Pyramid Healthcare, Inc.®

Helping people reclaim their health and well-being.

PYRAMID WALDEN, LLC

Certificate of Need Application – Harford Facility

February 21, 2020

SUBMISSION COPY

Application and Exhibits

Pyramid
Healthcare, Inc.

CORPORATE OFFICE
P.O. Box 967
Duncansville, PA 16635
P: 814-940-0407
F: 814-946-1402
1-888-694-9996

February 21, 2020

Ruby Potter
Health Facilities Coordinator
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Potter,

Following our Letter of Intent dated October 27, 2019, please accept this application submission for a Certificate of Need to establish a new, Track 2 Intermediate Care Facility offering Medically Monitored Inpatient treatment for individuals with Substance Use Disorder.

Enclosed you will find the requested six (6) hard copies of the application. The searchable PDF and Word document will be submitted via email.

Please feel free to contact me if you have any further questions.

Sincerely,

Jonathan Wolf, President

Pyramid
Healthcare, Inc.

CORPORATE OFFICE
P.O. Box 967
Duncansville, PA 16635
P: 814-940-0407
F: 814-946-1402
1-888-694-9996

Joppa – Certificate of Need

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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

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: Pyramid Walden - Joppa[WN1] Facility

Address:

1015 Pulaski Highway	Joppa	21085	Harford
Street	City	Zip	County

2. Name of Owner: Pyramid Walden, LLC.

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

Refer to Exhibit 1

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

Legal Name of Project Applicant:

Pyramid Walden, LLC

Address:

1015 Pulaski Highway	**Joppa**	**21085**	**MD**	**Harford**
Street	City	Zip	State	County
Telephone:	**(814) 940-0407**			

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

Applicant will be the licensee

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 DE 5/21/2018
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited Liability Partnership	☐	
	Limited Liability Limited Partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☒	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	☒	

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

A. Lead or primary contact:

Name and Title: Catherine Briggs, Vice President of Operations

Company Name: Pyramid Walden, LLC

Mailing Address:

271 Lakemont Park Boulevard	Altoona	PA	16602
Street	City	Zip	State

Telephone: (814) 940-0407 ext 1291

E-mail Address (required): cbriggs@pyramidhc.com

Fax: (814) 946-1402

If company name is different than applicant briefly describe the relationship

B. Additional or alternate contact:

Name and Title: Jonathan Wolf, President and CEO

Company Name Pyramid Healthcare, Inc.

Mailing Address:

271 Lakemont Park Boulevard	Altoona	PA	16002
Street	City	Zip	State

Telephone: (814) 940-0407
E-mail Address (required): jwolf@pyramidhc.com

Fax: (814) 940-1402

If company name is different than applicant briefly describe the relationship Pyramid Healthcare, Inc. is parent company of Pyramid Walden, LLC

7. TYPE OF PROJECT

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

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

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

http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf

8. PROJECT DESCRIPTION

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

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

Pyramid Healthcare, Inc. was established in 1999. Pyramid's mission is to develop and maintain a team of committed professionals, passionate about identifying human service needs and creating solutions for individuals and families that result in positive growth and a better quality of life. To that end, Pyramid Healthcare, Inc., provides behavioral healthcare in a multi-state region that includes over eighty inpatient and outpatient facilities with over 1,000 beds used for residential treatment and/or detoxification services for individuals with substance use disorders. Our model of treatment for Substance Use Disorder is to provide the entire continuum of care, from Medically Monitored Withdrawal Management through Level I Outpatient and Medication-Assisted Treatment (MAT)services, and to facilitate assessment and access to the right level of care when each person requests treatment.

In the state of Maryland, Pyramid Healthcare's subsidiary, Pyramid Walden, LLC, currently operates a 52-bed ICF in Charlotte Hall (St. Mary's County) that provides Levels III.7WM, III.7, and III.5 treatment; a 16-bed Residential facility in California (St. Mary's County) that provides Levels III.5 and III.1 treatment; and is preparing to expand the California campus to a total of 32 beds early in 2020. Those residential facilities are supported by several Outpatient facilities operated by Pyramid Walden in St. Mary's and Charles County that offer Assessment, Level II.5, Level II.1, and Level I Outpatient treatment. As we strive to ensure access to the continuum of care, Pyramid Healthcare and Pyramid Walden prides itself on offering assessment and treatment to all persons, regardless of payer source: We do not limit the number of residential beds accessible to persons who are indigent, referred by the judicial system, or who receive Medicaid benefit.

At this time, Pyramid Walden, LLC, proposes to bring its expertise and

treatment model to Harford County and the Central Region of Maryland by establishing and operating a new, Track 2 Intermediate Care Facility offering Medically Monitored Inpatient treatment for individuals with Substance Use Disorder (SUD). The proposed project will convert a building formerly used as a Super 8 motel located in Joppa, Harford County, MD into a 64-bed residential treatment facility. The proposed treatment facility will include fifty (50) beds licensed and designated for Withdrawal Management and Medically Monitored Inpatient (Level III.7WM and Level III.7), and an additional 22 beds licensed for Clinically Managed High Intensity Residential treatment (Level III.5). The particular building identified for the project was selected due to its location and speed with which the project can bring additional licensed beds on board. We are interested in increasing access to ICF services quickly in Maryland, as thousands of Maryland residents suffer from Substance Use Disorder and are in need of treatment. Maryland is ranked among the top five states for opioid-related overdose deaths, with a rate of 32.2 deaths per 100,000 population that is twice the national average of 14.6 deaths per 100,000. In 2017, 1,975 persons in Maryland died of opioid-related overdose. (source: NIH, National Institute on Drug Abuse). Our own experience as an organization providing treatment in Southern Maryland supports a need for additional ICF beds in Central Maryland and Harford County. This application will outline the number of Maryland residents who have contacted Pyramid Walden's call center requesting residential treatment that we have been unable to serve due to a lack of Medically Monitored beds. The addition of the proposed 50 ICF beds in Harford County will improve access for these persons and others in need of treatment. Pyramid Walden, LLC ("Applicant"), is prepared to devote significant financial and clinical resources to developing the facility and delivering high quality treatment to address the need. The total projected cost of the project is $5,194,069. Because Applicant will fund the project entirely through private channels, rather than seek state, local, or charitable funding, this cost represents a significant gain to the state of Maryland and its efforts to address the current addictions crisis.	

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.

Pyramid Walden Harford will operate within the physical structure of the former Super 8 motel building located at 1015 Pulaski Highway, Joppa, MD. There were no existing Departments or Units in this building, as it previously was used as a hotel and is now being converted to a new healthcare facility.

Following completion of the project, there will be increased and immediate access to ICF services for the residents of Harford County and the Central Maryland Region.

The renovations needed to convert this building to a healthcare facility do not include changes to the physical plant or location, demolition or construction. Instead, renovations will be undertaken to convert the existing floor plan into a healthcare facility with the following treatment areas:

1. Intake Unit – 1,221 Sq. Feet
2. Detox Unit – 3,081 Sq. Feet
3. Women's Inpatient Unit – 2,566 Sq. Feet
4. Men's Inpatient Unit - 7,887 Sq. Feet

The building purchase and initial zoning are completed. The permitting and project schedule targets are as follows:

a). Completed zoning approval – 8/12/19
b). Purchased building/property – 8/13/19
c). Renovation started – 9/9/19
d). Order additional Furnishings – 10/1/19
e). Certify Fire Safety Devices-Sprinkler System/Alarm System – completed 10/28/19
f). Painting Completed – 11/15/19
g). Installed Facility Signage – 11/25/19
h). Flooring Completed – 11/28/19
i). Project/Renovation Completed – 1/7/20
j). Anticipated Licensure Date for 3.5 treatment – 4/15/20
k). Anticipated Licensure Date for 3.7 treatment – 7/1/20

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

Table A from the CON Application Table included as Exhibit 2

10. REQUIRED APPROVALS AND SITE CONTROL - Jeff

A. Site size: *14.74 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__X___ 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: Pyramid Walden, LLC.

(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

(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 ____1____ months from approval date.

B. Beginning Construction _____1_____ months from capital obligation.

C. Pre-Licensure/First Use 4 months from capital obligation.
D. Full Utilization 5 months from first use.

For projects <u>not</u> involving construction or renovations.
<u>Project Implementation Target Dates</u>

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

For projects <u>not</u> involving capital expenditures.
<u>Project Implementation Target Dates</u>

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

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.

Labelled floor plans with furniture attached as Exhibit 3.

13. AVAILABILITY AND ADEQUACY OF UTILITIES

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.

The Utilities available at the site/building, ~~along with our the provider of each,~~ are as follows:

Sewage – Harford County Water and Sewage
Electric – BG&E
Gas – BG&E
Water – Harford County Water and Sewage

The site has three substantial buildings, each of these three buildings were serviced by the existing utilities. The main building housed a 40 room - double occupant bed hotel (80 Occupancy), the 2 other Motel Buildings housed an additional 20 rooms or with double occupancy this would be an additional 40 occupants. Collectively these three buildings and all the site utilities supported 120 occupants and additional supporting staff.

The proposed use is to occupy the Main Hotel with 64 occupants. The utilities recently supported 120 occupants and therefore we will not be stressing the utility demands for this property.

During the site plan/zoning review the utilities were reviewed and accepted by the county planning and zoning department.

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.).

Table B is attached as Exhibit 4

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.

Pyramid Walden, LLC 270 Lakemont Park Boulevard, Altoona, PA 16602
Jonathan Wolf, CEO 270 Lakemont Park Boulevard, Altoona, PA 16602

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.

Walden Charlotte Hall, 30007 Business Center Drive, Charlotte Hall, MD 20622.
Walden Dockside, 44867 St. Andrews Church Road, California, MD 20610
Walden Compass, 44863 St. Andrews Church Road, California, MD 20610
Walden Lexington Park, 21770 FDR Blvd, Lexington Park, MD 20653
Walden Waldorf, 85 Smallwood Village Center, Waldorf, MD 20602

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.

2/21/20
Date

Signature of Owner or Board-designated Official

President CEO
Position/Title

Jonathan Wolf
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.

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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

(2) The Commission will approve a Certificate of Need application for a new intermediate care facility only if the facility will have no more than 40 adolescent or 50 adult intermediate care facility beds, or a total of 90 beds, if the applicant is applying to serve both age groups.

(3) The Commission will not approve a Certificate of Need application for expansion of an existing alcohol and drug abuse intermediate care facility if its 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.

Applicant Response:
Standard .05A (1) does not apply: applicant seeks a total of 50 ICF beds.

Standard .05A (2) does apply: applicant will have (50) Adult ICF beds.

Standard .05A (3) does not apply: Applicant is proposing a new facility.

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

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

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

Applicant Response: Standard .05B(1)(a) does not apply as Applicant proposes to establish a Track 2 ICF with 50 beds.

(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.

Applicant Response:

Standard 05(B)(1)(b): Applicant proposes to establish a Track 2 ICF with 50 beds for adults. Applicant will serve all persons in need at the ICF facility, including those indigent / gray area persons, and no beds will be reserved for private-pay patients. Applicant is a credentialed Medicaid provider in the state of Maryland and will serve the indigent population, including Medicaid recipients, court referrals, and county-funded persons in this facility. Applicant will ensure that it provides at least 50% of its annual patient days to indigent and gray area patients. As evidence of its commitment, Pyramid Walden can show a history of serving indigent and gray area patients at its existing ICF located in St. Mary's County. At that location, Walden Charlotte Hall, more than 85% of patient days are provided to persons funded by Medicaid, Federal Probation and Parole, and County contracts.

(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.

Applicant Response:

Standard .05(B)(2)(a)
Applicant is proposing the addition of fifty (50) Track 2 ICF beds in Harford County, which is part of the Central Maryland region (comprised of Baltimore City and Baltimore,

Harford, Howard, and Anne Arundel Counties) as outlined in the State Health Plan (See Exhibit 5, State Health Plan for Facilities and Services: Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services, COMAR 10/24/14, Supplement 1 Effective February 18, 2013, page 25).

According to the most recent available State Health Plan for Facilities and Services, referenced above as Exhibit 5, in 2005 the Central Maryland Region was in need of between 287 and 342 ICF beds for adults (see Exhibit 5, Table 2 Gross and Net Private ICR Bed Need Projections for Adults Ages 18+ 2005). According to the document, that projection was based on a total 2005 Maryland projected Adult population of 4,568,305.

It is our assertion that the need for ICF beds, and specifically Track 2 ICF beds that serve the indigent population, has increased commensurate with the population increase since that date. The US Census Bureau projects Maryland's 2019 Total Population to be 6,045,680. Assuming that each Maryland Region's population as a percentage of the State population remained stable, and using the State Plan's previous assumptions to estimate the rate of Substance Abusers (8.64%), Target Population (25%), and Range Requiring Treatment (95%); we have estimated the current Gross Private Bed Need Range for the State of Maryland to be between to be between 754 and 918; we have estimated the current Gross Private Bed Need Range for the Central Region to be between 367 and 441 (see Table 1 below)

Table 1 - Estimated Track 2 Bed Need based on updated 2019 Maryland Census

	Western Maryland (9.75%)	Montgomery County (14.93%)	Southern Maryland (18.3%)	Central Maryland (50.53%)	Eastern Shore (6.53%)	Total
Projected Population - 2019	589,454	902,620	1,106,359	3,054,882	394,783	6,045,680
Indigent Population	30,828	31,140	54,654	171,379	28,622	316,624
Non-indigent Population	558,625	871,480	1,051,705	2,883,503	366,161	5,731,475
Est. No of Substance Abusers (8.64%)	48,265	75,296	90,867	249,135	23,913	487,476
Estimated Annual Target Population (25%)	12,066	18,824	22,717	62,284	5,978	121,869
Estimated Range Requiring Treatment (95%)	11,463	17,883	21,581	59,169	5,679	115,775
Estimated Range Requiring Intermediate Care (12.5% - 15%)						-
Minimum	1,433	2,235	2,698	7,396	1,420	15,182
Maximum	1,719	2,682	3,237	8,875	1,988	18,502
Estimated Range Requiring Readmission (10%)						-
Minimum	143	224	270	740	142	1,518
Maximum	172	268	324	888	199	1,850
Total Discharges from Out-of-State		-				-
Range Requiring Intermediate Care						
Minimum	1,576	2,459	2,967	8,136	1,562	16,700
Maximum	1,891	2,951	3,561	9,763	2,187	20,353
Gross Private Bed Need Range (14 ALOS - 85% Occupy)						-
Minimum	71	111	134	367	70	754
Maximum	85	133	161	441	99	918
Existing Private ICF Inventory (Track 2)	272	119	27	287	26	731
Net Intermediate Private Bed Need Range Track 2						-
Minimum	(201)	(8)	107	80	44	23
Maximum	(187)	14	134	154	73	187

Table 2 Below displays the current number of Track 2 ICF beds by Region, using information provided by the Maryland Health Care Commission in October 2019. (Exhibit 7)

Currently, there are 287 Track 2 Beds in the Central Region, indicating that ***the range of current need of additional Track 2 ICF beds to serve the Central Region is between 80 and 154 beds***.

Currently there are 705 Track 2 Beds in the State of Maryland, indicating that ***the range of current need of additional Track 2 ICF beds to serve the State of Maryland is between 21 and 187 beds.*** [JH2]

Region / Facility Name	Adult Track 2 ICF Beds
TOTAL TRACK 2 BEDS IN STATE OF MARYLAND	**705**
WESTERN MARYLAND	**272**
Allegheny County Health Dept (Massie & Jackson Unit)	114
Mountain Manor Treatment Center	118
Shoemaker Center	40
MONTGOMERY COUNTY	**60**
Avery Road Treatment Center	60
SOUTHERN MARYLAND	**86**
Anchor of Walden	27
Hope House Treatment Centers	59
CENTRAL MARYLAND	**287**
Hope House Treatment Center	49
Pathways	40
Baltimore Crisis Response	7
Gaudenzia at Park Heights	67
Mountain Manor	68
Turek House	29
Gaudenzia Crownsville	27
HARFORD COUNTY	**0**
No Track 2 Facilities	0

In addition to the above estimates, Applicant has specific internal referral data to support a number of Track 2 ICF beds in the Central Region of Maryland. Pyramid Walden has been tracking the needs and outcomes of Maryland residents contacting Pyramid's Central Call Center requesting medically monitored residential treatment (III.7 and III.7WM) that we were unable to serve at our Charlotte Hall ICF due to lack of beds (this metric will be referred to as "Turndowns" through the remainder of the application). Attached in Exhibit 7 is a grid showing the number of Turndowns during the 13-month period from January 2019 through – January 2020. This data is provided as an illustration of our process of collecting this information. However, the turndowns during the months of May 2019 – November 2019 are significantly under-reported due to Pyramid Walden's transition to a new Electronic Medical Record and process for collecting referral information. We are confident in the accuracy of the data between January and April 2019 and again from November 2019 through January 2020. As a result, we have selected the accurate 4-month data period of January – April 2019 to estimate the unmet need through analysis of our Turndowns. This data is extracted and shown in the below Table: ICF Turndowns by County January – April, 2019.

Pyramid Walden, LLC
ICF Turndowns by County January - April, 2019

County	Jan	Feb	Mar	Apr	Grand Total
Allegany	0	0	0	0	**0**
Anne Arundel	27	41	27	41	**136**
Baltimore	5	25	9	32	**71**
Baltimore City	0	3	4	4	**11**
Calvert	11	18	7	11	**47**
Carroll	1	0	0	1	**2**
Cecil	3	2	0	3	**8**
Charles	12	26	25	34	**97**
Frederick	1	2	2	8	**13**
Harford	0	4	1	10	**15**
Howard	1	0	1	3	**5**
Kent	0	1	0	0	**1**
Montgomery	0	6	4	11	**21**
Out of State	1	5	4	13	**23**
Prince George's	4	19	12	30	**65**
Somerset	0	0	2	0	**2**
St. Mary's	98	42	28	47	**215**
Washington	6	0	2	3	**11**
Wicomico	0	1	2	0	**3**
Worcester	1	0	1	0	**2**
Grand Total	**171**	**195**	**131**	**251**	**748**
Total Central Maryland	34	73	42	91	240

Although Pyramid Walden currently only operates ICF services in Southern Maryland, the above table shows that our Call Center receives and accepts calls from individuals and referral sources from throughout the State of Maryland. The highlighted areas are the Counties in the Central Maryland Region.

Using the State Plan's assumed Length of Stay of 14 Days, we have identified that in order to provide access to the individuals who contacted our Call Center during this 120-day period of time would require additional Track 2 ICF beds as follows:

- Entire State of Maryland: Treating the 748 persons Turned Down would require 87.3 additional beds

- Central Maryland: Treating the 240 persons Turned Down would require 28 additional beds.

Applicant is requesting the maximum allowed 50 Track 2 ICF beds due to the demonstrated need for 87 additional beds in the State of Maryland, just to serve the

persons turned down by Pyramid Walden. As demonstrated by our Call Center data and Pyramid Walden's commitment to ensure immediate access to treatment through 24-hour admissions and transportation, we anticipate these additional 50 beds serving and providing access to not only the Central Region of Maryland, but those persons in other parts of Maryland that are unable to find a bed closer to home.

With two ICF facilities in different regions of the State, a 24-hour Central Call Center and a transportation system, it will be Pyramid Walden's goal to serve every person who contacts us in need of ICF treatment at the time of their call.

Standard .05(B)(2)(b) Applicant agrees to serve indigent and gray area patients, and will serve all individuals in the same groups and treatment locations. All patients will be respected and treated together (comingled), regardless of ability to pay.

Standard .05(B)(2)(c) Applicant agrees to ensure that indigents, including court-referrals, receive preference for care. Pyramid Walden currently provides access to Medically Monitored treatment at our Charlotte Hall ICF using a centralized Call Center, with admission available 24-hours per day. The Call Center monitors bed availability using a real-time electronic bedboard, and persons are offered a bed according to availability when they call. This has resulted in a stable finding that more than 85% of persons admitted to ICF in Charlotte Hall have been indigent/gray area patients. As further demonstration of this commitment, applicant agrees to prioritize the indigent person in the event that two persons are referred at the same time for only one remaining bed.

Standard .05(B)(2)(d) Applicant agrees that if the facility license or Medicaid enrollment is terminated, applicant will notify the Commission and the Office of Health Care Quality immediately and agrees not to use its ICF 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.

The facility will utilize a sliding fee scale for uninsured and unfunded persons consistent with the individual's ability to pay. The fee schedule is summarized as follows, and represents discount percentages from the standard billing rate charged to insurance carriers for each service:
<100% of Federal Poverty Level 75%
<150% but >100% of Federal Poverty Level 50%
<200% but >150% of Federal Poverty Level 25%

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

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

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

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

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

(2) 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.

Applicant Response: Standard .05D(1-4) does not apply. Applicant seeks to establish a new Track 2 ICF.

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

Applicant Response: applicant agrees to post a fee schedule describing the range and types of services, and their charges, in a prominent place in the registration area.

Standard registration information will include a statement that this information is available to the public upon request.

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

Applicant Response: The proposed location is within 30 minutes driving distance of three (3) hospitals:

- UM Upper Chesapeake Medical Center (8.6 miles, 14 minutes)
- UM Harford Memorial Hospital (16 miles, 26 minutes)
- Johns Hopkins Bayview Medical Center (17 miles, 18 minutes)

.05G. Age Groups.

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

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

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

Applicant Response:

Standard .05G (1) does not apply: applicant seeks to establish a 50 bed Track 2 ICF for adults

Standard .05G (2) does apply: applicant seeks to establish a 50-bed Track 2 ICF for adults.

Standard .05G (3) does not apply: applicant seeks to establish a 50-bed Track 2 ICF for adults.

.05H. Quality Assurance.

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

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

Applicant Response: Upon obtaining a Certificate of Occupancy, Pyramid Walden, LLC will apply for state licensure and accreditation through CARF International and the Maryland Behavioral Health Administration (BHA). All of Pyramid Walden, LLC's programs, including its ICF in St. Mary's County, MD, are CARF accredited, and all policies and procedures for the proposed facility will follow those accreditation standards. (Current CARF Accreditation Letter is included as Exhibit 8).

(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.

Applicant Response: If Applicant loses its CARF accreditation, Applicant will notify the Commission and the Office of Health Care Quality in writing within fifteen days of receiving notice.

(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.

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

(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.

If Applicant loses its State certification, Applicant will notify the Commission in writing within fifteen days of receiving notice, and will 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.

(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.

Applicant Response: Applicant is committed to participating in utilization review and control programs. It is our philosophy to support individuals in using the entire continuum of treatment and support for persons with Substance Use Disorder. Our clinical assessment tools ensure that, upon initial assessment and at every subsequent treatment plan review, persons receive the level of treatment indicated by their ASAM score. Written policies governing admission, length of stay, discharge planning, and referral are attached as follows[WN3]:

Policy PHC 2.2 – Utilization Review
Policy PHC 1.3 – Admission Criteria
Policy PHC 1.18 – Coordination of Care
Policy PHC 2.2 – Discharge and Transfer Criteria

(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.

Applicant agrees to include in each patient's treatment plan, a discharge plan that recommends at least one year of aftercare following discharge. Applicant's Continuum of Care model of treatment implements that treatment plan by

a. Providing Outpatient treatment in close proximity to our residential treatment programs, and providing same-day / next-day appointments after discharge.
b. When aftercare is provided by another entity, attempting to obtain the first appointment as quickly after discharge as possible, and coordinating support with the individual's Care Coordinator to provide a Warm Handoff to the next level of care.

As described below in Standard .05(O), Applicant intends to establish an outpatient office in Harford County within 12 months of opening the ICF. Exhibit 11 is an Agreement to Cooperate signed by the Harford County BHA that delineates all levels of care that will be licensed at the facility.

Each person in our care is educated about the benefit of evidence-based treatment for 12-24 months to ensure the best outcome for substance use disorder. Every patient's treatment plan will include at least one year of aftercare following discharge from the facility. This care will be supported by referrals to care coordination, recovery support personnel, and will be monitored through quarterly follow up phone calls.

.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.

Applicant Response: On September 24, 2019, Pyramid Walden representatives participated in a joint meeting of the Harford County Mental Health & Addictions Advisory Council, the Local Health Improvement Coalition (LHIC) Behavioral Health Workgroup, and the Harford County OOCC Opioid Intervention Team (OIT). During the meeting Pyramid Walden described our program model and our intention to establish an Intermediate Care Facility in Harford County in early 2020 to address urgent need. The plans were met with overwhelming support, and twelve letters verifying the urgent need of Medically Monitored treatment in Harford County were received and are included in

Exhibit 11. Continued work to collaborate and establish transfer agreements with different treatment programs will be undertaken as we complete the project.

(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.

Applicant Response: The letters of support and transfer agreements obtained by Pyramid Walden are outlined in the grid below and attached as Exhibit 11.

Pyramid Walden, LLC Referral Agreements and Letters of Support for CON Application				
Required Types of Letters	***Name of Organization***	***Transfer/Referral Agreement***	***Letter of Support***	***Notes***
Acute Care Hospital	UM Upper Chesapeake Hospital	X		
HWH, local OP's, Recovery Residences	Stepping Stones Recovery House, LLC	X		
	Praising Through Recovery, Inc.	X		Provider of addiction recovery and housing services
	Ashley Addiction Treatment	X		Provider of III.5 Residential Treatment
	Recovery Centers of America	X		Provider of III.5 Residential Treatment
	The Bergand Group	X		Provider of IOP and OP Treatment
Local Community Health Center	Harford County Health Department	X	X	
The Jurisdiction's Mental Health and D&A Authorities	Harford County Health Department	X	X	Dr. Moy's letter covers both of these categories. We can see in the applications shared by the Commission that the same entity can cover both of these categories.
The Alcohol and Drug Abuse and Mental Health Commission	Harford County Health Department	X		
Agencies that provide prevention, education, DUI groups, family counseling, etc.	The Bergand Group	X		Provider of Prevention, Education, DUI Groups, and Outpatient / Family Counseling
	Family & Children's Services		X	Organization that provides family counseling
	Torsch Foundation		X	Organization that provides prevention, family support, and education
	Addictions Connection Resource, Inc.		X	Organization that facilitates access to treatment and housing.
	Bel Air Police Department		X	

.05K. Sources of Referral.

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

Applicant Response: Pyramid Walden's Call Center has been accepting referrals from Maryland County residents since January, 2019. In that time, the majority of referrals for medically monitored residential treatment have been from self, hospitals, emergency rooms, and opiate crisis centers. We can demonstrate our commitment to serve this population through our referrals by referral source from January 2019 – January 2020 attached in Exhibit 12. Of those referrals, the Pyramid Walden ICF located in Charlotte Hall, MD was able to admit approximately 90 per month. The percentage of these persons who were indigent/gray area consistently exceeded 85% each month. Because the referrals are from throughout the state of Maryland, we expect to serve those same individuals with the Harford County facility.

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

Applicant Response:

Standard 05.K does not apply to Applicant: we seek to establish a new Track 2 facility.

.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.

Applicant Response:

Applicant will institute a standardized in-service orientation and continuing education program for all categories of direct service personnel. Attached in Exhibit 13 is Pyramid Walden LLC's policy for orientation and in-service that will be replicated at the Harford location.

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

Applicant Response:

Pyramid Walden, LLC has developed an Admissions Criteria policy and procedure and Detox Treatment Protocols for the evaluation, treatment and detoxification for patients in the medically monitored intensive treatment program. A physician, CRNP, or Physician Assistant will assess each patient on the detoxification unit within 24 hours of admission, and will provide daily monitoring and evaluation of patients.

Please refer to Exhibit 14 for Detox Protocols as follows:

Policy PHC 2.11 – Short Term Buprenorphine Detoxification
Policy PHC 2.33 – Detox Observation

.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.

Applicant Response:

All Pyramid Walden staff will be trained in the treatment, care and management of individuals impacted by concurrent medical conditions. The Infection Control Policy will identify training for all staff that includes appropriate methods of infection control, universal precautions and any special environmental considerations for HIV+ persons and those living with AIDS. Applicant's policy on individuals with HIV includes facilitating a connection to the local Health Department to provide the specialized counseling, as described in the policies below.

Policies listed in Exhibit 15 are as follows:
Anchor/Medical Policy – HIV Admission Medication Procedure
Anchor Medical/Northstar, Compass Policy – HIV Procedure
PHC 3.8 – Confidentiality: HIV AIDS

.05O. Outpatient Alcohol & Drug Abuse Programs.

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

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

Applicant Response: Pyramid Walden, LLC is committed to ensuring access to the entire continuum of care to persons in our ICF. We plan to establish and license an outpatient office on the grounds of the Pyramid Walden Harford facility. We have secured the support of the Harford County BHA in licensing the location for Outpatient – see Exhibit 10 Agreement to Cooperate. This office will provide, at a minimum, individual needs assessment and evaluation; aftercare; and information and referral for at least one year after each patient's discharge from the ICF. In addition to the outpatient office on site, Pyramid Walden, LLC plans to lease space and open a larger outpatient facility in Harford County within one year of the ICF opening. This office will provide access to services in the evening and weekends and will have specialized treatment for different populations. In the meantime, Applicant has obtained written Referral Agreements with several agencies who provide Outpatient Services – listed above in Table 3.

.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.

Pyramid Walden, LLC will collect its own utilization data and other information previously required by the Alcohol and Drug Abuse Administration (now Behavioral Health Administration). As an enrolled Medicaid provider, Pyramid Walden provides outcome data to the ASO that has contracted with the State of Maryland through its Outcome Measuring System (OMS). In addition, Pyramid Walden, LLC is committed to providing any and all Staterequested data monitoring that may be established in the future.

.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;

(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;

(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;

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

(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.

Applicant Response: Preference does not apply to applicant: we seek to establish a new Track 2 facility.

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).

Applicant Response: Preference does not apply to applicant: we seek to establish a new Track 2 facility.

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.

Applicant Response:

Standard .05(B)(2)(a)

Through the responses above, Applicant has demonstrated our commitment to serving all individuals in the State of Maryland in need of treatment for Substance Use Disorder, particularly those who are indigent, through our continuum of care. We currently provide an ICF facility in the Southern Maryland Region that is unable to serve everyone who contacts us in need of ICF treatment. We have identified through our Call Center's Turndown data that there is a need in the Central Region of Maryland for Track 2 ICF beds that are able to serve the indigent population, and specifically Harford County, which has 0 Track 2 ICF beds. Our method of estimating this need was detailed above in Section .05B and is documented again below:

It is our assertion that the need for ICF beds, and specifically Track 2 ICF beds that serve the indigent population, has increased commensurate with the population increase since that date. The US Census Bureau projects Maryland's 2019 Total Population to be 6,045,680. Assuming that each Maryland Region's population as a percentage of the State population remained stable, and using the State Plan's previous assumptions to estimate the rate of Substance Abusers (8.64%), Target Population (25%), and Range Requiring Treatment (95%); we have estimated the current Gross Private Bed Need Range for the State of Maryland to be between to be between 754 and 918; we have

estimated the current Gross Private Bed Need Range for the Central Region to be between 367 and 441 (see Table 1 below)

Table 1 - Estimated Track 2 Bed Need based on updated 2019 Maryland Census

	Western Maryland (9.75%)	Montgomery County (14.93%)	Southern Maryland (18.3%)	Central Maryland (50.53%)	Eastern Shore (6.53%)	Total
Projected Population - 2019	589,454	902,620	1,106,359	3,054,882	394,783	6,045,680
Indigent Population	30,828	31,140	54,654	171,379	28,622	316,624
Non-indigent Population	558,625	871,480	1,051,705	2,883,503	366,161	5,731,475
Est. No of Substance Abusers (8.64%)	48,265	75,296	90,867	249,135	23,913	487,476
Estimated Annual Target Population (25%)	12,066	18,824	22,717	62,284	5,978	121,869
Estimated Range Requiring Treatment (95%)	11,463	17,883	21,581	59,169	5,679	115,775
Estimated Range Requiring Intermediate Care (12.5% - 15%)						-
Minimum	1,433	2,235	2,698	7,396	1,420	15,182
Maximum	1,719	2,682	3,237	8,875	1,988	18,502
Estimated Range Requiring Readmission (10%)						-
Minimum	143	224	270	740	142	1,518
Maximum	172	268	324	888	199	1,850
Total Discharges from Out-of-State		-				-
Range Requiring Intermediate Care						
Minimum	1,576	2,459	2,967	8,136	1,562	16,700
Maximum	1,891	2,951	3,561	9,763	2,187	20,353
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Maximum	(187)	14	134	154	73	187

Table 2 Below displays the current number of Track 2 ICF beds by Region, using information provided by the Maryland Health Care Commission in October 2019. (Exhibit 7)

Currently, there are 287 Track 2 Beds in the Central Region, indicating that ***the range of current need of Track 2 ICF beds to serve the Central Region is between 80 and 154 beds***.

