capital advance of $550,000 during 2012. The member received Class B voting only interests in the Company which were to be outstanding until the loan was repaid. During 2013, the loan was repaid in full and the Class B voting interests were retired. During the years ending December 31, 2013 and 2014, there was only one class of member interest as the Class B voting interest was retired.

Due from Members

The Company, from time to time, may advance its members funds, or pay personal expenses on their behalf. These advances are non-interest bearing. There are no terms specified for repayment of these advances and, for financial reporting purposes, they have been reflected as current assets as it is anticipated that they will be repaid within one year. As of December 31, 2014 and 2013, $397 and $289,989, respectively is due from members.

Operating Lease

The Company entered into a lease with another company related through common ownership. The lease commenced on March 1, 2014 and is for a term of three years. The lease requires monthly payments of $100,000 and a security deposit of $500,000 which will be applied as the rent payments on alternating months during 2015. See Note 5 for further details.

Guaranteed Payments to Members

During 2014, the Company paid a total of $155,652 to three members of the Company as compensation for their services provided during the year.

Services Provided by Related Parties

For the years ended December 31, 2014 and 2013, respectively, the Company incurred a total of $501,156 and $435,852 for billing services performed by a company related through common ownership. The amounts are included in the accompanying statement of income and changes in members' equity within operating expenses. At December 31, 2014, the Company owed $46,633 to the related company for these services.

Note 5 – Commitments and Contingencies

Leases

The Company leases certain facilities under various leases. These leases are classified as operating leases and expire at various dates during 2015 and 2017. The lease required the Company to pay for sales tax and common area maintenance. The Company recognizes rental expense for scheduled rent increases on a straight-line basis over the term of the lease. The difference between rent expense recorded and the amount paid is charged to "deferred rent" in the accompanying balance sheets.

Note 5 – Commitments and Contingencies - continued

Leases - continued

The future minimum payments under these agreements are as follows at December 31, 2014:

2015	$	1,508,578
2016		1,416,259
2017		291,120
Total	$	3,215,957

Rent expense for the years ended December 31, 2014 and 2013 was approximately $1,421,000 and $813,000, respectively and is included within facility and occupancy costs in the accompanying statements of income and changes in members' equity.

Litigation

From time to time the Company is exposed to claims and legal actions in the normal course of business, some of which are initiated by the Company. In management's opinion, the outcome of such matters, if any, will not have a material impact upon the Company's financial position and results of operations. As of December 31, 2014 and 2013 the Company was not aware of any litigation that would materially impact the financial statements.

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DELPHI Health Group

Delphi Health Group, LLC and Subsidiaries

Consolidated Financial Statements
From May 5, 2014 (Date of Inception)
to December 31, 2014

Delphi Health Group, LLC and Subsidiaries
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CPAs & CONSULTANTS
GOLDSTEIN SCHECHTER KOCH

er Koch, P.A.

Coral Gables, Florida
April 20, 2015

Delphi Health Group, LLC and Subsidiaries

Consolidated Balance Sheet

December 31, 2014

Assets		
Current assets:		
Cash	$	589,112
Accounts receivable		2,355,481
Total current assets		2,944,593
Equipment and leasehold improvements, net		192,842
Security deposits		32,741
Total assets	$	3,170,176
Liabilities and Equity		
Current liabilities:		
Accounts payable and accrued expenses	$	24,005
Due to related parties		92,872
Current portion of long-term debt		36,897
Total current liabilities		153,774
Long-term liabilities:		
Long-term debt, net of current portion		47,668
Total liabilities		201,442
Equity:		
Total members' equity attributable to Delphi Health Group, LLC		2,102,841
Non-controlling interest in consolidated subsidiaries		865,893
Total equity		2,968,734
Total liabilities and equity	$	3,170,176

See accompanying notes and independent accountants' review report.

