STATE OF MARYLAND

MARYLAND HEALTH CARE COMMISSION

_____
MATTER/DOCKET NO.

_____
DATE DOCKETED

INSTRUCTIONS FOR APPLICATION FOR CERTIFICATE OF NEED: ALCOHOLISM AND DRUG ABUSE INTERMEDIATE CARE FACILITY TREATMENT SERVICES

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 10.24.14.05(A) through 10.24.14.05(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.

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

Table of Contents

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: **Addiction Recovery Inc. dba Hope House Treatment Centers**

Address:

26 Marbury Dr	**Crownsville**	**21032**	**Anne Arundel**
Street	City	Zip	County

2. Name of Owner Addiction Recovery Inc. Private Non- Profit

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.

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

Legal Name of Project Applicant (Licensee or Proposed

Addiction Recovery Inc

Address:

26 Marbury Dr	**Crownsville**	**21032**	**MD**	**Anne Arundel**
Street	City	Zip	State	County
Telephone:	**410-923-6700**			

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

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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

Peter D'Souza

A. Lead or primary contact:

Name and Title: **Peter D'Souza CEO**

Company **Hope House Treatment Centers**

Name _____

Mailing Address:

26 Marbury Drive	**Crownsville**	**2103 2**	**MD**
Street	City	Zip	State

Telephone: 410-923-6700

E-mail Address (required): pdsouza@hopehousemd.org

Fax: 410-923-6213

If company name is different than applicant briefly describe the relationship

B. Additional or alternate contact:

Name and Title: _____

Company Name _____
Mailing Address:

Street	City	Zip	State

Telephone: _____
E-mail Address (required): _____

Fax:

If company name is different than applicant briefly describe the relationship
CEO _____

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	X ☐
(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

Hope House Treatment Centers operate Inpatient Programs for Addiction & Mental Illness at 2 locations. At Crownsville, we operate a Detox Program and Inpatient Rehab with 49 beds. At 419 Main Street we operate a Detox Program and Inpatient Rehab with 18 beds. Our Proposal for a Certificate of Need is for 429 Main Street, Laurel (which is adjacent to 419 Main Street), is to operate a Detox Program for 22 beds. We have always been an Inpatient Facility providing Addiction & Mental Health services to the Maryland Community. We have grown from a 20 bed facility to an 89 bed facility to become the largest community-based Inpatient Program in Maryland. We already operate 2 Detox facilities, one in Crownsville and one in Laurel at 419 Main Street. Most of the patients we serve are indigent and on Medicaid.

All these beds, presently, are Medicaid funded beds. The Rational for this project is that this helps us with the economies of scale by sharing the resources (Detox) that we already have at 419 Main Street. We have a waiting list for the beds at Laurel and a patient on our waiting list overdosed and died. There is a bottleneck for the Detox Beds at 419 Main Street and expanding the Detox Beds at 429 Main Street will facilitate more Detox Beds to take care of more patients. We are going to use a room at the ground floor level as a Doctors/Nurses station. There is no Predevelopment Costs or Capital Expenditures involved in implementing the Detox beds. All the work and material needed for furnishing the room as a Doctors/Nurses station will be completed by our full-time maintenance staff. There is minimal cost involved in furnishing the room. We are not bound by any jurisdiction to service patients. We will service patients primarily from Maryland but not exclusively. We already have an MOU from Behavioral Health of Prince George's County. We are the ONLY INPATIENT DETOXIFICATION FACILITY IN PRINCE GEORGE'S COUNTY.

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.

We are planning to convert our existing 3.3 level of care beds at 429 Main Street into 3.7D and 3.7Residential beds. We do not need a construction, renovation and demolition plan, no changes in square footage, physical plant or location changes. The changes to affected services following completion of the project would be the conversion of our existing 3.3 level of care beds to 3.7D and 3.7Residential beds.

9. CURRENT CAPACITY AND PROPOSED CHANGES: Complete Table A (Physical Bed Capacity Before and After Project) from the CON Application Table package

10. REQUIRED APPROVALS AND SITE CONTROL

Not Applicable

A. Site size: _____ 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 _____ (If NO, describe below the current status and timetable for receiving each of the necessary approvals.)

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

(1) Owned by: _____

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

(3) Land Lease held by: _____
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.

11. PROJECT SCHEDULE

Not Applicable

(Instructions: In completing this section, please note applicable performance requirement time frames 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 _____ months from approval date.
B. Beginning Construction _____ months from capital obligation.
C. Pre-Licensure/First Use _____ months from capital obligation.
D. Full Utilization _____ months from first use.

For projects not 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 not 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.

12. PROJECT DRAWINGS

Not Applicable

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.

13. **AVAILABILITY AND ADEQUACY OF UTILITIES**

Not Applicable

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.

PART II - PROJECT BUDGET

Complete Table B (Project Budget) of the CON Application Table 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.).

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.

President
Tammy Kennedy Wolfe
2636 Compass Drive
Annapolis, MD 21401
443-8717813
Tkw0812@aol.com

Vice President
Jerome Stanbury
1302 Beckenridge Circle
Riva, MD 21140
410-956-0554 Home
410-991-1415 Cell
301-459-1414 Other
sailjerry@aol.com

Shashi Patel
1000 Lake Claire Drive
Annapolis, MD 21409
443-629-3498 Cell
shodh@aol.com

William G. Simmons
227 Springloch Road
Silver Spring, MD 20904
240-620-3366

Peter D'Souza
Executive Director, Hope House
26 Marbury Drive
Crownsville, MD 21032

410-923-6700 x 103
pdsouza@hopehousemd.org

Joseph Berry
320 Cadle Avenue
Edgewater, MD 21037
410-798-6891 Home
410-533-8861
joefranberry@aol.com

Christine Hines
4950 Mercedes Blvd.
Camp Springs, MD 20746
410-963-8848 Cell
Ksyb01@aol.com

Pastor Terry Allen
7409-A Baltimore Annapolis Blvd.
Glen Burnie, MD 21061
410-869-7823
godsperfectwill@hotmail.com

Michael Hollins
931 King James Landing
Annapolis MD 21403
410-295-0615
mhollins@hollinspartners.com
Shelly Brouse
126 Crossfox Circle
Catonsville, MD 21228
410-504-2020
Shelly Brouse sbrouse@medchiagency.com

Brian McCarthy
276 GREENLEAF CIRCLE
ARNOLD MD. 21012
Brianmccarthy714@comcast.net
202-400-0759

Board Members Emeritus
Kimberly Shults
1621 Wyatts Ridge
Crownsville, MD 21032
410-849-3430

Patricia Weathersbee
834 Valentine View
Crownsville, MD 21032
410-923-0853
Pweath1@hotmail.com

Tom Casey
1615 L Street NW, Suite 600
Washington, DC 20036
410-533-7357 Cell
Tomc816@verizon.net

Gerard Evans
3506 Victoria Lane
Davidsonville, MD 21035
410-703-6262 Home
gevans@lobbymd.com

2. Is any applicant, owner, or responsible person listed above now involved, or has any such person ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each such facility, including facility name, address, the relationship(s), and dates of involvement.

No

3. In the last 5 years, has the Maryland license or certification of the applicant facility, or the license or certification from any state or the District of Columbia of any of the facilities listed in response to Question 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) ? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant(s), 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) ever received inquiries from a federal or any state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with Maryland, another 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. Has any applicant, owner, or responsible individual listed in response to Question 1, above, ever pled guilty to, received any type of diversionary disposition, 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 applicant regarding the project proposed in the application.