Currently there are 705 Track 2 Beds in the State of Maryland, indicating that ***the range of current need of Track 2 ICF beds to serve the State of Maryland is between 21 and 187 beds.***

Region / Facility Name	Adult Track 2 ICF Beds
TOTAL TRACK 2 BEDS IN STATE OF MARYLAND	**705**
WESTERN MARYLAND	**272**
Allegheny County Health Dept (Massie & Jackson Unit)	114
Mountain Manor Treatment Center	118
Shoemaker Center	40
MONTGOMERY COUNTY	**60**
Avery Road Treatment Center	60
SOUTHERN MARYLAND	**86**
Anchor of Walden	27
Hope House Treatment Centers	59
CENTRAL MARYLAND	**287**
Hope House Treatment Center	49
Pathways	40
Baltimore Crisis Response	7
Gaudenzia at Park Heights	67
Mountain Manor	68
Turek House	29
Gaudenzia Crownsville	27
HARFORD COUNTY	**0**
No Track 2 Facilities	0

In addition to the above estimates, Applicant has specific internal referral data to support a number of Track 2 ICF beds in the Central Region of Maryland. Pyramid Walden has been tracking the needs and outcomes of Maryland residents contacting Pyramid's Central Call Center requesting medically monitored residential treatment (III.7 and III.7WM) that we were unable to serve at our Charlotte Hall ICF due to lack of beds (this metric will be referred to as "Turndowns" through the remainder of the application). Attached in Exhibit 9 is a grid showing the number of Turndowns during the 13-month period from January 2019 through – January 2020. This data is provided as an illustration of our process of collecting this information. However, the turndowns during the months of May 2019 – November 2019 are significantly under-reported due to Pyramid Walden's transition to a new Electronic Medical Record and process for collecting referral information. We are confident in the accuracy of the data between January and April 2019 and again from November 2019 through January 2020. As a result, we have selected the accurate 4-month data period of January – April 2019 to

estimate the unmet need through analysis of our Turndowns. This data is extracted and shown in the below Table: ICF Turndowns by County January – April, 2019.

Pyramid Walden, LLC
ICF Turndowns by County January - April, 2019

	Jan	Feb	Mar	Apr	Grand Total
County					
Allegany	0	0	0	0	**0**
Anne Arundel	27	41	27	41	**136**
Baltimore	5	25	9	32	**71**
Baltimore City	0	3	4	4	**11**
Calvert	11	18	7	11	**47**
Carroll	1	0	0	1	**2**
Cecil	3	2	0	3	**8**
Charles	12	26	25	34	**97**
Frederick	1	2	2	8	**13**
Harford	0	4	1	10	**15**
Howard	1	0	1	3	**5**
Kent	0	1	0	0	**1**
Montgomery	0	6	4	11	**21**
Out of State	1	5	4	13	**23**
Prince George's	4	19	12	30	**65**
Somerset	0	0	2	0	**2**
St. Mary's	98	42	28	47	**215**
Washington	6	0	2	3	**11**
Wicomico	0	1	2	0	**3**
Worcester	1	0	1	0	**2**
Grand Total	**171**	**195**	**131**	**251**	**748**
Total Central Maryland	34	73	42	91	240

Although Pyramid Walden currently only operates ICF services in Southern Maryland, the above table shows that our Call Center receives and accepts calls from individuals and referral sources from throughout the State of Maryland. The highlighted areas are the Counties in the Central Maryland Region.

Using the State Plan's assumed Length of Stay of 14 Days, we have identified that in order to provide access to the individuals who contacted our Call Center during this 120-day period of time would require additional Track 2 ICF beds as follows:

- Entire State of Maryland: Treating the 748 persons Turned Down would require 87.3 additional beds

- Central Maryland: Treating the 240 persons Turned Down would require 28 additional beds.

Applicant is requesting the maximum allowed 50 Track 2 ICF beds due to the demonstrated need for 87 additional beds in the State of Maryland, just to serve the persons turned down by Pyramid Walden. As demonstrated by our Call Center data and Pyramid Walden's commitment to ensure immediate access to treatment through 24-hour admissions and transportation, we anticipate these additional 50 beds serving and providing access to not only the Central Region of Maryland, but those persons in other parts of Maryland that are unable to find a bed closer to home.

With two ICF facilities in different regions of the State, a 24-hour Central Call Center and a transportation system, it will be Pyramid Walden's goal to serve every person who contacts us in need of ICF treatment at the time of their call.

Standard .05(B)(2)(b) Applicant is committed to serving indigent and gray area patients, and will serve all individuals in the same groups and treatment locations. All patients will be respected and treated together (comingled), regardless of ability to pay.

Standard .05(B)(3)(c) Applicant provides access to Medically Monitored treatment using a centralized call center, available 24-hours per day. The Call Center monitors bed availability using a real-time electronic bedboard, and persons are offered a bed according to availability when they call, not according to their ability to pay. Based on our experience at our ICF located in St. Mary's County, it is expected that greater than 85% of persons admitted to the ICF will be indigent/gray area.

Standard .05(B)(3)(d) Applicant agrees that if the facility license or Medicaid enrollment is terminated, applicant will notify the Commission and the Office of Health Care Quality immediately and agrees not to use its ICF beds for private pay patients without obtaining a new Certificate of Need.

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

See Exhibit 16 for Table C

C. AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

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.

Applicant Response:

The proposed project involves renovating an existing structure to create a new Intermediate Care Facility for Alcohol and Drug Abuse treatment. Pyramid Walden, LLC has selected the proposed site based on the shortage of Track 2 ICF beds throughout the State of Maryland, in the Central Region, and in Harford County.

Applicant's turndown data demonstrates that existing providers do not have enough capacity to meet the immediate treatment needs of persons needing withdrawal management and medically intensive rehabilitation for Substance Use Disorder. The new resources provided by Applicant's proposed ICF brings a very rapid solution to this problem. As an alternative to approving a new ICF facility, the Commission could approve bed increases at existing facilities. However, this would not result in needed Track 2 beds in Harford County, where there currently are zero and where stakeholders have identified a need. Accordingly, Applicant proposes to build a new facility of a scope that could begin to address the need in Harford County and the Central Region of Maryland. The repurposing of an existing building also provides this resource in a very cost-effective manner.

D. VIABILITY OF THE PROPOSAL

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.

Applicant Response:
Pyramid Walden, LLC has funded this project through its ownership relationship with Pyramid Healthcare, Inc. and Clearview Capital, LLC (outlined in Exhibit 1, Ownership Information). At the time of his filing, the building has been purchased and the renovations completed.

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

Applicant Response:
See Tables E and F, attached in Exhibit 17, show the projected operating Revenue and Expenses for the New Facility and Service.

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

Applicant Response:
See Table G, attached in Exhibit 18

- 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.

Applicant Response:
See Exhibit 19 for Audited Financial Statements.

- 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.

Applicant Response: Not applicable: debt financing and grants will not be utilized for project.

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

Applicant Response:
On September 24, 2019, Pyramid Walden representatives participated in a joint meeting of the Harford County Mental Health & Addictions Advisory Council, the Local Health Improvement Coalition (LHIC) Behavioral Health Workgroup, and the Harford County OOCC Opioid Intervention Team (OIT). During the meeting Pyramid Walden described our program model and our intention to establish an Intermediate Care Facility in Harford County in early 2020 to address urgent need. The plans were met with overwhelming support, and a number of letters of support and Transfer Agreements were received. The agenda and attendance for this meeting is available in Exhibit 20.

- 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).

Applicant Response: Applicant has access to an internal Engineering team to lead our new facility projects. That team identified the location, completed the project design, and obtained all relevant State and local land use permits and approvals. At the time of this submission, all renovation work has been completed, and Applicant is awaiting the Certificate of Occupancy in order to proceed with licensure. Assuming the licensure process takes 60 days, we expect to be providing III.5 Residential Treatment in the facility by May 1, 2020. No additional modifications are necessary in order to provide III.7 and III.7WM, so there is minimal risk that the project will be completed within the described time frame.

E. COMPLIANCE WITH CONDITIONS OF PREVIOUS CERTIFICATES OF NEED

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.

Applicant Response:
Pyramid Walden, LLC currently operates one ICF facility in St. Mary's County (Walden, Charlotte Hall). The Charlotte Hall facility received its Certificate of Need more than 15 years ago, and has provided the ICF treatment programs meeting all conditions identified in that CON.

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

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;

Applicant Response: There is one Track 1 ICF provider in Harford County, and zero Track 2 ICF providers. Because the vast majority of our admissions will be indigent and Medicaid recipients, we anticipate minimal impact on the volume of service provided by the track 1 ICF.

We anticipate that, due to the introduction of our Call Center, transportation, and the ability to walk-in the facility and receive assessment, the local Emergency Rooms will experience a reduction in the volume of individuals presenting to the Emergency Room seeking referrals to treatment of Substance Use Disorder.

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.

Applicant Response: There is one Track 1 ICF provider in Harford County, and zero Track 2 ICF providers. Because the vast majority of our admissions will be indigent and Medicaid recipients, we anticipate minimal impact on the payer mix of service provided by the track 1 ICF.

b) 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);

Applicant Response: We anticipate that access to ICF services will improve for individuals throughout the state. Using a projected LOS of 14 days (assumption is from the Maryland State Health Plan), the additional 50 ICF beds will provide immediate access to 1303 additional individuals each year needing medically monitored treatment of SUD. Our internal Turndown data indicates that 748 people requested that service in the 4-month period from January – April, 2019. It is reasonable to assume that the 1303 additional admissions to an ICF each year will not ensure access to every person seeking care.

c) On costs to the health care delivery system.

Applicant Response: Applicant considered HSCRC's Total Cost of Care Agreement model to respond to this question. Maryland's Total Cost of Care Agreement has a patient-centered approach that focuses on improving care and outcomes. Part of those efforts is coordinating care across hospital and non-hospital settings. Pyramid Walden will support those efforts through the new Track 2 Intermediate Care Facility, which will achieve the goals of improving behavioral healthcare access and outcomes related to Substance Use Disorder and Opioids.

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.

Applicant Response: Not applicable as Applicant proposes a new Track 2 facility.

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

Ownership Distribution
Pyramid Walden, LLC. Tax ID # 83-1526132

Direct Ownership of Pyramid Walden, LLC.

- **Pyramid Healthcare, Inc. owns 100% Pyramid Walden, LLC.**
  - Tax ID # 23-3006202
  - PO Box 967
    Duncansville, PA 16635

Direct Ownership of Pyramid Healthcare, Inc.

- **Clearview Pyramid Acquisition Co. LLC (CPAC) owns 100% of Pyramid Healthcare, Inc.**
  - Tax ID # 32-0345075
  - 1010 Washington Blvd, 11th Floor | Stamford CT 16901

Indirect Ownership of Pyramid Healthcare, Inc

- **Clearview Capital Fund II, LP directly owns 65.05 % of CPAC**
  - Tax ID # 20-5569020
  - 1010 Washington Boulevard, 11th Floor | Stamford, CT 06901
  - **General Partner - Clearview Capital GP, LLC.**
    - 1010 Washington Boulevard, 11th Floor | Stamford, CT 06901
    - Tax ID: 20-5557455
    - *CSFB-VRS Private Equity Program I, OP indirectly owns 6.1% of CPAC (directly owns 9.37% of Clearview Capital Fund II, LP)*
      - Tax ID # 20-1751148
      - 11 Madison Avenue | New York, NY 10010
    - *Crane Investment Co., LLC indirectly owns 5.2% of CPAC (directly owns 7.99% of Clearview Capital Fund II, LP)*
      - Tax ID # 31-4363780
      - 330 West Spring Street, Suite 200 | Columbus, OH 43215
    - *RCP Fund IV LP indirectly owns 6.5% of CPAC (directly owns 9.99% of Clearview Capital Fund II, LP)*
      - Tax ID # 20-420528
      - 100 North Riverside Plaza, Suite 2400 |Chicago, IL 60606
- **Clearview Capital Fund II (Parallel), LP directly owns 5.39 % of CPAC**
  - Tax ID # 26-2415624
  - 1010 Washington Boulevard, 11th Floor | Stamford, CT 06901
  - **General Partner: Clearview Capital GP, LLC**
    - 1010 Washington Boulevard, 11th Floor | Stamford, CT 06901
    - Tax ID: 20-5557455
- **Northstar Mezzanine Partners V, LP directly owns 6.75 % of CPAC**
  - Tax ID # 26-0422865
  - 2310 Plaza VIII, 45 South Seventh Street |Minneapolis, MN 55402
  - **General Partner: Northstar Capital, LLC**
    - 45 South Seventh St, Suite 2319 | Minneapolis, MN 55402
    - Tax ID #41-1785830
- **Jonathan Wolf owns 12.0 % of CPAC**
  - SS # 196-52-9867
  - DOB: 08/14/59
  - State and Country of Birth: Erie, PA USA
  - Current Address: 113 Scott Ave | Altoona, PA 16602

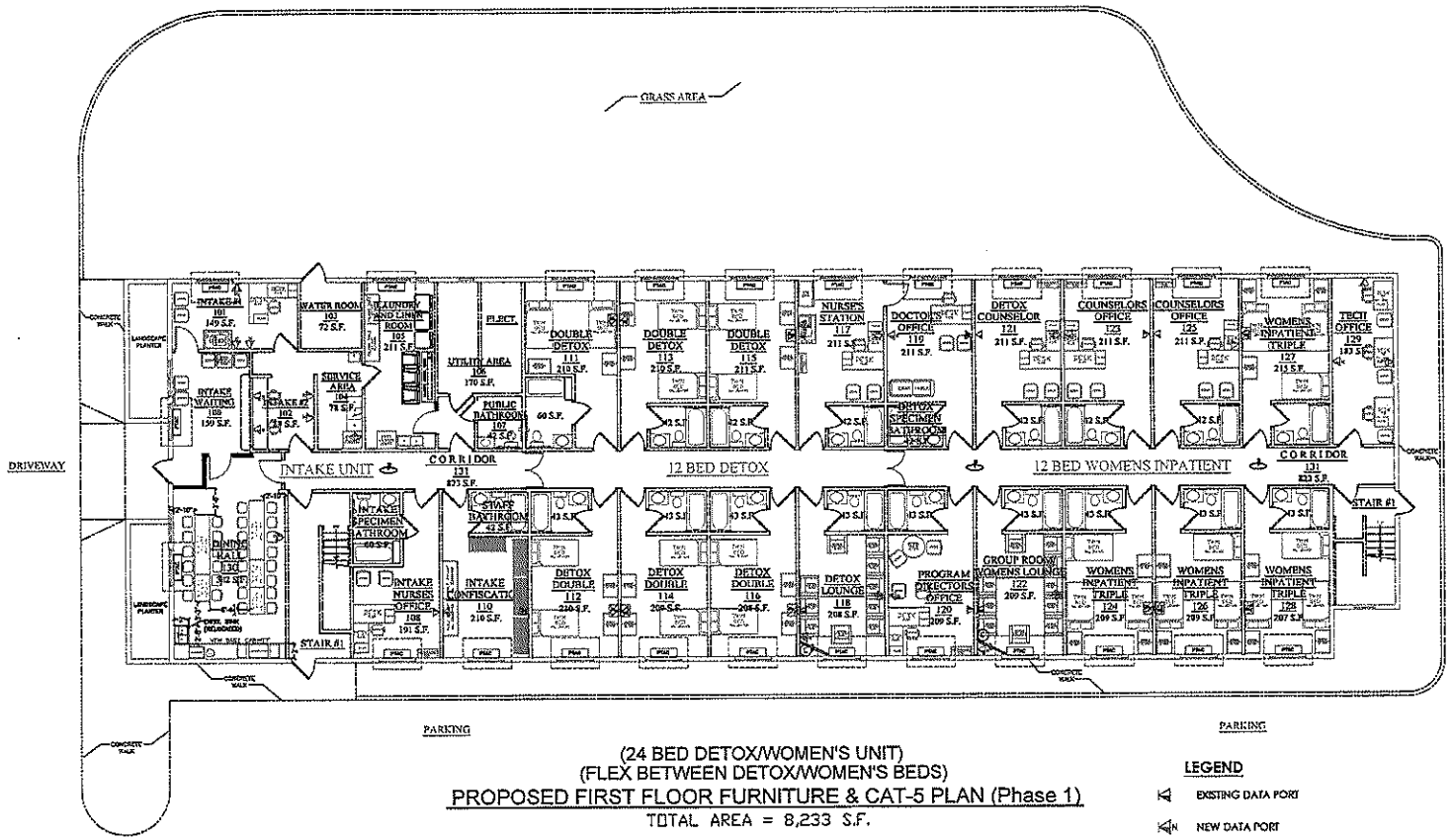
Exhibit 2

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. 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	Triple Rooms	Total Rooms	Physical Capacity
III.7 AND III.7D						III.7 AND III.7D						
	0			0	0	*1st floor*		0	2	4	6	16
				0	0	*2nd floor*		0	2	10	12	34
				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	4	14	18	50
RESIDENTIAL						RESIDENTIAL						
				0	0	1st floor		0	4	0	0	8
				0	0	2nd floor		0	0	2	0	6
Subtotal Residential	0	0	0	0	0	Subtotal Residential		0	4	2	0	14
TOTAL	0	0	0	0	0	TOTAL		0	8	16	18	64
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	0
FACILITY TOTAL	0	0	0	0	0	FACILITY TOTAL		0	8	16	18	64

Exhibit 3



(24 BED DETOX/WOMEN'S UNIT)
(FLEX BETWEEN DETOX/WOMEN'S BEDS)

PROPOSED FIRST FLOOR FURNITURE & CAT-5 PLAN (Phase 1)

TOTAL AREA = 8,233 S.F.

0 4 8 16 32

1/16"=1'-0"

LEGEND

- EXISTING DATA PORT
- NEW DATA PORT
- ACCESS POINTS (Wireless)
- NEW TV COAXIAL CABLE CONN.
- DESIGNATES EXIST. PORT TO BE REMOVED AND COVERED WITH A WALL PLATE
- NEW PYRAMID FURNITURE

FILE: /PYRAMID PROJECTS/JOPPA, MD/CAD Drawings/Phase 1 (No Construction)/First Floor Furniture Plan (Phase 1) (Option 2)

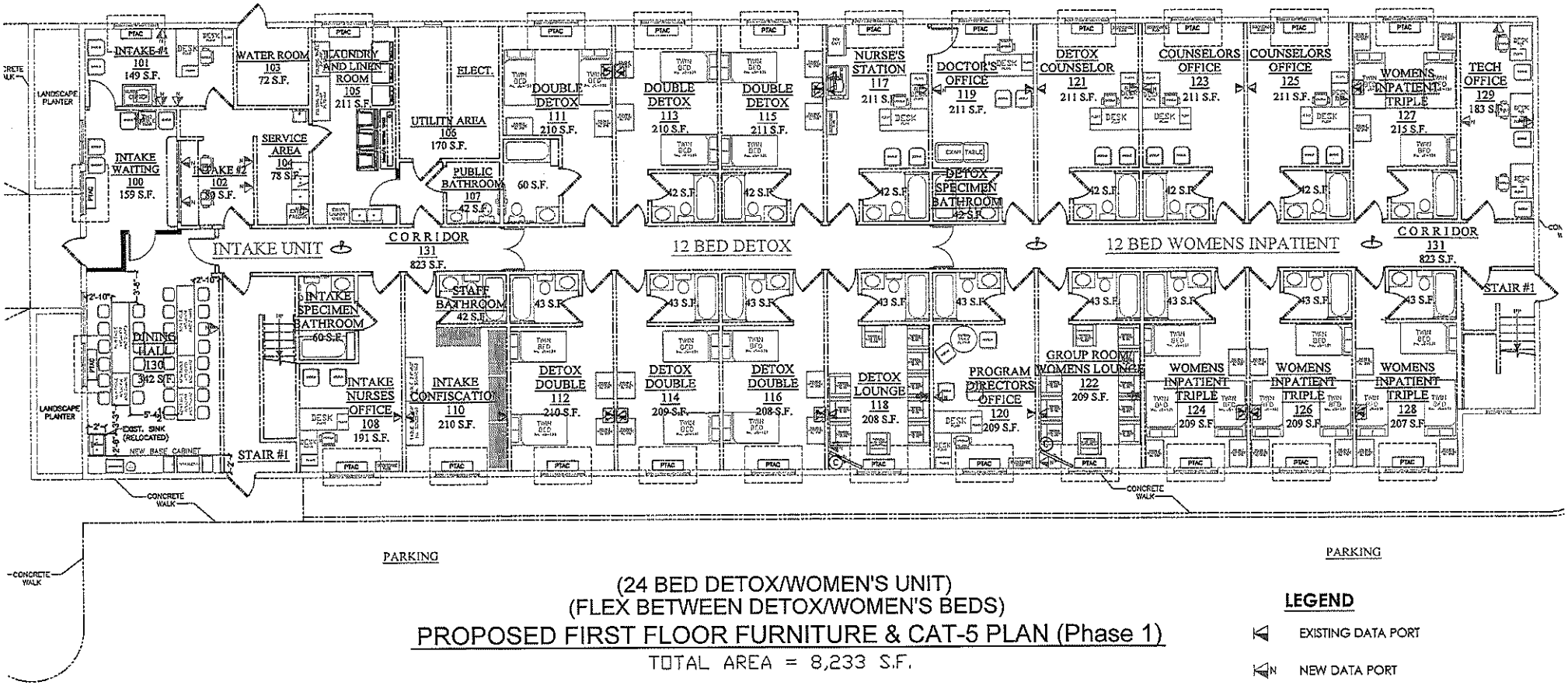
Pyramid Healthcare

2097 Route 19 North
Two Landmark Building
Suite 128
Cranberry Twp., Pa. 16066

JOPPA INPATIENT FACILITY
1015 PULASKI HIGHWAY
JOPPA, MD. 21085
FIRST FLOOR FURN. & CAT-5 PLAN (Phase 1)
Date: 10-4-19 Size: 11x17 Scale: 1/16"=1'-0"

Revisions	Date	& Des.
1	*	*
2	*	*
3	*	*
4	*	*

V.P. of Operations ***
V.P. of Engineering
Engineer
Dwg. No. 1



(24 BED DETOX/WOMEN'S UNIT)
(FLEX BETWEEN DETOX/WOMEN'S BEDS)

PROPOSED FIRST FLOOR FURNITURE & CAT-5 PLAN (Phase 1)

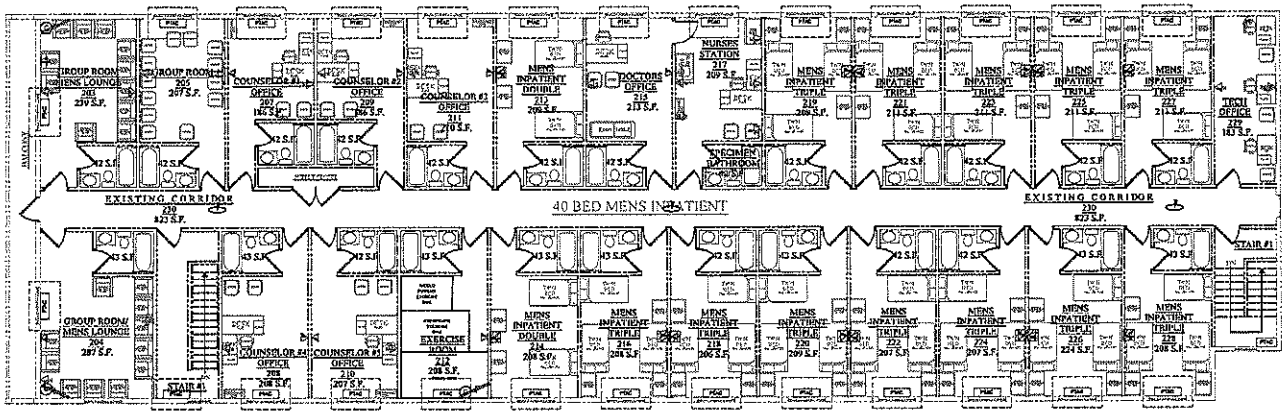
TOTAL AREA = 8,233 S.F.

0 4 8 16 32

1/16″=1′-0″

LEGEND

- EXISTING DATA PORT
- NEW DATA PORT
- ACCESS POINTS (Wireless)
- NEW TV COAXIAL CABLE CONN.
- DESIGNATES EXIST. PORT TO BE REMOVED AND COVERED WITH A WALL PLATE
- NEW PYRAMID FURNITURE



(MENS 40 BED)

PROPOSED SECOND FLOOR FURNITURE & CAT-5 PLAN (Phase 1)

TOTAL AREA = 8,233 S.F.

0 4 8 16 32

1/16"=1'-0"

LEGEND

- EXISTING DATA PORT
- NEW DATA PORT
- ACCESS POINTS (Wireless)
- NEW TV COAXIAL CABLE CONN.
- DESIGNATES EXIST. PORT TO BE REMOVED AND COVERED WITH A WALL PLATE
- NEW PYRAMID FURNITURE

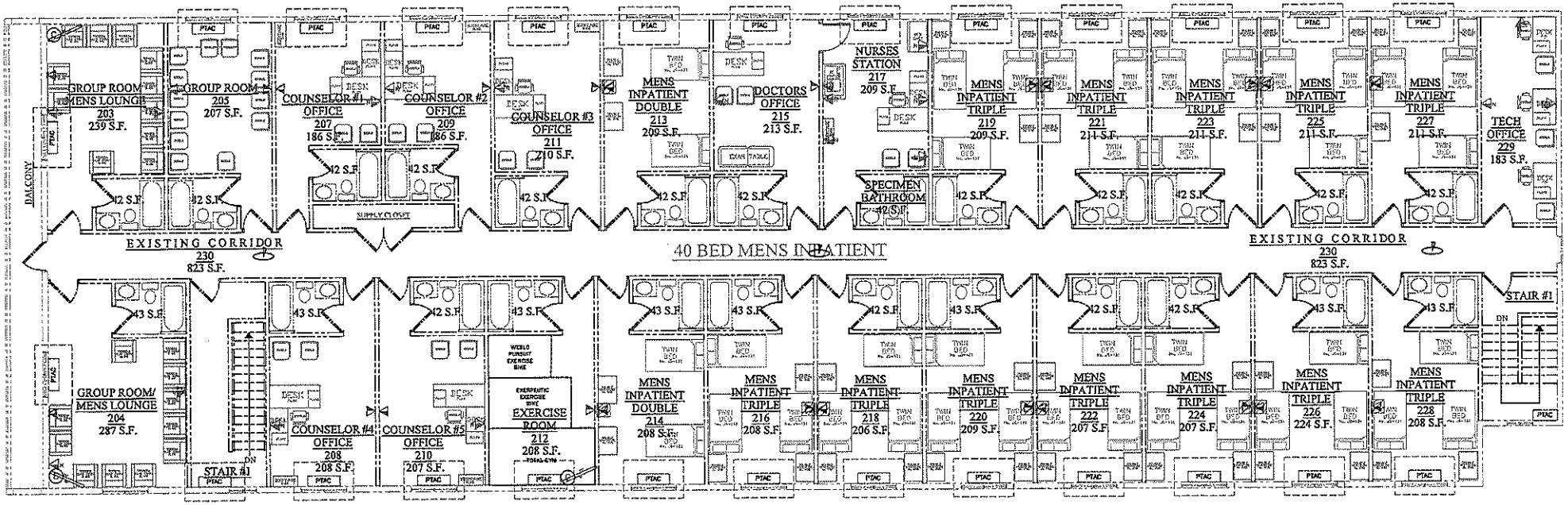
FILE: /PYRAMID PROJECTS/JOPPA, MD/CAD Drawings/Phase 1 (No Construction)/Second Floor Furniture Plan (Phase 1)

Dwg. No.	V.P. of Operations	V.P. of Engineering	Engineer
1	***		JB

Revisions	Date	& Des.
1	*	*
2	*	*
3	*	*
4	*	*

JOPPA INPATIENT FACILITY
1015 PULASKI HIGHWAY
JOPPA, MD. 21085
SECOND FLOOR FURN. & CAT-5 PLAN (Phase 1)
Date: 10-4-19 Size: 11x17 Scale: 1/16"=1'-0"

Pyramid Healthcare
20397 Route 19 North
Two Landmark Building
Suite 128
Cranberry Twp., Pa. 16066



(MENS 40 BED)

PROPOSED SECOND FLOOR FURNITURE & CAT-5 PLAN (Phase 1)

TOTAL AREA = 8,233 S.F.

0 4 8 16 32

1/16"=1'-0"

LEGEND

- EXISTING DATA PORT
- NEW DATA PORT
- ACCESS POINTS (Wireless)
- NEW TV COAXIAL CABLE CONN.
- DESIGNATES EXIST. PORT TO BE REMOVED AND COVERED WITH A WALL PLATE
- NEW PYRAMID FURNITURE

Exhibit 4

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. If the project involves services other than level III.7 and III.7D explain the allocation of costs between the levels. 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.d as a use of funds and on line B.8 as a source of funds

	III.7 and III.7D	RESIDENTIAL	TOTAL
	50.00	22.00	72.00
	69.4%	30.6%	100.0%
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	$183,007	$80,523	$263,530
(2) Fixed Equipment (not included in construction)	$41,667	$18,333	$60,000
(3) Architect/Engineering Fees	$79,245	$34,868	$114,113
(4) Permits (Building, Utilities, Etc.)	$1,944	$856	$2,800
SUBTOTAL	$305,863	$134,580	$440,443
c. Other Capital Costs			
(1) Movable Equipment	$162,372	$71,443	$233,815
(2) Contingency Allowance	$48,480	$21,331	$69,811
(3) Gross interest during construction period	$0	$0	$0
(4) Other *(Specify/add rows if needed)*	$0	$0	$0
SUBTOTAL	$210,851	$92,775	$303,626
TOTAL CURRENT CAPITAL COSTS	$516,715	$227,354	$744,069
d. *Land Purchase*	$555,556	$244,444	$800,000
e. *Building Purchase*	$2,375,000	$1,045,000	$3,420,000
f. Inflation Allowance	$0	$0	$0
TOTAL CAPITAL COSTS	$3,447,270	$1,516,799	$4,964,069
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees	$0	$0	$0
b. Bond Discount	$0	$0	$0
c. CON Application Assistance	$0	$0	
c1. Legal Fees	$0	$0	$0
c2. Other (Specify/add rows if needed)	$0	$0	
d. Non-CON Consulting Fees	$0	$0	
d1. Legal Fees	$10,417	$4,583	$15,000
d2. Other (Specify/add rows if needed)	$10,417	$4,583	$15,000
e. Debt Service Reserve Fund	$0	$0	$0
i. Other *(Specify/add rows if needed)*	$0	$0	$0
SUBTOTAL	$20,833	$9,167	$30,000
3. Working Capital Startup Costs	$138,889	$61,111	$200,000
TOTAL USES OF FUNDS	$3,606,992	$1,587,077	$5,194,069
B. Sources of Funds			
1. Cash	$3,606,992	$1,587,077	$5,194,069
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	$3,606,992	$1,587,077	$5,194,069
	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.