Delphi Health Group, LLC and Subsidiaries

Consolidated Statement of Income

From May 5, 2014 (Date of Inception) to December 31, 2014

Net service fees	**$**	2,708,931
Operating expenses:		
Salaries and wages		482,219
General and administrative		304,088
Advertising		194,113
Rent		82,032
Travel and entertainment		53,360
Professional fees		51,322
Depreciation and amortization		10,224
Total operating expenses		1,177,358
Net income		1,531,573
Non-controlling interest in net income of consolidated subsidiaries		(865,893)
Net income attributable to Delphi Health Group, LLC	**$**	665,680

See accompanying notes and independent accountants' review report.

Delphi Health Group, LLC and Subsidiaries
Consolidated Statement of Changes in Equity
From May 5, 2014 (Date of Inception) to December 31, 2014

	Delphi Health Group, LLC Members' Equity	Non-Controlling Interest	Total
Balances at inception (May 5, 2014)	$ -	$ -	$ -
Capital contributions	1,437,161	-	1,437,161
Net income	665,680	865,893	1,531,573
Balances at December 31, 2014	$ 2,102,841	$ 865,893	$ 2,968,734

See accompanying notes and independent accountants' review report.

Delphi Health Group, LLC and Subsidiaries

Consolidated Statement of Cash Flows

From May 5, 2014 (Date of Inception) to December 31, 2014

Cash flows from operating activities:		
Net income	$	1,531,573
Adjustments to reconcile net income to net cash used in operating activities:		
Depreciation and amortization		10,224
Changes in operating assets and liabilities:		
Accounts receivable		(2,355,481)
Security deposits		(32,741)
Accounts payable and accrued expenses		24,005
Due to related parties		92,872
Net cash used in operating activities		(729,548)
Cash flows from investing activities:		
Purchase of equipment and leasehold improvements		(142,227)
Cash flows from financing activities:		
Capital contributions		1,437,161
Proceeds from long-term debt		25,000
Repayments on long-term debt		(1,274)
Net cash provided by financing activities		1,460,887
Net increase in cash		589,112
Cash - at May 5, 2014 (date of inception)		-
Cash - end of period	$	589,112
Supplemental disclosure of cash flow information:		
Interest paid	$	376
Supplemental schedule of non-cash investing and financing activities:		
Purchase of vehicles with long-term debt	$	60,839

See accompanying notes and independent accountants' review report.

Note 1 – Nature of Operations and Summary of Significant Accounting Policies

Nature of Operations

Delphi Health Group, LLC, a Florida limited liability company, was formed on May 5, 2014 and commenced operations in May 2014. The consolidated financial statements of Delphi Health Group, LLC, (the "Parent") and its Subsidiaries (collectively referred to as the "Company") are prepared in conformity with accounting principles generally accepted in the United States of America.

The Company's principal business is the operation of behavioral health treatment centers. The Company is headquartered in Broward County, Florida. The behavioral health treatment centers are located in Florida and California.

Consolidation

The consolidated financial statements include the accounts of: Delphi Health Group, LLC; Banyan Recovery Institute, LLC; Trinity Rehab Group, LLC; My Recovery Helper, LLC; Bayview Marketing Group, LLC; Adrino Digital, LLC; and Elevate Recovery, LLC (collectively referred to as the "Subsidiaries").

All significant inter-company accounts and transactions have been eliminated in consolidation.

Use of Estimates and Basis of Presentation

The Company prepares its consolidated financial statements using accounting principles generally accepted in the United States of America ("GAAP"). The preparation of consolidated financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash

The Company maintains its cash in bank deposit accounts. These deposits may exceed the amount of FDIC insurance provided on such deposits; generally, these deposits may be redeemed upon demand and therefore bear minimal risk.

Accounts Receivable

Accounts receivable are stated at the amount the Company expects to be collected from outstanding balances. Interest is not charged on overdue accounts and collateral is not required. Based on the information available, the Company believes that no allowance for doubtful accounts as of December 31, 2014 is necessary.

