MARYLAND HEALTH CARE COMMISSION

2nd Completeness Letter Response

Seasons Residential Treatment Program, LLC

Prince George's County

June 18, 2018

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LIST OF COMPLETENESS LETTER QUESTIONS

LIST OF ABBREVIATIONS

Term	Abbreviation
American Society of Addiction Medicine	ASAM
Attention Deficit Hyperactivity Disorder	ADHD
Centers for Medicare and Medicaid Services	CMS
Code of Federal Regulations	CFR
Code of Maryland Regulations	COMAR
Colorado	CO
Community Services Boards	CSB
Department of Health and Human Resources	DHHR
Diagnostic & Assessment	D&A
Diagnostic and Statistical Manual of Mental Disorders, 5th Edition	DSM-V
(The) District of Columbia	DC
District of Columbia Child and Family Services Agency	DC CFSA
District of Columbia Department of Behavioral Health	DC DBH
District of Columbia Department of Youth Rehabilitation Services	DC DYRS
Early Periodic Screening Diagnosis and Treatment	EPSDT
Federal Bureau of Investigation	FBI
Fiber-Reinforced Plastic	FRP
Free Appropriate Public Education	FAPE
General Educational Development or General Education Diploma	GED
Health Insurance Portability and Accountability Act of 1996	HIPAA
Interstate Compact on the Placement of Children	ICPC
Individualized Education Program	IEP
Lesbian, Gay, Bisexual, Transgender, and Questioning	LGBTQ
Local Educational Agency	LEA
Local School System	LSS
Maryland	MD
Maryland Behavioral Health Administration	MD BHA
Maryland Department of Health	MD DOH
Maryland Department of Human Services	MD DHS
Maryland Department of Juvenile Services	MD DJS
Maryland Health Care Commission List	MHCC
Maryland Human Services Agency	MD HSA
Maryland State Department of Education	MSDE

Term	Abbreviation
Memorandum of Understanding	MOU
Mental Health Residential Placements	MHRP
Nevada	NV
New Mexico	NM
North Carolina	NC
Occupational Safety and Health Administration	OSHA
Personal Education Plan	PEP
Prince George's County Public Schools	PGCPS
Post-Traumatic Stress Disorder	PTSD
Psychiatric Residential Treatment Facility	PRTF
Residential Treatment Center	RTC
Seasons Residential Treatment Program	Seasons
State Educational Agencies	SEA
Substance Abuse and Mental Health Services Administration	SAMHSA
Tennessee	TN
Texas	TX
United States Department of Agriculture	USDA
Virginia	VA
West Virginia	WV
Wisconsin	WI

LIST OF TERMINOLOGY

Term	Meaning
Youth	Refers to the demographic served by Seasons prior to being admitted to the facility
Resident(s)	Refers to the demographic served by Seasons after being admitted to the facility
Student(s)	Refers to the residents of Seasons during any discussion related to education

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May 15, 2018

VIA Email & U.S. MAIL

Tyeaesis Johnson, CEO
Seasons Residential Treatment Program, LLC
145 Fleet Street, PMB #144
Oxon Hill, MD 20745

Re: Seasons Residential Treatment Program, LLC
Establishment of a 72-bed RTC
Matter No. 17-16-2408

Dear Ms. Johnson:

Commission staff has reviewed the responses submitted by Seasons Residential Treatment Program to the request for additional information dated January 23, 2018, and requests that you provide additional responses to the following questions:

1. **Regarding your response to Question #3, please explain:**

   a. **Why the agreement in Exhibit 36 is not dated;**

As stated in the first sentence of the agreement, "The following stipulates a collaborative research agreement between Strategic Behavioral Health, LLC and Dr. Art Frankel, Research Project Manager effective April 1, 2013."

The signers did not date at the time of signing, but the agreement became effective with the signatures on April 1, 2013.

   b. **What type of outcome data will UNCW track for the adolescent program on a monthly, six month and twelve month interval; and**

The type of data that will be collected for the adolescent program on a monthly, six month and twelve month interval is detailed on page 7 of Exhibit 10 (page 263 of the application) and is highlighted below for easy reference:

- Length of Stay
- % Re-hospitalized for MH Reasons
- If re-hospitalized, average length of stay
- % ER use for MH reasons
- % Suicidal ideation or attempt
- % police contact
- % reported serious physical aggression
- % using drugs or alcohol
- % taking meds appropriately
- % recommending facility to others

   c. **Exhibit 36 indicates an external use for the data collected by Dr. Art Frankel. Please state what this external use is and whether any publications or reports have been generated with the collection of this data.**

Exhibit 36 states, "Any external use of the research, including but not limited to publication, between the designated parties is subject to the review and approval of SBH, LLC". This statement is in place to enforce our right of approval prior to external use or publication; however, at this time the research has only been used internally.