Exhibit 5

Craig Tanio, M.D.
Chairman

Ben Steffen
Executive Director

STATE OF MARYLAND

MARYLAND HEALTH CARE COMMISSION
4160 PATTERSON AVENUE BALTIMORE, MARYLAND 21215
AREA CODE 410-764-3460 FAX 410-358-8811

STATE HEALTH PLAN FOR FACILITIES AND SERVICES:

ALCOHOLISM AND DRUG ABUSE INTERMEDIATE CARE FACILITY TREATMENT SERVICES

COMAR 10.24.14

Effective January 21, 2002
Supplement 1 Effective February 18, 2013

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10.24.14 State Health Plan for Facilities and Services: Alcohol and Drug Abuse Treatment Services

.01 Incorporation by Reference.

This Chapter is incorporated by reference in the Code of Maryland Regulations.

.02 Introduction.

A. Purposes of the State Health Plan for Facilities and Services.

The Maryland Health Care Commission has prepared this Chapter of the State Health Plan for Facilities and Services ("State Health Plan" or "Plan") in order to plan for the establishment of an integrated system of care that assures geographic and financial access to a range of quality health care services at a reasonable cost for all residents. The Commission views the State Health Plan, of which this Chapter is a part, as a policy blueprint for shaping and reshaping the health care system toward these ends through the action of public agencies and the cooperation of the private sector. The Commission undertakes an active role in proposing needed changes in the system, including the reallocation of resources to achieve a health care system that is cost-effective, and that balances considerations of affordability, access, and quality. In every aspect of the Plan, and in its individual Certificate of Need decisions, the Commission carefully weighs issues of access to services against the cost of those services to society.

The State Health Plan serves two purposes:

(1) It establishes health care policy to guide the Commission's policies and those of other health-related public agencies, and to foster specific actions in the private sector. Activities of state agencies must, by law, be consistent with the Plan.

(2) It is the legal foundation for the Commission's decisions in its regulatory programs. These programs ensure that appropriate changes in service capacity are encouraged, and that all major expenditures for health care facilities are needed and consistent with the Commission's policies. The State Health Plan, therefore, contains policies, standards, and service-specific need projection methodologies that the Commission uses in making Certificate of Need decisions.

The purposes of this State Health Plan Chapter are to increase access to care for indigent and gray area populations, and to foster good quality, cost-effective, and integrated alcohol and drug abuse facilities and services. To meet these goals, the Chapter coordinates and integrates the planning of alcohol and drug abuse services, proposes methods to contain healthcare costs, encourages more efficient and effective alternative service delivery systems, and forecasts future need.

B. Legal Authority for the State Health Plan for Facilities and Services

The State Health Plan for Facilities and Services is adopted under Maryland's health planning law, Maryland Code Annotated,[1] Health-General §19-121(a)(2). This Chapter fulfills the Commission's legal responsibility to adopt a State Health Plan for Facilities and Services at least every five years and to review and amend the Plan annually, or as necessary.

Health-General Article §19-121(a)(2) states that the State Health Plan shall include:

(i) The methodologies, standards, and criteria for certificate of need review; and

(ii) Priority for conversion of acute capacity to alternative uses where appropriate.

The authority of the Plan with respect to the responsibilities of other state agencies and departments is stated in §19-121(f):

> All state agencies and departments, directly or indirectly involved with or responsible for any aspect of regulating, funding, or planning for the health care industry or persons involved in it, shall carry out their responsibilities in a manner consistent with the State Health Plan for Facilities and Services and available fiscal resources.

In addition, §19-115 provides that the Governor shall direct, as necessary, a state officer, or agency, to cooperate in carrying out the function of the Commission.

C. Organizational Setting of the Commission.

The Commission is an independent agency located within the Department of Health and Mental Hygiene for budgetary purposes. The purposes of the Commission, as provided under §19-103(c), are to :

[1] Unless otherwise noted, statutory references are to the Health General Article.

(1) Develop health care cost containment strategies to help provide access to appropriate quality health care services for all Marylanders, after consulting with the Health Services Cost Review Commission;

(2) Promote the development of a health regulatory system that provides, for all Marylanders, financial and geographic access to quality health care services at a reasonable cost by advocating policies and systems to promote the efficient delivery of and improved access to health care services, and to enhance the strengths of the current health care service delivery and regulatory system;

(3) Facilitate the public disclosure of medical claims data for the development of public policy;

(4) Establish and develop a medical care data base on health care services rendered by health care practitioners;

(5) Encourage the development of clinical resource management systems to permit the comparison of costs between various treatment settings and the availability of information to consumers, providers, and purchasers of health care services.

(6) In accordance with Title 15, Subtitle 12 of the Insurance Article, develop a uniform set of effective benefits to be included in the Comprehensive Standard Health Benefit Plan, and a modified health benefit plan for medical savings accounts;

(7) Analyze the medical care data base and provide, in aggregate form, an annual report on the variations in costs associated with health care practitioners.

(8) Ensure utilization of the medical care data base as a primary means to compile data and information, and annually report on trends and variances regarding fees for service, cost of care, regional and national comparisons, and indications of malpractice situations;

(9) Establish standards for the operation and licensing of medical care electronic claims clearinghouses in Maryland;

(10) Reduce the costs of claims submission and the administration of claims for health care practitioners and payors;

(11) Develop a uniform set of effective benefits to be offered as substantial, available, and affordable coverage in the non-group market in accordance with §15-606 of the Insurance Article;

(12) Determine the cost of mandated health insurance services in the State in accordance with Title 15, Subtitle 15 of the Insurance Article; and

(13) Promote the availability of information to consumers on charges by practitioners and reimbursements from payors.

The Commission has sole authority to prepare and adopt the State Health Plan for Facilities and Services and to issue Certificate of Need decisions and exemptions based on that Plan. Subsection §19-121(e) requires the Secretary of Health and Mental Hygiene to make annual recommendations to the Commission on the Plan and permits the Secretary to review and comment on the specifications used in its development. However, §19-110(a) prohibits the Secretary from disapproving or modifying any determinations the Commission makes regarding the State Health Plan. The Commission pursues effective coordination with the Secretary and State health-related agencies in the course of developing its plans and plan amendments. As required by statute, the Commission coordinates with the hospital rate-setting program of the Health Services Cost Review Commission to assure access to care at reasonable costs. The Commission also coordinates its activities with the Maryland Insurance Administration. Any changes to the State Health Plan are submitted to the Governor and become effective 45 days thereafter, unless the Governor notifies the Commission of an intent to modify or revise the Plan or any amended chapter.

D. Applicability and Plan Content.

The statute defining medical services for the purpose of Certificate of Need coverage for addictions treatment in acute general hospitals and intermediate care facilities is found at §19-123(a)(4)(i)(1) and (4). In addition, §19-123(4)(ii) includes in the definition of medical service any subcategory of intermediate care services for which need is projected in the State Health Plan.

This Chapter repeals and replaces COMAR 10.24.14 State Health Plan: Alcoholism and Drug Abuse Treatment Services, which comprises one chapter of the overall State Health Plan for Facilities and Services for Maryland.

Issues and policies for alcohol and drug abuse treatment services are discussed in Regulation .03. Regulation .04 discusses the docketing requirements for Certificate of Need applications, .05 addresses Certificate of Need approval rules for new and existing intermediate care facilities, .06

lists the preferences for Certificate of Need approval, .07 describes the bed need methodology and .08 lists the definition of terms used in the Chapter.

.03 Alcohol and Drug Abuse Treatment Services

A. Introduction

The Commission has identified several issues which may be grouped into the following five broad issue areas, including access to care, funding, quality, data collection, and continuum of care. These areas directly impact intermediate care facilities for chemically dependent individuals.

B. Statement of Issues and Policies

1. Access To Care

While financial access for the indigent and gray area population has been improving, it continues to be Maryland's major problem in providing alcohol and drug abuse treatment services.[2] Historically, there has been and continues to be a two-tier system of care based upon the individual's ability to pay.[3] Individuals without the means to pay for treatment in private facilities have been either denied care or forced to wait several weeks for care in a publicly-funded facility that is reimbursed at less than half the rate of private facilities. Public facilities, length of stay is on average three days less than in private facilities.[4] Alcohol and drug abuse treatment, especially intermediate care, is not only out of reach of much of the indigent population, but is also too expensive for many low- and middle-income individuals. Publicly-funded intermediate care facilities (ICFs) are presently faced with growing waiting lists, while many private programs are experiencing relatively low occupancies.[5] While the goals of financial access and a one-tier system of care will be difficult to attain, the Commission sees increased financial access for the poor as one means toward the creation of a one-tier system of care. Therefore, it is the Commission policy to create a separate review procedure to increase access to additional bed need for public ICFs, subject to the limitation of public funding, in exchange for the facility providing a majority of its care to the indigent population and requiring

[2] Between FY 99 and FY 00, the total number of intermediate care facility discharges decreased by 11 percent from 8,435 to 7,579. However, the number of indigent discharges increased by 26 percent from 3,758 to 4,730 over the same time period.

[3] Substance Abuse Management Information Systems ("SAMIS") data show the disparity between public and private programs. Some private programs having only 10 percent of their population represent the indigent or gray area clients.

[4] Substance Abuse Management Information Systems, Length of Stay by Payor 1999-2000, Alcohol and Drug Abuse Administration, April 2001.

[5] Based on SAMIS reports, occupancy rates in private ICFs range from the low 40 to 75 percent in CY 2000.

partnerships among state, local jurisdictions, and non-profit providers. These ICFs are referred to in the State Health Plan as "Track Two facilities".

The Commission has projected separate bed need projection mechanisms for public and private patients in order to increase access to care for indigent patients and reduce competition among those facilities that take predominantly private patients. The Commission determines ICF private bed need on a regional rather than jurisdictional basis to help ensure financial feasibility of new facilities that are of sufficient size to provide quality care.

The Commission's projected range of bed need for private intermediate care facilities reflects the impact of utilization review by managed behavioral care organizations that has produced low occupancies in most facilities. This range gives the Commission the flexibility to review projects in light of issues relating to financing, capacity, and quality. These ICF beds are referred to in this State Health Plan as "Track One beds".

Another component of access is the needs of special populations. Clients and their families reflect the diversity of our population, including differences in race, ethnicity, socioeconomic status, education, religion, geographic location, age, sexual orientation, disability, and gender. Treatment should be responsive to the needs of different cultures and population groups, and to the client's family structure, social support structure, and community environment.

Certain groups have had inadequate access to treatment because of barriers, such as the lack of specialized or culturally relevant programs, lack of appropriate training for treatment staff, and lack of child care and interpreters.[6] The treatment system has also had difficulty treating the more chronic and difficult-to-treat patients and designing programs to meet their special needs.

The alcohol and drug abuse treatment system should improve services for individuals addicted to or abusing one or more substances (poly-addicted) and those who have co-existing conditions (mental illness and addiction). Providers should assure that patients with co-existing diagnoses of either alcohol or drug abuse and a psychiatric disorder are treated in the program appropriate to their primary diagnosis. Both conditions should be considered in planning for the treatment of this population.

[6] U.S. Department of Health and Human Services, SAMHSA, *Improving Substance Abuse Treatment: The National Treatment Plan Initiative*, Rockville, Maryland , November 2000.

Gender may be a barrier to treatment because programs have historically been aimed at men, and there are a limited number of programs oriented to the treatment of women and juveniles. To identify and treat the underserved female population and provide child care to their children, increased outreach efforts and alternative programming can be more efficiently directed toward, and coordinated with, primary care and obstetrical/gynecologic providers, the usual points of entry for women into the health care system.

Alcohol, cocaine, and intravenous drug abuse are strongly associated with multiple obstetrical complications and high rates of perinatal morbidity and mortality. Clinical reports and studies have confirmed that drug use during pregnancy can harm a pregnant woman, and her unborn child, and effect aspects of the child's development after birth.[7] Health care providers in routine drug treatment programs are not trained to address the specialized medical, psychological, and psycho-social problems that are presented by pregnant addicts and their addicted infants. The development and expansion of treatment programs for the pregnant addict will reduce the number of obstetrical complications, ensure the delivery of healthier infants, provide effective family planning, and provide long-term health benefits for both mothers and children.[8] [9]

State and local funding permit substance abuse treatment services to be provided to less than two-thirds of the prison and jail population. Increased treatment capacity in correctional facilities would help identify and treat many of the chronic recidivists who cost the treatment and criminal justice system a disproportionate share of state resources. The Alcohol and Drug Abuse Administration has significantly increased its commitment to this population.[10] The Division of

[7] Alcohol Resources and Health, *Prenatal Exposure To Alcohol,* Vol. 24, No. 1 2000; 32-41. Maternal alcohol consumption during pregnancy can cause serious birth defects, of which fetal alcohol syndrome (FAS) is the most devastating. Recognizable by characteristic craniofacial abnormalities and growth deficiency, this condition includes severe alcohol-induced damage to the developing brain. FAS children experience deficits in intellectual functioning; difficulties in learning; memory; problem-solving; and attention; and difficulties with mental health and social interactions. Fetal Alcohol Syndrome (FAS) is currently the major cause of mental retardation in the Western world.

[8] Daley M, Argeriou M, McCarty D, Callahan JJ Jr, Shepard DS, Williams CN.The Impact Of Substance Abuse Treatment Modality On Birth Weight And Health Care Expenditures. *Journal of Psychoactive Drugs.* : Vol. 33, No. 1, Jan-Mar, 2001: 55-66.

9 Daley M, Argeriou M, McCarty D, Callahan JJ Jr, Shepard DS, Williams CN. The Costs Of Crime And The Benefits Of Substance Abuse Treatment For Pregnant Women. *Journal of Substance Abuse Treatment,* Vol. 19 , No.4, Dec. 19 2000: 445-58.

[10]The ADAA is committed to funding jail-based treatment programs begun by federally funded Byrne Grant resources through the Governor's Office of Crime Control and Prevention. Historically, the ADAA funds approximately two new programs each year which are demonstrated to be an effective treatment resource, Memorandum, dated June 11, 2001, from Ray Miller.

Parole and Probation cannot duplicate the services provided by public or private agencies, but should be in a position to purchase services for a selected number of parolees and probationers under its jurisdiction. The potential payoffs to the system and society may be great if additional dollars are allocated to meet this need.

Services for children and adolescents have historically been under funded and unavailable in several areas of the state. Adolescents have special treatment needs because of their stage of life, including family problems and social dysfunction. A family-centered approach should be encouraged in the treatment of the population, when appropriate. There is a need for increased coordination and collaboration among the many agencies, especially the Department of Juvenile Justice to provide outreach, early intervention, and services to adolescents.

Two lesser known underserved populations are the hearing-impaired and the elderly. As outreach efforts are intensified and the hearing-impaired are made aware of the availability and accessibility of treatment and interpreter services, funds need to be provided to make services available. In addition, studies show that alcohol consumption rates among those over 60 are as high as for middle-aged adults.[11] As the elderly population grows, overmedication, prescription drug abuse, and over-the-counter drug abuse are expected to become more serious. The Commission supports providing substance abuse treatment services for persons with special needs including the hearing impaired and the elderly.

Policy 1.0 **The Commission will create a separate Certificate of Need review track to encourage public intermediate care facilities to increase access to services for indigent and gray area patients. To be considered for this review track, a project must document and secure public funding, make a commitment to allocate more than half of its capacity to treat the indigent and gray area population, and create an active partnership with local and state governments.**

[11] Atkinson, R.M. Age Specific Treatment of Older Adult Alcoholics, Alcohol Problems and Aging, NIAAA, Rockville, Maryland 2001.

Policy 1.1 **The Commission will require private intermediate care providers to achieve and maintain a specified minimum level of care to treat publicly funded indigent and gray area populations.**

Policy 1.2 **The Commission will support the development of programs to treat special and underserved populations, including: addicted pregnant women; mothers and their infants; women; the elderly; the homeless; low-income individuals; the disabled; minorities; persons involved with the criminal justice system; and others with special needs. All programs should be responsive to the needs of different cultures and to the client's family structure, social support structure, and community environment.**

2. Funding for Alcohol and Drug Treatment Services

In FY 1999, the Alcohol and Drug Abuse Administration has estimated that 232,807 individuals were in need of alcohol and drug abuse treatment.[12] In Maryland, problems associated with drug and alcohol abuse cost the state between $1.3 billion and $5.5 billion a year.[13] For every $1 spent on treatment, studies have shown, $5-$7 is saved in addiction-related costs including criminal justice, child welfare and education.[14] Over the past decade in Maryland, as a result of budget cuts and managed care, twelve private intermediate care facilities for addiction rehabilitation care were closed and several substance abuse programs were discontinued within hospitals.

As a result of significant support for expanding and improving drug and alcohol treatment services, the General Assembly passed legislation in 1998 (House Bill 149) establishing a Task Force to Study Increasing the Availability of Substance Abuse Programs ("Drug Treatment Task Force" or "Task Force"). The Drug Treatment Task Force published a needs assessment that identified scarce availability of several treatment modalities in each jurisdiction, including detoxification services, residential treatment, and halfway

[12] Estimate formulated by the Alcohol and Drug Abuse Administration & Center for Substance Abuse Research, 1999.
[13] Center for Substance Abuse Research. University of Maryland 1995.
[14] Gerstein et al , *The National Treatment Evaluation Study: Final Report*, Rockville, MD, 1997.

house/transitional placements.[15] This Task Force's needs assessment identified 20 of the 24 Maryland jurisdictions as needing intermediate care facilities or detoxification services.[16]

To address the downsizing of programs, the impact of utilization review by managed care, and reduction in services caused by state budget cuts, the Task Force has recommended increasing the baseline drug and alcohol treatment system funding for operational and capital expansion by an additional $300 million over the next ten years, from both public and private sources such as private health insurance.[17]

Policy 2.0 The Commission will support efforts to significantly increase both public and private funding for drug and alcohol treatment to close the treatment gaps and to create an effective system of care.

3. Quality of Care

Alcoholism and drug dependence are treatable illnesses. Individuals suffering from these illnesses deserve effective, state of the art treatment; however, the quality of treatment varies across the treatment system within Maryland. There is no system-wide, agreed upon quality measurement protocol. Lack of understanding and skepticism about the effectiveness of treatment has been a barrier to its expansion. Currently, the addiction field relies on an array of different approaches to assess the quality of care, including the use of different performance measures, practice guidelines, accreditation, licensing and certification, and credentialing.

To attain higher standards of care, the alcohol and drug abuse treatment system must promote the development and application of new knowledge and treatment approaches as well as innovations that improve efficiency and responsiveness. The system should make the best possible use of resources provided for care, and must be fully accountable to clients and families, to funding sources, and to the public.

A performance measurement system would help ensure this accountability. By annually evaluating information from drug and alcohol treatment programs on specific performance indicators, the State would be able to improve its management of the drug and alcohol treatment

[15] Id.
[16] Drug Treatment Task Force: *Filling In the Gaps: Statewide Needs Assessment of County Alcohol and Drug Treatment Systems,* February 29, 2000.
[17] Drug Treatment Task Force Final Report, *Blueprint For Change: Increasing the Effectiveness of Maryland's Drug and Alcohol Treatment Systems,* February 2001.

system. A performance measurement system may help build public support for additional treatment resources and expansion of these services. In collaboration with Maryland's drug treatment provider community, the Maryland Department of Health and Mental Hygiene, and the U.S. Department of Health and Human Services, the Drug Treatment Task Force has developed a core set of indicators to identify research-based performance measures.[18]

In addition to episodic monitoring, uniform monitoring of treatment facilities needs to be an ongoing process. ICFs have not been inspected by the state licensing authority from 1995 to 2001 due to a decision by the Department of Health and Mental Hygiene to rely upon Joint Commission on Accreditation of Healthcare Organizations (JCAHO) "deemed status" for certification and to not inspect ICF programs.[19] Currently there are four ICF in Maryland programs that are not JCAHO accredited. The Commission needs to rely upon other qualitative standards to ensure quality in these programs. To move closer toward a one-tier system of care, there must be uniformity among accreditation requirements.

Policy 3.0 **To improve the effectiveness of the drug and alcohol treatment system and its programs, the Commission will support efforts to implement a statewide performance measurement system as recommended by the Drug Treatment Task Force.**

Policy 3.1 **Each Maryland intermediate care facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or CARF ...The Rehabilitation Accreditation Commission or other accrediting body deemed appropriate by the Department of Health and Mental Hygiene and must also be certified by the Office of Health Care Quality of the Department of Health and Mental Hygiene.**

[18] The core set of indicators identified by the Drug Treatment Task Force include: drug/alcohol use, criminal involvement, employment status, and living arrangements. p.27.

[19] In 1995, the Office of Health Care Quality (formally the Office of Licensing and Certification Programs) made the decision to no longer inspect facilities due to reallocation of resources. JCAHO accreditation would be used as a "deemed status" for the facility. However, House Bill 403 passed in the 2001 General Assembly now requires all ICFs to be inspected and certified by the State.

4. **Data Collection Systems**

Gaps within the treatment system contribute to the difficulty of transferring patient-specific information from one system to another and of collecting comprehensive individual data. For systems to interface effectively, they must effectively share data. Currently, data systems with overlapping clients often do not exchange information. These systems frequently lack updated information systems, standard reporting requirements, and consistent and clear communications process.

Complicating matters is that the collection of data for detoxification and rehabilitative addiction care is inadequate and incomplete. Historically, the State Health Plan requires Certificate of Need applicants to report to the Substance Abuse Management Information System (SAMIS). However, SAMIS is not integrated with hospital data bases that include inpatient, emergency room, and outpatient data. Particularly important are five elements of data: patient origin; payor source; readmissions, length of stay; and charge per admission. SAMIS collects all the elements except change per admission. It is important to have a data system that can follow patients as they move into different parts of the treatment continuum. The collection of data must protect patient confidentiality and be consistent with federal and state regulations.

Although the Alcohol and Drug Abuse Administration can track individuals who obtain care in state-certified treatment programs, it cannot track individuals through all settings. For this reason, it is difficult to evaluate the quality and cost-benefit of the specific kinds of care.

Policy 4.0 **The Commission will support efforts to develop a more comprehensive and integrated data collection and management system administered by the Alcohol and Drug Abuse Administration through the Substance Abuse Management Information System (SAMIS) to obtain data required to plan for needed services, to evaluate outcomes, and to assess treatment innovations.**

Policy 4.1 **The Commission will support efforts to require all public and private intermediate care facilities to report on a regular basis to SAMIS data required to support planning for services.**

5. The Continuum of Care

There is limited capacity systemwide to provide treatment to addicted individuals.[20] The development of additional intensive, rehabilitative, and other outpatient services may provide alternatives for families to receive care near their homes and assist family members in the process of recovering together from addiction.

Economies of scale, quality of care, and distribution of services to increase geographic accessibility need to be considered in planning for the alcohol and drug abuse treatment system. Providers within the system should keep abreast of current trends, new and more effective treatments methods, and changing public priorities and policies. Public agencies and both public and private payors need to monitor the development of the treatment system to assure that, as treatment modalities change, programs incorporate these changes.

All acute general hospital emergency rooms provide substance abuse-related services. The Commission supports the development of regionalized systems of emergency care to meet the increasing demand for services.[21] Due to intensified utilization review by third party payors, and the inability of many acutely addicted patients to pay for hospital care, there are few hospitals that specialize in addiction care.[22] Since individual hospitals have reduced the availability of detoxification services, regionalization of services may assure continued access to hospitals for those who require this level of care.

Policy 5.0 **Each jurisdiction or region should have a balanced service system with increased capacity for intensive, rehabilitative and other kinds of outpatient and community based services, where needed.**

Policy 5.1 **The Commission, in cooperation with the Alcohol and Drug Abuse Administration, should support the development of regionalized acute detoxification units.**

[20] Drug Treatment Task Force; *Filling In the Gaps: Statewide Needs Assessment of County Alcohol and Drug Treatment Systems,* February 29, 2000.
[21] Alling, F.A. Detoxification and Treatment of Acute Sequelae. In: Lowinson, J.H., Ruiz, P., Millman, R.B., eds. *Substance Abuse: A Comprehensive Textbook.* Baltimore, MD: Williams and Wilkins; 1992.
[22] Alcohol and Drug Abuse Administration, Substance Abuse Directory, 2000.

.04 Docketing Requirements for Certificate of Need Applications to Establish Intermediate Care Facilities Providing Substance Abuse Treatment Services

The Commission reviews Certificate of Need applications to establish new ICFs or to expand existing ICFs providing substance abuse treatment services, depending on the level of publicly-funded treatment provided in the facility. Private beds, ("Track One") as defined at Regulation .08, refers to facilities that admit a majority of private-pay patients, and Publicly-funded beds, ("Track Two") also defined at Regulation .08, refer to those facilities with 50 percent or more of their beds funded by any combination of public funds.

A. The following requirements apply to both Track One and Track Two Certificate of Need applications.

(1) The Commission will docket Certificate of Need applications from applicants that apply only for either private bed capacity (Track One) or publicly-funded bed capacity (Track Two).

(2) The Commission will docket a Certificate of Need application for expansion of an existing intermediate care facility only if the applicant has been operating the facility for at least two years and is documented by the Alcohol and Drug Abuse Administration's Substance Abuse Management Information System (SAMIS) or by the applicant as having an 85 percent average annual occupancy rate of its beds for two consecutive years prior to the applicant's letter of intent. Occupancy calculated on the basis of physical bed capacity deemed usable by the applicant, when this differs from licensed bed capacity, can be found to comply with this standard, based on the applicant's documentation of physical bed capacity.

B. The following docketing requirements apply only to applicants to establish a Track Two intermediate care facility for substance abuse treatment.

(1) The Commission will docket a Certificate of Need for publicly-funded beds, as defined in Regulation .08 of this Chapter, only if the applicant proposes to reserve 50 percent or more of its proposed annual adolescent or adult intermediate care facility bed days for indigent and gray area patients.

(2) The Commission will docket a Certificate of Need application for new publicly-funded beds, as defined in Regulation .08 of this Chapter, to establish a new intermediate care facility, or to expand an existing facility only if the applicant:

(a) Provides a signed letter of commitment from the Alcohol and Drug Abuse Administration, or a signed agreement with one or more state or jurisdictional authorities that documents sufficient funding for the bed and service capacity proposed at the new facility, and

(b) Documents, through Memoranda of Understanding (MOUs), linkages with related state and local government agencies, defining:

(i) Areas of cooperation and shared responsibilities; and

(ii) The applicant's agreement to screen, evaluate, diagnose, and treat individuals with alcohol or drug diagnoses, including uninsured, underinsured, and court-committed persons;

I Documents that if the affected jurisdiction or region has a written plan that shows the need for the applicant's proposed service and that the applicant's proposal is consistent with the local plan(s);

(d) Documents that the applicant, in cooperation with the Mental Hygiene Administration and the Alcohol and Drug Abuse Administration will use approved admission criteria, to assure proper placement of mentally ill substance abusers, and will:

(i) Treat mildly mentally ill substance abusers;

(ii) Treat or refer the moderately mentally ill substance abuser to a more appropriate facility and program; and

(iii) Refer the severely mentally ill substance abuser to a facility with a medically appropriate level of care.

(e) Documents that the applicant will provide priority to each affected jurisdiction's residents for admission to the facility, regardless of their ability to pay for treatment.

(f) Documents that the entire facility, including existing and proposed intermediate care facility beds, will meet the annualized indigent and gray area requirements as specified in Regulation .08.

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

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

(1) The Commission will approve a Certificate of Need application for an intermediate care facility having less than 15 beds only if the applicant dedicates a special population as defined in Regulation .08.

(2) The Commission will approve a Certificate of Need application for a new intermediate care facility only if the facility will have no more than 40 adolescent or 50 adult intermediate care facility beds, or a total of 90 beds, if the applicant is applying to serve both age groups.

(3) The Commission will not approve a Certificate of Need application for expansion of an existing alcohol and drug abuse intermediate care facility if its 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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.

E. **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.

F. **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.

G. **Age Groups.**

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

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

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

***H.* Quality Assurance.**

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

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

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

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

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

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

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

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(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.

I. **Utilization Review and Control Programs.**

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

(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.

J. **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.

K. **Sources of Referral.**

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

(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.

L. **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.

M. **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.

N. **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.

O. **Outpatient Alcohol & Drug Abuse Programs.**

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

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

P. **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.

.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 to a proposed project seeking Certificate of Need approval to establish or 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;

(2) 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;

(3) 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;

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

(5) 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).

.07 Bed Need Projection Methodologies.

A. Acute Inpatient Bed Need. Need for alcohol and drug abuse acute inpatient beds is combined with the need for other medical/surgical beds and is projected in accordance with the methodology found in the Acute Inpatient Services Chapter of the State Health Plan for Facilities and Services for Facilities and Services, COMAR 10.24.10.

B. Intermediate Care Private Bed Need (Track One).

(1) Period of Time Covered.

(a) The base year is the most recent year for which the number of Medicaid recipients is available.

(b) The target year to which need is initially projected is five years from the base year.

(2) Age Groups.

(a) Need is projected separately for adolescent (12-17 years) and adult (18 years and over) populations.

(b) No need for children aged 0-11 is projected due to low prevalence.

(3) Geographic Regions. Need projections for Track I adolescent and adult facilities are made on a regional basis as follows:

(a) Western Maryland (Allegany, Garrett, Washington, Frederick , and Carroll Counties);

(b) Montgomery County;

(c) Southern Maryland (St. Mary's, Calvert, Charles, and Prince George's Counties);

(d) Central Maryland (Baltimore City and Baltimore, Harford, Howard, and Anne Arundel Counties) and;

(e) Eastern Shore (Cecil, Kent, Queen Anne's, Talbot, Caroline, Dorchester, Wicomico, Worcester, and Somerset Counties.

(4) Assumptions.

(a) Need is assumed to increase in proportion to the age-adjusted growth in population in each region.

(b) The size of the indigent population is assumed to remain the same from the base to the target year.

(c) Prevalence rates used in each age group are assumed to remain constant.

(i) A 15 percent prevalence rate for the adolescent population at-risk of alcohol or drug abuse, and an 8.64-percent prevalence rate for the adult population, are assumed.[22]

(ii) 20 percent of the at-risk adolescent population and 25 percent of the at-risk adult population are assumed to need some kind of treatment.

(d) 95 percent of the population in need of treatment are assumed to require some form of services, while five percent are assumed to require only information to recover without services.

(e) 12.5 to 15 percent of the adolescent target treatment population are assumed to require care in an intermediate care facility for all regions. For all regions except the Eastern Shore, 12.5 to 15 percent of the adult target treatment population are assumed to require care in an intermediate care facility. For the Eastern Shore it is assumed that 15 to 30 percent of the adult target treatment population are assumed to require care in an intermediate care facility.

(f) 20 percent of adolescents and 10 percent of adults receiving care in an intermediate care facility are assumed to require readmission during the year discharged from a facility.

(g) Projected in-migration is based upon out-of-state-generated discharges in the base year.

(h) Existing beds funded by contract with the Alcohol and Drug Abuse Administration and with local jurisdictions that are assumed to serve indigent patients are excluded from the Track I projections and ICF bed inventory.

(i) Existing beds in which charity care is provided within Track I facilities without public funding that are assumed to serve indigent and gray area patients are not excluded from the population for which need is projected.

(j) Projected need is for Maryland facilities only.

[22] Prevalence estimates have been reviewed by the Alcohol and Drug Abuse Administration and by the Center for Substance Abuse Research and are calculated using the *NIMH Epidemiologic Catchment Area Program Estimates, Archives of General Psychiatry*, 1984 for the adult population, and the National Household Survey on Drug Abuse, Population Estimates, Office of Applied Studies, SAMHSA 1996, Rockville, MD, Office of Applied Studies for the adolescent population.

(5) Data Sources.

(a) Population projections are obtained from the most recent figures prepared by the Maryland Office of State Planning.

(b) The indigent population is obtained by identifying the number of indigent and medically indigent federally and non-federally matched Medical Assistance recipients for the 12-17 and 18 and older age groups by region for the most recent calendar year of data available from the Medical Assistance program of the Department of Health and Mental Hygiene.