Note 1 – Nature of Operations and Summary of Significant Accounting Policies - continued

Net Service Fees

The Company provides services to its clients primarily in an inpatient treatment setting. Revenues are recognized when services are performed at estimated net realizable value from clients, third-party payors and others for services provided. The Company receives the vast majority of payments from commercial payors at out-of-network rates. Client service revenues are recorded at established billing rates less adjustments to estimate net realizable value. Adjustments are recorded to state client service revenues at the amount expected to be collected for the service provided based on historic adjustments for out-of-network services not under contract. Prior to admission, each client's insurance is verified and the client self-pay amount is determined.

Equipment and Leasehold Improvements

Equipment and leasehold improvements are stated at cost, less accumulated depreciation and amortization. Depreciation and amortization are provided using the straight-line method over the estimated lives of the related assets as follows:

Leasehold improvements	Shorter of economic life or lease term
Computer and software	3 years
Vehicles	5 years
Furniture and fixtures	5 years

Normal repairs and maintenance are expensed as incurred whereas significant improvements which materially increase values or extend useful lives are capitalized and depreciated over the remaining estimated useful lives of the related assets.

Advertising Costs

Advertising costs are charged to operations as incurred. Advertising expense amounted to approximately **$194,000** for the period from May 5, 2014 (date of inception) to December 31, 2014.

Income Taxes

The Parent and its Subsidiaries have elected to be treated as pass-through entities for income tax purposes and, as such, are not subject to income taxes. Rather, all items of taxable income and deductions are passed through to and are reported by the members. Therefore, no provision or liability for income taxes has been included in these consolidated financial statements.

The Parent and its Subsidiaries are required to file and do file tax returns with the Internal Revenue Service ("IRS") and the other taxing authorities in the locations where they operate. The Parent and its Subsidiaries have no tax positions that must be considered for disclosure. The income tax returns of the entities are subject to examination by the IRS and the other authorities, generally for three years after they are filed.

Subsequent Events

Management has evaluated subsequent events through April 20, 2015, the date which the consolidated financial statements were available for issue.

Note 2 – Equipment and Leasehold Improvements

At December 31, 2014, equipment and leasehold improvements consisted of the following:

Vehicles	$	101,839
Furniture and fixtures		57,217
Leasehold improvements		40,208
Computers and software		3,802
		203,066
Less: accumulated depreciation and amortization		(10,224)
Equipment and leasehold improvements, net	$	192,842

Depreciation and amortization expense totaled **$10,224** for the period from May 5, 2014 (date of inception) to December 31, 2014.

Note 3 – Long-Term Debt

At December 31, 2014, long-term debt consists of the following:

Note payable - Payable in monthly installments of $594, including interest at 4.25%, balance due November 5, 2018, secured by a vehicle.	$	26,125
Note payable - Payable in monthly installments of $550, including interest at 4.39%, balance due September 11, 2020, secured by a vehicle.		33,440
Note payable - The full balance of the note payable is due on March 31, 2015, including interest at 3%, secured by the Company's personal property. The Company paid the full balance of this note payable on February 2, 2015.		25,000
		84,565
Less current portion		(36,897)
Total long-term debt	$	47,668

Future maturities of long-term debt, as of December 31, 2014, are as follows:

2015	$	36,897
2016		11,898
2017		12,421
2018		12,317
2019		6,244
Thereafter		4,788
Total	$	84,565

Note 4 – Related Party Transactions

The Company incurred a total of $21,902 during the period from May 5, 2014 (date of inception) to December 31, 2014 for billing services performed by a company related through common ownership. Such amounts are included in the accompanying consolidated statement of income within general and administrative expense. At December 31, 2014, the Company owed $15,872 to the related company for these services. There are no terms specified for repayment of this amount due and, for financial reporting purposes, they have been reflected as current liabilities as it is anticipated that they will be repaid within one year.