2. **Regarding your response to Question #5, you indicate that the Garner, NC and Charlotte, NC facilities both operate 12 bed Coed PRTFs. Please discuss how the two facilities segregate the boys from the girls in these two units, and provide details as to the type of adolescents treated at these two facilities, and the type of treatment and care provided to this population.**

Both SBC-Garner and SBC-Charlotte operate two (2) 12-bed coed units. Each Unit has 6 "L-shaped" bedrooms and comfortably sleeps two adolescent residents in each room. The boys are housed in the back of the unit/hall and the girls are housed in the three rooms in the front of the unit/hall. The rooms are slightly offset, therefore, none of the rooms are directly across from each other and do not provide line of sight of residents housed across from each other. Nurses assigned to the unit/hall have complete "line of sight" for all bedrooms. North Carolina regulations require a 2:6 staff to student ratio. We have two staff of each gender with the students at all times.

Patients are divided by gender when they are transitioning to school, having meals in the cafeteria, participating in recreational therapy, attending individual and group counseling and following daily programs. During meals, residents dine at separate tables. During resident group sessions, therapist separate male and female residents in gender-specific seating pods. The only time residents from these units are integrated is during recreational therapy and team building exercises.

The children and adolescents receiving treatment at our residential facilities require clinically intensive treatment in a safe, secure, structured, therapeutic program. The children and adolescents in our care are more acutely or chronically psychiatrically ill than those served at a lower level of care. **Children who are appropriate for this level of care service may have the following behaviors and present with the following mental illness challenges:**

- Need extensive and clinically intensive workup to determine appropriate diagnosis and treatment plan.
- Have a major mental illness that is under sufficient control to allow for discharge from an inpatient hospital
- Need extended monitoring while undergoing medication trials/stabilization but who no longer met acute stay hospitalization criteria
- Need of highly intensive, clinically specialized therapies that require a specially trained and clinically sophisticated milieu for effective delivery (such as but not limited to: sexually aggressive youth, deaf/hard of hearing, substance abusing youth)
- Failed treatment in services along the outpatient and other residential continuum of care and whose presentation is clinically challenging enough to warrant the level of clinical intensity provided by PRTF

The staff actively works with the residents, family and other stakeholders to offer strengths-based, culturally competent, trauma-informed, medically appropriate treatment designed to meet the individual needs of the residents.

3. Regarding Exhibit 10, please respond to the following:

a. On p. 263, approximately one out of six (17%) of the adolescents in the study encountered a re-hospitalization that is 19.8 days ALOS, which was longer than the initial stay of 9.6 days ALOS for the initial treatment.

***Please note the data referenced above is for adolescents admitted for **acute psychiatric hospitalization,** the data **does not reflect** adolescents admitted to our psychiatric residential treatment programs. ***

i. Why was the ALOS for re-hospitalizations over twice the ALOS for the initial admissions;

In treating psychiatric illness and mental health issues, patients in need of re-hospitalization generally have a higher acuity level and are tougher to treat. Patients requiring re-hospitalization may have been previously under or misdiagnosed and have a more refractory illness requiring a more targeted treatment plan and close monitoring of and changes to psychotropic medications.

The reviewers conducting the study said many of the re-hospitalized patients with the longer ALOS had more significant symptomology, required more extensive medication review and modification and required more resources and care to meet treatment goals and discharge standards.

This group of patients also needed specific discharge plans and found it difficult to reintegrate with family and community due to prior offenses. Patients who were re-hospitalized often required a few extra days in care to find appropriate, stable and supportive living arrangements prior to discharge. Any combination of these factors can contribute to longer lengths of stay for re-hospitalized patients compared to initial admissions.

ii. What were the reasons for these re-hospitalizations; and

In addition to the statement above regarding the potential likelihood of patients with mental illness under-diagnosed or misdiagnosed (sometimes for years) prior to inpatient hospitalization and admission to SBH hospitals, the reviewers stated many of the re-hospitalized patients had more significant symptomology, required significant changes to one or more of their psychiatric medications, required extensive medication review and had more refractory behaviors than patients admitted for the first time.