(c) The adult prevalence rate is developed from the recent national survey data from the National Institute of Mental Health, and the adolescent prevalence rate is obtained by trending the annual survey of high school drug use conducted by Maryland State Department of Education.[23]

(d) Utilization data from the Alcohol and Drug Abuse Administration's Substance Abuse Management Information System (SAMIS) is used to determine the average length of stay, the rate of in-migration and the readmission rates.

(e) The number of discharges of out-of-state residents who received care in Maryland in the base year is obtained from SAMIS data.

(f) The inventory of private and publicly-funded intermediate care adolescent and adult beds are those beds:

(g) Certified by the Office of Health Care Quality; and

(h) Identified and recognized as providing intermediate care by the Commission and by the Alcohol and Drug Abuse Administration, regardless of licensure status.

(6) Revisions.

(a) The Commission will revise the need projections every two years to account for updated population projections, changes in the inventory of licensed and certified beds, and changes in the number of Medical Assistance recipients.

(b) Revised need projections will be published as a notice in the *Maryland Register.*

[23] Maryland Adolescent Survey Maryland State Department of Education, 1998.

(7) **Method of Calculation for Private Beds.** The need for private beds is calculated as follows:

(a) Identify by geographic region the non-indigent Maryland population for the 12-17 years and 18 years and above age groups by subtracting the number of Medical Assistance recipients from the projected Maryland population for the target year.

(b) Estimate the adolescent and adult populations at risk of alcohol and drug abuse by multiplying the non-indigent population in Maryland by a prevalence rate of 0.15 for the adolescent population and a prevalence rate 0.0864 for the adult population.

(c) Estimate the non-indigent adolescent and adult target population by multiplying the at-risk adolescent population by 0.20 and the at-risk adult population by 0.25. Estimate the non-indigent adolescent and adult populations requiring some form of treatment by multiplying the adolescent and adult target populations by 0.95.

(d) Estimate the non-indigent adolescent and adult target treatment populations requiring care in an intermediate care facility by multiplying the adolescent target treatment population and the adult target treatment population by 0.15.

(e) Estimate the intermediate care treatment populations requiring readmission in the target year by multiplying the adolescent intermediate care treatment population by 0.20 and the adult intermediate care treatment population by 0.10.

(f) Calculate the total number of persons requiring intermediate care by adding the intermediate care treatment population, readmissions, and the number of out-of-state discharges from intermediate care facilities in the base year.

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

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

(i) Calculate the total net number of adolescent and adult intermediate are beds needed by subtracting the adjusted inventory from the gross number of intermediate care beds needed.

(8) Mathematical Formulas.

(a) Definition of Terms. Terms used in subsection (b) below are defined in the following table:

Term	Definition
h	Region
k	Age group, where adolescents = 12-17 and adults = 18 and older
m	Minimum and maximum intermediate care treatment rate, where 1 = 0.125 and 2 = 0.15
NIPOP	Non-indigent Maryland population
POP	Maryland population in the target year
IPOP	Indigent Maryland population
ARPOP	Population at risk of substance abuse
PREV	Prevalence rate of substance abusers, where 0.15 = adolescent and 0.0864 = adult
TPOP	Target population
TPR	Target population rate, where 0.20 = adolescent and 0.25 = adult
TTPOP	Target treatment population
ICTPOP	Intermediate care treatment population
ICTR	Intermediate care treatment rate
READD	Readmissions
RR	Readmission rate, where 0.20 = adolescents and 0.10 = adults
TOTPOP	Total population requiring intermediate care treatment in Maryland
OOSPOP	Discharges of out-of-state patients
GPNEED	Gross private intermediate care beds needed
ALOS	Average length of stay
AINV	Adjusted inventory of private intermediate care beds
PINV	Inventory of intermediate care beds that comprise facilities at least 50 percent of whose annual patient days are generated by indigent or gray are population consistent with Regulation .08
TNEED	Total net intermediate care bed need

(b) The need projection methodology described above is shown in the following table in mathematical form:

$NIPOP_{hk}$	=	$POP_{hk} - IPOP_{hk}$
$ARPOP_{hk}$	=	$(NIPOP_{hk})(PREV_k)$
$TPOP_{hk}$	=	$(ARPOP_{hk})(TPR_k)$
$TTPOP_{hk}$	=	$.95(TPOP_{hk})$
$ICTPOP_{hkm}$	=	$(TTPOP_{hk})(ICTR_{km})$
$READD_{hkm}$	=	$(ICTPOP_{hkm})(RR_k)$
$TOTPOP_{hkm}$	=	$(ICTPOP_{hkm} + READD_{hk} + OOSPOP_{hk})$
$GPNEED_{hkm}$	=	$(TOTPOP_{hkm})(ALOS_k)/(365)(.85)$
$AINV_{hk}$	=	$INV_{hk} - PINV_{hk}$
$TNEED_{hkm}$	=	$GPNEED_{hkm} - AINV_{hk}$

C. Intermediate Care Publicly-Funded Bed Need (Track Two).

The Commission has established criteria for approval of projects outside of the bed need methodology. Such projects must demonstrate need and meet additional standards, as provided in Regulation .04C.

.08 Definitions.

A. In this Chapter, the following terms have the meanings indicated.

B. **Terms Defined.**

(1) "Acute alcohol and drug abuse services" means emergency and detoxification services provided to individuals requiring 24-hour medical or psychiatric care as a result of life-threatening or serious acute or chronic alcohol or drug abuse, or medical psychiatric illness associated with substance abuse, provided in licensed acute general hospitals defined in Health-General Article §19-301(f)-(g), Annotated Code of Maryland.

(2) "Alcohol and Drug Abuse Administration" means the agency of the Department of Health and Mental Hygiene responsible for planning and funding treatment of persons abusing or addicted to alcohol or other drugs.

(3) "Alcoholism and drug abuse rehabilitation" means rehabilitation provided in any of five settings: intermediate care (ICF-C/D) facilities for the treatment of alcohol abuse (previously called quarterway programs); hospital-based alcoholism rehabilitation units; long-term residential care programs; residential drug abuse treatment facilities; and alternative rehabilitation care (alternative living unit, non-residential intermediate care, intensive and other outpatient programs).

(4) Charity Care.

(a) "Charity care" means care for which there is no means of payment by the patient or any third party payor, except public funding.

(b) "Charity care" does not mean the uninsured or partially insured days designated as deductibles or copayments in patient insurance plans, nor that portion of charges not paid as a consequence of either a contract or agreement between a provider and an insurer or between a provider and a patient, or a waiver of payment due to family relationship, friendship, or professional courtesy.

(5) "CON-approved" beds means those beds that are approved by the Commission to provide care but have not yet been licensed, or have not yet received general certification by the Office of Health Care Quality, as required to begin providing services.

(6) "Detoxification" means the systematic medically-supervised reduction of the effects of alcohol or drugs and the effects of alcohol or drug withdrawal in the body, which commonly occurs in one of four settings: acute general hospitals (acute detoxification only);

alcoholism rehabilitation units and intermediate care facilities (sub-acute detoxification only); non-hospital detoxification (sub-acute only); or non-health care settings (self-induced withdrawal).

(7) "Emergency alcohol and drug abuse service" means evaluation and treatment for life-threatening medical complications of alcohol or drug abuse.

(8) "General certification" means the status given to an intermediate care facility by the Department of Health and Mental Hygiene's Alcohol and Drug Abuse Administration upon compliance with program standards found in COMAR 10.47.10.05,C granted to any alcoholism or drug abuse treatment program which fully meets all standards established by the Alcohol and Drug Abuse Administration.

(9) "Gray area population" means those persons who do not qualify for services under the Maryland Medical Assistance Program but whose annual income from any source is no more than 180 percent of the most current Federal Poverty Index, and who have no insurance for alcohol and drug abuse treatment services.

(10) "Halfway house" means a facility for rehabilitating recovering alcohol or drug abusers who need a community-based residence that provides a controlled, supportive, alcohol-free and drug-free environment and who are ambulatory and capable of self-care but are not yet ready to return to their families or to live on their own. Services often include informational, social, and recreational activities; vocational rehabilitation; and self-help group meetings, including individual and group counseling for a length of stay ranging from three to twelve months.

(11) "Indigent population" means those persons who qualify for services under the Maryland Medical Assistance Program, regardless of whether Medical Assistance will reimburse for alcohol and drug abuse treatment.

(12) "Intensive outpatient program" means the outpatient programs intended for alcohol or drug abusers who live at home but require an intensive therapeutic environment that provides treatment several hours a day, up to seven times per week, often in evenings, during weekends, or both, and provides a full range of group and individual therapy, counseling, and educational programs.

(13) "Intermediate care facility" means a facility designed to facilitate the sub-acute detoxification and rehabilitation of alcohol and drug abusers by placing them in an

organized therapeutic environment in which they receive medical services, diagnostic services, individual and group therapy and counseling, vocational rehabilitation, and work therapy while benefiting from the support that a residential setting can provide.

(a) An adolescent intermediate care facility is programmatically designed to serve those 12-17 years of age for lengths of stay of 30-60 days.

(b) An adult intermediate care facility is programmatically designed to serve those 18 and older for lengths of stay of 7-21 days.

(14) "Jurisdiction" means any of the 23 Maryland counties or Baltimore City.

(15) "Long-term care facility" means a program with a treatment regimen that provides continuous treatment for over 60 days, including halfway houses, therapeutic communities, long-term residential care programs, and other alternative stay programs that provide care over an extended period of time.

(16) "Long-term residential care program" means a program serving chronic alcoholic substance abusers who: are ambulatory and not in need of daily nursing, medical, or psychiatric care; have a history of multiple admissions to alcoholism or drug abuse treatment facilities in addition to physical and mental disabilities as a result of prolonged alcohol or drug abuse; and have been identified as persons for whom a controlled environment and supportive therapy is necessary for an indefinite period of time. Services include meals, medical and psychiatric services, individual and group therapy and counseling, and education, recreation, and work therapy.

(17) "Mental Hygiene Administration" means the agency of the Department of Health and Mental Hygiene responsible for planning and funding the treatment of mentally ill persons.

(18) "Office of Health Care Quality" means the agency of the Department of Health and Mental Hygiene responsible for the licensing, certification, and quality assurance of health care facilities.

(19) "Outpatient alcoholism and drug abuse treatment program" means care provided on both a scheduled and non-scheduled basis to alcohol or drug abusing persons and their families whose physical and emotional status allow them to live at home while obtaining treatment in settings such as local health departments, hospital clinics, community centers, private counseling centers, and private physicians' offices.

(20) "Private beds" mean intermediate care facility beds not sponsored by local jurisdictions and without significant funding by the state or local jurisdictions, the need for which is identified in accordance with Regulation .07 of this Chapter to serve patients in a facility providing no less than 30 percent of its annual patient days to the indigent and gray area population for an adolescent intermediate care facility and no less than 15 percent of the facility's annual patients days for an adult intermediate care facility (Track One).

(21) "Publicly-funded beds" means intermediate care beds in facilities owned and wholly operated by the State or substantially funded by the budget process of the State; or in facilities substantially funded by one or more jurisdictional governments, which are established jointly by providers and the jurisdiction or jurisdictions to meet the special needs of their residents and that reserve at least 50 percent of their proposed annual adolescent or adult bed capacity for indigent and gray area patients (Track Two).

(22) "Relapse" means an interruption or termination of the recovery process as a result of resumption of the use of alcohol or drugs and the deterioration of lifestyle and level of functioning that is an integral part of the disease of addiction for which appropriate intervention strategies should be incorporated at each level of treatment.

(23) "Self-help groups" means Narcotics Anonymous, Chemical Dependence Anonymous, Alcoholics Anonymous, Women for Sobriety, and other voluntary fellowships or groups that support persons in recovery from drug and alcohol and provide individual needs assessment, treatment planning, referral to additional sources of care, treatment, and aftercare.

(24) "Special populations" means those populations that historically have not been, or are not now served by the alcohol and drug abuse treatment delivery system including, women and women with dependent children, the elderly, the homeless, the poor, adolescents, persons with mixed dependencies, hearing impaired, the disabled, minorities, and others with special needs.

(25) "Sub-acute detoxification" means short-term treatment for the intoxicated or overdosed individual who may be appropriately treated outside an acute care hospital.

(26) "Substance Abuse Management Information System" (SAMIS) means the Alcohol and Drug Abuse Administration's management information system to which intermediate care facilities and other alcohol and drug abuse facilities and programs must report utilization, cost, and other data.

(27) "Support services" means alcohol and drug abuse services such as diagnosis, information and referral, ambulatory care treatment, individual and family counseling, treatment follow-up, and privately organized therapeutic group counseling.

(28) "Uncompensated care" means that portion of a facility's charges that it is unable to collect from either patients or a third-party payor, and includes both charity care and bad debts.

APPENDIX

TABLES

Table 1
Gross and Net Private Intermediate Care Facility (ICF) Bed Need Projections
For Adolescents (Ages 12-17), 2005

	Western Maryland (1)	Montgomery County	Southern Maryland	Central Maryland (2)	Eastern Shore	Total
Projected Population- 2005	50,497	74,334	96,929	194,025	32,754	448,539
Indigent Population	6,906	6,677	14,079	41,228	7,084	75,974
Non-Indigent Population	43,591	67,657	82,850	152,797	25,670	372,565
Est. No. of Substance Abusers (15%)	6,539	10,149	12,428	22,920	3,851	55,885
Estimated Annual Target Population (20%)	1,308	2,030	2,486	4,584	770	11,177
Estimated No. Requiring Treatment (95%)	1,242	1,928	2,361	4,355	732	10,618
Estimated Range Requiring Intermediate Care (12.5%-15%)						
Minimum	155	241	295	544	91	1,327
Maximum	186	289	354	653	110	1,593
Estimated Range Requiring Readmission (20%)						
Minimum	31	48	59	109	18	265
Maximum	37	58	71	131	22	319
Total Discharges from Out-of-State	0	0	0	8	0	8
Range Requiring Intermediate Care						
Minimum	186	289	354	661	110	1,601
Maximum	224	347	425	792	132	1,919
Gross Private Bed Need Range (22 ALOS - 85% Occupy.)						
Minimum	13	21	26	47	8	114
Maximum	16	25	30	56	9	136
Existing Private (3) ICF Inventory (No. of Beds)	0	0	0	68	0	68
Net Intermediate Private Bed Need Range						
Minimum	13	21	25	(0)	8	64
Maximum	16	25	30	(0)	9	80

Notes:
(1) Western Maryland includes Carroll County
(2) Negative bed need is tabulated as zero (0)
(3) Does not include facilities within the juvenile justice system.

Source: Maryland Health Care Commission (Data on ALOS and discharges from out-of-state are from the Substance Abuse Management Information System; data on the indigent population is from the Maryland Medical Assistance Program, June 2000; population projections are from the Maryland Office of Planning, updated February 2000; and the ICF bed inventory is based on Commission files and a telephone survey conducted in June 2000.)

Table 2
Gross and Net Private Intermediate Care Facility (ICF) Bed Need Projections
For Adults (Ages 18+), 2005

	Western Maryland (1,2)	Montgomery County	Southern Maryland	Central Maryland	Eastern Shore (4)	Total
Projected Population- 2005	445,321	682,209	834,128	2,308,229	298,418	4,568,305
Indigent Population	23,501	23,523	41,187	129,424	21,642	239,277
Non-Indigent Population	421,820	658,686	792,941	2,178,805	276,776	4,329,028
Est. No. of Substance Abusers (8.64%)	36,445	56,910	68,510	188,249	23,913	649,354
Estimated Annual Target Population (25%)	9,111	14,228	17,128	47,062	5,978	162,339
Estimated No. Requiring Treatment (95%)	8,656	13,516	16,271	44,709	5,679	154,222
Estimated Range Requiring Inter. Care (12.5%-15%)						
Minimum	1,082	1,690	2,034	5,589	1,420	19,278
Maximum	1,298	2,027	2,441	6,706	1,988	23,133
Estimated Range Requiring Readmission (10%)						
Minimum	108	169	203	559	142	1,928
Maximum	130	203	244	671	199	2,313
Total Discharges from Out-of-State	10	0	4	204	12	230
Range Requiring Intermediate Care						
Minimum	1,200	1,858	2,241	6,351	1,574	21,435
Maximum	1,438	2,230	2,689	7,581	2,199	25,677
Gross Priv. Bed Need Range (14 ALOS - 85% Occupy.)						
Minimum	54	84	101	287	71	968
Maximum	65	101	121	342	99	1,160
Existing Private ICF Inventory (3)	111	10	0	80	42	243
Net Intermediate Private Bed Need Range						
Minimum	(0)	74	101	207	29	411
Maximum	(0)	91	121	262	57	531

Notes:
(1) Western Maryland includes Carroll County
(2) Negative bed need is tabulated as zero (0)
(3) Does not include ICFs in the adult justice system
(4) At the request of ADAA, assumptions for the Eastern Shore are that 25%-35% will require ICF care.

Source: Maryland Health Care Commission (Data on ALOS and discharges from out-of-state are from the Substance Abuse Management Information System; data on the indigent population is from the Maryland Medical Assistance Program, June 2000; population projections are from the Maryland Office of Planning, updated February 2000; and the ICF bed inventory is based on Commission files

COMAR 10.24.14
Table 3
Inventory of Private Intermediate Care Facility (ICF) Alcohol and Drug Abuse Treatment Beds for Adults and Adolescents: Maryland, October 2000

Region/Facility Name	Adult ICF Beds			Adolescent ICF Beds		
	Certified by DHMH	CON Approved	Total	Certified by DHMH	CON Approved	Total
WESTERN MARYLAND	111	0	111	0	0	0
Mountain Manor	111	0	111	0	0	0
MONTGOMERY COUNTY	10	0	10	0	0	0
Montgomery General	10	0	10	0	0	0
SOUTHERN MARYLAND	0	0	0	0	0	0
CENTRAL MARYLAND	80	0	80	68	0	68
Mountain Manor	0	0	0	68	0	68
Ashley	80	0	80	0	0	0
EASTERN SHORE	42	0	42	0	0	0
Warrick Manor	42	0	39	0	0	0
MARYLAND TOTAL	**243**	**0**	**243**	**68**	**0**	**68**

Source: Maryland Health Care Commission (Data reported is based on Commission files and a telephone survey conducted in June 2000 and updated in October 2000.)

COMAR 10.24.14
Table 4
Inventory of Publicly-Funded Intermediate Care Facility (ICF) Alcohol and Drug Abuse Treatment Beds for Adults and Adolescents: Maryland, October 2000

Region/Facility Name	Adult ICF Beds			Adolescent ICF Beds		
	Certified by DHMH	CON Approved	Total	Certified by DHMH	CON Approved	Total
WESTERN MARYLAND	64	0	64	33	0	33
Finan Center						
Massie Unit	25	0	25	0	0	0
Jackson Unit	0	0	0	33	0	33
Carroll Addiction Rehab Center	20	0	20	0	0	0
Shoemaker Womens Program	19	0	19	0	0	0
MONTGOMERY COUNTY	32	0	32	0	0	0
Avery Treatment Center	32	0	32	0	0	0
SOUTHERN MARYLAND	40	0	40	0	0	0
Anchor @ Walden-Sierra	20	0	20	0	0	0
Reality House	20	0	20	0	0	0
CENTRAL MARYLAND	117	0	117	20	0	20
Pathways	20	0	20	20	0	20
Hope House	18	0	18	0	0	0
Turek House	63	0	63	0	0	0
Arc House	16	0	16	0	0	0
EASTERN SHORE	53	0	53	0	0	0
Whitsett Rehab Center	20	0	20	0	0	0
Hudson Center	33	0	33			
				0		
MARYLAND TOTAL	**306**	**0**	**306**	**53**	**0**	**53**

Source: Maryland Health Care Commission (Data reported is based on Commission files and a telephone survey conducted in June 2000 and updated in August 2001.)

COMAR 10.24.14
Table 5
Summary of Net Intermediate Care Facility (ICF) Private Bed Need Range,
by Region and Age Group: Maryland, 2005
(Track One)

Region	Age Group	Intermediate Care Facility (ICF) Bed Need Range (2005)
Western Maryland		13-16
	Adolescents	13-16
	Adults	0
Montgomery County		95-116
	Adolescents	21-25
	Adults	74-91
Southern Maryland		126-151
	Adolescents	25-30
	Adults	101-121
Central Maryland		207-262
	Adolescents	0
	Adults	207-262
Eastern Shore		21-29
	Adolescents	8-9
	Adults	29-57
Maryland State Total		459-574
	Adolescents	64-80
	Adults	411-532

(*) Negative bed need is tabulated as zero.

Source: Maryland Health Care Commission, October 2000

Exhibit 6

TABLE 2

Inventory of Track 2 Intermediate Care Facility (ICF) Alcohol and drug Abuse Treatment Beds for Adults and Adolescents: Maryland October 2018

Region / Facility Name	Adult Track 2 ICF Beds
WESTERN MARYLAND	**272**
Allegheny County Health Dept (Massie & Jackson Unit)	114
Mountain Manor Treatment Center	118
Shoemaker Center	40
MONTGOMERY / PRINCE GEORGE'S COUNTY	**119**
Avery Road Treatment Center	60
Hope House Treatment Centers	59
SOUTHERN MARYLAND	**27**
Anchor of Walden	27
CENTRAL MARYLAND	**287**
Hope House Treatment Center	49
Pathways	40
Baltimore Crisis Response	7
Gaudenzia at Park Heights	67
Mountain Manor	68
Turek House	29
Gaudenzia Crownsville	27

Exhibit 7

Exhibit 6 – Pyramid Walden ICF Turndowns by Month by County January 2019 – January 2020

	2019												2020	Grand Total
	Qtr1			Qtr2			Qtr3			Qtr4			Qtr1	
Row Labels	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
Allegany						1	1	4		1	7	4	4	22
Anne Arundel	42	62	62	63	25	11	4	4			8	64	22	367
Baltimore	5	43	24	60	29	16	6	2			6	26	12	229
Baltimore City		4	6	6	5	1					3	3		28
Calvert	20	24	22	22	18	3	4	2			6	7	6	134
Caroline				1										1
Carroll	1		1	3							3	1		9
Cecil	5	8	2	3	6				1		2	3		30
Charles	30	49	71	74	17	13	8	9	1		13	45	9	339
Dorchester				1										1
Frederick	2	4	5	13	5						5	4		38
Garrett				1							2			3
Harford		4	2	19	5	1					1	3	3	38
Howard	1		3	5	2						1	3		15
Kent		1												1
Montgomery	1	10	10	14	4		1				1	11	3	55
Out of State	2	11	11	22	3	3	1	2						55
Prince George's	8	30	21	41	33	6	3	6			8	23	9	188
Queen Anne's											1		1	2
Somerset			2											2
St. Mary's	129	81	99	89	50	13	16	7			41	113	49	687
Talbot			1									1	1	3
Virgina					1									1
Washington	4		1	8	8	2	1	2				2		28
Wicomico		1	2		1	2					8	15	2	31
Worcester	1		1								2	6		10
(blank)														
Bucks										1	1			2
Beaver										1				1
Northampton											1			1
Lackawanna											1			1
Richmond												1		1
Camden										1				1
Lehigh													1	1
Monroe											1			1
Cape May													1	1
N/A										1	1			2
Fairfax												1		1
Grand Total	**251**	**332**	**346**	**445**	**212**	**72**	**45**	**38**	**2**	**5**	**123**	**336**	**123**	**2330**

Exhibit 8

carf INTERNATIONAL

Survey Accreditation Detail

As of 4/25/2019

Survey Number:	106073
Company Number:	229725
Accreditation Decision:	Three-Year Accreditation
Accreditation Expiration Date:	6/30/2021
Company Submitting Application:	Pyramid Healthcare, Inc. 270 Lakemont Park Boulevard Altoona, PA 16602-5944

Program Summary:

Administrative Location Only
Assessment and Referral: Alcohol and Other Drugs/Addictions (Adults)
Assessment and Referral: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Detoxification/Withdrawal Management: Alcohol and Other Drugs/Addictions (Adults)
Detoxification/Withdrawal Management: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Detoxification/Withdrawal Support: Alcohol and Other Drugs/Addictions (Adults)
Inpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Criminal Justice)
Intensive Outpatient Treatment: Mental Health (Adults)
Intensive Outpatient Treatment: Mental Health (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Criminal Justice)
Outpatient Treatment: Mental Health (Adults)
Outpatient Treatment: Mental Health (Children and Adolescents)
Partial Hospitalization: Alcohol and Other Drugs/Addictions (Adults)
Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)
Residential Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)

Companies with Programs:

Pyramid Healthcare, Inc. (229725)

270 Lakemont Park Boulevard
Altoona, PA 16602-5944
Administrative Location Only

Allentown OP: Dieruff High School (280386)

815 North Irving Street
Allentown, PA 18109
Outpatient Treatment: Mental Health (Children and Adolescents)

Allentown OP: Raub Middle School (280389)

102 South St. Cloud Street
Allentown, PA 18104
Outpatient Treatment: Mental Health (Children and Adolescents)

Survey Accreditation Detail

As of 4/25/2019

Allentown OP: William Allen High School (280388)

106 North 17th Street
Allentown, PA 18102
Outpatient Treatment: Mental Health (Children and Adolescents)

Allentown OP: William Penn Alternative School (280387)

401 Allen Street
Allentown, PA 18102
Outpatient Treatment: Mental Health (Children and Adolescents)

Allentown Outpatient (262970)

1605 North Cedar Crest Boulevard, Suite 602, Roma Corporate Center
Allentown, PA 18104
Assessment and Referral: Alcohol and Other Drugs/Addictions (Adults)
Assessment and Referral: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Mental Health (Adults)
Intensive Outpatient Treatment: Mental Health (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Mental Health (Adults)
Outpatient Treatment: Mental Health (Children and Adolescents)

Altoona Outpatient (262969)

Two Sellers Drive
Altoona, PA 16601
Assessment and Referral: Alcohol and Other Drugs/Addictions (Adults)
Assessment and Referral: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)

Bartonsville Outpatient (271372)

3180 Route 611, Suite 19, Fountain Court
Bartonsville, PA 18321
Assessment and Referral: Alcohol and Other Drugs/Addictions (Adults)
Assessment and Referral: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Mental Health (Adults)
Intensive Outpatient Treatment: Mental Health (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Mental Health (Adults)
Outpatient Treatment: Mental Health (Children and Adolescents)

Survey Accreditation Detail

As of 4/25/2019

Belleville Inpatient (262966)

3893 West Main Street
Belleville, PA 17004-9252
Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)

Bristol Outpatient (262980)

1230 Veteran Highway, Suite F1
Bristol, PA 19007
Assessment and Referral: Alcohol and Other Drugs/Addictions (Adults)
Assessment and Referral: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)

Chambersburg Outpatient (262971)

124 Chambers Hill Drive
Chambersburg, PA 17201
Assessment and Referral: Alcohol and Other Drugs/Addictions (Adults)
Assessment and Referral: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)

Compass Residential Treatment Program (278068)

44863 Saint Andrew's Church Road
California, MD 20619
Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)

Dockside (314722)

44867 Saint Andrews Church Road
California, MD 20619
Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)

Duncansville Inpatient (262965)

1894 Plank Road
Duncansville, PA 16635-8380
Detoxification/Withdrawal Management: Alcohol and Other Drugs/Addictions (Adults)
Detoxification/Withdrawal Management: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)

Survey Accreditation Detail

As of 4/25/2019

Erie Outpatient (262972)

2409 State Street, Suite C
Erie, PA 16503
Assessment and Referral: Alcohol and Other Drugs/Addictions (Adults)
Assessment and Referral: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)

Gratitude House (Halfway House) (262975)

901 Sixth Avenue
Altoona, PA 16602-2503
Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)

Hawley Outpatient Treatment Center (299187)

2515 Route 6, Suite B
Hawley, PA 18428
Assessment and Referral: Alcohol and Other Drugs/Addictions (Adults)
Assessment and Referral: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)

Hillside Inpatient (262967)

420 Supreme Court
East Stroudsburg, PA 18302
Detoxification/Withdrawal Management: Alcohol and Other Drugs/Addictions (Adults)
Detoxification/Withdrawal Management: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)

Langhorne Inpatient (262979)

1990 Woodbourne Road
Langhorne, PA 19047
Detoxification/Withdrawal Management: Alcohol and Other Drugs/Addictions (Adults)
Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)

Lehigh Valley Inpatient Treatment Center (299186)

124 Bridge Street
Catasauqua, PA 18032
Detoxification/Withdrawal Management: Alcohol and Other Drugs/Addictions (Adults)
Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)

Survey Accreditation Detail

As of 4/25/2019

Mazzitti and Sullivan Harrisburg (295784)

3207 North Front Street
Harrisburg, PA 17110
Assessment and Referral: Alcohol and Other Drugs/Addictions (Adults)
Assessment and Referral: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Mental Health (Adults)
Outpatient Treatment: Mental Health (Children and Adolescents)

Mazzitti and Sullivan Hershey (295766)

1345 East Chocolate Avenue
Hershey, PA 17033
Assessment and Referral: Alcohol and Other Drugs/Addictions (Adults)
Assessment and Referral: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Mental Health (Adults)
Outpatient Treatment: Mental Health (Children and Adolescents)

Mazzitti and Sullivan Mechanicsburg (295780)

5021 East Trindle Road, First Floor
Mechanicsburg, PA 17050
Assessment and Referral: Alcohol and Other Drugs/Addictions (Adults)
Assessment and Referral: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Mental Health (Adults)
Outpatient Treatment: Mental Health (Children and Adolescents)

Mazzitti and Sullivan Middletown (295781)

1801 Oberlin Road, Suite 303, Twelve Oaks Center
Middletown, PA 17057
Assessment and Referral: Alcohol and Other Drugs/Addictions (Adults)
Assessment and Referral: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Mental Health (Adults)
Outpatient Treatment: Mental Health (Children and Adolescents)

Survey Accreditation Detail

As of 4/25/2019

Pine Ridge Manor (Halfway House) (262977)

13505 South Eagle Valley Road
Tyrone, PA 16686-7817
Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)

Pittsburgh Outpatient (262973)

1401 Forbes Avenue, Suite 200
Pittsburgh, PA 15219
Assessment and Referral: Alcohol and Other Drugs/Addictions (Adults)
Assessment and Referral: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)

Pyramid Harrisburg Outpatient Treatment Center (316113)

8012 Bretz Drive
Harrisburg, PA 17112
Assessment and Referral: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)

Pyramid Healthcare Dallas (315553)

100 Upper Demunds Road
Dallas, PA 18612
Detoxification/Withdrawal Management: Alcohol and Other Drugs/Addictions (Adults)
Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)

Pyramid Healthcare York Inpatient (318305)

5849 Lincoln Highway
York, PA 17406
Detoxification/Withdrawal Management: Alcohol and Other Drugs/Addictions (Adults)
Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)

Pyramid Pittsburgh Inpatient (262968)

306 Penn Avenue
Pittsburgh, PA 15221-2134
Detoxification/Withdrawal Management: Alcohol and Other Drugs/Addictions (Adults)
Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)

Pyramid Walden LLC (205146)

21770 Franklin Delano Roosevelt Boulevard, Suite A
Lexington Park, MD 20653
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Partial Hospitalization: Alcohol and Other Drugs/Addictions (Adults)

Survey Accreditation Detail

As of 4/25/2019

Quakertown Inpatient (262981)

2705 Old Bethlehem Pike
Quakertown, PA 18951-4047
Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)

Quest - Bellefonte (276339)

210 1/2 West High Street
Bellefonte, PA 16823
Assessment and Referral: Alcohol and Other Drugs/Addictions (Adults)
Assessment and Referral: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)

Quest - Phillipsburg (276321)

9 West Pine Street
Philipsburg, PA 16866
Assessment and Referral: Alcohol and Other Drugs/Addictions (Adults)
Assessment and Referral: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)

Ridgeview Inpatient (262982)

4447 Gibsonia Road
Gibsonia, PA 15044-7998
Assessment and Referral: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Residential Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)

State College (266593)

270 Walker Drive, Suite 108A
State College, PA 16801
Assessment and Referral: Alcohol and Other Drugs/Addictions (Adults)
Assessment and Referral: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)

Tradition House (Halfway House) (262976)

830 Sixth Avenue
Altoona, PA 16602-2502
Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)

Survey Accreditation Detail

As of 4/25/2019

Walden Outpatient Charlotte Hall Office (205147)

30007 Business Center Drive
Charlotte Hall, MD 20622
Detoxification/Withdrawal Support: Alcohol and Other Drugs/Addictions (Adults)
Inpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Partial Hospitalization: Alcohol and Other Drugs/Addictions (Adults)
Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)

Walden Outpatient Waldorf Office (238994)

85 High Street, Suite 2
Waldorf, MD 20602
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)

Walden Saint Mary's County Detention Center Services (256666)

41880 Baldridge Street
Leonardtown, MD 20650
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Criminal Justice)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Criminal Justice)

Walden/Sierra Corporation - Administration (280337)

21770 Franklin Delano Roosevelt Boulevard
Lexington Park, MD 20653
Administrative Location Only

Walden/Sierra Outpatient (79083)

44867 Saint Andrews Church Road
California, MD 20619
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)

Waynesboro Outpatient (262978)

626 North Grant Street
Waynesboro, PA 17268
Assessment and Referral: Alcohol and Other Drugs/Addictions (Adults)
Assessment and Referral: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Mental Health (Adults)
Outpatient Treatment: Mental Health (Children and Adolescents)

Survey Accreditation Detail

As of 4/25/2019

York Outpatient (262974)

18 South George Street, Suite 402
York, PA 17401
Assessment and Referral: Alcohol and Other Drugs/Addictions (Adults)
Assessment and Referral: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)

York Pharmacotherapy Services (299188)

104 Davies Drive
York, PA 17402
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)

Company Count: 45

Exhibit 9

Pyramid Healthcare Treatment Facilities

POLICY/PROCEDURE

Section:	Provision of Care
Policy Name:	Utilization Review
Policy Number:	PHC 2.2

Date Issued:	7/1/1999
Date Reviewed:	
Date Revised:	2/23/2000; 10/1/2009; 7/1/2010; 8/13/2012; 6/18/2018; 4/9/2019

POLICY: Pyramid Healthcare, Inc. is committed to providing the highest quality of care based on the assessed needs of the individual client and to realizing the optimal outcomes for every client treated. The basis for the individualized care provided to each client stems from the integration of information obtained through the screening and assessments completed or obtained during the admissions process. The second step in the admissions process is the Level of Care Assessment, where the client is assessed and level of care recommendations are identified. During the level of care assessment, and throughout treatment, the client's needs are assessed and reassessed and treatment recommendations are formulated and implemented. In an attempt to ensure the client is receiving the appropriate services at the appropriate level of care, the care of each individual client is reviewed on a consistent basis and adjustments to the plan of care are initiated as indicated.