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.

2/28/18

Date

Signature of Owner or Board-designated Official

CEO

Position/Title

Peter D'Souza

Printed Name

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

INSTRUCTION: Each applicant must respond to all applicable criteria included in COMAR 10.24.01.08G. These criteria follow, 10.24.01.08G(3)(a) through 10.24.01.08G(3)(f).

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.

<u>10.24.14.05 Certificate of Need Approval Rules and Review Standards for New Substance Abuse Treatment Facilities and for Expansions of Existing Facilities.</u>

.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

[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

adolescent or 50 adult intermediate care facility beds, or a total of 90 beds, if the applicant is applying to serve both age groups.

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

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

We are a (1) (b)(i) (ii) type of facility. To establish the needs of the population in the health planning region, we already have a big waiting list of patients who require Detoxification, Stabilization and Treatment. Maryland is already experiencing a Heroin Epidemic and the Governor has declared a State of Emergency.

(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.

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

Currently Medicaid pays for Inpatient Residential Care. The vast majority of the patients we treat are on Medicaid. Any Uninsured patient services are paid by Beacon Health. We are required to get them quickly to apply for Medicaid eligibility. Since there are no grey area patients a sliding fee scale is redundant.

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

Explanation above covers provision of service to indigent and grey area patients.

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

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

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

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

(2) 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.

.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.

Not Applicable

.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.

The 429 Main Street location is 15 minutes away from the Howard Hospital and the Laurel Regional Hospital.

.05G. Age Groups.

Not Applicable

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

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

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

.05H. Quality Assurance.

Addiction Recovery inc dba (doing business as)Hope House Treatment Centers is Accredited by CARF up to September 30, 2019. (Exhibit 1).

(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.

.05I. Utilization Review and Control Programs.

Utilization Management Plan included (Exhibit 2)

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

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

.05J. Transfer and Referral Agreements.

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

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

(a) Acute care hospitals;
(b) Halfway houses, therapeutic communities, long-term care facilities, and local alcohol and drug abuse intensive and other outpatient programs;
(c) Local community mental health center or center(s);
(d) The jurisdiction's mental health and alcohol and drug abuse authorities;
(e) The Alcohol and Drug Abuse Administration and the Mental Hygiene Administration;
(f) The jurisdiction's agencies that provide prevention, education, driving-while-intoxicated programs, family counseling, and other services; and,
(g) The Department of Juvenile Justice and local juvenile justice authorities, if applying for beds to serve adolescents.

.05K. Sources of Referral.

More than 80% of the patients that we serve are on Medicaid and are considered indigent or gray area population.

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

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

.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.

We maintain a standardized in-service orientation and continuing education program for all categories of direct service personnel with the help of a Program named Accreditation Now. We also conduct hands-on in-service programs and education like 'Techniques for De-Escalation, Managing a Troubled Patient, Medication Management, Cultural Competency, Safety Awareness / Drills including fire, natural disaster, active shooter. Clinical Topics Include.
1. American Society of Addiction Medicine: ASAM National Practice Guideline for use of Medication Assisted Treatment involving Opiod abuse.
2. Treatment Planning- Creating a Living Document. Principles of effective Treatment through Quality Record Reviews.
3. Assessing the Severity of Substance Use Disorders.
4. Assessing the Severity of Co-Occurring disorders.
5. Motivational Interviewing and readiness for Change.
6. Implementing an Effective Treatment Planning Process.

.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.

We are already managing two Detoxification Units, one at Crownsville and the other at 419 Main Street, Laurel. The Policies and Procedures for Detoxification is included as (Exhibit 3).

.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.

.05O. Outpatient Alcohol & Drug Abuse Programs.

Besides referrals to other Outpatient Programs, Halfway Houses, Hope House Treatment Center also provides an Intensive Outpatient Program, MAT (Medication Assisted Program) Outpatient Program and a generic Outpatient Program. We provide individual, group and family counseling and aftercare. The Outpatient Programs that we have an MOU (Memorandum of Understanding) meet all the requirements listed below. MOU's with other service providers Exhibit 4).

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

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

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

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

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

.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.

In lieu of the SAMIS program being discontinued, we are providing Data and other required information to Beacon Health who, I presume, manages the information for the Department of Health, Maryland.

.06 Preferences for Certificate of Need approval.

A. In a comparative review of applicants for private bed capacity in Track One, the Commission will give preference expand an intermediate care facility if the project's sponsor will commit to:

(1) Increase access to care for indigent and gray area patients by reserving more bed capacity than required in Regulation .08 of this Chapter;

We already treat more than 80% indigent and gray area patients.

(3) Treat special populations as defined in Regulation .08 of this Chapter or, if an existing alcohol or drug abuse treatment facility, treat special populations it has historically not treated;

Besides Detoxification, we provide Residential Services for Stabilization and Treatment. We also provide MAT (Medication Assisted Treatment) in an Outpatient Program

(4) Include in its range of services alternative treatment settings such as intensive outpatient programs, halfway houses, therapeutic foster care, and long-term residential or shelter care;

We provide Intensive Outpatient Program as well as a Medication Assisted Treatment in an Outpatient setting. We consider these as long term Outpatient Programs.

(5) Provide specialized programs to treat an addicted person with co-existing mental illness, including appropriate consultation with a psychiatrist; or,

CARF Accreditation already acknowledges Hope House as a Co-Occurring Enhanced Facility. We have a Psychiatric Nurse Practitioner

who provides Psychotropic Medications and we have Mental Health Counselors to provide Mental Health Services.

(6) In a proposed intermediate care facility that will provide a treatment program for women, offer child care and other related services for the dependent children of these patients.

B. If a proposed project has received a preference in a Certificate of Need review pursuant to this regulation, but the project sponsor subsequently determines that providing the identified type or scope of service is beyond the facility's clinical or financial resources:

(1) The project sponsor must notify the Commission in writing before beginning to operate the facility, and seek Commission approval for any change in its array of services pursuant to COMAR 10.24.01.17.

(2) The project sponsor must show good cause why it will not provide the identified service, and why the effectiveness of its treatment program will not be compromised in the absence of the service for which a preference was awarded; and

(3) The Commission, in its sole discretion, may determine that the change constitutes an impermissible modification, pursuant to COMAR 10.24.01.17C(1).

B. NEED

Maryland is already experiencing a Heroin Epidemic and the Governor has declared a State of Emergency. The implementation of this service will directly provide life-saving Detoxification, Stabilization and Effective Treatment to patients in Prince George's County (where we are the only Inpatient Addiction Service Provider) and the surrounding Counties. Besides we have an active Waiting List of Patients who want to come to our program. Our Waiting List presently has 40 patients wanting services of Hope House Treatment Center.

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

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.

Complete Table C (Statistical Projections – Entire Facility) from the CON Application Table Package.

C. AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

Hope House Treatment Center in Laurel is the only Inpatient Addiction Program in Prince George's County with the ability to provide 3.7D and 3.7 Residential Services. As part of the planning process, we experienced a growing number of patients wanting these dire services to the point that we had to have a Waiting List.

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

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.

D. VIABILITY OF THE PROPOSAL

We do not need a funding plan for the project. As explained in the Summary, we are going to make use of our existing facility at 429 Main Street without any major renovations to implement the project.