For child and adolescent patients, there are many reasons for re-hospitalization; however, the most recurrent reason is poor community and family reintegration due to limited access to services and resources. It is often very difficult for parents and guardians to follow and execute post-discharge treatment recommendations due to limited resources. Many of our hospitals are located or adjacent to rural areas without adequate community-based programs and services. This makes it very difficult for children and

adolescents to receive adequate supports, counseling and related therapeutic and medical services after they are discharged from our inpatient care.

iii. What is SBC doing to reduce these re-hospitalizations?

Strategic Behavioral Health is committed to community education and awareness to help provide access to patients and families living with mental illness. Our ultimate goal is to try to reduce the number of patients in need of inpatient hospitalization and residential treatment by providing or partnering with community-based intensive outpatient and partial hospitalization programs to provide resources at the community level.

Strategic Behavioral Health has launched intensive outpatient and partial hospitalization programs in many of our hospitals with plans for all hospitals to support outpatient programs by December of 2018. While this will not reduce re-hospitalization in the most refractory patients, it will allow patients to extend their care within our continuum and provides an additional resource to stakeholders struggling to find community-based care as part of their post-discharge treatment plan.

Experienced clinicians staff outpatient programs. The clinical team monitors symptoms and address issues around pharmacology and medication management. Our goal is to provide appropriate resources for patients who need therapeutic support prior to an acute hospitalization or major psychotic event.

In our hospitals where we do not have outpatient programs, we have partnered with community-based programs whose goals and treatment philosophy are consistent with those of Strategic Behavioral Health. All of these aftercare programs are vetted by SBH staff and are licensed according to state regulations. Upon notification of patient discharge, our case managers and therapist provide a minimum of three (3) community resources to support aftercare plans.

In an effort to prevent re-hospitalization, Strategic Behavioral Health also employs a clinical team tasked with delivering 72-hour follow up calls with all patients discharged from our hospitals. The team contacts discharged patients to ensure they have received all discharge paperwork, understand their aftercare plan, filled prescribed medications and are not experiencing any relapse in symptoms or events.

If the team determines patients do not have or understand their treatment plan, or, they do not have sufficient medication or resources, they will reach out to the clinical team at the hospital where their care was managed and connect them with the right resources. Since we have instituted this process, we have seen a decrease in re-hospitalization and recidivism and an increase in medication compliance.

Strategic Behavioral Health also employs a patient advocate and discharge planner at each hospital. This team is responsible for meeting with patients during intake and throughout their stay to discuss prescribed medications, current treatment plans and after care resources and options.

b. What is SBC doing to:

i. Increase the number of adolescents taking their medications appropriately (80%) and

It is the goal of the clinical team to have 100% medication compliance for all patients; however, medication compliance for patients (and particularly adolescents) on psychiatric medication is very hard to manage. The level of compliance depends of multiple factors and varies across psychiatric diagnosis (i.e., mood disorder, schizophrenia, anxiety, depression, etc.) disease onset, patient age, and supervision of medication administration, natural supports and stability of home environment.

Other factors contributing to patient non-compliance include a broad range of drug side effects, the severity of which depends on the medication, however, patients reported the following with the greatest level of frequency: perception and onset of efficacy, changes in mood, weight gain, psychosis, drug interactions and lethargy.

Our therapist work closely with family members and other stakeholders during the intake and admissions process to identify risk factors with the goal of improving medication compliance rates among adolescent patients. Our clinical team reviews all prescribed medications, including how long the medication has been prescribed, dosage and administration and whether the medications have improved patient mood and behaviors.

All parents, guardians and stakeholders also receive calls from our outbound compliance team to discuss medications and the importance of compliance to prevent relapse, decomposition and rehospitalization. During these calls, we share side effect profiles, relative risk and use of psychotropic medications with co-morbid substance abuse. We are also working with our therapist, case managers and discharge planners to close the gap in the medication compliance rate by implementing a psycho-education program for patients and families, including more patient friendly brochures to promote changes in skills, behaviors and attitude about taking psychiatric medications. The goal is to help patients/parents understand the importance of compliance to improve patient mental health and symptom reduction.

ii. Increase the number of patients who would recommend SBC to others for treatment (77%).

We provide many opportunities for both our patients and other stakeholders to provide anonymous and "on the record" feedback about all aspects of our admissions process, physical plant, environment of care, treatment, provider access, food services and the discharge process. Our team reviews and synthesizes all patient survey data and distributes patient "report cards" to hospital CEOs every month. Our full time patient advocate manages the reviewing and reporting process. Upon admission, every patient and family member meets with the patient advocate and is given their contact information. Every hospital is required to post a picture and phone number for the patient advocate on every unit.