SCOPE: The Executive Director of the facility is responsible for adherence to this policy.

PROCEDURE:

I. Purpose

A. Utilization Review is the process by which the use of available facilities and services is evaluated. The purpose is to assure that each client receives the appropriate care based on the individual assessment and to assure that the treatment, care and services provided are:

1. Medical or Clinical necessity
2. Delivered in an efficient and cost effective manner
3. Provided at the least restrictive level of care necessary to assure the best client outcomes
4. In conformity with state and federal regulations governing the service provided
5. In compliance with CARF standards of care
6. In line with established admission criteria

B. Utilization Review is employed as an instrument to ensure the provision of the best possible care for patients/residents, as a medium for education of the clinical staff, as a basis for comparative studies within the organization and among health care facilities, and as a foundation for making necessary changes to individual treatment plans, programs and services.

II. Organization:

A. The UR coordinator or designee is responsible for gathering and integrating information from the treatment team staff, including, but not limited to:

1. Medical and Psychiatric Providers
2. Clinical staff
3. Nursing staff (where applicable)

4. Support staff

B. The UR coordinator or designee reviews the treatment information and communicates with appropriate parties, in compliance with all state and federal confidentiality laws governing the treatment, care or services provided, to ensure the client is receiving the necessary care, at the most appropriate and least restrictive level.

1. ASAM 3rd Edition criteria is utilized for evaluating appropriateness and medical/clinical necessity of admission, continued stay, transfer and discharge for drug and alcohol clients.

2. DSM-V criteria are used for diagnostic and placement determination for mental health clients.

C. The UR staff reviews any discrepancies in level of care recommendations, funding issues, delays in the provision of treatment, care or services, and initiates action to resolve the discrepancies in a timely manner.

D. All UR issues are reviewed with the Executive Director and/or Director of Utilization Review. Any trends identified are reviewed at the facility and corporate level for performance improvement.

III. Admission and Continued Stay Reviews:

A. At Admission, an initial length of stay is assigned following the determination that the client meets criteria for the level of care in which he or she is placed.

B. Continued Stay Reviews occur at the request of the payor source for Residential clients and on a monthly basis for Halfway House, Partial Hospital, and Outpatient clients.

1. Continued Stay Reviews occur more often when authorized length of stay is shorter or there is a significant clinical change in the client condition, suggesting a need for a change in level of care.

2. Continued Stay Reviews are documented on facility approved forms and are maintained as a permanent part of the client record.

C. When a client does not meet Continued Stay Review criteria the client will be assessed and transferred to the appropriate level of care, if necessary.

IV. All denials of reimbursement for recommended care from referral and/or funding sources are reviewed by the Executive Director and/or Director of Utilization Review.

A. The grievance process will be utilized as necessary to ensure the client needs are met.

B. A request for scholarship can be submitted to the Vice President of Operations if deemed appropriate by the Executive Director.

C. No decisions regarding the treatment, care or services offered to clients will be made strictly based on reimbursement related issues.

Pyramid Healthcare Treatment Facilities

POLICY/PROCEDURE

Section:	Assessment	**Date Issued:**	7/1/1999
Policy Name:	Admission Criteria	**Date Reviewed:**	
Policy Number:	PHC 1.3	**Date Revised:**	2/23/00; 1/29/07; 7/1/10; 8/13/12; 6/3/15; 6/15/15; 8/1/16; 6/22/18; 11/30/18, 1/1/19

POLICY: Pyramid Healthcare, Inc. ensures that each individual is treated at the most appropriate level of care based on the assessed severity of his/her illness and individual needs. Established admission criteria have been developed in order to facilitate access to high quality treatment in the least restrictive atmosphere required.

SCOPE: The Executive Director of the facility is ultimately responsible for adherence to this policy.

PROCEDURE:

I. All Drug and Alcohol programs utilize the American Society of Addiction Medicine (ASAM) criteria to determine the appropriate level of care for each individual.

II. All mental health programs use the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSMV) criteria for mental health diagnosis and medical necessity criteria to determine appropriate level of care.

III. Pyramid Healthcare, Inc. can accommodate both male and female clients at all levels of care throughout the continuum of services provided.

IV. For any client or potential client who meets exclusionary criteria, Pyramid Healthcare, Inc. will facilitate a referral to an appropriate care provider.

V. Each program adheres to the following additional criteria:

A. **ADULT DETOXIFICATION**

1. Admission criteria include:

   a. 14 years of age or older
   b. Clients are reviewed on a case by case basis to determine medical appropriateness
   c. Are able to communicate on a level to participate in therapeutic programming
   b. Possess the ability for self-care
   c. Meet appropriate DSMV criteria for substance use disorder
   d. Meet ASAM criteria for level 3.7WM Medically Monitored Intensive Inpatient Services Withdrawal Management

2. Exclusions from admission are:

   a. Pregnant females
   b. Clients requesting detoxification from methadone who are maintained on greater than 30 mg of methadone daily
   c. Mental illness requiring acute hospitalization or at a level that cannot be managed in a residential treatment setting (suicidal, homicidal, actively psychotic, aggressive, combative)
   d. Severe physical conditions requiring acute hospitalization or at a level that cannot be managed in a residential setting
   e. Co-existing life threatening medical conditions requiring medically managed, hospital based detoxification, such as acute Pancreatitis, liver failure, uncontrolled diabetes mellitus, end stage AIDS
   f. High dose and/or long term benzodiazepine dependent clients requiring acute detoxification

g. Any person with an open warrant

B. **ADULT RESIDENTIAL OR INPATIENT**

1. Admissions must:

a. Be 18 years of age or older
b. Meet DSMV criteria for an Axis I and/or II psychiatric diagnosis
c. Meet the DSM-V criteria for substance use disorder
d. Be experiencing moderate to severe psychiatric symptoms causing impairment in social and occupational functioning
e. Have impairment of judgment or functioning capacity and capability compromised to such a degree that self-maintenance, occupational and/or social functioning is impaired and successful treatment at a lesser level of care is unlikely
a. Meet ASAM criteria for 3.5 or 3.7
b. Be able to communicate on a level to participate in therapeutic programming
c. Possess the ability for self-care

2. Exclusions from admission to the dual diagnosis program are the same as for the residential inpatient programs.

3. Special considerations are made for pregnant women on a case by case basis.

C. **ADOLESCENT RESIDENTIAL**

1. Admissions must:

a. Meet ASAM criteria (Adolescent Level of Care Index- 2R) for residential inpatient treatment
b. Be 12 to 18 years of age, or 19 years old without a high school diploma
c. Be able to communicate on a level to participate in therapeutic programming
d. Meet the DSMV criteria for substance use disorder
e. Possess the ability for self-care

2. Exclusions:

a. Clients requiring moderate to maximum assistance with self-care activities
b. Mental illness requiring acute psychiatric hospitalization or at a level not able to be managed in a residential setting (suicidal, homicidal, actively psychotic, aggressive, combative)
c. Severe physical conditions requiring acute hospitalization or at a level that cannot be managed in a residential setting
d. Life threatening physical conditions that require treatment in a medically managed residential treatment program
e. Any person with a documented IQ of 70 or lower.

D. **HALFWAY HOUSE**

1. Admissions must:

a. Be Male (Pine Ridge Manor, Gratitude House) or Female (Tradition House)
b. Be 18 years of age or older
c. Be able to communicate on a level to participate in therapeutic programming
d. Meet the DSMV criteria for substance use disorder
e. Meet ASAM criteria 3.1
f. Be ambulatory or able to evacuate the building with or without assistive devices
g. Be medically and psychiatrically stable and compliant with their medication regimen
h. Be willing to seek opportunities to gain their independence
i. Possess ability for self-care
j. If diabetic, able to independently monitor blood sugars and self-administer insulin

2. Exclusions from admission are:

a. Non-ambulatory clients, who are unable to manage self-care
b. Acute mental illness (suicidal, homicidal, or actively psychotic)
c. Life-threatening medical conditions requiring a medically managed program

3. Special Considerations:

a. Pine Ridge Manor is handicap accessible
b. Pregnant women on a case by case basis.

E. ADULT PARTIAL HOSPITAL PROGRAMS

1. Admissions must:

a. Be 18 years of age or older
b. Meet ASAM criteria 2.5
c. Be psychiatrically stable and compliant with prescribed medications
d. Be able to communicate on a level to participate in therapeutic programming
e. Meet the DSMV criteria for substance use disorder

2. Exclusions from admission are:

a. Non-ambulatory clients for facilities that are not handicap accessible
b. Individuals with life threatening medical or psychiatric conditions requiring a higher level of care

F. ADOLESCENT PARTIAL HOSPITAL PROGRAMS

1. Admissions must:

a. Be between 12 and 18 years of age
b. Be able to communicate on a level to participate in therapeutic programming
c. Possess the ability for self-care
d. Meet DSMV criteria for substance use disorder
e. Meet ASAM 2.5 criteria
f. Be fully ambulatory in facilities that are not handicap accessible, or able to evacuate the building with or without the use of assistive devices.

2. Exclusions from admission are:

a. Any person with a documented IQ of 70 or below
b. Non-ambulatory clients for facilities that are not handicap accessible
c. Individuals with life threatening medical or psychiatric conditions requiring a higher level of care

G. ADULT INTENSIVE OUTPATIENT AND OUTPATIENT

1. Admissions must:

a. Meet ASAM criteria 1 or 2.1
b. Be 18 years of age or older
c. Meet the DSMV criteria for substance use disorder or mental health diagnosis (for programs that are OMHSAS licensed)
d. Be able to communicate on a level to participate in therapeutic programming
e. Possess the ability for self-care

2. Exclusions from admission are:

a. Non-ambulatory for facilities that are not handicap accessible
b. Acute mental illness (suicidal, homicidal, or actively psychotic)
c. Life threatening medical conditions requiring a medically managed program

H. ADOLESCENT INTENSIVE OUTPATIENT AND OUTPATIENT

1. Admissions must:

    a. Meet ASAM criteria 1 or 2.1
    b. Be 13 years of age or older
    c. Meet the DSMV criteria for substance use disorder or mental health diagnosis (for programs that are OMHSAS licensed)
    d. Be able to communicate on a level to participate in therapeutic programming
    e. Possess the ability for self-care

2. Exclusions from admission are:

    a. Non-ambulatory for facilities that are not handicap accessible
    b. Acute mental illness (suicidal, homicidal, or actively psychotic)
    c. Life threatening medical conditions requiring a medically managed program

Pyramid Healthcare Treatment Facilities

POLICY/PROCEDURE

Section:	Assessment
Policy Name:	Coordination of Care
Policy Number:	PHC 1.18

Date Issued:	7/14/2016
Date Reviewed:	
Date Revised:	7/3/2017, 11/30/2018

POLICY: Pyramid Healthcare, Inc. provides quality care to all individuals. Individuals with substance abuse and mental illness benefit from family and significant other involvement and often require additional services from a variety of community resources. Coordination of Care is an essential part of providing a complete system of care and support.

SCOPE: The Executive Director of the facility is ultimately responsible for adherence to this policy.

PROCEDURE:

I. Every effort will be made to coordinate care with family, significant others and external providers involved in the current or future care of clients in treatment.

   A. Coordination with Natural Supports (which include family, significant others, and/or community supports that are voluntarily or involuntarily involved with the client's life).

      1. In most instances, for an individual to attain lasting recovery and resiliency, natural supports must be involved in the recovery process.

      2. For these reasons, Pyramid Healthcare, Inc. involves natural supports in all aspects of treatment:

         a. When it is approved by the client and as deemed clinically appropriate.

         b. Family members/significant others are provided educational and counselling services through family sessions with counseling staff and/or via the Family Programs that are established at the facility level.

         c. Natural supports are encouraged to contact primary counselors for advice about particular aspects of treatment (within the constraints of confidentiality).

         d. Individual and/or Family counseling sessions are available as needed, and as requested by the client and/or family.

         e. Open communication with natural supports is expected and highly encouraged.

   B. Coordination with Primary Care Physician

      1. Consent should be obtained at admission to communicate with client's Primary Care Physician.

      2. Once consent has been completed, an admission letter is sent to the Primary Care Physician informing them of the client's admission and information for communication as needed.

      3. Upon discharge, a discharge letter will be sent to alert the Primary Care Physician of the client's discharge.

      4. Any collaboration with the Primary Care Physician will be documented appropriately in the record.

      5. Refusal to allow coordination should be documented in the client record.

C. Coordination with other Behavioral Health Providers

1. Consent should be obtained to communicate with other Behavioral Health Providers identified by the client.

2. Any collaboration with Behavioral Health Providers will be documented appropriately in the record.

D. Referrals to Aftercare Services with Internal Agencies

1. Internal referrals between Pyramid Healthcare facilities should be communicated through primary clinical and aftercare staff.

2. Documentation will be shared through current EMR.

E. Referrals to Aftercare Services with External Agencies

1. Consent should be obtained to communicate with Aftercare Service Providers

2. Any collaboration with Behavioral Health Providers will be documented appropriately in the record.

3. Discharge Treatment Information should be shared and communicated appropriately.

Pyramid Healthcare Treatment Facilities

POLICY/PROCEDURE

Section:	Provision of Care	**Date Issued:**	7/1/1999
Policy Name:	Discharge and Transfer Criteria	**Date Reviewed:**	8/13/2012
Policy Number:	PHC 2.2	**Date Revised:**	11/1/2001; 8/7/2003; 7/1/2010; 6/18/2018

POLICY: Pyramid Healthcare, Inc. ensures that each individual is treated at the most appropriate level of care based on the assessed severity of his/her illness and his or her individual needs. The policy of Pyramid Healthcare, Inc. is to have guidelines that define successful treatment completion and how to achieve this outcome as well as criteria for client transfers, when appropriate. Pyramid Healthcare, Inc. also acknowledges that not all clients reach successful completion and discharge, and therefore categorize other types of discharge possibilities. Discharge planning begins upon admission to any Pyramid Healthcare, Inc. program.

SCOPE: The Executive Director of the facility is responsible for adherence to this policy.

PROCEDURE:

I. Types of client discharge statuses:

A. Successful

1. Treatment team and client agree treatment plan goals have been met
2. Treatment team and client agree that treatment is complete.

B. Partially Successful

1. Client completed treatment days but did not achieve all treatment plan goals
2. Client made moderate progress on treatment goals and has developed an aftercare plan with the treatment team, when deemed clinically appropriate

C. Against Medical Advice

1. Client elects to leave treatment before being medically or psychiatrically stable

D. Against Facility Advice

1. Client left treatment before it was clinically appropriate
2. Client required and refused higher level of care when unable to meet treatment plan goals
3. Client left treatment against the advice of the treatment team and without making adequate progress on treatment plan goals
4. Unable to re-engage client in treatment due to loss of contact or refusal to contact treatment in return

E. Behavioral

1. Imminent safety concern to self, treatment team, community, etc.
2. Violated safety, behavioral or motivational contract

F. Transfer

1. Requested/needed different external provider
2. Client incarcerated
3. Client has medical treatment scheduled that prohibits participation in treatment at recommended level of care
4. Client is admitted to the hospital or psychiatric unit due to acute condition that cannot be managed at the facility (i.e. cancer, suicidal ideation, chest pain, etc.)
5. Conflict of interest
6. Funding issue
7. Referred to external higher level of care
8. Referred to external lower level of care

G. Deceased/death of client

II. The requirements for successful completion of treatment are:

A. Demonstrated achievement of or significant progress towards the person-centered treatment goals identified in the Comprehensive Treatment Plan including the significant decrease or elimination of symptoms that initiated treatment.

B. Regular attendance and active participation in scheduled treatment sessions.

C. Continued mental stability with no suicidal or homicidal ideation or intent.

D. Successful completion of treatment assignments including regular attendance and active participation in scheduled treatment sessions, completion of homework assignments/tasks, practicing coping skills outside treatment, and recommendation for follow up care (as agreed upon by client) through psychiatry/medication management, MAT services, etc.

E. Client is able to function consistently and positively with their activities of daily living.

F. Participation in the development of and agreement with the follow-up Aftercare Plan (developed in collaboration with client and clinician).

G. A client may be successfully discharged from one type of treatment (i.e., substance abuse, mental health, or eating disorder treatment) while remaining in treatment for other issues, as appropriate.

III. A discharge Against Medical Advice is a voluntary discharge initiated by the client when the client has been assessed by the treatment team as either medically or psychiatrically unstable and, as such, in danger of imminent harm.

A. Prior to discharge, the treatment team will meet with the client to discuss the risks associated with leaving treatment prematurely. Alternative treatment options will be discussed, as appropriate, in an attempt to re-engage the client.

B. If warranted by the client's condition, the treatment team will also disclose any emergency protocols which they will be mandated to engage if the client leaves.

C. Every attempt will be made to safely re-engage the client in treatment.

D. If the client discharges despite all attempts, the treatment team will follow mandated emergency protocols, as appropriate.

E. If the client chooses to discharge, the referral source and other stakeholders (i.e., probation/parole) are notified of the discharge status, as consent allows.

IV. A discharge Against Facility Advice is a voluntary discharge initiated by the client when the client elects to leave treatment before the treatment team believes is clinically appropriate.

A. Prior to discharge, the treatment team will meet with the client to discuss the risks associated with leaving treatment prematurely. Alternative treatment options will be discussed, as appropriate, in an attempt to re-engage the client.

B. Every attempt will be made to re-engage the client in treatment.

C. If the client chooses to discharge, the referral source and other stakeholders (i.e., probation/parole) are notified of the discharge status, as consent allows.

V. A Behavioral Discharge may occur from the treatment program at the discretion of the treatment team.

A. Behaviors that may lead to involuntary discharge from the program include, but are not limited to:

1. Imminent safety concerns such as:
   a. Illicit substance distribution
   b. Physical altercations or threats to do bodily harm to other clients or staff
   c. Sexual boundary violation
2. Violations of a safety, behavioral, or motivational contract such as:
   a. Continued use of contraband
   b. Ongoing boundary concerns
   c. Continued use of illegal/non-prescribed substances while in treatment, if verified or and/or admitted by client
   d. Ongoing failure to participate in programming

B. The staff obtains approval to behaviorally discharge a client from treatment from the Executive Director, Clinical Supervisor for residential and outpatient clients, or the Nurse Manager for detox clients.

C. Whenever safely possible, the client is made aware of the behaviors that may lead to a behavioral discharge from the program and is given an opportunity to change the behaviors prior to being discharged.

1. The primary counselor or the nursing staff may develop a behavioral contract to clarify behavioral expectations and consequences. The contract is reviewed and signed by the client.
2. A decision is then made as to whether or not the client may remain in the program based on their response and compliance the behavioral contract, when applicable.
3. Safe treatment or disposition options are put in place.

D. Serious consideration is given to the detox client's medical condition prior to a behavioral discharge. Safe treatment and/or disposition options are put in place.

1. The medical physician on-call must be consulted on all behavioral discharges from the detox unit.
2. The client is assessed by nursing staff to determine if the inappropriate behavior is a complication of the withdrawal process, including:
   a. Is the behavior a result of a delusional/hallucinatory process that requires acute psychiatric treatment?
   b. Is the behavior related to a delirium process that requires acute medical treatment?
   c. Is the behavior willful?
3. The Counselor, Detox Specialist or Nurse documents the necessary information in the clinical record.

E. When a client is behaviorally discharged from any Pyramid Healthcare, Inc. program:

1. A **Notice of Involuntary Discharge** is presented to the client.
   a. The Notice includes a listing of the specific reasons for the behavioral discharge.
   b. Treatment recommendations post discharge are identified.
   c. The Counselor, Program Director and client, when available, sign the Notice.

2. The original **Notice of Involuntary Discharge** is maintained as a part of the client's medical record.
3. With appropriate consent, the referral source and other stakeholders (i.e., probation/parole) are notified of the discharge status.

F. The client has the right to appeal the decision in writing, following the procedure for **Conflict Resolution/Grievance Procedure.**

VI. A client will be transferred when appropriate care cannot be provided at the facility. Transfers may be internal to the Pyramid Healthcare, Inc. system of care or they may be made to an external provider.

A. Internal Transfers

1. When a client meets criteria for another level of care offered within the Pyramid Healthcare, Inc. system and chooses to remain in the Pyramid Healthcare, Inc. system, appropriate transfer arrangements are discussed with the client, significant other and/or referral source and necessary arrangements are made.

2. When a client has personal concern resulting in a request to transfer from one Pyramid facility to another, please refer to PHC 3.10 Conflict Resolution/Grievance Procedure.

B. External Transfers

1. An external transfer occurs when the client's ongoing care will be provided by another provider or entity. Examples of external transfers are:

a. The client requests a transfer to a different external provider

b. The client is incarcerated

c. The client has medical treatment scheduled that prohibits participation in treatment at the recommended level of care.

d. The client is admitted to the hospital or psychiatric unit due to an acute condition that cannot be managed at the facility (i.e. cancer, suicidal ideation, chest pain, etc.).

e. Either the client or the treatment team identifies that a conflict of interest exists

f. Funding issue

g. Referred to external higher level of care

h. Referred to external lower level of care

C. When a client no longer meets criteria for services provided within the Pyramid Healthcare, Inc. system or is electing to seek services outside of the Pyramid Healthcare, Inc. continuum, alternative arrangements are explored with the client, significant other, and/or referral source. Initial referral and transfer contacts should be established in 48 hours or less.

1. Discharge/transfer/referral to an appropriate level of care occurs within 72 hours of initial request.

a. The designated staff will explore and review available treatment options with the client, significant other and/or referral agency and involve them in the planning process.
b. In cases where the clinical staff do not feel transfer or change in services is appropriate, the following will occur:

1) Counselor and Program Director will meet with the client, significant other and/or referral agency to discuss rationale regarding the appropriateness of the referral of change in services.
2) Counselor and Program Director will assist client in exploring all viable options to meet the treatment needs of the client.
3) Counselor and Program Director will offer the client the opportunity to be reassessed in order to determine the most appropriate level of care for the client.

c. The program to which the individual is being transferred is notified, and admission procedures are initiated, when appropriate.
d. Transportation is arranged as necessary.
e. The Program Director will review any transfer that does not occur within 72 hours and document cause for the delay in transfer. In the interim, appropriate modifications to the treatment plan will be made to support the well-being of the client.

D. Discharge decisions are not based solely on reimbursement decisions made by a third party payer. If reimbursement for treatment is denied:

1. The counselor/staff member meets with the client to discuss the situation and explore appropriate options with the client.

2. The UR Coordinator or designated staff explores alternative treatment or funding options, as appropriate.

3. The treatment team discusses client condition, response to treatment, and recommendations for continued treatment

a. If the client is assessed by the treatment team to meet the criteria for continued stay, but the funding agency denies payment:

1) The Counselor/Staff member completes a **Scholarship Request Form**
2) The form is submitted to the Program Director for review and approval.
3) The form is forwarded to the Vice President of Operations for review and approval.
4) The UR Coordinator or designated staff files a grievance with the funding agency when appropriate.

b. If the individual does not meet criteria for the current level of care or if the scholarship request is denied:

1) The Counselor/staff member presents the client with current options for treatment.
2) The Finance Department is involved to assist the client in making decisions regarding continuation of treatment.

A) Payment schedules and options are reviewed with the client should they decide to remain in treatment at the current level of care.
B) These payment schedules are determined on an individual basis for each client.

E. No referrals are made without appropriate, signed authorization and consent.

VII. Due to the nature of services provided, there are occasions when a client death may occur and results in their discharge. Pyramid complies with all legal, regulatory, accreditation and internal reporting requirements. The referral source and other stakeholders (i.e., probation/parole) are notified, as consent allows.

Exhibit 10

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*: **Pyramid Walden Harford**
Primary Program Address: **1015 Pulaski Highway**
Primary Contact Name: **Catherine Briggs**
Primary Contact Phone: **(814) 515-8595**
Primary Contact Email: **cbriggs@pyramidhc.com**

Local Behavioral Health Authority Information

Local Jurisdiction: **Harford County Health Department**
Primary Contact Name: **Marcy Austin**
Primary Contact Phone: **(410) 838-1500**
Primary Contact Email: **marcy.austin@maryland.gov**

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	
Opioid Treatment	**Withdrawal Management**

* Program name should match the corporate/business name included on the application for licensure.

DHMH #4781 (September 21, 2016)

As required under COMAR 10.63.01.05, Pyramid Walden, LLC enters into the following agreement with 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 — Date: **1/27/2020**

Catherine O. Briggs
Print Name

Local Behavioral Health Authority

Signature — Date: **1/27/2020**

Marcy Austin
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.

Exhibit 11

WALDEN
A Pyramid Healthcare Company

Help for Today; Hope for Tomorrow
30007 Business Center Drive, Charlotte Hall, MD 20622
P: (301) 997-1300 | F: (301) 290-0280

TRANSFER AND REFERRAL AGREEMENT

This agreement is to facilitate continuity of care, treatment resources, timely transfer of medical records and information between Pyramid Walden and

_____

Both institutions agree that:

A. When a need for transfer or referral from one institution to the other is determined, the receiving institution agrees to admit the patient as promptly as possible, provided admission criteria is met.

B. The referring institution will provide appropriate completed forms, mutually agreed upon to provide the patient continuity of care, and information necessary to facilitate transfer and assist in assessment. Consent forms will be signed by the patient prior to the transfer of records. Both parties to this agreement will abide with all standards dealing with confidentiality of patient and treatment information.

C. The patient shall agree to the referral.

D. The patient, not the referring institution, shall be responsible for charges incurred in each institution.

E. This agreement shall be in effect for two (2) years from the date below and may be terminated by either party, upon 30 days written notice, and shall be automatically terminated should either institution fail to maintain its present authority or standards.

F. To comply with all State, Federal, HIPPA, and CARF Laws, Rules, Regulations, and Standards.

Catherine Briggs, Vice President of Operations
Pyramid Healthcare, Inc.

Date 10/1/19

Facility Representative

Date 10/1/19

Effective Date October 1, 2019

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

REGIONAL COLLABORATIVE FOR
BEHAVIORAL HEALTH (763) 355-4029

January 9, 2020

Maryland Health Care Commission

I am pleased to write and submit this letter in support of Walden and Pyramid Healthcare and their plans to develop an Intermediate Care Facility (ICF) in Harford County to better serve the needs of adults with Substance Use Disorder. The region continues to experience a shortage of services to support withdrawal management as well as short-term residential rehabilitation.

As a hospital system, our inability to locate such services in a shortage area can mean longer emergency department stays and/or hospitalizations. The project, as envisioned by Walden and Pyramid Healthcare, will open more doors and provide increased, appropriate access for these individuals-in-need.

Walden's history of providing ICF services in southern Maryland for two decades is well known but is not easily accessible for those in need in Harford County. Transporting individuals from Harford to the facility in Charlotte Hall can be burdensome and lead some individuals to refuse treatment rather than make that journey. Providing services closer to the need can be a key factor in a positive treatment experience.

I have found Walden committed to the service of the indigent and publicly funded population. We have joined a number of local organizations in developing a collaborative referral relationship with Walden to ensure a more comprehensive and coordinated treatment experience. We join Walden in sharing a goal of "warm handoffs" to create a seamless transfer experience for the individuals we serve.

Thank you for your consideration of the Walden/Pyramid Certificate Of Need application for substance use disorder treatment.

Respectfully

Rod L. Kornrumpf, FACHE

Regional Executive Director-Behavioral Health
UM Upper Chesapeake Health System
rkornrumpf@uchs.org
763-355-4029

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January 9, 2020

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Respectfully

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Regional Executive Director-Behavioral Health
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WALDEN
A Pyramid Healthcare Company

Help for Today, Hope for Tomorrow
30007 Business Center Drive, Charlotte Hall, MD 20622
P: (301) 997-1300 | F: (301) 290-0280

TRANSFER AND REFERRAL AGREEMENT

This agreement is to facilitate continuity of care, treatment resources, timely transfer of medical records and information between Pyramid Walden and

Stepping Stones Recovery Houses, LLC.

Both institutions agree that:

A. When a need for transfer or referral from one institution to the other is determined, the receiving institution agrees to admit the patient as promptly as possible, provided admission criteria is met.

B. The referring institution will provide appropriate completed forms, mutually agreed upon to provide the patient continuity of care, and information necessary to facilitate transfer and assist in assessment. Consent forms will be signed by the patient prior to the transfer of records. Both parties to this agreement will abide with all standards dealing with confidentiality of patient and treatment information.

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E. This agreement shall be in effect for two (2) years from the date below and may be terminated by either party, upon 30 days written notice, and shall be automatically terminated should either institution fail to maintain its present authority or standards.

F. To comply with all State, Federal, HIPPA, and CARF Laws, Rules, Regulations, and Standards.

Catherine Briggs, Vice President of Operations Pyramid Healthcare, Inc.	1/20/20 Date	Facility Representative	1/20/20 Date

Effective Date October 1, 2019

carf

WALDEN
A Pyramid Healthcare Company

Help for Today; Hope for Tomorrow
30007 Business Center Drive, Charlotte Hall, MD 20622
P: (301) 997-1300 | F: (301) 290-0280

TRANSFER AND REFERRAL AGREEMENT

This agreement is to facilitate continuity of care, treatment resources, timely transfer of medical records and information between Pyramid Walden and

Praising Through Recovery, Inc.