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

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 D (Revenues & Expenses, Uninflated – Entire Facility) and F (Revenues & Expenses, Uninflated – New Facility or Service) from the CON Application Table Package.

- Complete Table G (Work Force Information) from the 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).

E. COMPLIANCE WITH CONDITIONS OF PREVIOUS CERTIFICATES OF NEED

We have been in full compliance with the previous Certificate of Need. We have executed the conditions with ongoing approvals for Licensing from the State of Maryland and the stringent requirements from CARF International. The Certificate of Need for Crownsville had been granted prior to 15 years.

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

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.

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

We are the only Inpatient Addiction Service Provider in Prince George's County. The Governor of Maryland has decreed that we have an Opioid Crisis in Maryland. We have a Waiting List for patients who want the services. It will help the Healthcare Delivery System to get rid of the Gridlock for Detoxification, Stabilization and Treatment for those affected by Addiction and Mental Illness.

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

services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

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.

REMEMBER TO SUBMIT THE COMPANION TABLE SET FEATURING PROJECT BUDGET, STATISTICAL PROJECTIONS, REVENUE AND EXPENSE PROJECTIONS, AND WORKFORCE INFORMATION

Created March 24, 2017

EXHIBIT 1 .05H (1) Accreditation by CARF

carf INTERNATIONAL

A Three-Year Accreditation is awarded to

Addiction Recovery, Incorporated dba Hope House

for the following program(s):

Detoxification/Withdrawal Support: Alcohol and Other Drugs/Addictions (Adults)
Inpatient Treatment: Integrated: AOD/MH (Adults)
Intensive Outpatient Treatment: Integrated: AOD/MH (Adults)
Outpatient Treatment: Integrated: AOD/MH (Adults)
Partial Hospitalization: Integrated: AOD/MH (Adults)
Residential Treatment: Integrated: AOD/MH (Adults)

This accreditation is valid through
September 30, 2019

The accreditation seals in place below signify that the organization has met annual conformance requirements for quality standards that enhance the lives of persons served.

This accreditation certificate is granted by authority of:

Herb Zaretsky, Ph.D.
Chair
CARF International Board of Directors

Brian J. Boon, Ph.D.
President/CEO
CARF International

EXHIBIT 2 .05I Utilization Review and Control Programs. Utilization Management Plan.

ADDICTION RECOVERY INC.
UTILIZATION MANAGEMENT PLAN FOR CLIENT'S WITH PRIVATE INSURANCE OR MEDICAL ASSISTANCE

OBJECTIVE: The objective of Addiction Recovery Inc. Utilization Management/Review activities is to increase the effective utilization of the facility's resources of staff, space and money to maintain high quality patient care and achieve cost-efficiency. This is accomplished through concurrent, retrospective, and occasional focused studies of patterns of care. The purpose is to identify under or over utilization of resources and services in order to fulfill the overall Mission of Addiction Recovery Inc. Treatment Center.

Utilization Management functions are linked to Addiction Recovery Inc. Treatment Center's Continuous Quality Improvement and Clinical Risk Management functions and activities.

SCOPE: The Utilization Management process will address under-utilization/over-utilization and the efficient scheduling and delivery of facility resources.

Utilization Management will primarily focus on two major areas related to Patient Management.

1. The appropriateness and clinical necessity of admitting a patient to one of the levels of care reflected in the American Society of Addiction Medicine Patient Placement Criteria 2-R.

2. The appropriateness of a patient's continuation in treatment.

RESPONSIBILITY: The Treatment Team serves as the Committee for Utilization Management issues. The Front Office Staff is responsible for validating benefits of insured clients, making referrals if Addiction Recovery Inc. is not in the network to provide services. The Utilization Review team is responsible for opening cases with insurance carriers including pre-certification. The Utilization Review team is responsible for concurrent reviews and working closely with clinical staff and counseling regarding discharge planning per managed care organization protocols.

PROACTIVE
PATIENT REVIEW
PROCESS:

A. APPROPRIATENESS OF ADMISSION.

1. Pre-Admission Utilization Review

If, during the admission process, additional questions arise about the appropriateness of admission, the admitting/Utilization nurse, the Director of Treatment, the Director of Nursing and/or the Medical Director will case conference to determine the appropriateness for Addiction Recovery Inc. levels of care. They may also confer with the Executive Director for a final decision.

Insurance Case Management

On the day of admission, the designated Addiction Recovery Inc. utilization nurse will open a case and carry out the pre-certification process with the client's insurance company once the clinical nursing assessment is completed. A level of care, based on the individual insurance company's criteria, is then decided upon by the UM coordinator and the case manager of the insurance company. This outcome is communicated to the client, and any revisions in financial arrangements are relayed to the financial office. If access to benefits is denied, the patient is notified and a referral to another agency is given by the client's insurance company. A client always has the right to a self-pay option, but they will be charged Addiction Recovery Inc. full rate.

The designated Addiction Recovery Inc. insurance reviewer will generate an Insurance Tracking Form noting all contacts with insurance. A copy of the client's insurance card is scanned into the Credible electronic record, and any written communication from the insurance carrier is also kept in this section for billing purposes as well as consent from the client to release information.

The Insurance Tracking form and all authorizations and documentation from the client's insurance company will be obtained by the Utilization Review department. The authorization numbers are entered into the Authorization tab of the Credible electronic record. The claim will be billed electronically by our in-house biller upon discharge.

RETROSPECTIVE
PATIENT
REVIEW PROCESS:

B. RETROSPECTIVE REVIEWS.

1. The Treatment team may randomly review records for documentation which justifies the necessity for admission. The appropriateness for admission is determined by comparing the clinical information documented in a patient's record with the ASAM PPC-2R criteria.

2. Based upon the review of the record, the Treatment team determines whether or not the admission appears appropriate based on criteria.

   a. If the admission is justified and the patient is still in treatment, the case will be reviewed at the appropriate intervals by the treatment team.

   b. If the admission does not appear to be justified based upon documentation in the patient record, the Treatment team will confer with the, U.R., Director of Nursing, and the Medical Director for input. If a consensus cannot be reached, the case may be presented to the Executive Director for final decision. If a patient is deemed inappropriate for the levels of care offered by Addiction Recovery Inc., they will be informed by their Case Manager and an appropriate referral made.

CONCURRENT REVIEWS:

C. APPROPRIATENESS AND CLINICAL NECESSITY OF CONTINUED STAY AT ADDICTION RECOVERY INC.

Once a patient has been admitted to Addiction Recovery Inc. and certified for admission, the case manager and treatment team will monitor the patient's clinical record for documentation of progress or lack of progress and outcomes related to the need for continued stay.

1. The primary emphasis on continued stay review relates to over utilization or under utilization of services. "Over" utilization is defined as excessive need for staff intervention, patient refusal or inability to progress in treatment or disruptive behavior. "Under" utilization is defined as no longer requiring the levels of care offered at Addiction Recovery Inc., or verbalization of readiness for discharge.