Recently, we reviewed our feedback loop and determined while we are collecting and reporting patient recommendations and complaints regarding treatment issues, we are not as responsive to issues we consider more subjective (quantity of food, noise level of television and staff, shampoo and lotion selection). As of May 1, 2018, we have placed new suggestion boxes on the unit and implemented an "ask the CEO" forum to help identify and solve some of the issues contributing to patient comfort. We hope these solutions help increase the number of patients who would recommend Strategic Behavioral Health for treatment.

4. **Regarding your response to Question #9 and Exhibit 49, please provide background and causes for the allegations and issues that were settled between the North Carolina Department of Health and Human Services with Strategic Behavioral Center - Raleigh and Strategic Behavioral Center- Charlotte facilities. Besides the fines, what efforts did SBC make to resolve these allegations and issues with these two North Carolina RTCs treating female and male adolescents?**

The leadership teams at both SBC-Raleigh and SBC-Charlotte take incidents involving adolescents in our care extremely seriously. While we can't cite the specific causes for the allegations cited by the North Carolina Department of Human Resources surveyors, we understand we are obligated to ensure patients in our care are receiving clinically sound supportive treatment in a safe, secure, structured environment. Survey results indicating anything outside this commitment to our stakeholders is a failure on the part of our staff and leadership team.

During the survey review process, we conducted extensive root cause analyses to identify areas where we can improve our policies, processes, procedures, and training. The results of the root cause analysis required that we immediately implement numerous processes, policies, procedures, and other improvements to ensure all areas of deficiencies were corrected. We worked with a cross-section of internal stakeholders to increase communication and outreach about the state surveyor sanctions with staff at every level of the organization. We also required each staff member to attend retraining around the specific sanctioned areas and participate in a bi-annual policy review around the areas of focus.

As part of our process, we also replaced members of the leadership team in areas where there were deficiencies around communicating facility policy. We implemented a policy that states any deviation of our standards related to our commitment to quality patient care is immediately addressed by the Home Office leadership team and the facility staff. Penalty for policy violation includes verbal warning and termination of employment.

Both facilities submitted thorough plans of correction to the state agency for each sanction. Each of those plans of correction has been accepted, and each of the sanctions imposed by state and federal agencies been reversed or rescinded.

5. Regarding your response to Question #16, please respond to the following:

a. You state that "Connections Academy combines the best online and offline resources from leading educational publishers and curriculum specialists ...." Please discuss how Seasons can make this representation when SBH currently does not use Connections Academy at its existing PRTFs, and Connections Academy is still under development and not in operation for residents of Maryland, Virginia, Washington, D.C., and West Virginia.

The statement, "Connections Academy combining the best online and offline resources from leading educational publishers and curriculum specialists..." is based on a April 2018 efficacy research report and comparative review conducted by Pearson. Pearson has expertise in educational courseware and assessment and is committed to researching and reporting statistically significant data regarding the impact of technology on student achievement and outcomes. The most recent Connections Academy Efficacy Research Report is attached in Exhibit 50.

b. The contingency plans are to use International Connections Academy, which has the same business address and similar information on its website as Connections Academy (i.e., 10960 Grantchester Way in Columbia, MD). Please explain how the use of International Connections Academy is an appropriate contingency to address the educational requirements for the proposed Seasons RTC in Prince George's County.

As noted in the Certificate of Need application, Seasons Residential Treatment Program will apply to become a licensed educational program as required, outlined and regulated by the Maryland State Department of Education. None of the Connections Academy programs will replace the federal and state requirements to provide SEA approved education to students admitted to a licensed psychiatric residential treatment program. The International Connections Academy was cited as a contingency in order to broaden access to and availability of student coursework for specific courses. All virtual coursework will *supplement* MSDE curriculum and/or will be used for patients who are in our **diagnostic and assessment** unit (short term) for remedial or elective coursework or older students admitted to our adult program interested in pre-college or technical school assessment and coursework.