The Company incurred a total of $107,000 during the period from May 5, 2014 (date of inception) to December 31, 2014 for general and administrative services performed by a company related through common ownership. Such amounts are included in the accompanying consolidated statement of income within general and administrative expense. At December 31, 2014, the Company owed $77,000 to the related company for these services. There are no terms specified for repayment of this amount due and, for financial reporting purposes, they have been reflected as current liabilities as it is anticipated that they will be repaid within one year.

Note 5 – Commitments and Contingencies

Operating Leases

The Company is committed to minimum annual payments with respect to operating leases for certain of its premises and equipment over the next three years as follows:

2015	$	223,346
2016		123,987
2017		53,971
Total	$	401,304

Rent expense related to certain of its premises was $82,032 for the period from May 5, 2014 (date of inception) to December 31, 2014. Rent expense related to certain equipment was $8,123 for the period from May 5, 2014 (date of inception) to December 31, 2014 and is included within general and administrative expense in the accompanying consolidated statement of income.

Equity Based Compensation

On September 8, 2014, the Company entered into employment contracts with two employees which provides for the granting of membership interests in the Company. Each employee is entitled to 5% membership interest in the Company which will be granted to each employee following the one year anniversary date of each employment contract. The Company estimated that the fair value was zero as the Company had no significant transactions and had a deficit at the date of the contracts; therefore, no compensation expense was recorded for the equity based compensation.

Note 6 – Concentration of Risk

For the period from May 5, 2014 (date of inception) to December 31, 2014, approximately 70% of the Company's revenues were reimbursed by one insurance company. At December 31, 2014 approximately 80% of accounts receivable represent amounts expected to be collected from this insurance company.

Note 7 – Subsequent Event

Subsequent to December 31, 2014, the Company ceased operations of one of its consolidated subsidiaries, Adrino Digital, LLC ("Adrino"). The Company received distributions of $4,000 from Adrino after operations ceased. Adrino had only one sale and reported a net loss of $4,040 during the period from May 5, 2014 (date of inception) to December 31, 2014 for the Company. Adrino had a deficit at December 31, 2014 and was an insignificant subsidiary of the Company.

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2121 Ponce de Leon Blvd.
11th Floor
Coral Gables, FL 33134
305.442.2200

Fort Lauderdale
2400 E. Commercial Blvd.
Suite 517
Fort Lauderdale, FL 33308
954.351.9800

Hollywood
4000 Hollywood Blvd.
Suite 215 South
Hollywood, FL 33021
954.989.7462

Boca Raton
2255 Glades Rd.
Suite 324A
Boca Raton, FL 33431
561.395.3550

GSK CPAs & CONSULTANTS
GOLDSTEIN SCHECHTER KOCH

Exhibit 10

Alternative Project Schedule
Alternative Tables 3 and 4

ALTERNATIVE PROJECT SCHEDULE

Schedule	Start	Days to Complete	Finish
Construction Permit Submission/Bid/Contract	12/1/16	60	2/1/17
Submission for Use	12/1/16	60	2/1/17
Construction	2/1/17	152	6/31/16
Submission for Occupancy	6/31/16	0	6/31/16
Submission for Accreditation/Licensure	3/1/16	90	6/31/16
First Use			Target 7/1/17

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project)

(INSTRUCTION: ALL EXISTING FACILITY APPLICANTS MUST SUBMIT AUDITED FINANCIAL STATEMENTS)

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	2016	2017	2018	20___	20-___
1. Revenue							
a. Inpatient services			0	$3,600,720	$9,600,000		
b. Outpatient services			0	0	0		
c. Gross Patient Service Revenue			0	$3,600,720	$9,600,000		
d. Allowance for Bad Debt			0	$1,200,240	$3,360,000		
e. Contractual Allowance							
f. Charity Care				$600,120	$1,200,000		
g. Net Patient Services Revenue			0	$1,800,360	$5,040,000		
h. Other Operating Revenues (Specify)							
i. Net Operating Revenue			0	$1,800,360	$5,040,000		