2. A concurrent review is conducted at various intervals during a client's stay, depending on what level of care a client is in and what insurance they have. If a client is in Detox, a review is conducted daily, and all other clients have a review done weekly. These reviews identify the ASAM Dimensions where improvement has been made, and those where discharge criteria has not been met. This allows input from all disciplines in

an effort to revise treatment plans already in place or institute new ones. This review may include:

a. Continuing care plans
b. Discharge plans
c. The necessity for community referrals
d. Patient's progress in meeting treatment plan objectives

3. If the necessity for continued treatment appears justified, treatment plans may be revised or maintained until the next review, based upon the patient's progress.

4. If a client no longer meets criteria for continued stay at any level of care at Addiction Recovery Inc., they will be discharged to a lower level of care. The case manager will offer the patient a variety of after-care facilities to make a selection from.

5. If a client disputes whether they meet ASAM criteria for continued stay vs transitioning to another level of care, the same procedures apply to a concurrent review as to a retrospective review. The final decision may require the Executive Director's input.

D. EXHAUSTION OF INSURANCE BENEFITS WHILE IN TREATMENT

If a client utilizes all insurance benefits for all levels of care (In-patient, Partial, IOP) while in treatment but still meets criteria for continued stay, he/she may opt to stay on a self pay level of care. This must be approved by the Director of Treatment, and the client must have an additional intake by the financial office to complete the necessary paperwork

E. REVIEW OF THE UTILIZATION MANAGEMENT PLAN

1. The Utilization Plan will be revised as appropriate to reflect any changes in protocols. The Executive Committee will have full input in this process, based upon changing Managed Care processes.

UTILIZATION MANAGEMENT FOR PATIENTS WITH PRIVATE INSURANCE

PURPOSE:

(1) To identify a specific process for accessing benefits for patients who have private or public assistance insurance and are seeking admission to Addiction Recovery Inc..

(2) To clarify the financial obligations of those patients who have private health insurance or public assistance with Managed Care Organizations.

(3) To maximize revenues for Addiction Recovery Inc. services.

POLICY :

1. Telephone screening forms are completed by the Front Office Staff the first time phone contact is made. All information regarding insurance coverage including policy number and telephone number to verify benefits must be given or else the screening process is stopped, and the client told to call back when he/she can provide this information.

2. The Office Manager verifies that Addiction Recovery Inc. is In-Network to provide treatment services, or that the client has Out-Of -Network benefits. If a client's private insurance cannot be accessed, they will be referred back to their member services department so they may be given the name of a provider who is in their network. If a client insists on being considered for admission to Addiction Recovery Inc. against the directives of their insurance, they will be charged Addiction Recovery Inc. full daily rate. Patients are, however, always encouraged to access treatment through their own network of providers.

3. If the client has **no** substance abuse benefits connected with their insurance coverage, the patient will be processed by the Financial Office as having no insurance, and will apply for Uninsured Reimbursement concomitantly applying for Medicaid. If the patient is ineligible for Medicaid then he/she can opt for self-pay. The client will be informed of this on the day of admission.

4. If private insurance provides benefits but requires specific assessments and/or contacts to access benefits, the client is expected to comply with this direction. If the client does not do so and benefits are unavailable or denied because of failure to comply, the client will be assessed for the full cost of services.

5. On the day of admission, a client's insurance company will be contacted by a designated Addiction Recovery Inc. Insurance Utilization reviewer for pre-certification of benefits. Once the client has had his nursing assessment and been accepted for admission by the Medical Director, a consent to release information is obtained from the client prior to contacting the insurance company. At Addiction Recovery Inc., designated insurance reviewers are the Utilization Review Department.

    a. Every effort will be made to access in-patient benefits based on ASAM PPC 2-R criteria. If the client does not meet criteria for in-patient treatment, Partial Hospitalization or IOP benefits will be sought.
    b. It should be noted that "court mandated" treatment is usually not considered as satisfying the criteria for "medical necessity" regarding in-patient benefits, and, in some cases, is a key exclusion from any benefits.

    c. An Insurance tracking form will be completed and kept in a

separate section of the client's active record. It will contain patient demographic information, insurance information regarding a client's policy, date and time of the pre-certification, name of the case reviewer, Level of Care accessed, number of days obtained, and any authorization codes received. It will also specify the date of the next review. The case manager/nurse will provide the information available when formulating the individual's treatment plans.

6. The designated insurance reviewer will carry out vigorous efforts to continue to access a client's benefits in the form of ongoing concurrent reviews

    a. On the date of the concurrent review, the designated insurance reviewer will review the patient's chart regarding clinical progress and justification for continued stay. Information may be obtained from but is not limited to :

        1. The case manager
        2. The Nursing Department
        3. Any independent consultants such as the Medical Director, Nurse Practitioner, or Physician Assistant.

7. The above information is reported to the clients insurance case manager in order to justify additional treatment days at the current level of care. Once the review has taken place, the outcome will be documented on the Insurance Tracking form.

    a. If additional days are approved at the previous level of care, the number of additional days received, authorization number, and date of next review is recorded as well as the date, time, and name of case reviewer.

8. If client is transitioned to a lower level of care, the number of days at the next level of care and authorization number is recorded. The date and time of the review as well as the name of the case reviewer is also documented.

9. If the case reviewer does not feel additional time at any level of care offered at Addiction Recovery Inc. is warranted and the Addiction Recovery Inc. designated insurance reviewer feels that client does meet at least IOP criteria, a physician to Utilization Review manager will be requested.

10. The Medical Director/or designee will then be contacted directly and informed of the need to conduct a physician to physician review. All clinical information will be relayed to the Medical Director supporting the need for additional time at the IOP level of care. In addition, the Medical Director may obtain clinical updates from the following Addiction Recovery Inc. staff members:

    a. The Case Manager
    b. The Nursing Department
    c. Any independent clinician rendering services to the client (ie: dietician, PA, outside medical agencies)

11. The designated insurance reviewer will act as facilitator and liaison between the insurance case worker and the Medical Director.

12. Following the review, all approved days and authorization numbers will be recorded on the Insurance Tracking form and the case manager and client informed regarding the outcome and any assessments based on new level of care explained.

13. If the client is not approved for any additional days, a meeting will be held between the client, the case manager and the Director of Treatment. The need to follow the insurance company recommendation will be explained, and a referral to an outpatient provider in the clients insurance company network will be made. The client will always have the choice of selecting a self-pay option and remain at Addiction Recovery Inc. for additional treatment, but will be subject to full cost of services.

14. If a client exhausts his substance abuse benefits through his insurance company while in treatment and he/she meets criteria for continued stay, they will be given the option of completing treatment as self-pay.

15. Some insurances require submission of written, concurrent treatment plans for review. These plans will be completed and submitted as required by the designated insurance reviewer. Some insurance companies require reviews to be done electrically through the insurance company web portal.

16. Billing is a joint activity involving the billing department and accounting department, the billing department will bill each client based on services rendered. The billing team will only batch services that are attached to an authorization, any unbatched services are left for the accounting department to write-off and all write-offs are then reviewed on a monthly basis by the Director of Finance in addition to being summarized in the monthly board report, this helps us to identify any on-going issues or concerns in our UR process.

17. The billing department will work with each claim until all service ledger items have been paid in full. The accounting department runs quarterly outstanding insurance reports that report any unpaid services after 3 months. At this point in time the billing department will record any appeal processes or resubmittals that have been performed for outstanding claims.

18. If payment is denied by the insurance company, depending on the reason for the denial it will either be processed as a patient’s responsibility or be written off if due to internal error.

19. All re-admissions must resolve any outstanding financial obligations prior to readmission to Addiction Recovery Inc., dba/Hope House Treatment Center.