As such, any consideration for using virtual coursework delivered by Connections Academy (in any form) for students admitted to Seasons Residential Treatment Program, will include the following:

- Students in our diagnostic and assessment (short term) program in need of credit recovery or remedial coursework;
- Students in our residential program in need of fewer than two (2) courses as part of graduation requirement; courses approved by home state educational authority;
- Adult students planning to take the General Equivalency Diploma (GED);
- Adult students (with GED or HS diploma) interested in remedial core curriculum coursework;

6. Regarding your response to Question #20, please provide a revised Table L that provides the number and costs of contracting with a licensed psychologist, speech pathologist/audiologist, movement therapist, and occupational therapists for Seasons RTC.

What factors will the clinical team and referral agency use to determine the specific needs and services that these contractual staff will provide?

TABLE L. REVISED 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 F and G.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** (should be consistent with projections in Table G, if submitted).	**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)											
Executive Director				1.0	$141,458	$141,458				1.0	$141,458
Director of Finance				1.0	$75,444	$75,444				1.0	$75,444
Director of Academics				1.0	$75,444	$75,444				1.0	$75,444
Clinical Director				1.0	$81,911	$81,911				1.0	$81,911
Director of Admissions				1.0	$75,444	$75,444				1.0	$75,444
Director of Human Resources				1.0	$75,444	$75,444				1.0	$75,444
Milieu Mgr./Program Mgr.				1.0	$66,822	$66,822				1.0	$66,822
Director of Nursing				1.0	$94,844	$94,844				1.0	$94,844
Total Administration				***8.0***		***$686,813***				***8.0***	***$686,813***

Direct Care Staff (List general categories, add rows if needed)											
Registered Nurse				21.1	$82,286	$1,732,757				21.1	$1,732,757
Therapist				11.2	$75,498	$847,904				11.2	$847,904
Discharge Planner				2.8	$58,845	$165,217				2.8	$165,217
Mental Health Technician				46.7	$37,952	$1,772,662				46.7	$1,772,662
Total Direct Care				***81.8***		***$4,518,541***				***81.8***	***$4,518,541***
Support Staff (List general categories, add rows if needed)											
General Ed Teacher				8.3	$72,012	$600,101				8.3	$600,101
Teacher Assistant				8.3	$54,009	$450,076				8.3	$450,076
IEP Coordinator				2.5	$57,205	$143,013				2.5	$143,013
Food Service Manager				1.0	$57,205	$57,205				1.0	$57,205
Line Cook/Food Prep				4.0	$27,052	$108,209				4.0	$108,209
Clinical Department Secretary				1.0	$43,499	$43,499				1.0	$43,499
Marketing/Bus Dev Coordinator				2.0	$51,733	$103,467				2.0	$103,467
UR/Credentialing/Ins Verification				1.0	$51,733	$51,733				1.0	$51,733
Finance Ops/Admin Assistant				1.0	$43,499	$43,499				1.0	$43,499
Receptionist/General				2.8	$31,104	$87,092				2.8	$87,092
Account Payable				1.0	$51,733	$51,733				1.0	$51,733
Account Receivable				1.0	$51,733	$51,733				1.0	$51,733
Admissions Coordinator				2.0	$57,205	$114,410				2.0	$114,410
Maintenance Manager				1.0	$51,733	$51,733				1.0	$51,733
Maintenance Technician				2.0	$37,308	$74,615				2.0	$74,615
Housekeeping Technician				2.0	$33,162	$66,325				2.0	$66,325
Security Staff				1.5	$31,104	$46,656				1.5	$46,656
Teacher - Spl Ed Day School 1:6				2.0	$72,641	$145,282				2.0	$145,282
Total Support				***44.5***		***$2,290,381***				***44.5***	***$2,290,381***

REGULAR EMPLOYEES TOTAL				***134.3***		***$7,495,735***				***134.3***	***$7,495,735***
2. Contractual Employees											
Administration (List general categories, add rows if needed)											
						$0				*0.0*	*$0*
Total Administration						*$0*				*0.0*	*$0*
Direct Care Staff (List general categories, add rows if needed)											
Licensed Psychologist				0.1	$97,387	$9,739				0.1	$9,739
Speech Pathologist/Audiologist				0.1	$78,835	$7,884				0.1	$7,884
Movement Therapist				0.1	$53,252	$5,325				0.1	$5,325
Occupational Therapist				0.1	$85,176	$8,518				0.1	$8,518
Psychiatrist				3.0	$118,723	$356,170				3.0	$356,170
Internist				0.2	$98,313	$19,663				0.2	$19,663
Pediatrician				1.1	$125,575	$138,133				1.1	$138,133
Total Direct Care Staff				***4.7***		***545,430***				***4.7***	***545,430***
Support Staff (List general categories, add rows if needed)											
						$0				*0.0*	*$0*
Total Support Staff						*$0*				*0.0*	*$0*
CONTRACTUAL EMPLOYEES TOTAL				***4.3***		***$746,610***				***4.3***	***$746,610***
Benefits *(State method of calculating benefits below):*											
TOTAL COST				***139.0***		***$8,041,165***				***139.0***	***$8,041,165***

With the expense of an additional 0.4 FTEs added to the RTC, the following revised Table 4. Revenues & Expenses – Proposed Project illustrates the financial change with the additional staff.