Table 3 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle	20___	20___	2016	2017	2018	20___	20-___
2. Expenses							
a. Salaries, Wages, and Professional Fees, (including fringe benefits)			$163,800	$1,611,307	$2,293,760		
b. Contractual			$0	$40,000	$60,000		

Services							
c. Interest on Current Debt			N/A	N/A	N/A		
d. Interest on Project Debt			N/A	N/A	N/A		
e. Current Depreciation			N/A	N/A	N/A		
f. Project Depreciation							
g. Current Amortization			N/A	N/A	N/A		
h. Project Amortization							
i. Supplies			$49,000	$25,000	$25,000		
j. Other Expenses (Specify)			$202,450	$285,630	$327,560		
k. Total Operating Expenses			$415,250	$1,961,937	$2,706,320		
3. Income			($415,250)	($161,577)	$2,333,680		
a. Income from Operation			($415,250)	($161,577)	$2,333,680		
b. Non-Operating Income							
c. Subtotal			($415,250)	($161,577)	$2,333,680		
d. Income Taxes					($702,741)		
e. Net Income (Loss)			($415,250)	($161,577)	$1,630,939		

Table 3 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	2016	2017	2018	20___	20-___
4. Patient Mix: A. Percent of Total Revenue							
1. Medicare							
2. Medicaid							
3. Blue Cross				20%	20%		

4. Commercial Insurance				62.5%	62.5%		
5. Self-Pay				5%	5%		
6. Other (Charity)				12.5%	12.5%		
7. TOTAL	100%	100%	100%	100%	100%	100%	100%
B. Percent of Patient Days/Visits/Procedures (as applicable)							
1. Medicare							
2. Medicaid							
3. Blue Cross				20%	20%		
4. Commercial Insurance				62.5%	62.5%		
5. Self-Pay				5%	5%		
6. Other (Charity)				12.5%	12.5%		
7. TOTAL	100%	100%	100%	100%	100%	100%	100%

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

(INSTRUCTION: Each applicant should complete this table for the proposed project only)

	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	2016	2017	2018	20___
1. Revenues				
a. Inpatient Services	0	$3,600,720	$9,600,000	
b. Outpatient Services	0	0	0	
c. Gross Patient Services Revenue	0	$3,600,720	$9,600,000	
d. Allowance for Bad Debt	0	$1,200,240	$3,360,000	
e. Contractual Allowance				
f. Charity Care	0	$600,120	$1,200,000	
g. Net Patient Care Service Revenues	0	$1,800,360	$5,040,000	
h. Total Net Operating Revenue	0	$1,800,360	$5,040,000	
2. Expenses				
a. Salaries, Wages, and Professional Fees, (including fringe benefits)	$163,800	$1,611,307	$2,293,760	
b. Contractual Services	$0	$40,000	$60,000	
c. Interest on Current Debt	N/A	N/A	N/A	
d. Interest on Project Debt	N/A	N/A	N/A	
e. Current Depreciation	N/A	N/A	N/A	
f. Project Depreciation				
g. Current Amortization	N/A	N/A	N/A	
h. Project Amortization				
i. Supplies	$49,000	$25,000	$25,000	
j. Other Expenses (Specify)	$202,450	$285,630	$327,560	
k. Total Operating Expenses	$415,250	$1,961,937	$2,706,320	

STATEMENT OF ASSUMPTIONS

General: The Applicant assumes the 16-bed facility will begin treating patients on July 1, 2017. The Applicant also assumes that in 2017, the census of the facility will remain constant at 75% utilization from initial treatment and be at 100% utilization beginning with January 1, 2018 remaining static throughout 2018. The Applicant also assumes that approximately 12.5% of it's beds, or 2 out of the 16, will be for charity, which do not fluctuate with utilization of overall bed count.