EXHIBIT 3 .05m Sub-Acute Detoxification. Policies & Procedures

Hope House Laurel
Policies and Procedures for Detoxification

PURPOSE: To provide a safe, non-hospital environment to assist patients with physical effects of withdrawal from alcohol, benzodiazepines or opioids and to encourage continuing treatment in an appropriate level of care based upon individualized patient needs.

SCOPE: Hope House Laurel will provide detoxification services (III.7D ASAM) as part of the continuum of care for those clients meeting criteria based on their self-report, use history and drug urine dips.

All patients requiring detoxification must meet criteria for service, as described in the following procedure sections.

PROCEDURES:

I. INITIAL TELEPHONE CONTACT:

The administrative office staff accepts referrals from outside agencies or individuals seeking treatment, Monday through Friday, 8:00 AM – 4:00 PM. The administrative office staff completes these initial phone contact forms for general information. This includes initial information regarding the patient's condition, drugs of choice, living environment, past treatments, current health problems, and insurance information.

1. The administrative office staff screens for age appropriateness (18 or over) and answers initial questions regarding the treatment program. An information guide for phone inquiries is provided for use.
2. If the client’s screening information does not have to undergo a review for admission by the DOT, DON or treatment team, the administrative office staff will have that individual come in that day, if possible, for admission once the client’s insurance has been checked on-line or telephonically. If the client is unable to come in that day for admission, they are scheduled for the next available admission date/time.
3. If the caller does not have insurance they will be

scheduled for admission. At the time of admission, the client will be assisted in applying for medical insurance through Maryland Health Connection. Once the application has been completed, we then apply for an uninsured authorization through the federally funded program to cover costs until the insurance has been activated. If the client is an IV drug abuser every effort is made to provide admission to Hope House Laurel within 14 days. The patient will be placed on a waiting list until a bed becomes available.

4. If the client does not meet the criteria for residential treatment after detox, the client will be offered enrollment in the Hope House Treatment Center IOP program for interim services which will include MAT (Medication Assisted Treatment), counseling and education about HIV and tuberculosis (TB), the risks of needle sharing, the risks of transmission to sexual partners and infants and steps to ensure that HIV and TB transmission does not occur. These interim services will include, if necessary, a referral for HIV and TB treatment services. Finally, the client will receive counseling on the effects of alcohol and other drug use on the fetus for pregnant women and referrals for prenatal care for pregnant women.

II. VERIFICATION AND EXPANSION OF INITIAL INFORMATION:

Categories of applicants who may require a pre-admission review or Treatment team review include:

1. Stabilized Co-occurring Disorder
   Patients who are not severely unstable e.g. Hallucinations (Visual & Command), Extreme High Blood Pressure, Diabetes Heart Problems.
2. Pregnancy (Known or suspected)
   a. Hope House Laurel only accepts clients who are less than 32 weeks pregnant and do not require medication assisted detoxification. Clients who are less than 32 weeks but require medication assisted detoxification are referred to Johns Hopkins Bayview Center for Addiction Pregnancy (CAP) for the medication assisted detoxification portion of treatment. Hope House Laurel will admit

client once the client has completed the detoxification as long there are no on-going acute significant medical issues, and the client has physician's statement she can fully participate in treatment. All pregnant clients must demonstrate they have had care from an obstetrician and or a recent normal sonogram within the last 30 days. If deemed manageable at this level of care by the Medical Director, Hope House Laurel will admit approved pregnant individuals within 48 hours of requesting treatment.

3. Re-admission of previous patients.
4. HIV Positive applicants – recent CD4 counts are usually requested.
5. Clients requiring detox with significant medical problems.

Priority status for admission is given in accordance with directives from the Maryland Alcohol and Drug Abuse Administration to include:

a. Individuals who are pregnant, or have given birth within the past 12 months
b. HIV Positive applicants
c. IV drug abusers

III. CLIENTS INELIGIBLE FOR ADMISSION:

1. Clients who are requesting a different level of treatment not available at Hope House Treatment Center.

2. Clients requiring medical/dental intervention for a problem not manageable within Hope House resources or requiring immediate intervention. Clients are encouraged to re-apply when the problem has been evaluated and/or resolved.

3. Mental health issues requiring immediate intervention such as active SI or hallucinations.

4. Clients who the DON or the Medical Director determine/require a hospital detoxification.

IV. ADMISSION PROCEDURES/PATIENT REGISTRATION

Patients undergo the same procedure for patient registration as outlined in the pre-admission policy.

V. ADMISSION PROCEDURES/INITIAL PATIENT ASSESSMENT

1. The nursing assistant and nurse will carry out the nursing data collection form in Credible process to determine if the patient is able to be detoxified in a non-hospital setting and can be admitted to the Hope House Laurel program. The nurse will review the record once the client has finished with the nursing assistant, complete her section which includes an assessment and treatment plan/plans.

IF AT ANY TIME THE PATIENT IS TOO PHYSICALLY ILL FOR DETOXIFICATION AT THIS LEVEL, A REFERRAL TO THE NEAREST HOSPITAL EMERGENCY ROOM WILL BE MADE BY THE NURSE.

2. The MD/NP will then be contacted with the nursing assessment information and the appropriate detoxification protocol and care plan will be initiated by the nurse. (See admission orders). If there is an initial dosing the patient will receive, they may be given it prior to leaving the nursing station if their vital signs/OOWS/CIWA are stable, and there has been insurance approval obtained by the UR staff. Otherwise, the client is escorted back to the lobby to wait for the approval.

Once insurance approval has been obtained the nurse will contact the treatment aides in order to have the patient checked into a room. Linens will be issued and a room inspection report, check-in form will be completed.

VI. CONTINUING ASSESSMENT/TREATMENT PROCEDURES

1. The client will be assigned a primary counselor in the next morning meeting.
   Depending upon the patient's physical status, the assigned counselor will meet with
   him/her that day and complete the following:

   a. The psychosocial assessment/TAP which incorporates all the required SAMIS data.
   b. Begin planning for discharge.

****The nurse will complete a daily continuing stay assessment (ASAM Continuing Stay Criteria) to determine the appropriate length of stay as well as ongoing treatment needs. Treatment plan goals will be reviewed and completed/closed on the last day of detoxification medication.

2. The nurse will assess the patient's physical status prior to dispensing detoxification medication, using the CIWA or OOWS scales.

3. The counselor will meet at regular intervals with the patient and provide him/her with motivational counseling both individually and in a group environment to encourage the patient to enter the next appropriate level of treatment and plan for an appropriate discharge environment. The patient's family may be involved in the discharge planning, if appropriate, and with the appropriate consents to release information.
The level of involvement depends upon the patient's individual situation, living environment, and family status.

4. When the patient no longer meets continuing stay criteria for detoxification services, discharge plans will be finalized. The patient will either be transferred to a lower level of care or discharged to an alternative treatment setting, based upon individualized need.

VII. DISCHARGE TO AN ALTERNATIVE TREATMENT FACILITY:

1. If the patient is assessed as needing a treatment facility other than the Hope House Laurel for aftercare, the counselor will:

   a. Obtain all required consents to make appropriate referrals.
   b. Complete the Counselor portion of the Discharge Instruction Sheet for the patient in Credible and then contact the Nursing Department to complete their section before the client signs the final Discharge Instruction form. The nurse will then give a copy of the instructions to the patient.
   c. Inform the patient that he/she needs to check out with the administrative office and the treatment aides.
   d. The Discharge Plan will include services required to sustain the sobriety and mental health of the patient for at least a year with the addition of ongoing support systems.