TABLE 4. REVISED REVENUES & EXPENSES - PROPOSED PROJECT			
	Projected Years (ending with first full year at full utilization)		
Indicate CY or FY	**CY2020**	**CY2021**	**CY2022**
1. REVENUE			
a. Inpatient Services	$12,397,000	$25,684,500	$27,412,000
b. Outpatient Services			
c. Gross Patient Service Revenues	***$12,397,000***	***$25,684,500***	***$27,412,000***
d. Allowance For Bad Debt	$123,970	$256,845	$274,120
e. Contractual Allowance	$7,769,031	$15,824,685	$16,761,558
f. Charity Care	$176,820	$362,413	$380,564
g. Net Patient Services Revenue	***$4,327,179***	***$9,240,557***	***$9,995,758***
Other Operating Revenues (Education/Day School)	$1,727,009	$3,058,792	$3,204,362
h. NET OPERATING REVENUE	***$6,054,188***	***$12,299,349***	***$13,200,120***
2. EXPENSES			
a. Salaries, Wages, & Professional Fees (including benefits)	$5,293,873	$8,649,492	$9,219,754
b. Contractual Services	$264,040	$517,215	$545,430
c. Interest on Current Debt			
d. Interest on Project Debt	$351,671	$334,788	$317,041
e. Current Depreciation			
f. Project Depreciation	$787,199	$787,199	$787,199
g. Current Amortization			
h. Project Amortization	$112,800	$112,800	$112,800
i. Supplies	$108,394	$230,847	$249,012
j. Other Expenses (Specify)	$551,956	$720,257	$741,053
k. TOTAL OPERATING EXPENSES	**$7,469,932**	**$11,352,598**	**$11,972,289**
3. INCOME			
a. Income From Operation	**$(1,415,744)**	**$946,751**	**$1,227,831**
b. Non-Operating Income			
c. SUBTOTAL	***$(1,415,744)***	***$946,751***	***$1,227,831***
d. Income Taxes		$86,572	$111,448
e. NET INCOME (LOSS)	***$(1,415,744)***	***$860,179***	***$1,116,383***

Seasons did not provide a response to Question #22, which address COMAR standards related to Certificate of Need Preference Rules related to a comparative review. Therefore, the applicant's numeration for Questions #23 through #30 of the January 23, 2018 completeness questions are off by one.

Staff will reference the following questions in reference to the January 23rd request for additional information.

7. Regarding your response to Question #26, please respond to the following:

a. Provide the link to the 2015 Median Property value per county located on the Data USA website.

The website link is www.usadata.io and the county's name can be typed into the search window. The following table provides the link for each county's 2015 Median Property value; however, the website has been updated for 2016 values and the reviewer must scroll to the bottom of the page to see the 2015 Median Property value.

Figure 79: County 2015 Median Property Value Website Link

County	Data USA Website Link
Allegany	datausa.io/profile/geo/allegany-county-md/
Anne Arundel	datausa.io/profile/geo/anne-arundel-county-md/
Baltimore	datausa.io/profile/geo/baltimore-county-md/
Baltimore City	datausa.io/profile/geo/baltimore-city-md/
Calvert	datausa.io/profile/geo/calvert-county-md/
Caroline	datausa.io/profile/geo/caroline-county-md/
Carroll	datausa.io/profile/geo/carroll-county-md/
Cecil	datausa.io/profile/geo/cecil-county-md/
Charles	datausa.io/profile/geo/charles-county-md/
Dorchester	datausa.io/profile/geo/dorchester-county-md/
Frederick	datausa.io/profile/geo/frederick-county-md/
Garrett	datausa.io/profile/geo/garrett-county-md/
Harford	datausa.io/profile/geo/harford-county-md/
Howard	datausa.io/profile/geo/howard-county-md/
Kent	datausa.io/profile/geo/kent-county-md/
Montgomery	datausa.io/profile/geo/montgomery-county-md/
Prince George's	datausa.io/profile/geo/prince-george's-county-md/
Queen Anne's	datausa.io/profile/geo/queen-anne's-county-md/
Somerset	datausa.io/profile/geo/somerset-county-md/