General – Revenue: The Applicant performed a comprehensive analysis of billings and charges of detoxification services across it's entities as well as collaborate with its third party billing company as to expected reimbursement rates. Based on the information reviewed, historical experience and future expected fluctuations in billings and collections, the Applicant believes gross billings for services provides will average to be approximately $1,667 per day, which includes a blended mix of out-of-network and in-network payors, which will result in an average collected rate of $1,000 per day. For purposes of the assumptions and tables, the Applicant has utilized a 360 day year.

Table 3 – Line 1a – Inpatient Services: The table assumes that 12 beds will be utilized beginning July 1, 2017, with an average gross billing rate of $1,667 and a 360-day year. Beginning in 2018, the table assumes the facility will be at a 100% utilization rate. The revenues can be calculated as follows:

2017: 12 (beds utilized) x $1,667 x 30 (days in month) x 6 (months in year) = $3,600,720 (rounded in table)

2018: 16 (beds utilized) x $1,667 x 30 (days in month) x 12 (months in year) = $9,601,920 (rounded in table)

Table 3 – Line 1d – Allowance for bad debt: The allowance for bad debt is based upon a historical analysis of reconciling gross billed amounts to average collected amounts whether via 3rd party insurance reimbursement or patient co-pays and deductibles. Historically, the Company has experienced an approximate allowance amount of 40% of gross charges for detoxification services provided. The table assumes that of the number of beds utilized, that 2 will be directly allocated to charity usage. The remaining beds will be subject to an allowance for bad debt of 40%. The total gross billings allocable to charity usage are further described in their applicable section. The allowance can be calculated as follows:

2017: 3,600,720 (gross billings) – 600,120 (charity usage) = 3,000,600 (gross billings to non-charity patients)

3,000,600 (gross billings to non-charity patients) x 40% = $1,200,240 (allowance)

2018: 9,600,000 (gross billings) – 1,200,000 (charity usage) = 8,400,000 (gross billings to non-charity patients)

8,400,000 (gross billings to non-charity patients) x 40% = $3,360,000 (allowance)

Table 3 – Line 1f – Charity Care: The Applicant has designated 2 beds, or 12% of total bed count, to directly account for charity care. The total charity care in both 2017 and 2018 can be calculated as follows:

2017: 2 (beds utilized) x 1,667 (gross billing rate) x 30 (days in month) x 6 (months) = $600,120 (rounded in table)

2018: 2 (beds utilized) x 1,667 (gross billing rate) x 30 (days in month) x 12 (months) = $1,200,000 (rounded in table)

Table 3 – Line 2a – Salaries and wages: For all amounts included within this category, all applicable taxes and benefits estimated to be 12% of compensation have been included in this category.

2016: During the start-up phase of the project, the Applicant has assumed that key employees will be required to start prior to treating patients. The Applicant has assumed that the President will be required to begin employment on April 1, 2016 and the public relations staff will begin work on July 1, 2016.

2017: The staff as identified above is expected to continue employment for the entire calendar year 2017. In addition, the clinical staff is expected to begin employment as of May 1, 2017, 2 months before the Applicant plans on treating patients.

2018: As of January 1, 2018, the facility is expecting to be fully staffed to treat 16 patients at all times throughout these years.

Table 3 – Line 2b – Contractual services: The Applicant expects to incur expenses related to marketing efforts of 3rd party contractors and expects to pay $5,000 per month beginning May 1, 2017.

Table 3 – Line 2c and 2d – Interest on debt: Since the Applicant plans to use cash from operations from other operating facilities as the primary source of funding working capital, no amount for interest on current or expected debt has been recorded.

Table 3 – Line 2i – Supplies:

2016: In 2016, the Applicant expects to incur costs of approximately $1,500 per patient bed to furnish with beds, nightstands, armoires and bedding. In addition, the Company intends to expend $25,000 to furnish the administrative offices (including office supplies), lounges, laboratory, and other miscellaneous expenditures.