Both institutions agree that:

A. When a need for transfer or referral from one institution to the other is determined, the receiving institution agrees to admit the patient as promptly as possible, provided admission criteria is met.

B. The referring institution will provide appropriate completed forms, mutually agreed upon to provide the patient continuity of care, and information necessary to facilitate transfer and assist in assessment. Consent forms will be signed by the patient prior to the transfer of records. Both parties to this agreement will abide with all standards dealing with confidentiality of patient and treatment information.

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F. To comply with all State, Federal, HIPPA, and CARF Laws, Rules, Regulations, and Standards.

Catherine Briggs, Vice President of Operations
Pyramid Healthcare, Inc.

Date: 1/17/20

Facility Representative

Date: 1/17/2020

Effective Date October 1, 2019

ASPIRE to Excellence® carf ACCREDITED

WALDEN
A Pyramid Healthcare Company

Help for Today; Hope for Tomorrow
30007 Business Center Drive, Charlotte Hall, MD 20622
P: (301) 997-1300 | F: (301) 290-0280

TRANSFER AND REFERRAL AGREEMENT

This agreement is to facilitate continuity of care, treatment resources, timely transfer of medical records and information between Pyramid Walden and

Ashley Addiction Treatment

Both institutions agree that:

A. When a need for transfer or referral from one institution to the other is determined, the receiving institution agrees to admit the patient as promptly as possible, provided admission criteria is met.

B. The referring institution will provide appropriate completed forms, mutually agreed upon to provide the patient continuity of care, and information necessary to facilitate transfer and assist in assessment. Consent forms will be signed by the patient prior to the transfer of records. Both parties to this agreement will abide with all standards dealing with confidentiality of patient and treatment information.

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F. To comply with all State, Federal, HIPPA, and CARF Laws, Rules, Regulations, and Standards.

Catherine Briggs, Vice President of Operations
Pyramid Healthcare, Inc.

Date 1/20/20

Facility Representative

Date 1/20/2020

Effective Date October 1, 2019

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WALDEN
A Pyramid Healthcare Company

Help for Today; Hope for Tomorrow
30007 Business Center Drive, Charlotte Hall, MD 20622
P: (301) 997-1300 | F: (301) 290-0280

TRANSFER AND REFERRAL AGREEMENT

This agreement is to facilitate continuity of care, treatment resources, timely transfer of medical records and information between Pyramid Walden and

_____Recovery Centers of America_____

Both institutions agree that:

A. When a need for transfer or referral from one institution to the other is determined, the receiving institution agrees to admit the patient as promptly as possible, provided admission criteria is met.

B. The referring institution will provide appropriate completed forms, mutually agreed upon to provide the patient continuity of care, and information necessary to facilitate transfer and assist in assessment. Consent forms will be signed by the patient prior to the transfer of records. Both parties to this agreement will abide with all standards dealing with confidentiality of patient and treatment information.

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F. To comply with all State, Federal, HIPPA, and CARF Laws, Rules, Regulations, and Standards.

_____	1/29/20	Melaina Cimini__	1/29/2020___
Catherine Briggs, Vice President of Operations Pyramid Healthcare, Inc.	Date	Facility Representative	Date

Effective Date October 1, 2019

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WALDEN
A Pyramid Healthcare Company

Help for Today; Hope for Tomorrow
30007 Business Center Drive, Charlotte Hall, MD 20622
P: (301) 997-1300 | F: (301) 290-0280

TRANSFER AND REFERRAL AGREEMENT

This agreement is to facilitate continuity of care, treatment resources, timely transfer of medical records and information between Pyramid Walden and

The Borgand Group

Both institutions agree that:

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B. The referring institution will provide appropriate completed forms, mutually agreed upon to provide the patient continuity of care, and information necessary to facilitate transfer and assist in assessment. Consent forms will be signed by the patient prior to the transfer of records. Both parties to this agreement will abide with all standards dealing with confidentiality of patient and treatment information.

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F. To comply with all State, Federal, HIPPA, and CARF Laws, Rules, Regulations, and Standards.

10/25/19		10/25/19	
Catherine Briggs, Vice President of Operations Pyramid Healthcare, Inc.	Date	Facility Representative Craig Liggins	Date

Effective Date October 1, 2019

WALDEN
A Pyramid Healthcare Company

Help for Today; Hope for Tomorrow
30007 Business Center Drive, Charlotte Hall, MD 20622
P: (301) 997-1300 | F: (301) 290-0280

TRANSFER AND REFERRAL AGREEMENT

This agreement is to facilitate continuity of care, treatment resources, timely transfer of medical records and information between Pyramid Walden and Harford County Health Department.

Both institutions agree that:

A. When a need for transfer or referral from one institution to the other is determined, the receiving institution agrees to admit the patient as promptly as possible, provided admission criteria is met.

B. The referring institution will provide appropriate completed forms, mutually agreed upon to provide the patient continuity of care, and information necessary to facilitate transfer and assist in assessment. Consent forms will be signed by the patient prior to the transfer of records. Both parties to this agreement will abide with all standards dealing with confidentiality of patient and treatment information.

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F. To comply with all State, Federal, HIPPA, and CARF Laws, Rules, Regulations, and Standards.

Catherine Briggs, Vice President of Operations
Pyramid Healthcare, Inc.

9/27/19
Date

Russell Moy, MD, MPH, Health Officer
Harford County Health Department

9-27-19
Date

Effective Date October 1, 2019

WALDEN
A Pyramid Healthcare Company

Help for Today; Hope for Tomorrow
30007 Business Center Drive, Charlotte Hall, MD 20622
P: (301) 997-1300 | F: (301) 290-0280

TRANSFER AND REFERRAL AGREEMENT

This agreement is to facilitate continuity of care, treatment resources, timely transfer of medical records and information between Pyramid Walden and

New Life Addiction Counseling & Mental Health Services

Both institutions agree that:

A. When a need for transfer or referral from one institution to the other is determined, the receiving institution agrees to admit the patient as promptly as possible, provided admission criteria is met.

B. The referring institution will provide appropriate completed forms, mutually agreed upon to provide the patient continuity of care and information necessary to facilitate transfer and assist in assessment. Consent forms will be signed by the patient prior to the transfer of records. Both parties to this agreement will abide with all standards dealing with confidentiality of patient and treatment information.

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Catherine Briggs, Vice President of Operations
Pyramid Healthcare, Inc.

Date

Facility Representative

1-20-20
Date

Effective Date October 1, 2019

ASPIRE to Excellence
carf
ACCREDITED

DANIEL CARL TORSCH FOUNDATION

A New Day, A New Beginning, A New Life...

October 8, 2019

Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Maryland Health Care Commission,

I am writing this letter of support on behalf of Walden and Pyramid Healthcare in their development of an Intermediate Care Facility in Harford County to serve adults with Substance Use Disorder. There are not enough resources to meet the needs of local and surrounding communities. We continue to experience critical levels of both fatal and nonfatal drug overdoses, and lengthy wait times in hospital emergency rooms only to be discharged without a clear treatment plan. There is a desperate need for medically monitored inpatient treatment programs. For 20 years Walden has been providing a quality High Intensity Medically Monitored treatment program in Southern Maryland and I have referred many to their facility. Unfortunately, due to the distance and transportation issues, only a few have been able to take advantage of their services.

Thankfully, Pyramid Walden is committed to serving the indigent and publicly funded population and has entered into solid relationships with many organizations in our region to ensure comprehensive and coordinated treatment. These partnerships and relationships that Pyramid Walden has formed shows that they are a leader in this community and it will ensure positive outcomes. Together we intend to ensure that treatment transitions for persons in our community include collaboration, care coordination, warm handoffs and recovery support.

Thank you for your consideration of Pyramid Walden's application for a Certificate of Need for an ICF for Substance Use Disorder. We are eager to have access to this needed treatment in Harford County and to save lives. I recommend Pyramid Walden's treatment model without hesitation. If you have any questions, please do not hesitate to contact me.

Sincerely,

Toni

Toni Torsch, Director
Daniel Carl Torsch Foundation

Mission: to provide assistance for substance abuse treatment and sober living; promote and provide overdose prevention programs
501(c)3 non profit number 45-3123369

4501 Ebenezer Road, Nottingham MD 21236

ADDICTION CONNECTIONS RESOURCE, INC.

1804 Harford Road
Fallston, Maryland 21084
PHONE: 443-417-7810
E-MAIL: acrhelps@gmail.com
WEBSITE: acr-helps.org

Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Maryland Health Care Commission,

Addiction Connections Resource is writing this letter to strongly support Pyramid Walden's proposal for the purpose of operating an Intermediate Care Facility offering Medically Monitored Inpatient treatment (Level III.7) and Clinically Managed High-Intensity Residential Program (Level 3.5) located at 1015 Pulaski Highway, Joppa, Maryland 21085.

I am the Executive Director of Addiction Connections Resource which is a major SUD treatment referral source in Harford County. As a parent who lost a child and an advocate, I was appointed to Maryland Governor Larry Hogan's Emergency Opioid and Heroin Task Force in 2015. As part of the Task Force and the experience of my own nonprofit, I have seen the need for not just treatment resources, but quality treatment resources. That is why my organization, ACR, was the catalyst in bringing Pyramid Walden to Harford County. My hope is that Pyramid Walden can provide quality treatment in Harford County.

There are 23,000 alcoholic and substance abusers in Harford County alone. This number does not take into consideration Cecil County and Baltimore County. Between these 3 counties there are only 80 beds that take Medicaid. The numbers of overdoses may be down, but we are still in a crisis. ACR refers approximated 80 Harford County residents per month to treatment and halfway housing. ACR cannot keep up with the demand for treatment. If we are truly in a crisis, immediate action would be taken to give a Certificate of Need to Pyramid Walden.

Pyramid Walden helps individuals affected by chemical dependency, mental illness, and related conditions achieve a better quality of life allowing them to live as productive and accountable individuals.

Please feel free to contact me if you need any further information at 443-417-7810.

Sincerely,

Linda Williams

Executive Director

BEL AIR POLICE DEPARTMENT

39 Hickory Avenue, Bel Air, Maryland 21014
410-638-4500 or 410-893-0200 (Baltimore Line)

Chief of Police
Charles A. Moore

October 7, 2019

Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Maryland Health Care Commission,

It is with pleasure that I write this letter of support on behalf of Walden and Pyramid Healthcare in their development of an Intermediate Care Facility in Harford County to serve adults with Substance Use Disorder. We continue to experience a need for immediate transfer of individuals to Medically Monitored Inpatient Treatment, and there are not enough resources in our community to meet the current need. Walden has been a provider of High Intensity Medically Monitored treatment in Southern Maryland for the past 20 years, and many residents from our region are transported to their facility in Charlotte Hall for treatment, then referred back to Harford County for continuing care.

Pyramid Walden is committed to serving the indigent and publicly funded population and has entered into collaborative referral relationships with our organization and others in the region to ensure comprehensive and coordinated treatment. We have found Pyramid Walden to be a leader in collaborating with community providers to ensure positive outcomes, and together we intend to ensure that treatment transitions for persons in our community include collaboration, care coordination, warm handoffs and recovery support.

Thank you for your consideration of Pyramid Walden's application for a Certificate of Need for an ICF for Substance Use Disorder. We are eager to have access to this needed treatment in Harford County and recommend Pyramid Walden's treatment model without hesitation. If you have any questions, please do not hesitate to contact me.

Sincerely,

Charles A. Moore
Chief of Police
Town of Bel Air, Maryland

Exhibit 12

Exhibit 12 – Pyramid Walden ICF Referrals by Source January 2019 – January 2020

	2019												2020	Grand Total
	Qtr1			Qtr2			Qtr3			Qtr4			Qtr1	
Row Labels	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
A F Whitsitt Center								2						2
Adventist Healthcare Hospital		2		2	1	4								9
Adventist Healthcare Hospital Maryland											1	9		10
All Care Treatment Center	2	3												5
American Addictions Center				1										1
Anne Arundel Circuit Court		3	3	5	2	1			1			1	2	18
Anne Arundel County Crisis Response	3	9	9	5	3	2			4	1	3			39
Anne Arundel County Parole and Probation			1	1										2
Anne Arundel Health Department	1	3	5	6	2									17
Anne Arundel Medical Center				2		1								3
Anne Arundel Medical Center Maryland										2		1		3
Attorney									1		1			2
Avery Road Treatment Center	1													1
Bach's Helathcare				1										1
Baltimore Crisis Response Inc	1			1		2	1						1	6
Baltimore Washington Hospital		1	2	1	1									5
Baltimore Washington Hospital Maryland											1			1
Bayside Recovery	4		2	2				1						9
Beacon Health		1	2	5		2		1						11
Beacon Health Maryland												1		1
Calvert County Care Coordination						1								1
Calvert County Courts				1			1							2
Calvert County Detention Center	1			3	1									5
Calvert County Health Department		3	1	1	1	1	1							8
Calvert County Health Department Maryland												1		1
Calvert County Office of Public Offenders				1										1
Calvert County Parole & Probation					1									1
Calvert County Substance Abuse Services	1													1
Calvert County Substance Abuse Services, Maryland											1			1
Calvert Memorial Hospital	4		1	3	2									10
Calvert Memorial Hospital Maryland									2		1			3
Carol Porto	1	2		2	1									6
Cecil County				2	1									3
Charles Circuit Court													1	1
Charles County Department of Social Services			3	2										5
Charles County Department of Social Services Maryland									3			2		5
Charles County Detention Center	2		7	1							1	1		12
Charles County Family Recovery Court								1						1
Charles County Health Department	3	3	3	7	1			1						18
Charles County Parole and Probation					1									1
Charles County Public Defenders Office				1							1	1		3
Charles District Court		1									1	2	1	5
Chrysalis House Inc							1	1						2
COE - Center of Excellence Lehigh Co.													1	1
Courts										1	1	1	2	5
Crownsville Crisis Center												2	1	3
Dundalk Health-Dundalk, MD												6	1	7
Facebook												1		1
Federal Parole and Probation	1								1					2
Frederick Memorial Hospital	1	2	2	12	5			1						23
Frederick Memorial Hospital Maryland										6	4	2		12
Gaudenzia Sunbury, PA												1		1
Gaudencia Crisis House		3												3
Gaudencia Crisis House, Maryland												1		1
Gaudenzia Inc				2	2									4
Gaudenzia Inc Maryland												1	1	2

Exhibit 12 – Pyramid Walden ICF Referrals by Source January 2019 – January 2020

Harbour House				2	1	1			5				1	10
Hartford County Health Department		2		9										11
Health Partners		1												1
Helping Hand Behavioral Health Clayton, NJ										1				1
Hope Center Ministries		2												2
Hope Center Ministries Maryland											1			1
Hope House Treatment Center				1										1
Howard County General Hospital			4	1	2									7
Howard County General Hospital Maryland										2	3	1		6
Hoyle House										1				1
Hudson Health Services, Inc.	1													1
IME Addictions Access Center										1			1	2
Johns Hopkins Bayview Medical Center- CAP- Center for Addiction and			2	6										8
Johns Hopkins Bayview Medical Center- CAP- Center for Addiction and Pregnancy Maryland										1				1
Jude House Inc		1	4		1		1							7
Jude House Inc Maryland											2	7		9
Lehigh Valley Hospital Muhlenberg- Bethlehem PA											1			1
Life Line Recovery Support Service										1				1
Maryland Centers for Addictions-Waldorf, MD												3		3
Maryland House		1								1				2
Maryland Physicians Care		1												1
Medstar Montgomery			1	2										3
Medstar Southern Maryland	1	2	1	2			2				2	2	1	13
Medstar St. Mary's Hospital	1	1	1	3	5		2	1		1	1	9	3	28
Mercy Medical Center		2	1		1	1								5
Meritus Health	3		1	5	6	1								16
Meritus Health Maryland										1				1
Midoula Health			1											1
Mountain Manor Safe Harbor Project			1											1
Mountain Manor Treatment Center		1												1
Mountain Manor Treatment Center Maryland												1		1
New Bridge Medical Center Paramus, NJ											1			1
New Life Addictions		2	2											4
Online Search								2	75	117	158	77	52	481
Open Arms Recovery Center- Hanover, PA											1			1
Other	24	36	46	56	25	11	13	8	1					220
Other / Doctor / Private Practice								2	18	22	58	68	18	186
Other External Detox / Rehab									3	2	24	10	2	41
Other External Mental Health Inpatient									4	11	4	2		21
Other Hospital									5	11	5	4	4	29
Other Insurance									1	2		1		4
Outlook Recovery	1	2	2				1							6
Outlook Recovery Maryland											1	1		2
PA Get Help Now												1		1
PA Psychiatric Institute Harrisburg											1			1
Pasacal Crisis Center	12	15	20	11	3	1	1	2	6	13	28	46	6	164
Pathways					4		1							5
Pathways Maryland												1		1
People Encouraging People		1												1
PHC Walden Anchor											3	2	1	6
PHC Walden Charlotte Hall										1	2	8	2	13
PHC Walden Lexington Park											16	29	5	50
PHC Walden Waldorf											5	5		10
Phone Book											2			2
Prince George's County Health Department		1	1	1	3	2								8
Prince George's County Hospital	2	4	1	8	3			1						19
Prince George's County Hospital Maryland									4			6	3	13
Prince George's Courts		9	2									1		12
Project Chesapeake		1						1						2
Project Chesapeake Maryland											1	8	6	15
Recovery Center Of America Maryland												1	1	2
Riverside Treatment	2	3	1	8	3	1								18
Riverside Treatment Services-Baltimore, MD												1	1	2
Safe House		3						1						4
Safe House Maryland										5	5		1	11
Safe Journey House	1	3												4
Samaritan House		1												1
Self	161	44	153	232	111	35	7	16						759
Serenity Health Aberdeen				1										1
Serenity Health Elkton		1												1
Serenity Health Elkton Maryland												2		2

Exhibit 12 – Pyramid Walden ICF Referrals by Source January 2019 – January 2020

Shady Grove Maryland									3	1	1	2		7
Sheppard Pratt	1	1												2
Southern MD Hospital	1		1		6			1				2	1	12
St. Joseph's Medical Center		8	1		1	2								12
St. Mary's County Health Department			2	3	2									7
St. Mary's County Health Department Maryland												2		2
St. Mary's County Parole & Probation	4	1	1	1	1		1					2	2	13
St. Mary's County's Drug Court	1			1								1	1	4
St. Mary's Department of Social Services	1	1	2	1			1							6
St. Mary's Department of Social Services Maryland											1		1	2
St. Mary's Detention Denter	1	2	4	1	2		1				1	5	2	19
St. Mary's Hospital	1		2	1	1		1							6
St. Mary's Hospital Maryland									3	2	2	14	1	22
Step By Step Bethlehem, PA									2		2			4
Stepping Stones			1											1
Surburban Hospital			1	10	1	1								13
Surburban Hospital Maryland											1			1
University of Maryland Charles Regional Medical Center				2		1					1	1		5
Vesta Inc					1	1								2
Walden Anchor Maryland									2	2				4
Walden Charlotte Hall										1				1
Walden Lexington Park										4				4
Walden Sierra Inc	6	135	43	6	1			9						200
Walden Waldorf, MD										1				1
Warwick Manor Behavioral Hlth Inc					1									1
Washington Adventist Hospital		5	2		2									9
Web Submission										1	2	3		6
Wells House		2												2
Wells House, Maryland									2					2
(blank)														
Cigna								1						1
RCA Recovery Centers of America Bracebridge Hall Earleville, MD									1					1
Grand Total	**251**	**332**	**346**	**445**	**212**	**72**	**36**	**53**	**147**	**216**	**352**	**363**	**127**	**2952**

Exhibit 13

Clearview Pyramid Acquisition Company, LLC.

POLICY/PROCEDURE

Section:	Human Resources
Policy Name:	In-Service Education and Training
Policy Number:	20,012

Issued By:	Human Resources
Date Issued:	7/1/99
Date Reviewed/ Revised:	8/25/06; 8/13/14; 12/16/14; 1/2/15; 3/24/15; 5/1/17; 6/6/17; 3/16/18

PURPOSE: To provide identified staff with an understanding of policies, procedures, methods and other important operational information; to improve employee performance; to help prepare employees for accepting additional or different job responsibilities; to support quality care and customer service.

POLICY: PYRAMID will educate and train employees through a variety of approaches, including orientation sessions, in-service activities, and the support of externally offered seminars, conferences, workshops, and similar events; these activities will be provided or supported on the basis of support of operational goals and objectives and the mutual benefit of the event to the employee and PYRAMID.

CORE VALUES: We are committed and proud to live our CORE values and use them to inspire those around us. Our employees are expected to align with these values, behaviors and standards. We are held accountable for upholding these CORE Values: INTEGRITY is striving to be honest, transparent and ethical when dealing with clients, staff and the community. DEDICATION is demonstrating an unwavering commitment to always provide exceptional care and support to those we serve is needed daily. COLLABORATION is a steadfast, team-focused approach; working together to achieve excellence. PASSION is genuine, compelling and relentless desire to improve lives and support Pyramid Healthcare's mission.

SCOPE: Organization-wide.

PROCEDURE:

1. Certain in-service training sessions may be established as mandatory by the CEO. All new employees are required to attend New Hire Orientation within 30 days of date of employment. All employees with client care responsibilities are also required to attend a CPR certification class and any other orientation or in-service programs required by local, state, or federal regulatory agencies.

2. Employee attendance for non-mandatory in-services will be assigned and approved by the employee's direct supervisor. A written record of attendance will be maintained, and it is the responsibility of the immediate supervisor to forward this information to the Human Resources Department for maintenance in the employee's personnel file.

3. *Approved* in-service education and training hours will be counted as hours worked, and compensation provided, in accordance with applicable federal/state Wage and Hour regulations.

4. Management is required to develop individual employee training and development plans annually, and to recommend attendance at internal and external training and education activities, based on several factors. These factors, in order of importance and priority for allocating resources, are:
   A. Employee's current level of performance and any need to improve work quality or productivity as relevant to company and department goals, objectives, or needs.
   B. Employee's anticipated job responsibilities, in conjunction with anticipated company and department goals, objectives, or needs.
   C. Employee's professional goals.
   D. Employee's personal enrichment.

5. The individual staff development plans, as well as requests for employees to attend specific education or training events, should be submitted through the chain of supervision, and to Human Resources. A written record of attendance shall be maintained. It is the responsibility of the immediate supervisor to provide this information to Human Resources for maintenance in the

employee's personnel file.

6. Employees who attend approved seminars, classes, conferences, or workshops may receive full or partial reimbursement for related fees and travel expenses incurred, with proper approval. It is the responsibility of the Department Manager to utilize the most economically judicious method for travel and overnight stays when sending an employee to such activities out of town.

7. Presenters of training or education sessions conducted at a Company facility are expected to request an evaluation of the session from all attendees, for analysis and reference purposes.

8. Employees attending any outside trainings must complete a Company evaluation. A copy of the evaluation and training certificate must be turned into Human Resources within 3 days of completion.

9. Training Requirements:
   A. **HIV/AIDS & TB/STD/Hepatitis**
      All staff shall receive a minimum of 6 hours of HIV/AIDS and at least 4 hours of TB/STD/Hepatitis and other heath related topics using a Department approved curriculum.
      1) Exempt employees include physicians, PA's, CRNP's, Nurses per Licensing Alert 02-12
      2) Clinical Staff shall complete the training within the 365 days of employment.
      3) All other staff shall complete the training with the first 730 days of employment.

   B. **CPR & FIRST AID**
      The training shall be provided to a sufficient number of staff, so that at least one person trained in these skills is on site during the facility's hours of operations. Training must be completed prior to working alone with children and within 365 days of date of employment.
   C. **CONFIDENTIALITY**
      Clinical Staff and other staff who has access to client information (medical, nursing, clerical, receptionist, medical records) shall complete Confidentiality Training within 180 days of date of employment.
   D. **FIRE SAFETY**
      All staff shall complete Fire Safety training within 30 days of date of employment.
   E. **CLINICAL SUPERVISION**
      All Clinical Managers, Clinical Supervisors and Lead Counselors who have not functioned for 2 years as supervisors in the provision of clinical services shall complete a core curriculum in clinical supervision within 365 days of date of employment.
   F. **MEDICATION ADMINISTRATION**
      Assigned staff shall complete 12 hours of a Department-approved course. Training must be completed prior to administering any medications. This course must be completed every 2 years.
   G. **CULTURAL COMPETENCY/DIVERSITY**
      All staff are required to attend two (2) trainings per year to increase their awareness and competency in diverse cultural environments within 90 days of date of employment.
   H. **DEFENSIVE DRIVING**
      All staff are required to attend defensive driving if they will be driving clients and/or Company vehicles. Training must be completed as soon as it become available. This course must be completed every 2 years.

10. Additional Training Requirements for Facilities licensed by Department of Human Services:
    A. **CPR & FIRST AID**
       All staff, who will have regular & significant contact with children, shall complete training in First Aid, Heimlich Technique and CPR at least every year. Training must be completed prior to working alone with children and within 120 days of date of employment.
    B. **MANDATED REPORTER TRAINING**
       All staff who have regular direct contact with individuals under the age of 18 shall have a Department of Human Services approved 3 hour training within 7 days of date of employment. Staff shall receive 3 hours of training every 5 years thereafter.
    C. **SAFE CRISIS MANAGEMENT**
       The training shall be provided to a sufficient number of staff, so that at least one person trained in these skills is on site during the project's hours of operation. Training must be completed prior to working alone with children and within 120 days of date of employment. Re-certification in SCM must be completed every year. If re-certification is not completed within

one year, full certification must be completed again.

D. **FIRE SAFETY**
All staff shall complete Fire Safety training. Training must be completed prior to working alone with children and within 7 days of date of employment.

11. Training requirements for non-Drug & Alcohol facilities or non-children and youth residential facilities receive a total of 6 hours of training per year. Required Trainings are:
    A. Orientation and Re-Orientation
    B. Confidentiality
    C. HIV
    D. TB/STD/Hepatitis
    E. Cultural Competency
    F. Defensive Driving

12. Training Reimbursement:
    A. Employees **will be** paid for travel time – if they are traveling to another location (other than their regular work site) from their home to attend a mandatory meeting/training. Time will be deducted from the total travel time that the employee would normally spend commuting to the regular work site.
    B. Employees **will be** paid for training hours – if the training is mandatory for the required hours.
    C. Employees **will not be** paid for training hours – if they have already completed their required number of training hours, and the Supervisor is not requesting that they attend.
    D. Employees **will be** reimbursed on mileage to and from the trainings.

TRAINING HOUR REQUIREMENTS (PER CALENDAR YEAR):

Program Manager	12 Hours
Clinical Manager / Supervisor	12 Hours
OP- Caseload of 5 or more	25 Hours
IP- Caseload of 1 or more	25 Hours
Counselor / Lead Counselor	25 Hours
Counselor Assistant	40 Hours, year 1
	30 Hours, year(s) 2-5
BH / Detox Techs	6 Hours
Licensed Nurses	6 Hours
Non-Direct Care Staff	6 Hours
Adolescent Program Staff	40 Hours
Non-Direct Care Staff	6 Hours

New Hire Orientation Agenda

8:30 am - 8:45 am **Welcome and Introductions**

8:45 am - 9:00 am **HR Housekeeping/Documentation Collection**

I9 documents - Passport, or Drivers License + Birthcertificate OR SS card

9:00 am - 10:30 am **Pyramid Healthcare Overview/Core Values**

Presenter: **Courtney Thacker**

10:30 am - 10:45 am **Break**

10:45 am - 12:00 pm **HR Overview: Benefits, ADP, Payroll, Trainings, Policy Review**

Presenter: **Courtney Thacker**

12:00 pm - 12:45 pm **Lunch**

12: 45 pm - 1:45 pm **Safety: Fire Safety and Incident Reporting**

Presenter: **Jesse Hertzler or Eric Raley**

1:45 pm - 2:00 pm **Break**

2:00 pm - 4:00 pm **Ethics, Boundaries, and Confidentiality**

Presenter: **Lindsay Laundermilch or Bartonsville Staff**

Exhibit 14

Pyramid Healthcare Treatment Facilities

POLICY/PROCEDURE

Section:	Provision of Care
Policy Name:	Short Term Buprenorphine Detoxification
Policy Number:	PHC 2.11

Date Issued:	9/3/2003
Date Reviewed:	8/13/2012; 10/21/2016
Date Revised:	11/29/2003; 1/5/2004; 2/27/2004; 2/25/2005; 6/14/2006; 3/7/2007; 2/12/2013; 8/12/2013; 5/18/2018

POLICY: Pyramid Healthcare utilizes buprenorphine in opiate detoxification treatment for clients who:

1. Are opiate dependent
2. Meet the PCPC criteria for non-hospital detoxification
3. Meet established admission criteria
4. Voluntarily consent to the use of buprenorphine in this medically supervised detoxification process.

Restrictions include:

1. Clients must be at least 18 years of age to participate in the buprenorphine detox program.
2. Pregnant female clients are not eligible for admission to the buprenorphine detox program.

Pyramid Healthcare, Inc. adheres to all applicable federal, state and local ordinances, regulations and statutes that pertain to buprenorphine use.

SCOPE: The Director of Nursing is responsible for adherence to this policy.

PROCEDURE:

I. The Medical Directors of Pyramid Healthcare detoxification facilities are registered with the DEA to prescribe buprenorphine.

II. The responsibilities of the Medical Director include:

A. Formulate, order and revise detoxification protocols

B. Issue verbal orders pertaining to patient care

C. Be available for consultation and verbal medication orders at all times when clients are being treated with buprenorphine in the detox area.

1. Each region will have a Medical Director available at all times. In the event of Vacations or Holidays, the Doctors will arrange to cover each other, so at least one Medical Director is available for consultation and to provide verbal medication orders at all times, 24 hours a day, 7 days per week, 365 days per year.

D. Provide at least 1 hour of onsite medical coverage per week for every ten (10) detox clients in treatment.

1. Ensure that at least one-third of all required narcotic treatment time is provided by a narcotic treatment physician.

2. Ensure that time provided by a PA or CRNP does not exceed two-thirds of the required narcotic physician time.

E. Ensure that no buprenorphine is prescribed or administered until after the completion of a face-to-face evaluation and determination of physical dependence by a physician who is registered with the DEA to prescribe buprenorphine.

F. Supervise Physicians, Certified Registered Nurse Practitioners, and Physician Assistants in:

1. Conducting a medical history and physical exam on all clients within 24 hours of admission to the detox program.

2. Determining diagnosis and determining narcotic dependence

3. Reviewing treatment plans

4. Discussing cases with the treatment team

5. Issuing verbal orders pertaining to patient care (as applicable to licensure)

6. Assessing coexisting medical and psychiatric disorders

7. Treating or making appropriate referrals for the treatment of these disorders

G. Countersign all orders, reports and documentation completed by a PA.

III. The responsibilities of physician staff, under the supervision of the Medical Director, include:

A. Conduct a full medical history and physical exam on clients within 24 hours of admission to the detox program.

B. If the medical history and physical exam was not completed by the prescribing physician, the prescribing physician will consult with the PA, CRNP or other physician who conducted the full medical history and physical exam on a client.

1. The consultation is documented in the medical record.

2. The prescribing physician will conduct a face-to-face evaluation of the client prior to the prescription or administration of any buprenorphine.

C. Make a face-to-face determination of current dependency prior to ordering buprenorphine.

1. **Buprenorphine will not be administered until the physician registered to prescribe buprenorphine has conducted a face-to-face evaluation of the client.**
2. **Buprenorphine will not be administered until the client's age and identity have been verified**
3. **Buprenorphine will not be administered until a urine drug screen has been collected**

D. Order buprenorphine and other medications for clients as appropriate.

1. **Only a physician who is registered with the DEA to prescribe buprenorphine may order buprenorphine for clients.**

E. Examine client daily while in detox and dictate/write progress notes for the medical record, documenting the findings.