County	Data USA Website Link
St. Mary's	datausa.io/profile/geo/st.-mary's-county-md/
Talbot	datausa.io/profile/geo/talbot-county-md/
Washington	datausa.io/profile/geo/washington-county-md/
Wicomico	datausa.io/profile/geo/wicomico-county-md/
Worcester	datausa.io/profile/geo/worcester-county-md/

b. Regarding the response to (d), provide the breakdown on the types of expenses included in the table, and the time period this comparison represents for the proposed RTC.

Please refer to the response to Question 8.

8. Regarding your response to Question #27d, the applicant does not provide the information requested. As previously requested, please provide a breakdown on the types of expenses included in the table, time period this comparison represents for the proposed RTC, and the assumptions used to calculate each of these identified costs.

The table is based on the construction, development, and initial operating period of Seasons. All expenses are based on the capital costs illustrated in Table E. Project Budget. The following table highlights those expenses for the 72-bed and 45-bed facility comparison.

Figure 80: 72-Bed and 45-Bed Facility Cost Comparison Breakdown

	72-Bed	45-Bed
Building - Administrative/Support Construction	***$4,376,000***	***$4,376,000***
Building - Resident Construction ($90,000 per bed)	***$6,624,000***	***$4,140,000***
Site and Infrastructure	$2,321,000	$1,624,700
Architect ($199,400) Civil Engineer ($51,469) Mech., Elec., Plumb ($132,600) Structural engineer ($20,000) Landscape Design ($5,000)	$408,469	$408,469
Permits (Building, Utilities, Etc.)	$125,000	$125,000
Kitchen ($105,000) Security/CCTV ($330,000)	$435,000	$435,000
Contingency Allowance	$717,623	$558,608
Furniture (72-bed: $300,000) (45-bed: $273,000) Computers ($80,000)	$380,000	$353,000
Land Purchase	$498,000	$498,000
CON Legal Fees	$15,000	$15,000
CON Consultant	$11,000	$11,000
Non-CON Legal Fees	$50,000	$50,000
Non-CON Printing	$3,000	$3,000
Interest During Construction	$250,000	$250,000
Land Due Diligence W&S Approvals Subdivision Appraisals	$50,000	$50,000
Working Capital Start Up Costs	$1,693,908	$1,005,223
Miscellaneous	***$6,958,000***	***$5,387,000***
Project Costs	**$17,958,000**	**$13,903,000**
# of Facility Beds	72	45
Cost per Bed	**$249,417**	**$308,956**

9. **Regarding your response to Question #27f, the response lists all of the programs offered by four of SBH's existing facilities, which includes programs for adolescents and adults. Please identify which specific aftercare programs Seasons will provide at the adolescent RTC program in Prince George's County.**

As part of the commitment to aftercare planning and successful community and family reintegration for adolescents in our RTC program, Seasons Residential Treatment Program will seek to partner with all Community-Based Service Providers listed in Exhibit 37 of the 1st Completeness Letter of the CON application. The type of partnership will depend on the type of services offered by the provider, the needs of the resident and the proximity of the resources to the patient.

The list of providers included in Exhibit 37 represents the providers we have reached out to date and is not an exhaustive list of resources we plan to make available to our residents and families.

10. Regarding your response to Question #30, please respond to the following:

a. Under Exhibit 48, please provide some background about Jasper Mountain and David Ziegler, Ph.D. Provide the name of the journal or publication and the date of publication for this article.

The article, *Appropriate and Effective Use of Psychiatric Residential Treatment Services*, by Dave Ziegler, Ph.D. was published on the Jasper Mountain Center website at www.jaspermountain.org/articles.html.

Dave Ziegler, Ph.D., L.M.F.T., L.P.C.
Licensed Psychologist, Executive Director, and Organization Founder of Jasper Mountain Center. Began career as a therapist, clinical supervisor, foster parent and program manager in 1972. Author of multiple books and publications. International authority and presenter on issues related to trauma and psychological treatment.

b. Please identify the organization Jasper Mountain and provide background information on this organization.