2. The administrative office will:

   a. Meet with the patient to answer any financial questions and obtain a final billing address.
   b. Complete the appropriate portion of the database discharge form.

3. The treatment aides:

a. Check the patient out of his/her room, completing the patient check-out form for room inspection.
   b. Provide the patient with his/her luggage.
   c. Obtain linens back from the patient for sanitation.
d. Insure cleanliness of the room following discharge, utilizing all required infection control procedures.

VIII. TRANSFER PROCEDURES FOR A PATIENT TO BE ADMITTED TO LOWER LEVELS OF CARE AT HOPE HOUSE LAUREL:

1. If the patient is assessed by the counselor as appropriate for lower levels of care, the counselor will report this transfer in the Daily Morning Treatment Team meeting.

2. At the MAT Outpatient Level of Care, the patient will be followed for treatment at least for a year, if not more.

IX. IF THE PATIENT IS APPROVED FOR ADMISSION TO A LOWER LEVEL OF CARE, THE COUNSELOR WILL COMPLETE THE FOLLOWING PAPERWORK, DATED THE DAY OF TRANSFER:

a. Provide this information in AM Team meeting to the front office representative so they can be transferred in the Credible electronic record.

1. The administrative office will:

a. Enter the patient transfer information into Credible, including discharge from the original level of care and admission to the new level of care.

b. Update or re-sign any consents/financial obligations as appropriate and collect any fees due as a result of transitioning to the lower level of care.

EXHIBIT 4 Memorandum of Understanding

BEHAVIORAL HEALTH ADMINISTRATION (BHA)

AGREEMENT TO COOPERATE
(REQUIREMENT UNDER COMAR 10.63.01.05)

Before applying for licensure under Subtitle 10.63 - *Community-Based Behavioral Health Programs and Services*, behavioral health programs in Maryland must enter into an Agreement to Cooperate with the CSA, LAA, or LBHA in each of the relevant counties or Baltimore City in which the program operates. Agreements are required when submitting an initial application, renewal application, or when a change to a program's license is requested (e.g., change in service array or locations). Please note that separate agreements are not required per site, unless there is a change to the program's existing license, such as adding a new location.

Program Information

Program Name*: **Addiction Recovery Inc. dba Hope House**
Primary Program Address: **419 / 429 Main St.**
Laurel, Maryland 20707
Primary Contact Name: **Peter D'Souza, Executive Director**
James A. Goines, MA, CAC-AD, Director of Treatment
Primary Contact Phone: **301 490-5551**
Primary Contact Email: **jgoines@hopehousemd.org**

Local Behavioral Health Authority Information

Local Jurisdiction: **Behavioral Health Services**
Prince George's County
Primary Contact Name: **Wright F. Doss, MSW, LICSW, LCSW-C**
Primary Contact Phone: **301 883-7903**
Primary Contact Email: LZwaddler@co.pg.md.us

Type of Program

Non-Accredited Program Types	
☒ DUI Education	☒ Substance-Related Disorder Assessment and Referral
☒ Early Intervention Level 0.5	
Accredited Program Types	
☐ Group Homes for Adults with Mental Illness	☐ Psychiatric Rehabilitation Program for Minors (PRP-M)
☒ Integrated Behavioral Health	☐ Residential Crisis Services (RCS)
☒ Intensive Outpatient Treatment Level 2.1	☐ Residential: Low Intensity Level 3.1
☐ Mobile Treatment Services (MTS)	☐ Residential: Medium Intensity Level 3.3
☐ Outpatient Mental Health Center (OMHC)	☐ Residential: High Intensity Level 3.5
☒ Outpatient Treatment Level 1	☒ Residential: Intensive Level 3.7
☒ Partial Hospitalization Treatment Level 2.5	☒ Residential Rehabilitation Program (RRP)
☐ Psychiatric Day Treatment Program (PDTP)	☐ Respite Care Services (RPCS)
☐ Psychiatric Rehabilitation Program for Adults (PRP-A)	☐ Supported Employment Program (SEP)
Accredited Services	

DHMH #4781 (September 21, 2016)

☐ Opioid Treatment	☐ Withdrawal Management

* Program name should match the corporate/business name included on the application for licensure.
As required under COMAR 10.63.01.05, Addiction Recovery Inc. dba Hope House enters into the following agreement with Behavioral Health Services Division Prince George's County Health Department to provide for coordination and cooperation between the parties in carrying out behavioral health activities in the jurisdiction, including complaint investigation and the transition of services if the program closes.

Additional activities identified by the program and local authority will include (optional):
(Please note that the agreement may not include a provision to prohibit a program from offering services at any location.)

Click here to enter text.

Behavioral Health Program

Signature — 1/13/2017 Date

James A. Goines, MA, CAC-AD
Print Name

Local Behavioral Health Authority

Signature — Date

Print Name

Regulatory Authority

COMAR 10.63.01.02B(5)

B. Terms Defined.
(5) "Agreement to cooperate" means a written agreement between the program and a core service agency, local addictions authority, or local behavioral health authority that provides for coordination and cooperation in carrying out behavioral health activities in a given jurisdiction.

COMAR 10.63.01.05E

E. Agreement to Cooperate.
(1) Before applying for licensure, a program shall enter into an agreement to cooperate with the CSA, LAA, or LBHA that operates in the relevant county or Baltimore City.
(2) The agreement to cooperate shall provide for coordination and cooperation between the parties in carrying out behavioral health activities in the jurisdiction, including but not limited to facilitating:
(a) A complaint investigation; and
(b) The transition of services if the program closes.
(3) The agreement to cooperate may not include a provision that authorizes the CSA, LAA, or LBHA to prohibit a program from offering services at any location.

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Table Number	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	Project Budget	All applicants, regardless of project type or scope, must complete Table B.
Table C	Statistical Projections - Entire Facility	Existing facility applicants must complete Table C. All applicants who complete this table must also complete Table D.
Table D	Revenues & Expenses, Uninflated - Entire Facility	Existing facility applicants must complete Table D. The projected revenues and expenses in Table D should be consistent with the volume projections in Table C.
Table E	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 E. All applicants who complete this table must also complete Table F.
Table F	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 complete a Table F must complete Table F. The projected revenues and expenses in Table F should be consistent with the volume projections in Table E.
Table G	Work Force Information	All applicants, regardless of project type or scope, must complete Table G.