F. Revise medications as warranted by client condition.

G. Review and revise treatment plans as warranted by client condition.

H. Discuss cases with treatment team.

I. Issue verbal orders pertaining to patient care.

J. Assess coexisting medical and psychiatric disorders.

K. Treat or make appropriate referrals for the treatment of these disorders.

IV. The responsibilities of CRNP and/or PA staff, under the supervision of the Medical Director, include:

A. Conduct a full medical history and physical exam on clients within 24 hours of admission to the detox program.

B. Discuss results of medical history and physical exam with the prescribing physician.

1. The consultation is documented in the medical record.

C. Order medications for clients as appropriate.

1. Only a physician may prescribe buprenorphine.

2. The CRNP or PA may prescribe clonidine and other medications as appropriate to their licensure and DEA registration.

D. Examine client daily while in detox and dictate/write progress notes for the medical record documenting the findings.

E. Revise medications as warranted by client condition.

F. Review and revise treatment plans as warranted by client condition.

G. Discuss cases with treatment team.

H. Assess coexisting medical and psychiatric disorders.

I. Treat or make appropriate referrals for the treatment of these disorders.

V. Staffing and job responsibilities:

A. Licensed Registered Nurses and/or Licensed Practical Nurses manually administer buprenorphine to clients as prescribed by the physician.

1. All clients are identified by **at least 2 means** prior to receiving medications. Examples of client identifiers include:

a. Client to state name; name marked on MAR for comparison

b. Photograph of client in the MAR for visual comparison

c. Client to state birth date; birth date marked on MAR for comparison

d. Client to state social security number; social security number marked on MAR for comparison

2. Only a licensed nurse is permitted to remove buprenorphine from the storage area.

3. Only authorized staff and clients who are receiving medication are permitted in the dispensing area.

4. Only one client is permitted in the dispensing area at a time.

5. Each client is visually observed while ingesting the buprenorphine.

6. Each dose of buprenorphine administered is documented on the MAR (medication administration record) and all documentation of medication includes:

a. The name of the medication

b. The date the medication was prescribed

c. The dosage

d. The frequency

e. The route of administration

f. The date and time of administration

g. The name of the person administering the medication

7. Each dose of buprenorphine is signed out on the narcotic administration record and an accurate count of all the buprenorphine on site is maintained at all times.

8. Buprenorphine stock is counted by two licensed nurses each shift to verify correct inventory count.

   a. The time and date of the count is documented on the narcotic inventory sheet.

   b. The name and amount of each product is documented

   c. The signatures of both licensed nurses completing the narcotic count are documented.

9. Drug reactions and Medication Errors:

   a. A licensed nurse reports all adverse drug reactions or medication errors involving buprenorphine to the physician and the Director of Nursing immediately.

   b. Corrective action is initiated immediately as ordered by the physician.

   c. An incident report is filled out and forwarded to the Director of Nursing.

   d. The reaction or error is documented on the MAR and in the client record.

   e. The appropriate staff members involved in the administration of buprenorphine are informed about the error and the plans to prevent a similar error from occurring in the future.

B. The clinical staffing ratio for the detox unit is:

1. 1 licensed nurse (RN or LPN) to every 7 detox clients 24 hours a day

2. 1 Detox Specialist/Detox tech for every 12 detox clients during primary care hours

3. 1 RN on call 24 hours a day

4. 1 Narcotic Treatment Physician on-call at all times

C. Buprenorphine is administered only by order of a physician, after the physician completes a face-to-face determination of current dependence, within established time frames and parameters.

1. Clonidine detox protocols are initiated upon the arrival if the physician is not on site to perform the initial face-to-face evaluation.

2. Once current dependence has been determined, buprenorphine may be ordered.

   a. Buprenorphine is initiated per valid order of a physician registered to prescribe buprenorphine.

   b. The standing clonidine protocol is discontinued upon initiation of buprenorphine.

3. Buprenorphine may not be administered until the client's age and identity have been verified.

4. Buprenorphine may not be administered until after an initial urine drug screen is collected.

D. A licensed nurse (RN or LPN) is available in the detox area at all times to medicate detox clients as needed.

E. Buprenorphine is administered within 15 minutes of the client arriving at the dispensing station.

VI. Intake and admission

A. The admissions staff will screen each individual for appropriateness prior to admission to the detox program.

1. Information obtained and verified will include, but is not limited to:

a. The individual is at least 18 years of age or older

b. The individual's name, address, date of birth, social security number and any other pertinent identifying information

c. The opiate dependent female client is not currently known to be pregnant

d. A current drug use status is obtained

e. A current medical status and history is obtained

f. An attempt is made to obtain emergency contact, referral contact, Primary Care Physician contact, behavioral healthcare contact and funding contact information.

g. If the client is requesting detoxification from methadone, the daily dosage is verified with the narcotic treatment provider to be no more than 30mg per day, unless reviewed and approved by the Medical Director.

2. If a client was previously discharged from treatment at another narcotic treatment program, the admitting narcotic treatment program, with client authorization and consent, will contact the previous facility for the treatment and dosage history.

3. The admissions staff determines eligibility for admission based on information gathered, utilizing the following criteria:

a. PCPC criteria for non-hospital detoxification

b. Admission criteria

c. Bed availability

4. All information obtained by the admissions staff is documented on the appropriate forms, which include, but are not limited to:

a. The personal data form

b. The pre-admission assessment form

B. The nursing staff completes an initial triage assessment of the client within 1 hour of arrival at the facility.

1. Clonidine protocols are initiated for the opiate dependent client until a physician examines the client and buprenorphine use is approved and ordered.

2. A urine drug screen is obtained and sent to the contracted laboratory for a complete toxicological evaluation.

a. A staff member will accompany the client to the bathroom to ensure that the urine collected is unadulterated.

b. Staff will perform the observational duties in a professional manner that demonstrates respect for the client's rights to privacy, dignity and respect.

c. All urine specimens are handed directly to the staff member, who:

1) Labels the specimen with the client name and number
2) Places the labeled specimen jar in a specimen collection bag
3) Labels the specimen bag with the client's name and number

d. A random urine drug screen may be collected and sent to the contracted laboratory for testing at any time during treatment.

e. A urine or serum drug test may be ordered to screen for any particular substance of abuse that is known to be abused in the local area or is identified in the client's drug and alcohol history as a drug of abuse or use.

f. A body and property search is conducted upon admission to prevent contraband from entering the facility.

3. If a client is assessed to be medically or psychiatrically unstable for admission to the non-hospital detox program, arrangements are made to have the client evaluated at the local hospital ER or Crisis Unit.

C. Verbal orders for short term use of buprenorphine during **urgent** situations **only**:

1. A verbal order for buprenorphine can only be given if the following **three** criteria are met:

   a. The client must be physiologically dependent on opioids and experiencing significant withdrawal symptoms that potentially put the client at risk for negative outcomes.

   b. The RN/CRNP completing the assessments/instruments concludes that there is no appropriate alternative treatment other than buprenorphine available to adequately stabilize the client. Documentation of the effect of non-opioid medication, such as Clonidine, on the client condition and evaluate the need for opioid medication.

   c. There is no significant sedative-hypnotic physical dependence present. If the client is dependent on alcohol or other sedative-hypnotics, such as benzodiazepines, the client must be assessed personally by the physician.

2. The physician approves or disapproves administration of buprenorphine. If a verbal order is given, the physician determines the initial dose. Only a single dose, or a dose divided in two, may be ordered verbally, and the verbal dose may not exceed 8mg.

3. The physician must see the client within 24 hours and sign off on the verbal medication order. The physician must co-sign the various assessments/instruments when he signs the verbal order.

4. The physician must be registered with the DEA to prescribe Buprenorphine.

5. Assessments/Instruments used to determine if client is eligible to receive Buprenorphine to be completed **only** by a Registered Nurse/CRNP. After Completion the RN/CRNP calls the physician and reviews the assessment findings with the physician.

   a. Nursing assessment/H&P to include:

      1) Documentation of past and current drug dependency
      2) Treatment history
      3) Drug use status and history
      4) Current medications (licit or illicit) that may be contraindicated for Buprenorphine (sedative-hypnotics)
      5) Biographical data
      6) Medical history including current health and illness
      7) Documentation of the psychological support given to the client

   b. Clinical Opiate Withdrawal Scale that must be completed and client must be in Mild to Moderate withdrawal.

   c. Urine Toxicology results

d. All applicable consent forms are completed and filed in the client record.

D. A nursing assessment is completed within 8 hours of admission to the detox program. This assessment includes, but is not limited to:

1. A complete drug and alcohol history

2. A medical history

3. The client's current and past narcotic dosage level

4. Other drugs prescribed to the client and the reasons for their use

E. A preliminary treatment plan is initiated within 8 hours of admission to the detox program.

F. A history and physical examination is completed by the physician, PA or CRNP within 24 hours of admission to the detox program.

G. The prescribing physician makes a face-to-face determination of current dependency prior to the prescription or administration of any buprenorphine.

1. The physician documents in the client's record the basis for the determination of current dependency.

2. If a PA, CRNP or other physician completes the history and physical evaluation, the prescribing physician will consult with the licensed professional prior to the prescription or administration of any buprenorphine and document the consultation in the medical record.

3. No buprenorphine is administered prior to the completion of a complete history and physical, a face-to-face determination of current dependency and a valid order is obtained except in urgent situations only (see page 8).

VII. Continued stay documentation

A. A licensed nurse writes a progress note every shift while the client is in detox.

B. A detox record of service is completed to reflect treatment services provided to/attended by the client throughout his/her stay.

C. Individual and group therapy notes are completed by the staff member providing those services, to reflect the client's level of participation and progress in treatment.

D. All laboratory-testing results are filed in the client's record.

E. All treatment plans, reviews and updates are documented and included in the record.

1. The treatment plan will outline realistic short and long-term goals, which are mutually acceptable to the client and the treatment staff.

2. The treatment plan will identify the behavioral tasks a patient will perform to complete each short-term goal.

F. A psychosocial evaluation is completed and entered into the client record upon completion of all preliminary evaluations.

G. The results of any psychiatric, psychological or other evaluations are included in the record.

H. Any referrals made to other projects or services are documented in the client record

I. If a client requests Buprenorphine Maintenance treatment while being treated for opiate detoxification and requests discharge to Pyramid OP, the client will meet with the Physician to discuss options. If determined that

the client will discharge to Outpatient Buprenorphine Maintenance, the physician will initiate the transition from Subutex to Suboxone. This will occur prior to discharge to ensure stability. Coordination of care between physicians and Pyramid OP providers will occur.

VIII. Transfer

A. Any client who requests a transfer to another narcotic treatment program for continued detoxification services will be transferred within 7 days of their request.

1. The transfer will be coordinated with the referral and/or funding sources as applicable.

2. All attempts to arrange transfer will be documented in the client record.

B. Information to be provided, with appropriate client authorization and consent, to the receiving treatment program will include:

1. Date of admission

2. Medical summary

3. Psychosocial summary

4. Buprenorphine dosage and schedule

5. Urinalysis and laboratory reports

6. Exception requests

7. Current client status

C. Confidentiality of client records will be maintained in accordance with all state and federal confidentiality regulations.

D. A transfer note is written, including a description of all materials that were sent to the receiving narcotic treatment program.

E. The transferring treatment program will notify the receiving treatment program of the admission and the MAR/client record regarding doses given to the client. This information will be documented in the client record.

IX. Discharge documentation

A. The aftercare plan is completed prior to discharge and is signed by the client and staff member.

1. A copy of the aftercare plan is provided to the client.

2. The original aftercare plan is maintained in the client record.

B. A discharge summary is completed within 48hours of discharge by the Physician, PA or CRNP and is counter-signed by the Medical Director.

C. The licensed nurse writes a transfer note when a client transfers directly from the detox program into the inpatient program in the same facility.

D. Follow-up calls are documented on the aftercare plan and are maintained as a permanent part of the client record.

E. Involuntary termination of treatment will occur when all other efforts to retain the client in the program have failed.

1. A client will be involuntarily discharged if it is deemed that the termination would be in the best interests of the health or safety of the client and others.

2. A client may be involuntarily discharged from the detox program if any of the following conditions exist:

    a. The client has committed or threatened to commit acts of violence in or around the program premises.

    b. The client possessed a controlled substance without a prescription or sold or distributed a controlled substance, in or around the program premises.

    c. The client leaves the program premises without staff accompaniment or approval.

    d. The client has failed to follow treatment plan objectives.

3. If a client is terminated involuntarily, except a client who commits or threatens to commit acts of physical violence, the client will be offered the opportunity to receive detoxification of at least 7 days if appropriate.

    a. The client may be referred to another narcotic treatment program or hospital licensed and approved by the Department for detoxification to complete the detox if appropriate.

    b. The rationale for not providing a referral is documented in the client's file (i.e. if the client committed or threatened to commit violence on the premises).

X. Any grievance filed by a client is documented in the medical record, including the results of the investigation and the final determination.

A. The investigation will allow for the client to be heard, to question, and confront persons and evidence used against them to have a fair review.
B. If the grievance is filed against the narcotic treatment Program Director, the administrative team will conduct the initial investigation.
C. No penalty may be initiated prior to final resolution.
D. The client may, at his or her own expense, seek legal counsel at any time during the treatment process.

XI. Inspection of Medication Storage Areas:

A. Buprenorphine is stored in a double locked designated area.

B. An inspection of the medication storage area is conducted monthly by a representative from the contracted pharmacy and a nursing staff representative.

C. The results of the inspection are documented on the medication area checklist.

1. The inspection form is forwarded to the Director of Nursing/ Assistant Director of Nursing/ Nurse Manager for review and intervention.

2. The Performance Improvement Committee monitors issues and resolution of these issues identified in the monthly inspections.

3. The inspection documentation includes verification that:

    a. Disinfectants and drugs for external use are stored separately from oral or injectable drugs.

    b. Drugs requiring special conditions for storage to insure stability are properly stored.

    c. Outdated and contaminated drugs are removed and destroyed according to Federal and State regulations.

    d. Administration of controlled substances is documented.

    e. Controlled substances and other abusable drugs are stored in accordance with Federal and State regulations.

XII. Loss, theft or misuse of buprenorphine:

A. Any loss, theft, or misuse of buprenorphine, is immediately reported to the Program Director and to the Director of Nursing/ Assistant Director of Nursing/ Nurse Manager so that an appropriate investigation can be initiated.

1. In the event of loss or suspected theft or diversion of buprenorphine:

a. A search of the medication storage area is conducted immediately to determine if there are any obvious breeches to the security system.

b. A search of the facility and facility grounds is conducted if there is suspicion that the buprenorphine may be in the possession of clients, staff or is otherwise hidden on the premises.

c. Staff interviews are conducted as a routine part of the investigation and a review of staff schedules and assignments relative to the time period of the suspected loss or theft is also completed by the Program Director and/or the Director of Nursing/ Assistant Director of Nursing/ Nurse Manager.

d. A review of the narcotic administration records and inventories is conducted to determine the date and time of the suspected loss or theft, the amount of buprenorphine missing, and/or the staff members involved in the security and administration of the buprenorphine during the period of the suspected loss or theft.

e. The local police are notified of any suspected theft or crime against the premises and a police report is filed.

2. In the event that a client has an emesis that contains the buprenorphine, or otherwise spits out or expels the undigested buprenorphine tablet:

a. The presence of the undissolved buprenorphine tablet is verified by a licensed nurse.

b. The licensed nurse disposes of the buprenorphine tablet per facility policy.

1) A second staff member witnesses the disposal of all narcotic medications.

2) The licensed nurse documents the entire incident, including the disposal of the medication in the presence of a staff witness, in the medical record.

c. The physician is contacted and orders are obtained and initiated.

1) No additional buprenorphine is administered unless the initial dose of buprenorphine is obtained, verified and disposed of by a licensed nurse, **and** an order to re-administer the buprenorphine dose is obtained from a physician registered with the DEA to prescribe buprenorphine.

2) If the client has repeated episodes of emesis or inability to tolerate the buprenorphine, the physician is consulted and alternative medications are considered.

3. In the event of an adverse reaction or medication error, follow the procedures as outlined previously in this policy regarding Drug Reactions and Medication Errors.

4. In the event that a client is suspected of cheeking, pocketing or otherwise not ingesting the buprenorphine dose:

a. A body and property search is conducted immediately by facility staff in compliance with facility body and property search policy and procedure.

b. The Program Director/Nurse Manager is contacted immediately and further actions are determined based on the results of the body/property search.

c. Clients who are found to be misusing buprenorphine in any manner may be subject to immediate involuntary discharge from the facility.

d. A police report may be filed and criminal charges may result if a client is found to be diverting buprenorphine to other clients within the facility or from the premises.

B. All loss, theft or misuse of buprenorphine is:

1. Documented on an incident report and is reported to the Safety Committee.

2. Reported to DDAP, Division of Licensing via an unusual incident report as defined in the Incident and Sentinel Event Reporting policy.

C. A root cause analysis is performed within 24 hours to identify areas requiring action to prevent loss, theft or misuse in the future.

D. Action plans are developed, implemented and evaluated for effectiveness based on the findings of the root cause analysis.

XIII. Community Responsiveness

A. The program director of each respective detox program is identified as the community liaison.

B. The community liaison will attend pertinent meetings in the community, respond to questions or concerns brought by community members, evaluate treatment services, design new services, and redesign existing services to meet the needs of the community whenever possible.

C. A Community Outreach plan is developed by each program and updated annually

Pyramid Healthcare Treatment Facilities

POLICY/PROCEDURE

Section:	Provision of Care
Policy Name:	Detox Observation
Policy Number:	PHC 2.33

Date Issued:	1/15/13
Date Reviewed:	8/13/17
Date Revised:	6/22/18

POLICY: Pyramid Healthcare, Inc. will establish parameters and principles for direct observation of clients in the Detox Unit.

A. To ensure client safety, comfort and staff accountability by regularly observing all clients.
B. To note the mental status and behavior of clients.
C. To provide a level of observation which correlate to the levels of client acuity and risk.

SCOPE: The Executive Director and Director of Nursing are responsible for adherence to this policy.

PROCEDURE:

Staff will conduct direct observation rounds observing each client, with notation of whereabouts, at intervals of 30 minutes or less, daily without interruption.

A. Each staff member is responsible for completing direct observation rounds on all clients at their assigned times. The nurse on duty will be responsible for assignments and assuring that client rounds have been completed.
B. At the time of rounds, the staff member is to locate the client face-to-face.
C. While making observation rounds, staff will check the environment for safety and security risks including any unusual client behaviors. Any observation of unusual behaviors or change in the client's physical condition will be reported to the nurse on duty.
D. If staff is unable to complete rounds during their assigned time they must communicate this to nurse and hand off rounds documentation to the nurse on duty.
E. The client's whereabouts will be documented on the Client Observation Form utilizing the legend provided. The staff's initials will be affixed to form with each observation noted.
F. When completed the Client Observation Form will become a permanent part of the client's medical record.
G. Nurse Manager or designee will assure adherence to this policy.

Exhibit 15

Subject: HIV Admission Medication Procedure		
Issued: 6/1/00 Revised: 2.1.17	Policy & Procedures Manual Category: Anchor/Medical	Page 1 of 1

Purpose:
To provide a procedure for admission medications process.

Procedure:

1. On pre-admission, if a client identifies positive HIV testing with medications, the Supervisor/Nurse must be notified prior to admission.

2. With appropriate client release, the Medical Department must contact the Regional HIV manager for Southern Maryland at the Charles County Health Department, if the client is from Charles, St. Mary's, or Calvert County. If the client is not from Charles, St. Mary's, or Calvert County, the client's case manager must be contacted. This must be done prior to admission.

3. An evaluation of Medication/HIV status follow-up meeting must occur with the Supervisor of Anchor ICF, Walden/Sierra, Inc., and the Medical Staff of Anchor prior to admission.

Subject: HIV Procedure		
Issued: 6/1/2000 Revised: 2.1.17	Policies & Procedures Manual Category: Anchor Medical, Northstar, Compass	Page **1** of **1**

Purpose:
To provide initial counseling, risk assessment, and referral support for testing, post-test counseling, appropriate treatment and related needs to clients re: HIV/AIDS.

Procedure:

1. Staff will complete an HIV/AIDS Risk Assessment on admission.

2. Staff will see that appropriate linkages with the county Health Department or client's healthcare provider are made for HIV/AIDS testing as appropriate, including tests to diagnose the extent of the deficiency in the immune system and tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease.

3. Staff will refer clients as appropriate to the county Health Department or client's healthcare provider for pre and post-test counseling.

4. Staff will provide referrals, primarily via relationship with the local Health Department, to make available therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease.

5. Staff maintains established linkages with a comprehensive community resource network of related health and social services organizations to ensure a wide-based knowledge of the availability of these services and to facilitate referral.

6. The program ensures that HIV early intervention services are undertaken voluntarily, provided with patients' informed consent, and are not required as a condition of receiving substance abuse treatment or any other services.

7. When medications are needed and with appropriate client release, staff will contact the Regional HIV manager for Southern Maryland at the Charles County Health Department, if the client is from Charles, St. Mary's, or Calvert County. If the client is not from Charles, St. Mary's, or Calvert County, the client's case manager must be contacted. This must be done prior to admission.

SUBJECT: CONFIDENTIALITY: HIV/AIDS RELATED INFORMATION

POLICY: PYRAMID Healthcare, Inc. strictly maintains the confidentiality of all HIV/AIDS-related information.

HIV/AIDS-related information is defined as any information which is in the possession of a person who provides one or more health or social services or who obtains the information pursuant to a release of confidential HIV/AIDS-related information and which concerns whether an individual:

1. Has been the subject of an HIV-related test
2. Is HIV positive
3. Has HIV-related illness
4. Has AIDS
5. Or any of the information which identifies or reasonably could identify a person as having one or more of these conditions, including information pertaining to the individual's contacts

PROCEDURE:

I. HIV/AIDS-related information is only disclosed to the following persons:

A. The client

B. The physician who ordered the test, or the physician designee

C. Any persons specifically designated in a written authorization and consent

1. Every disclosure made pursuant to a written release is accompanied by a written statement detailing the limitations of the release

D. Medical staff members of a health care provider that have already received confidential HIV/AIDS-related information provided they are currently involved in the medical care of the client.

E. Federal or State government agencies with oversight responsibilities over health care providers.

F. Health care providers providing emergency care to the client when the information is necessary to provide that care.

G. An insurer, to the extent necessary to reimburse health care providers or to make any payment of a claim submitted to an insured person's policy.

H. The Commonwealth Department of Health and persons authorized to collect vital statistics

I. The Commonwealth Department of Health and local boards and departments of health authorized to collect information pursuant to the Disease and Prevention Law.

J. Persons granted access pursuant to a court order.

- **If a court order requesting HIV/AIDS-related information is received, consult legal counsel before disclosing information, as there are prerequisites to the release of such information.**
- **Release the information only upon direction of legal counsel.**

K. Funeral Directors

L. Employees of county mental health agencies, county children and youth agencies, county juvenile probation departments, county or state facilities for delinquent youth, and contracted residential providers for the above named entities receiving or contemplating residential placement of a minor consumer who:

1. Generally are authorized to receive medical information

2. Are responsible for ensuring that the minor consumer receives proper health care.

3. Have a need to know HIV/AIDS-related information in order to ensure such care is given

- The above named entities may release the information to a court in the course of a dispositional proceeding under 42 PA C.S. §6351 (relating to the dispositions of a child) and §6352 (relating to the disposition of a delinquent child) when it is determined that such information is necessary to meet the medical needs of the minor client.

II. Re-disclosure of confidential HIV/AIDS-related information is generally prohibited unless a written consent is obtained or the above provisions authorize the release.

III. Every disclosure of HIV/AIDS-related information includes a statement regarding the prohibition of re-disclosure of the information.

IV. HIV/AIDS-related information is released when a separate authorization and consent for the release of HIV/AIDS-related information is signed and maintained in the clients file.

A. In order to release the information the authorization/consent must:

1. Cover the information requested

2. Be current

B. The authorization/consent contains the following information:

1. The client's name

2. The name of the person, agency, or organization to whom the disclosure will be made

3. The specific information requested

4. The purpose of the disclosure

5. Dated signature of the client or the legal guardian (if necessary)

6. The expiration of the consent

7. The name of the program disclosing the information

8. Revocation statement

9. Written notice of prohibition of re-disclosure

V. If the information requested is for the purpose of a medical emergency, the following is done immediately:

A. Any person seeking information will identify themselves and provide proof of status as a person who can obtain information without a signed release or court order:

- For example: obtain a badge number if a police officer is requesting the information.

B. Provide only the information necessary to alleviate an emergency

C. Immediately document in the file what information was provided, to whom, and why.

D. Notify the client as soon as possible that the information was released

VI. If a subpoena is received requesting confidential HIV/AIDS-related information:

A. Fax a copy of the subpoena to the corporate office and obtain legal counsel.

B. Do not release any information until directed to do so by legal counsel.

C. Notify the client that the confidential information has been subpoenaed.

VII. If a court order is received directing that confidential HIV/AIDS-related information be released:

A. Fax a copy of the court order to the corporate office and obtain legal counsel.

B. Do not release any information until directed to do so by legal counsel.

Exhibit 16

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.

	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										
1. DISCHARGES										
a. Residential										
b. III.7 and III.7D										
c. Other (Specify/add rows of needed)										
TOTAL DISCHARGES	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
2. PATIENT DAYS										
a. Residental										
b. III.7 and III.7D										
c. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. Residental	#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/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
4. NUMBER OF LICENSED BEDS										
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
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/add rows of needed)	#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/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.

Exhibit 17

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.

	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 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022				
1. DISCHARGES										
a. Residential	0	0	0	115	232	232				
b. III.7 and III.7D	0	0	0	650	1,785	1,785				
c. Other (Specify)	0	0	0	0						
TOTAL DISCHARGES	***0***	***0***	***0***	***765***	***2,018***	***2,018***	***0***	***0***	***0***	***0***
2. PATIENT DAYS										
a. Residental	0	0	0	2,275	4,599	4,599				
b. III.7 and III.7D	0	0	0	5,983	16,425	16,425				
c. Other (Specify)	0	0	0	0						
TOTAL PATIENT DAYS	***0***	***0***	***0***	***8,258***	***21,024***	***21,024***	***0***	***0***	***0***	***0***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. Residental	#DIV/0!	#DIV/0!	#DIV/0!	19.8	19.8	19.8	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. III.7 and III.7D	#DIV/0!	#DIV/0!	#DIV/0!	9.2	9.2	9.2	#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 AVERAGE LENGTH OF STAY	#DIV/0!	#DIV/0!	#DIV/0!	10.8	10.4	10.4	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
4. NUMBER OF LICENSED BEDS										
f. Rehabilitation	0	0	0	14	14	14				
g. Comprehensive Care	0	0	0	50	50	50				
h. Other (Specify)	0	0	0	0	0	0				
TOTAL LICENSED BEDS	***0***	***0***	***0***	***64***	***64***	***64***	***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!	44.5%	90.0%	90.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. III.7 and III.7D	#DIV/0!	#DIV/0!	#DIV/0!	32.8%	90.0%	90.0%	#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!***	***35.4%***	***90.0%***	***90.0%***	***#DIV/0!***	***#DIV/0!***	***#DIV/0!***	***#DIV/0!***
6. OUTPATIENT VISITS										
a. Residential				402	903	903				
b. III.7 and III.7D				1,879	4,417	4,417				
c. Other (Specify)				0	0					
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***2,281***	***5,320***	***5,320***	***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 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	
1. REVENUE							
a. Inpatient Services	$ -		$ -	$ 2,671,036	$ 7,631,279	$ 7,631,279	
b. Outpatient Services				$ 302,141	$ 704,687	$ 704,687	
Gross Patient Service Revenues	***$ -***	***$ -***	***$ -***	***$ 3,173,177***	***$ 8,335,966***	***$ 8,335,966***	***$ -***
c. Allowance For Bad Debt			$ -	$ 63,464	$ 166,719	$ 166,719	
d. Contractual Allowance			$ -	$ -	$ -	$ -	
e. Charity Care			$ -	$ -	$ -	$ -	
Net Patient Services Revenue	***$ -***	***$ -***	***$ -***	***$ 3,109,714***	***$ 8,169,247***	***$ 8,169,247***	***$ -***
f. Other Operating Revenues (Specify)							
NET OPERATING REVENUE	***$ -***	***$ -***	***$ -***	***$ 3,109,714***	***$ 8,169,247***	***$ 8,169,247***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)			$ -	$ 2,705,554	$ 4,994,869	$ 5,144,715	
b. Contractual Services			$ -	$ 618	$ 12,360	$ 1,360	
c. Interest on Current Debt			$ -	$ -	$ -	$ -	
d. Interest on Project Debt			$ -	$ -	$ -	$ -	
e. Current Depreciation				$ 96,922	$ 193,844	$ 193,844	
f. Project Depreciation			$ -	$ -	$ -	$ -	
g. Current Amortization			$ -	$ -	$ -	$ -	
h. Project Amortization			$ -	$ -	$ -	$ -	
i. Supplies			$ -	$ 62,194	$ 87,188	$ 87,188	
j. Other Expenses (Specify)			$ -	$ 746,331	$ 1,960,619	$ 1,960,619	
TOTAL OPERATING EXPENSES	***$ -***	***$ -***	***$ -***	***$ 3,611,619***	***$ 7,248,880***	***$ 7,387,726***	***$ -***
3. INCOME							
a. Income From Operation	***$ -***	***$ -***	***$ -***	***$ (501,905.80)***	***$ 920,366.72***	***$ 781,520.66***	***$ -***
b. Non-Operating Income							
SUBTOTAL	***$ -***	***$ -***	***$ -***	***$ (501,905.80)***	***$ 920,366.72***	***$ 781,520.66***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ -***	***$ -***	***$ -***	***$ (501,905.80)***	***$ 920,366.72***	***$ 781,520.66***	***$ -***
4. PATIENT MIX				-16%	11%	10%	
a. Percent of Total Revenue							
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2) Medicaid	0.0%	0.0%	0.0%	85.0%	85.0%	85.0%	85.0%
3) Blue Cross	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
4) Commercial Insurance	0.0%	0.0%	0.0%	12.0%	12.0%	12.0%	12.0%
5) Self-pay	0.0%	0.0%	0.0%	3.0%	3.0%	3.0%	3.0%
6) Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2) Medicaid	0.0%	0.0%	0.0%	85.0%	85.0%	85.0%	85.0%
3) Blue Cross	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
4) Commercial Insurance	0.0%	0.0%	0.0%	12.0%	12.0%	12.0%	12.0%
5) Self-pay	0.0%	0.0%	0.0%	3.0%	3.0%	3.0%	3.0%
6) Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Exhibit 18

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.