Jasper Mountain Center began in 1982 with the purchase of a large historic ranch with roots going back to the pioneering days of the Oregon Trail and Native American Indians before that. It was on this property, rich in history, that a new home for very special children was founded. The lush forest, complete with streams, two rivers and a thousand foot mountain are an encapsulation of the beauty of Oregon. The program was designed to give abused children a beautiful setting in which to heal and grow.

Jasper Mountain Center accepted its first child in 1982. From the beginning, the children who came to live at Jasper Mountain talked of physical and sexual abuse. The common denominator and the focus of the program has remained treating the young, abused child in a family setting, not an institution. The program has combined traditional psychological and psychiatric interventions with innovations in treating abused and emotionally disturbed children.

As patterns of behavior became better understood, the residential treatment program developed areas of clinical specialization. Nearly three decades of experience have produced effective treatment for the most challenging childhood disorders such as: traumatic stress, violence, sexual misbehavior, and attachment issues. The program has been nationally recognized for innovative treatment in each of these areas.

Treating seriously abused children is essential, but more had to be done in the community to prevent this terrible problem. In 1983, a task force of community leaders considered the statistics, the complexity, and the magnitude of the child abuse problem in Lane County. The seventeen-member task force saw only one viable solution: the creation of a new social service agency with a mission to eliminate child

abuse. Springfield Child Abuse Resources (SCAR) opened an office in December of 1983.

SCAR and Jasper Mountain remained separate agencies, working together, until their directors met in 1987 and developed a plan to merge into a single, comprehensive, child abuse agency, with treatment, prevention, education and residential programs. Jasper Mountain is the result of the merged agencies with new programs being developed over time. A full educational program began in 1989 (Jasper Mountain School); and a short-term evaluation center (SAFE Center) and a Therapeutic Foster Care Program started in 1995. A Day Treatment Program was developed in 1997. Community-based wraparound services, called the Village Program began in 2004. The newest program is the Crisis Response Program that began in 2005. Jasper Mountain has grown to become one of Oregon's most significant efforts to treat child abuse and has grown to become a national and international resource for children.

Licensing of Organization Services:

- Child Care Facility, State of Oregon Department of Human Services

Certifications:

- Oregon Department of Human Services Addictions and Mental Health Division:
  - Residential Psychiatric Treatment Programs Services
  - Residential Psychiatric Assessment and Evaluation Services
  - Intensive Mental Health Services
  - Community Treatment Services for Children
- Oregon Department of Education:
  - Private Alternative Education Program
  - Private Special Education Provider
- Certified Out-of-State Group Home for the State of California
- Certified Non-Public School for the State of California
- Certified Residential Treatment Care Center for the State of Alaska

National Accreditation:

- Council on Accreditation For Children and Family Services

Affiliations:

- Child Welfare League of America
- American Association of Children's Residential Centers
- Oregon Alliance of Children's Programs

Federal Classification:

- Internal Revenue Service 501(c)(3) Public Charity
- Department of Health and Human Services approved Medicaid provider

c. Regarding Exhibit 33, please provide a key which identifies each of the headings reported on pp. 612 through 615.

The Annual Program Cost Sheet attached in Exhibit 33 is created by the Maryland State Department of Education and is published on the agency website. As noted in the heading, the issued program cost sheet template is the official tool that documents the issued rates as reported by the school (listed in far left column). This program rate spreadsheet is a tool of convenience, intended for use by placing agencies.

As designated by the MSDE, the headings not clearly defined are as follows:

School ID	Program #	School Name	Ed Days	Res Days	ESY Days	MA	Ed Per Diem	Res Per Diem
As assigned by MSDE	As Assigned by MSDE	Non Piub School Name	Educational Days – total number of days school provides education	Residential Days – total days students could be In class (RTC)	Schools Provide Extended School Year	Medical Assistance as a Related Services	Daily reimbursement rate for educational services	Residential Reimbursement paid by MSDEI

Please note, we did not define headings with program codes, as those definitions are listed in the column above the code

d. Regarding Exhibit 33, please show how Seasons obtained the financial data reported in Figure 62 (p. 190) for (a) Adventist Behavioral Health Eastern Shore and (b) Chesapeake Treatment Center.

The rates reported in Figure 62 (p 190) for (a) Adventist Behavioral Health Eastern Shore and (b) Chesapeake Treatment Center, please refer to Exhibit 33 for a copy of the MSDE FY2016 Nonpublic Special Education Rates.

LIST OF EXHIBITS

Exhibit #	Exhibit Description	2nd Completeness Letter Response Page
50	Parsons Connections Academy Research Report	1287