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

INSTRUCTIONS: 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					
Service Location (Floor/Wing)	Current Licensed Beds	Based on Physical Capacity				Service Location (Floor/Wing)	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
III.7 AND III.7D						III.7 AND III.7D					
				0	0	Second Floor			5	5	14
				0	0	Third Floor			2	2	8
				0	0					0	0
				0	0					0	0
				0	0					0	0
Subtotal III.7 AND III.7D	**0**	**0**	**0**	**0**	**0**	**Subtotal III.7 and III.7 D**		**0**	**7**	**7**	**22**
RESIDENTIAL						RESIDENTIAL					
III.3 -Second Floor	10		5	5	10					0	0
III.3 -Third Floor	6		2	2	6					0	0
Subtotal Residential	**16**	**0**	**7**	**7**	**16**	**Subtotal Residential**		**0**	**0**	**0**	**0**
TOTAL	**16**	**0**	**7**	**7**	**16**	**TOTAL**		**0**	**7**	**7**	**22**
Other *(Specify/add rows as needed)*				0	0	**Other** *(Specify/add rows as needed)*				0	0
TOTAL OTHER	**0**	**0**	**0**	**0**	**0**	**TOTAL NON-ACUTE**		**0**	**0**	**0**	**0**
FACILITY TOTAL	**16**	**0**	**7**	**7**	**16**	**FACILITY TOTAL**		**0**	**7**	**7**	**22**

TABLE B. 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

	III.7 and III.7D	RESIDENTIAL	TOTAL
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building			$0
(2) Fixed Equipment			$0
(3) Site and Infrastructure			$0
(4) Architect/Engineering Fees			$0
(5) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	**$0**	**$0**	**$0**
b. Renovations			
(1) Building			$0
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees			$0
(4) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	**$0**	**$0**	**$0**
c. Other Capital Costs			
(1) Movable Equipment			$0
(2) Contingency Allowance			$0
(3) Gross interest during construction period			$0
(4) Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$0***	***$0***	***$0***
TOTAL CURRENT CAPITAL COSTS	**$0**	**$0**	**$0**
d. *Land Purchase*			
e. Inflation Allowance			$0
TOTAL CAPITAL COSTS	**$0**	**$0**	**$0**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			$0
b. Bond Discount			$0
c. Legal Fees (CON)			$0
d. Legal Fees (Other)			$0
e. Non-Legal Consultant Fees (CON application related - specify what it is and why it is needed for the CON)			$0
f. Non-Legal Consultant Fees (Other)			$0
g. Liquidation of Existing Debt			$0
H. Debt Service Reserve Fund			$0
i. Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$0***	***$0***	***$0***
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$0***	***$0***	***$0***
B. Sources of Funds			
1. Cash			$0
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds			$0
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$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
TOTAL SOURCES OF FUNDS			**$0**
	III.7 and III.7D	***RESIDENTIAL***	***TOTAL***
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

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

TABLE C. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	FY'16	FY'17	FY'18	FY'19	FY'20					
\										
a. Residential	0	0								
b. III.7 and III.7D	0	0	1,740	1,827	1,827					
c. PHP (	911	989								
d. Ambulatory Detox	648	669								
TOTAL DISCHARGES	***1,559***	***1,658***	***1,740***	***1,827***	***1,827***	***0***	***0***	***0***	***0***	***0***
2. PATIENT DAYS										
a. Residental		0								
b. III.7 and III.7D	0	0	15,712	16,497	16,497					
c. PHP	10,157	11,619								
d. Ambulatory Detox	3,473	3,345								
TOTAL PATIENT DAYS	***13,630***	***14,964***	***15,712***	***16,497***	***16,497***	***0***	***0***	***0***	***0***	***0***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. Residental	0.0	0.0	0.0	0.0	0.0					
b. III.7 and III.7D	0.0	0.0	9.0	9.0	9.0					
c. PHP (	11.1	11.7	0.0	0.0	0.0					
d. Ambulatory Detox	5.4	5.0								
TOTAL AVERAGE LENGTH OF STAY	8.7	9.0	9.0	9.0	9.0					
4. NUMBER OF LICENSED BEDS										
f. Rehabilitation-III.7	52	52	52	52	52					
g. Comprehensive Care										
h. Detox III.7D	13	13	35	35	35					
i. PHP III.3	16	16	0	0	0					
TOTAL LICENSED BEDS	***81***	***81***	***87***	***87***	***87***	***0***	***0***	***0***	***0***	***0***
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. Residential	0.0%	0.0%	0.0%	0.0%	0.0%					
b. III.7 and III.7D	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!					
c. Other (Specify/add rows of needed)	73.2%	70.5%	0.0%	0.0%	0.0%					
TOTAL OCCUPANCY %	**46.1%**	**50.6%**	**49.5%**	**52.0%**	**52.0%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
6. OUTPATIENT VISITS										
a. Residential										
b. III.7 and III.7D										
c. Other (Specify/add rows of needed)										
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***

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

TABLE D. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY'16**	**FY'17**	**FY'18**	**Fy'19**	**FY'20**					
1. REVENUE										
a. Inpatient Services	$ 4,558,924	$ 4,959,339	$ 6,727,889	$ 7,064,283	$ 7,417,498					
b. Outpatient Services	$ 122,061	$ 96,994	$ 106,195	$ 111,505	$ 117,080					
Gross Patient Service Revenues	***$ 4,680,985***	***$ 5,056,333***	***$ 6,834,084***	***$ 7,175,788***	***$ 7,534,578***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 330,346	$ 283,920	$ 202,276	$ 212,390	$ 223,009					
d. Contractual Allowance										
e. Charity Care										
Net Patient Services Revenue	***$ 4,350,639***	***$ 4,772,413***	***$ 6,631,808***	***$ 6,963,399***	***$ 7,311,568***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues										
Grants	$ 209,800	$ 86,541	***$ 82,102***	***$ 78,600***	***$ 78,600***					
Contributions	$ 7,790	$ 30,779	$ 32,583	$ 34,212	$ 35,923					
Other	$ 7,364	$ 2,667	$ 12,988	$ 13,637	$ 14,319					
NET OPERATING REVENUE	***$ 4,575,593***	***$ 4,892,400***	***$ 6,759,481***	***$ 7,089,848***	***$ 7,440,410***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 3,286,182	$ 3,738,634	$ 4,662,284	$ 4,895,398	$ 5,140,168					
b. Contractual Services	$ 135,752	$ 167,106	$ 176,480	$ 185,304	$ 194,569					
c. Interest on Current Debt	$ 3,917	$ 2,351	$ 2,200	$ 2,000	$ 2,000					
d. Interest on Project Debt										
e. Current Depreciation	$ 128,658	$ 148,247	$ 135,091	$ 141,846	$ 148,938					
f. Project Depreciation										
g. Current Amortization										
h. Project Amortization										
i. Supplies	$ 21,404	$ 25,350	$ 26,528	$ 27,854	$ 29,247					
j. Other Expenses (See attached detail)	$ 735,593	$ 765,699	$ 1,756,898	$ 1,837,446	$ 1,925,488					
TOTAL OPERATING EXPENSES	***$ 4,311,506***	***$ 4,847,387***	***$ 6,759,481***	***$ 7,089,848***	***$ 7,440,410***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME										
a. Income From Operation	***$ 264,087***	***$ 45,013***	***$ -***	***$ 0***	***$ 0***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
b. Non-Operating Income										
SUBTOTAL	***$ 264,087***	***$ 45,013***	***$ -***	***$ 0***	***$ 0***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ 264,087***	***$ 45,013***	***$ -***	***$ 0***	***$ 0***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE D. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY'16	FY'17	FY'18	Fy'19	FY'20					
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare										
2) Medicaid										
3) Blue Cross										
4) Commercial Insurance										
5) Self-pay										
6) Other										
TOTAL	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
b. Percent of Equivalent Inpatient Days										
1) Medicare										
2) Medicaid										
3) Blue Cross										
4) Commercial Insurance										
5) Self-pay										
6) Other										
TOTAL	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