2017 and 2018: Once the Applicant makes the initial furnishings in 2016, it is expected that costs will be minimal. The Applicant has assumed annual costs of $25,000 per year in 2017 and 2018.

Table 3 – Lina 2i – Other Expenses: The Applicant used the following information to determine the other expenses associated with the facility:

OTHER EXPENSES			
Description	**2016**	**2017**	**2018**
Rent	$ 162,750	$ 186,000	$ 186,000
Property Management	$ 15,000	$ 15,000	$ 15,000
Utilities	$ 13,200	$ 19,200	$ 25,200

Food costs	$ -	$ 27,430	$ 54,860
Insurance	$ 10,000	$ 15,000	$ 15,000
Electronic medical records	$ -	$ 5,000	$ 7,500
Automobile	$ 1,500	$ 6,000	$ 6,000
Support costs	$ -	$ 12,000	$ 18,000
Total	**$ 202,450**	**$ 285,630**	**$ 327,560**

- *Rent*: For 2016, rent is $7,750 per month in the first 3 months of the year. Beginning on April 1, 2016, rent expense is increased to $15,500 per month and remains at that rate until the end of 2018.
- *Property Management*: The Applicant uses a property management for services rendered to the commercial building. The expense is set at $1,250 per month and is expected to remain static for 2016, 2017 and 2018.
- *Utilities*: In 2016 and through June 30, 2017, utilities are expected to be $1,100 per month, inclusive of electricity and gas. Beginning on July 1 2017, these costs are expected to increase to $2,100 per month.
- *Food costs*: The Applicant has received quotes from 3rd party vendors as it relates to food costs. The expected cost is $1,055 per week.
- *Insurance*: Insurance costs are expected to cover general liability, professional liability, and auto insurance and has been estimated at $10,000 for 2016 and $15,000 for 2017 and 2018.
- *Electronic medical records*: This cost has been estimated at $0 in 2016, $5,000 in 2017, and $7,500 in 2018 as census is expected to grow.
- *Automobile*: The Applicant expects to spend $500 per month on an automobile beginning October 1, 2016. This expense is expected to continue throughout 2017 and 2018.
- *Support costs*: The Applicant expects to incur support costs (book keeping, miscellaneous labor, unexpected expenses) of approximately $1,500 per month beginning on May 1, 2017 and continuing throughout 2018.

Table 3 – Lina 3d – Income Taxes: Although the Applicant is an LLC which will taxed as a partnership with the ultimate taxes paid by the partners, for illustrative purposes, the Applicant has included an estimated income tax expense as if it were to be paid by the entity. No income tax expense was recognized in 2016 as the Applicant expects to incur loss. In 2017, the Applicant expects to income offset by the expected carry forward loss from 2016. The 2018 income tax expense can be calculated as follows:

> $2,333,680 (2018 income) - $576,827 (2016 and 2017 loss) x 40% = $702,741 (income tax expense)

Table 4 Assumptions – Since the Applicant does not have any other services other than the ones proposed in this project, all assumptions used in Table 4 are identical to the assumptions used in Table 3. No variations between the Tables exist.

Exhibit 11

Authorizations

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

3/7/16
Date

Signature of Owner or Board-designated Official
CEO Maryland House Detox, BOD MHD
Position/Title
David Stup
Printed Name

3/7/16
Date

Signature of Owner or Board-designated Official
COO Maryland House Detox
Position/Title
Cynthia Curtis
Printed Name

3/7/16
Date

Signature of Owner or Board-designated Official
Chairman of Board, Delphi Behavioral Health Group, Chairman of Board, Maryland House Detox
Position/Title
Ryan Collison
Printed Name

3/7/16
Date

Signature of Owner or Board-designated Official
CEO, Delphi Behavioral Health Group
Position/Title
Dominic Sirianni
Printed Name

3/7/16
Date

Signature of Owner or Board-designated Official
CFO, Delphi Behavioral Health Group
Position/Title
Michael Borkowski
Printed Name

References

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