TABLE E. 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.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	FY'16	FY'17	FY'18	FY'19	FY'20					
1. DISCHARGES										
a. Residential										
b. III.7 and III.7D				264	264					
c. Other (Specify)	264	264	264							
TOTAL DISCHARGES	***264***	***264***	***264***	***264***	***264***	***0***	***0***	***0***	***0***	***0***
2. PATIENT DAYS										
a. Residental										
b. III.7 and III.7D				7,920	7,920					
c. Other (Specify)	7,920	7,920	7,920							
TOTAL PATIENT DAYS	***7,920***	***7,920***	***7,920***	***7,920***	***7,920***	***0***	***0***	***0***	***0***	***0***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. Residental	0.0	0.0	0.0	0.0	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. III.7 and III.7D	0.0	0.0	0.0	30.0	30.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Other (Specify)	30.0	30.0	30.0	0.0	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	30.0	30.0	30.0	30.0	30.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
4. NUMBER OF LICENSED BEDS										
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify)										
TOTAL LICENSED BEDS	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. Residential	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. III.7 and III.7D	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Other (Specify)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
6. OUTPATIENT VISITS										
a. Residential										
b. III.7 and III.7D										
c. Other (Specify)										
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***

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

TABLE F. 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 F should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table E and with the costs of Manpower listed in Table G. 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.							
Indicate CY or FY	**FY'19**	**FY'20**					
1. REVENUE							
a. Inpatient Services	$ 2,032,281	$ 2,032,281					
b. Outpatient Services							
Gross Patient Service Revenues	***$ 2,032,281***	***$ 2,032,281***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt							
d. Contractual Allowance							
e. Charity Care							
Net Patient Services Revenue	***$ 2,032,281***	***$ 2,032,281***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify)							
NET OPERATING REVENUE	***$ 2,032,281***	***$ 2,032,281***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 1,309,321	$ 1,440,254					
b. Contractual Services	$ 61,927	$ 68,119					
c. Interest on Current Debt	$ 1,067	$ 1,120					
d. Interest on Project Debt							
e. Current Depreciation	$ 16,500	$ 18,150					
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 8,400	$ 9,240					
j. Other Expenses (See attached)	$ 210,222	$ 231,298					
TOTAL OPERATING EXPENSES	***$ 1,607,437***	***$ 1,768,181***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ 424,844.00**	**$ 264,099.65**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ 424,844.00***	***$ 264,099.65***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ 424,844.00***	***$ 264,099.65***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare							
2) Medicaid	100.0%	100.0%					
3) Blue Cross							
4) Commercial Insurance							
5) Self-pay							

TABLE F. 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 F should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table E and with the costs of Manpower listed in Table G. 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.							
Indicate CY or FY	**FY'19**	**FY'20**					
6) Other							
TOTAL	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare							
2) Medicaid							
3) Blue Cross							
4) Commercial Insurance							
5) Self-pay							
6) Other							
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE G. 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. See additional instruction in the column to the right of the table.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT	
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 D, if submitted)*	FTEs	Average Salary per FTE	Total Cost	FTEs	Total Cost *(should be consistent with projections in Table D)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Executives	6.0	$93,740	$93,740			$0			$0	6.0	$93,740
Billing	3.0	$48,600	$48,600			$0			$0	3.0	$48,600
Accounting	2.0	$38,000	$38,000			$0			$0	2.0	$38,000
Compliance	1.0	$34,000	$34,000			$0			$0	1.0	$34,000
Admissions	7.0	$34,000	$34,000			$0			$0	7.0	$34,000
Total Administration	19.0	248,340.0	$248,340			$0			$0	19.0	$248,340
Direct Care Staff *(List general categories, add rows if needed)*											
Addiction Counselors	10.0	$46,510	$46,510			$0			$0	10.0	$46,510
Psychologists	1.0	$63,000	$63,000			$0			$0	1.0	$63,000
Out Patient	2.0	$50,000	$50,000			$0			$0	2.0	$50,000
Nurses	41.0	$49,915	$49,915			$0			$0	41.0	$49,915
Total Direct Care	54.0	209,425.0	$209,425			$0			$0	54.0	$209,425
Support Staff *(List general categories, add rows if needed)*											
Out Patient Driver	1.0	$32,870	$32,870			$0			$0	1.0	$32,870
Cooks	10.0	$26,580	$26,580			$0			$0	10.0	$26,580
Housekeeping	3.0	$36,000	$36,000			$0			$0	3.0	$36,000
Maintenance	2.0	$48,000	$48,000			$0			$0	2.0	$48,000
Treatment Aides	24.0	$27,850	$27,850			$0			$0	24.0	$27,850
Total Support	40.0	171,300.0	$171,300			$0			$0	40.0	$171,300
REGULAR EMPLOYEES TOTAL	***113.0***	***629,065.0***	$629,065			$0			$0	113.0	$629,065
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
Direct Care Staff *(List general categories, add rows if needed)*											
Medical Doctor	1.0	$50,000	$50,000			$0			$0	1.0	$50,000
Nurse Practitioner	2.0	$41,600	$41,600			$0			$0	2.0	$41,600
Psy. Nurse Practitioner	1.0	$740,720	$740,720			$0			$0	1.0	$740,720
			$0			$0			$0	0.0	$0
Total Direct Care Staff	4.0	832,320.0	$832,320			$0			$0	4.0	$832,320
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
CONTRACTUAL EMPLOYEES TOTAL	***4.0***	***832,320.0***	$832,320			$0			$0	4.0	$832,320
Benefits *(State method of calculating benefits below):*											
TOTAL COST	***117.0***		***$1,461,385***	***0.0***		***$0***	***0.0***		***$0***		***$1,461,385***

Detail of Other Expenses
(From Table D)

	FY'16	FY'17	FY'18	FY'19
Food Service	193,149	214,476	317,847	333,739
Utilites	126,285	132,457	131,277	137,841
Building maintenance, and security	110,587	121,631	146,747	154,084
Professional fees	105,421	84,096	85,809	90,099
Purchase of service	59,952	66,989	68,895	72,340
Medical supplies	60,444	54,146	68,827	72,268
Insurance	37,714	43,073	44,711	46,947
Bank fees	6,392	11,817	9,686	10,170
Misellaneous	12,220	12,675	35,170	36,929
Auto and travel	12,182	11,251	11,397	11,967
Professional dues	4,186	5,718	5,826	6,117
Loss on claim	2,369	2,723	-	-
Advertising	15	2,707	24,000	25,200
Staff training	4,677	1,940	5,000	5,250
Investment Reserve	-	-	801,706	834,494
Total	735,593	765,699	1,756,898	1,837,446

FY'20
350,426
144,733
161,789
94,604
75,957
75,882
49,294
10,679
38,775
12,565
6,423
-
26,460
5,513
872,389
1,925,488

Other Expenses
(From Table F)

	FY'19	FY'20
Food Service	69,515	76,466
Utilities	47,648	52,412
Building maintenance, and security	41,504	45,653
Professional fees	15,710	17,281
Purchase of service	6,897	7,587
Medical supplies	4,960	5,456
Insurance	11,028	12,130
Bank fees	1,279	1,463
Misellaneous	5,657	6,223
Auto and travel	957	1,053
Professional dues	893	983
Loss on claim	-	-
Advertising	3,450	3,795
Staff training	724	796
Total	210,222	231,298