	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)*											
Program Director	32.0		$0	1.0	$125,000	$125,000			$0	33.0	$125,000
Clinical Director			$0	1.0	$100,000	$100,000			$0	1.0	$100,000
Medical Director			$0	0.5	$250,000	$125,000			$0	0.5	$125,000
			$0			$0			$0	0.0	$0
Total Administration			$0	2.5	$475,000	$350,000			$0	2.5	$350,000
Direct Care Staff *(List general categories, add rows if needed)*											
Behavioral Health Technicians			$0	34.0	$31,200	$1,060,800			$0	34.0	$1,060,800
Behavioral Health Supervisors			$0	6.0	$37,440	$224,640			$0	6.0	$224,640
Charge Nurse (RN)			$0	6.0	$79,040	$474,240			$0	6.0	$474,240
Staff Nurse (LPN)			$0	10.8	$52,000	$561,600			$0	10.8	$561,600
Addictions Counselors			$0	11.0	$55,000	$605,000			$0	11.0	$605,000
Clinical Supervisors			$0	2.0	$70,000	$140,000			$0	2.0	$140,000
CRNP			$0	1.0	$190,000	$190,000			$0	1.0	$190,000
			$0			$0			$0	0.0	$0
Total Direct Care			$0	70.8	514,680.0	3,256,280.0			$0	70.8	$3,256,280
Support Staff *(List general categories, add rows if needed)*											
Administrative Assistants			$0	5.0	$31,200	$156,000			$0	5.0	$156,000
Case Managers			$0	4.0	$45,000	$180,000			$0	4.0	$180,000
			$0			$0			$0	0.0	$0
Total Support			$0	9.0	76,200.0	336,000.0			$0	9.0	$336,000
REGULAR EMPLOYEES TOTAL			$0	*82.3*	*1,065,880.0*	*3,942,280.0*			$0	82.3	$3,942,280
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)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff			$0			$0			$0	0.0	$0
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			$0			$0			$0	0.0	$0
Benefits *(State method of calculating benefits below):*											
TOTAL COST	*0.0*		*$0*	*82.3*		*$3,942,280*	*0.0*		*$0*		*$3,942,280*

Exhibit 19

Clearview Pyramid Acquisition Company, LLC

Independent Auditor's Report and Consolidated Financial Statements

June 30, 2018 and 2017

Clearview Pyramid Acquisition Company, LLC

June 30, 2018 and 2017

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BKD
CPAs & Advisors

201 N. Illinois Street, Suite 700 | P.O. Box 44998 | Indianapolis, IN 46244-0998
317.383.4000 | Fax 317.383.4200 | bkd.com

Independent Auditor's Report

Board of Directors
Clearview Pyramid Acquisition Company, LLC
Altoona, Pennsylvania

We have audited the accompanying consolidated financial statements of Clearview Pyramid Acquisition Company, LLC and its subsidiaries, which comprise the consolidated balance sheets as of June 30, 2018 and 2017, and the related consolidated statements of operations, members' equity and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Clearview Pyramid Acquisition Company, LLC and its subsidiaries as of June 30, 2018 and 2017, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating information listed in the table of contents is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

BKD, LLP

Indianapolis, Indiana
October 1, 2018

Clearview Pyramid Acquisition Company, LLC

Consolidated Balance Sheets
June 30, 2018 and 2017

	2018	2017
Current Assets		
Cash	$ 3,053,359	$ 2,691,270
Patient accounts receivable, net of allowance of $4,729,740 and $5,733,472, respectively	14,717,072	10,704,404
Other receivables	824,396	1,280,428
Refundable income taxes	408,453	451,349
Prepaids and other current assets	629,640	418,134
Total current assets	19,632,920	15,545,585
Property and Equipment, net	50,799,782	35,881,529
Other Assets		
Goodwill, net	23,084,831	26,806,329
Other intangible assets, net	27,550,085	29,914,585
Deferred income tax asset, net	-	2,106,394
Other long-term assets	490,187	424,146
Total other assets	51,125,103	59,251,454
Total assets	$ 121,557,805	$ 110,678,568

Liabilities and Members' Equity

Current Liabilities		
Outstanding checks in excess of bank balance	$ 507,158	$ -
Current maturities of long-term debt	2,464,463	1,904,551
Accounts payable	3,788,050	1,411,186
Accrued expenses	12,514,881	8,239,011
Total current liabilities	19,274,552	11,554,748
Long-Term Liabilities		
Line of credit	2,000,000	2,200,000
Long-term debt	89,844,897	74,655,640
	91,844,897	76,855,640
Members' Equity		
Members' capital	36,069,172	36,348,073
Accumulated deficit	(25,946,978)	(14,291,935)
Total Clearview Pyramid Acquisition Company, LLC members' equity	10,122,194	22,056,138
Noncontrolling interests	316,162	212,042
Total members' equity	10,438,356	22,268,180
Total liabilities and members' equity	$ 121,557,805	$ 110,678,568

Clearview Pyramid Acquisition Company, LLC

Consolidated Statements of Operations
Years Ended June 30, 2018 and 2017

	2018	2017
Revenues		
Patient service revenue, net of allowances and contractual adjustments	$ 168,641,064	$ 146,772,168
Provision for uncollectible accounts, net of recoveries and adjustments	(14,690,799)	(13,154,946)
Net patient service revenue, less provision for uncollectible accounts	153,950,265	133,617,222
Operating Expenses		
Salaries	84,798,308	71,505,426
Employee benefits	17,177,036	15,645,276
Purchased services and professional fees	14,922,566	11,026,037
Food, clothing, drugs and supplies	6,089,012	5,437,143
Property leases and other rentals	7,005,065	7,464,019
Repairs and maintenance	2,104,916	1,800,680
Utilities	3,635,916	3,199,607
Travel	2,827,577	2,069,072
Insurance	868,292	903,744
Property and local taxes	669,513	507,022
Depreciation and amortization	11,035,007	9,305,535
Gain on capital leases upon termination	(420,035)	-
Loss on disposal of property and equipment	234,874	-
Other operating expenses	4,510,100	2,829,197
Total operating expenses	155,458,147	131,692,758
Operating Income (Loss)	(1,507,882)	1,924,464
Other Income (Expense)		
Interest expense	(7,876,409)	(5,536,597)
Other	93,049	175,214
Total other expense	(7,783,360)	(5,361,383)
Loss Before Income Taxes	(9,291,242)	(3,436,919)
Income Tax (Benefit) Expense	2,241,821	(555,584)
Net Loss	(11,533,063)	(2,881,335)
Less: Net Income Attributable to Noncontrolling Interests	121,980	53,215
Net Loss Attributable to Clearview Pyramid Acquisition Company, LLC	$ (11,655,043)	$ (2,934,550)

See Notes to Consolidated Financial Statements

Clearview Pyramid Acquisition Company, LLC

Consolidated Statements of Members' Equity
Years Ended June 30, 2018 and 2017

	Total	Clearview Pyramid Acquisition Company, LLC		Noncontrolling Interests
		Members' Capital	Accumulated Deficit	
Balance July 1, 2016	$ 26,092,226	$ 37,233,689	$ (11,357,385)	$ 215,922
Distribution	(942,711)	(885,616)		(57,095)
Net loss	(2,881,335)		(2,934,550)	53,215
Balance June 30, 2017	22,268,180	36,348,073	(14,291,935)	212,042
Distribution	(296,761)	(278,901)		(17,860)
Net loss	(11,533,063)		(11,655,043)	121,980
Balance June 30, 2018	$ 10,438,356	$ 36,069,172	$ (25,946,978)	$ 316,162

See Notes to Consolidated Financial Statements

Clearview Pyramid Acquisition Company, LLC

Consolidated Statements of Cash Flows
Years Ended June 30, 2018 and 2017

	2018	2017
Operating Activities		
Net loss	$ (11,533,063)	$ (2,881,335)
Items not requiring (providing) cash		
Depreciation	4,901,198	2,989,205
Amortization of intangible assets and goodwill	6,133,809	6,316,330
Amortization of deferred finance cost - (interest expense)	768,682	425,447
Loss on disposal of property and equipment	234,864	-
Gain on capital leases upon termination	(420,035)	-
Provision for uncollectible accounts	14,690,799	13,154,946
Deferred income tax (benefit) expense	2,106,394	(920,524)
Changes in		
Patient accounts receivable	(18,703,467)	(11,480,599)
Other receivables	408,221	(1,025,428)
Accounts payable and other payables	833,393	(408,331)
Prepaids and other assets	(239,897)	250,916
Accrued expenses	4,275,870	1,793,429
Income taxes	92,896	172,597
Net cash provided by operating activities	5,499,664	8,386,653
Investing Activities		
Purchase of property and equipment	(15,432,194)	(12,734,913)
Cash paid for business acquisition, net of cash acquired	-	(4,473,878)
Net cash used in investing activities	(15,432,194)	(17,208,791)
Financing Activities		
Change in checks outstanding in excess of bank balance	507,158	-
Proceeds from issuance of senior debt	18,974,000	8,395,000
Finance cost paid	(533,745)	(572,154)
Principal payments on senior debt	(4,731,000)	(671,000)
Principal payments on installment sale note payable	(73,141)	(70,103)
Principal payments on capital lease	(1,351,892)	(669,895)
Borrowings under line of credit agreement	8,300,000	6,200,000
Repayments under line of credit agreement	(8,500,000)	(4,000,000)
Distribution	(296,761)	(942,711)
Net cash provided by financing activities	12,294,619	7,669,137
Increase (Decrease) in Cash	362,089	(1,153,001)
Cash, Beginning of Year	2,691,270	3,844,271
Cash, End of Year	$ 3,053,359	$ 2,691,270
Supplemental Cash Flows Information		
Interest paid	$ 5,735,021	$ 5,096,304
Income taxes paid, net of refunds	61,350	192,144
Capital asset acquisitions in account payable	1,543,471	264,954
Capital asset acquisition through capital lease	2,696,265	2,265,937
Noncash working capital adjustment related to business combination	47,811	-
Estimated business acquisition purchase price adjustment due from seller	-	255,000

Clearview Pyramid Acquisition Company, LLC

Notes to Consolidated Financial Statements
June 30, 2018 and 2017

Note 1: Nature of Operations and Summary of Significant Accounting Policies

Nature of Operations and Change in Reporting Entity

Clearview Pyramid Acquisition Company, LLC (Company or Parent) was formed on May 2, 2011 for the purpose of effecting the acquisition of Pyramid Healthcare, Inc. (Pyramid). Effective July 1, 2011, the Company acquired 100% of the outstanding stock of Pyramid Healthcare, Inc.

Pyramid Healthcare, Inc. acquired 100% of the stock of October Road, Inc. on April 30, 2012 and acquired 100% of the membership units of American Day CD Centers, LLC (High Focus Centers) on October 1, 2012. In 2014, Pyramid contributed capital for a 57% ownership in Foundations Medical Services, LLC (Foundations) of which it previously held a minority interest. Pyramid acquired 100% of the stock of Onward Behavioral Health, Inc. (Onward) on May 1, 2014. On December 9, 2013, Parent formed Silvermist, LLC and contributed capital for a 94% ownership. On July 3, 2015, Parent formed Twelve Oaks Holdings, LLC (Silver Ridge) and holds 94% ownership. Pyramid acquired 100% of the outstanding stock ownership of Real Recovery of Asheville, Inc. (effective March 23, 2016), Mazzitti & Sullivan Counseling Services, Inc. (effective April 21, 2016), Quest Services, Inc. (effective May 2, 2016) and Meadow Haven Recovery Services, LLC (Tapestry - effective June 30, 2017) in separate acquisitions. Pyramid acquired 100% of the membership interests in Meadow Haven Recovery Services, LLC (Tapestry) effective June 30, 2017.

The Parent and operating subsidiaries are collectively referred to as the "Company." The 2017 operations include closing and transaction costs for the acquisition of Tapestry effective June 30, 2017. The acquisition was led by the Parent's primary investor, Clearview Capital, LLC and affiliates (Clearview).

The Company is based in Altoona, Pennsylvania with operations throughout Pennsylvania, New Jersey and North Carolina. The Company provides drug and alcohol inpatient and outpatient treatment programs for adults and adolescents and other mental health services. The Company contracts with commercial insurance payers and, in certain markets, contracts with state and county authorities in addition to managed care behavioral health medical assistance organizations (Medicaid).

Limited Liability Company

Clearview Pyramid Acquisition Company, LLC was formed as a limited liability company. Each member's interest in the Company is divided into and represented by Class A and Class B units. Voting rights are held only by Class A unit holders. Class B units that were granted to employees vest over a three to four year period from the date of grant. Class A units are entitled to a preference in the allocation and distribution of profits in the amount of their unrecovered capital. Profit allocation and distributions to Class B unit holders is pro-rata with Class A unit holders once the capital component assigned to such Class B units has been satisfied as a result of reduced distributions.

The capital component amount of the Class B units issued during July 2011 varies with respect to the tranche the units were issued according to the limited liability company agreement, with per unit minimums that range from 15% to 75% of the Class A unit capital contributions. All other Class B units have a capital component equal to fair value as determined by the board of directors at issuance. All members' equity and accumulated deficit amounts are allocated to Class A unit holders. The personal liability of a member is limited to the amount of the member's capital contribution, less any distributions.

The operating agreement includes certain restrictions on the transfer and sale of the member units including drag along and tag along rights. In addition, certain members have preemptive rights to purchase additional member units under certain instances. The operating agreement has no termination date.

Principles of Consolidation

The consolidated financial statements include the accounts of the Company, its wholly-owned subsidiaries, Pyramid Healthcare, Inc., American Day CD Centers, LLC, October Road, Inc., Onward Behavioral Health, Inc., Real Recovery of Asheville, Inc., Mazzitti & Sullivan Counseling Services, Inc., Quest Services, Inc., and Meadow Haven Recovery Services, LLC, and its majority-owned subsidiaries, Foundations Medical Services, LLC, Silvermist, LLC, and Twelve Oaks Holdings, LLC. All significant intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Noncontrolling Interest

Noncontrolling interest represents the minority ownership interest in Foundations (43%), Silvermist (6%), and Silver Ridge (6%), that the Company does not own. Losses attributable to the noncontrolling interest are allocated to the noncontrolling interest even if the carrying amount of the noncontrolling interest is reduced below zero.

Cash

At June 30, 2018, the Company's cash accounts exceeded federally insured limits by approximately $4,138,000.

Net Patient Service Revenue

The Company has agreements with third-party payers that provide for payments to the Company at amounts different from its established rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payers and others for services rendered and includes estimated retroactive revenue adjustments. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered and such estimated amounts are revised in future periods as adjustments become known.

Patient Accounts Receivable

Accounts receivable are reduced by an allowance for doubtful accounts and allowances for contractual adjustments with third-party payers. In evaluating the collectability of accounts receivable, the Company analyzes its past history and identifies trends for each of its major payer sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for uncollectible accounts. Management regularly reviews data about these major payer sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts.

For receivables associated with services provided to patients who have third-party coverage, the Company analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for uncollectible accounts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payer has not yet paid, or for payers who are known to be having financial difficulties that make the realization of amounts due unlikely).

For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Company records a significant provision for uncollectible accounts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated or provided by policy) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The Company's allowance for doubtful accounts for both insured and self-pay patients was $4,729,740 and $5,733,472 at June 30, 2018 and 2017, respectively.

Property and Equipment

Property and equipment acquisitions are stated at cost, less accumulated depreciation and amortization. Depreciation and amortization is charged to expense on the straight-line basis over the estimated useful life of each asset. Assets under capital lease obligations and leasehold improvements are amortized over the shorter of the lease term or their respective estimated useful lives.

The estimated useful lives for each major depreciable classification of property and equipment are as follows:

Buildings and improvements	27-50 years
Leasehold improvements	5-15 years
Equipment and vehicles	3-10 years
Furniture and fixtures	5-10 years
Software	3 years

The Company capitalizes interest costs as a component of construction in progress, based on the rates paid for long-term borrowing. The following table summarizes capitalized interest in 2018 and 2017. Interest expense in the table below does not include amortization of deferred financing fees which was $768,682 in 2018.

	2018	2017
Total interest incurred	$ 7,107,727	$ 5,111,150
Capitalized interest	(387,440)	-
Interest expensed	$ 6,720,287	$ 5,111,150

Goodwill

The Company accounts for goodwill under the alternative accounting provided in ASU 2014-02, *Intangibles - Goodwill and Other (Topic 350): Accounting for Goodwill*, which allows private companies to amortize goodwill and apply a simplified impairment test. Under this alternative, goodwill is amortized on a straight-line basis over ten years. Amortization of goodwill totaled $3,769,309 and $3,364,955 in 2018 and 2017, respectively.

The Company evaluates the recoverability of the carrying value of goodwill at the entity level whenever events or circumstances indicate the carrying amount may not be recoverable. In testing goodwill for impairment, the Company has the option first to perform a qualitative assessment to determine whether it is more likely than not that goodwill is impaired or the entity can bypass the qualitative assessment and proceed directly to the quantitative test by comparing the carrying amount, including goodwill, of the entity with its fair value. The goodwill impairment loss, if any, is measured as the amount by which the carrying amount of the reporting unit, including goodwill, exceeds its fair value. Subsequent increases in goodwill value are not recognized in the consolidated financial statements.

The Company also elected the private company accounting alternative provided in ASU 2014-18, *Business Combinations (Topic 850): Accounting for Identifiable Intangible Assets in a Business Combination* for identifiable intangible assets in a business combination. Under this alternative, certain customer-related intangible assets and noncompetition agreements are subsumed into goodwill and are no longer required to be recognized separately in the accounting for a business combination. This change was applied prospectively as of the beginning of the period of adoption, which was July 1, 2015.

Other Intangible Assets

The Company has other intangible assets including noncompete agreements, payer contracts, network patient referrals and other intangibles. Amortization for these items is computed using the straight-line method with lives ranging from 2 to 20 years. Such assets are periodically evaluated as to the recoverability of their carrying values.

Trade names and licenses associated with Pyramid and its subsidiaries have indefinite lives. These intangible assets are evaluated annually for impairment or more frequently if impairment indicators are present. A qualitative assessment is performed to determine whether the existence of events or circumstances leads to a determination that it is more likely than not the fair value of the long-lived intangible asset is less than the carrying amount. If, based on the evaluation, it is determined to be more likely than not that the fair value is less than the carrying value, then the indefinite-lived intangible asset is tested further for impairment. If the implied fair value of the indefinite-lived intangible asset is lower than its carrying amount, an impairment loss is recognized for the difference. Subsequent increases in the indefinite-lived intangible asset values are not recognized in the consolidated financial statements.

Long-Lived Asset Impairment

The Company evaluates the recoverability of the carrying value of long-lived assets whenever events or circumstances indicate the carrying amount may not be recoverable. If a long-lived asset is tested for recoverability and the undiscounted estimated future cash flows expected to result from the use and eventual disposition of the asset is less than the carrying amount of the asset, the asset cost is adjusted to fair value and an impairment loss is recognized as the amount by which the carrying amount of a long-lived asset exceeds its fair value.

No asset impairment was recognized during the years ended June 30, 2018 and 2017.

Income Taxes and Uncertain Tax Positions

The Parent is not directly subject to income taxes under the provisions of the Internal Revenue Code and applicable state laws. Taxable income or loss is allocated to its members in accordance with their respective percentage ownership for inclusion in their respective tax returns.

The Parent's wholly-owned subsidiary, Pyramid Healthcare, Inc., is subject to federal and state income taxes. Deferred tax assets and liabilities are recognized for the tax effects of differences between the financial statements and tax basis of assets and liabilities of the subsidiary. A valuation allowance is established to reduce deferred tax assets if it is more likely than not that a deferred tax asset will not be realized.

The Company recognizes the benefit or expense of an uncertain tax position in accordance with the Financial Accounting Standards Board Accounting Standards Codification (ASC) Topic 740, *Income Taxes*, after considering if it is more likely than not, based on the technical merits, that a tax position will be realized and sustained upon examination. For tax positions meeting a "more-likely-than-not" threshold, the amount recognized in the consolidated financial statements is the largest amount expected to be realized upon settlement with the tax authority. The Company's income tax returns filed subsequent to 2014 are still subject to federal and state examinations by tax authorities. As of June 30, 2018, the Company had no material uncertain tax positions.

Self Insurance

The Company has elected to self-insure certain costs related to employee health benefit programs. Costs resulting from noninsured losses are charged to income when incurred, as the Company accrues for incurred but not reported claims. The Company has purchased insurance that limits its exposure for individual claims to $150,000 per occurrence, with no cap per person per plan year.

Liquidity and Going Concern

As discussed in Note 7, the Company's credit agreement governing the revolving line of credit, senior and delayed draw term loans matures on August 22, 2019, which is within twelve months of the issuance of the 2018 consolidated financial statements. Management has evaluated this condition and has determined that the credit facility is probable of being extended on comparable terms on a long-term basis. This evaluation was made based on current facts and circumstances and could change by future events or future changes in business and economic conditions.

The Company reported an operating loss for 2018 but had positive cash flows from operations and invested significantly in the operating facilities during 2018 and 2017. Management was not aware of any violation with the lender's required financial covenants at June 30, 2018 and in subsequent periods and expects to maintain compliance through June 30, 2019.

Note 2: Net Patient Service Revenue

The Company recognizes patient service revenue associated with services provided to patients who have third-party payer coverage on the basis of contractual rates for the services rendered. For uninsured patients, the Company recognizes revenue on the basis of its standard rates for services provided. On the basis of historical experience, a significant portion of amounts due directly from patients, primarily self pay, co-payments and deductibles, will not be collected. Thus, the Company records a significant provision for uncollectible accounts related to these patients in the period the services are provided. This provision for uncollectible accounts is presented on the statements of operations as a component of net patient service revenue.

The Company has agreements with third-party payers that provide for payments to the Company at amounts different from its established rates. These payment arrangements include:

Medicaid

Services rendered to Medicaid program beneficiaries are reimbursed at established rates based on the type of service provided. Laws and regulations governing Medicaid programs are complex and subject to interpretation and change. As a result, it is reasonably possible that recorded estimates could change materially in the near term.

County and Other Government Funding

The Company is contracted through certain counties and state-sponsored government agencies to provide services to eligible individuals. The Company is reimbursed by the various agencies at contracted rates.

Other

The Company has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations and preferred provider organizations. The basis for payment to the Company under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

Patient service revenue, net of contractual allowances and discounts but before the provision for uncollectible accounts recognized in the years ended June 30, 2018 and 2017 was:

	2018	2017
Medicaid	$ 70,443,634	$ 56,397,285
County and other government funding	14,871,027	14,160,851
Other third-party payers	76,307,207	73,619,309
Other	7,019,196	2,594,723
	$ 168,641,064	$ 146,772,168

Note 3: Concentration of Credit Risk

The Company grants credit without collateral to its patients, of which many are insured under third-party payer agreements. The mix of net receivables from patients and third-party payers at June 30, 2018 and 2017, is:

	2018	2017
Medicaid	28%	17%
County and other government funding	11%	3%
Other third-party payers	53%	71%
Self-pay and patient co-pays and deductibles	8%	9%
	100%	100%

Note 4: Business Combinations

The Company acquired 100% of the membership interests of Meadow Haven Recovery Services, LLC d.b.a. Tapestry Eating Disorder Program (Tapestry) effective June 30, 2017. The Company paid approximately $4,303,000 in total cash consideration, which was funded through borrowings under the Delayed Term Loan of the Company's credit agreement (see Note 8). At June 30, 2017, the Company had estimated an expected purchase price reduction of $255,000, which was included in total consideration. During 2018, the Company agreed to a final purchase price reduction of $207,081 related to final working capital allocations. The Company executed the acquisition as part of the overall investment strategy of its investor group, which considered several factors including industry growth and market presence. In connection with the purchases, the Company incurred purchase transaction costs of approximately $179,700, which were expensed and included in other nonoperating expense as part of acquisition cost during the year ended June 30, 2017.

The Company previously adopted the alternative accounting for business combinations provided in ASU 2014-18, *Business Combinations (Topic 805): Accounting for Identifiable Intangible Assets in a Business Combination*. Under this guidance, the Company does not recognize apart from goodwill the intangible assets related to certain customers and non-competition agreements.

The consideration paid for the goodwill was primarily attributable to the expected future cash flows and growth of the business. Goodwill for this transaction is deductible for income tax purposes.

The following table summarizes the consideration paid in addition to the assets acquired and liabilities assumed at the acquisition date.

Fair Value of Consideration	
Cash paid to sellers	$ 4,558,035
Estimated purchase price adjustment due from sellers	(255,000)
Total	4,303,035
Recognized Amounts of Identifiable Assets Acquired and Liabilities Assumed	
Assets Acquired	
Cash	84,157
Patient accounts receivable	204,955
Total assets	289,112
Liabilities Assumed - Accounts payable and accrued expenses	(29,668)
Total identifiable net assets	259,444
Goodwill	$ 4,043,591

The fair value of the accounts receivable includes gross amounts of $445,233 of which $240,278 is expected to be uncollectible.

Note 5: Property and Equipment

Property and equipment consist of the following at June 30, 2018 and 2017:

	2018	2017
Land	$ 1,183,750	$ 763,717
Buildings and leasehold improvements	28,395,723	26,801,511
Equipment and vehicles	16,488,969	10,742,451
Furniture and fixtures	726,781	636,093
Software	750,771	638,605
Construction in progress	16,412,893	5,305,145
Total cost	63,958,887	44,887,522
Accumulated depreciation	(13,159,105)	(9,005,993)
Total	$ 50,799,782	$ 35,881,529

Note 6: Goodwill and Other Intangible Assets

The carrying basis and accumulated amortization of recognized goodwill and other intangible assets at June 30, 2018 and 2017 were:

	2018			
	Amortization Period (Years)	Gross Carrying Amount	Accumulated Amortization	Net Carrying Value
Amortized intangible assets				
Network patient referrals	10 - 20	$ 25,090,000	$ (7,849,208)	$ 17,240,792
Payer contracts	4 - 5	13,160,000	(12,351,707)	808,293
Noncompete agreement	3 - 5	930,000	(930,000)	-
Licenses and certifications	2 - 3	354,000	(354,000)	-
Goodwill	10	37,740,928	(14,656,097)	23,084,831
		$ 77,274,928	$ (36,141,012)	$ 41,133,916
Unamortized intangible assets				
Trade names		$ 5,955,000	$ -	$ 5,955,000
Licenses and providers numbers		3,546,000	-	3,546,000
		$ 9,501,000	$ -	$ 9,501,000

	2017			
	Amortization Period (Years)	Gross Carrying Amount	Accumulated Amortization	Net Carrying Value
Amortized intangible assets				
Network patient referrals	10 - 20	$ 25,090,000	$ (6,477,208)	$ 18,612,792
Payer contracts	4 - 5	13,160,000	(11,381,667)	1,778,333
Noncompete agreement	3 - 5	930,000	(907,540)	22,460
Licenses and certifications	2 - 3	354,000	(354,000)	-
Goodwill	10	37,693,117	(10,886,788)	26,806,329
		$ 77,227,117	$ (30,007,203)	$ 47,219,914
Unamortized intangible assets				
Trade names		$ 5,955,000	$ -	$ 5,955,000
Licenses and providers numbers		3,546,000	-	3,546,000
		$ 9,501,000	$ -	$ 9,501,000

Amortization expense related to goodwill and intangible assets for the years ended June 30, 2018 and 2017 was $6,133,809 and $6,316,330, respectively. Estimated amortization expense for each of the following five years is:

2019	$ 5,949,645
2020	5,141,312
2021	5,141,312
2022	5,141,312
2023	5,141,312

Changes in goodwill for the years ended June 30, 2018 and 2017 were as follows:

	2018	2017
Balance as of July 1	$ 26,806,329	$ 26,127,693
Acquired goodwill in business combination	-	4,043,591
Final purchase price adjustment	47,811	-
Amortization expense	(3,769,309)	(3,364,955)
Balance as of June 30	$ 23,084,831	$ 26,806,329

Note 7: Long-Term Debt and Line of Credit

On August 22, 2014, The Company entered into a credit agreement with a group of lenders. The agreement provides a $51,000,000 term note facility and a $4,000,000 revolving credit facility. The agreement has been amended through October 2017 to increase the revolving credit limit to $6,000,000 and increase the term loan credit facility to $69,282,750. Total outstanding balance on the term note was $68,749,500 and $65,450,500 at June 30, 2018 and 2017, respectively. Under the revolving credit facility, $2,000,000 and $2,200,000 was outstanding at June 30, 2018 and 2017.

The credit agreement provides for an additional $15,000,000 senior term note commitment through an incremental senior delayed draw term loan commitment (DDTL). The DDTL will be available through the 18-month anniversary of the amendment closing date and is available for purposes of financing growth through capital expenditure projects subject to funding conditions outlined in the credit agreement. Total outstanding balance under the DDTL was $ 4,477,500 and $8,395,000 at June 30, 2018 and 2017.

Effective October 10, 2017, the credit agreement was amended to increase the commitment under the DDTL to $25,000,000 and added an additional delayed draw term loan (DDTL1). The additional delayed draw term loan (DDTL-1) had an outstanding balance of $14,861,500 at June 30, 2018. Fees incurred related to this amendment totaled $554,000. The credit agreement expires on August 22, 2019 and contains certain restrictive covenants including the maintenance of certain financial ratios. The facility is collateralized by substantially all assets of the Company and contains prepayment penalties through 2019.

Interest is payable quarterly on the term, DDTLs and revolving facilities at a LIBOR-based rate or a prime base rate, plus applicable margin. The interest rate at June 30, 2018 and 2017 was 8.89% and 7.50%, respectively. Principal payments for the term note facility and DDTLs are made quarterly in equal aggregate installments of $226,500 at June 30, 2018, with the balance of the note due at maturity. Additional principal payments are due annually based on the Company's excess cash flow as defined in the credit agreement.

On October 1, 2014, the Company entered into an installment sales agreement for the acquisition of property and equipment for the operation of a single drug addiction recovery and rehabilitation center. The agreement calls for 240 monthly installment payments of $8,500 for the first sixty months and $4,087 for the remaining 180 months. The discount rate utilized for this sales agreement was 4.25%, which is reflected as imputed interest.

The Company leases various vehicles through capital lease arrangements. The leases expire at various times through 2022 and include interest ranging from 5.6% to 10.0%. The Company is obligated for the residual value of the vehicle which is included within the present value of lease payments. Should the prevailing market value exceed the residual value at the term of the lease, the Company will receive credit or be refunded the difference. During 2018, the Company realized lease termination gain of $420,035.

Long-term debt consists of the following at June 30, 2018 and 2017:

	2018	2017
Senior term note payable, bank	$ 68,749,500	$ 65,450,500
Delayed draw term note payable, bank	4,477,500	8,395,000
Delayed draw term note payable - 1, bank	14,861,500	-
Capital lease payable	4,524,182	3,179,809
Installment sale note payable	639,169	712,310
	93,251,851	77,737,619
Less unamortized debt issuance costs	(942,491)	(1,177,428)
Less current maturities	(2,464,463)	(1,904,551)
	$ 89,844,897	$ 74,655,640

Aggregate annual maturities of long-term debt and capital leases at June 30, 2018 are:

	Long-Term Debt (Excl. Leases)	Capital Lease Obligations
2019	$ 982,310	$ 1,776,974
2020	87,221,832	1,779,656
2021	27,320	1,032,755
2022	28,504	409,135
2023	29,740	98,074
Thereafter	437,963	-
	$ 88,727,669	5,096,594
Less amount representing interest		(572,412)
Present value of future minimum lease payments		$ 4,524,182

Property and equipment include the following property under capital leases:

	2018	2017
Equipment and vehicles	$ 6,953,807	$ 4,574,767
Less accumulated depreciation	(2,129,804)	(1,294,050)
	$ 4,824,003	$ 3,280,717

Note 8: Operating Leases

The Company leases various treatment facilities and certain other equipment under operating leases. The leases expire in various periods through 2026. The terms of the facility leases generally allow for extension of the lease terms and require the Company to pay insurance, utilities, maintenance and property taxes in addition to monthly rental amounts.

Minimum annual rental payments required under facility operating leases, which have remaining terms in excess of one year as of June 30, 2018, are as follows:

2019	$ 5,962,339
2020	4,898,043
2021	3,078,188
2022	2,208,942
2023	1,216,792
Thereafter	569,019
	$ 17,933,323

Total rental expense was $7,005,065 and $7,466,932 during the years ended June 30, 2018 and 2017, respectively. See Note 12 for rental expense paid to related parties.

Note 9: Employee Benefits

The Company offers a 401(k) plan covering all eligible employees. The Company provides a matching contribution of 100% of employee contributions, up to 1% of eligible employee compensation under the 401(k) plan, plus 50% of salary deferrals for the next 5% of eligible employee compensation. For the years ended June 30, 2018 and 2017, the Company had contribution expense of $1,510,059 and $1,294,246, respectively.

Note 10: Income Taxes

The income tax benefit includes these components for the years ended June 30, 2018 and 2017:

	2018	2017
Taxes currently payable (refundable)	$ 135,427	$ 364,940
Deferred income taxes	2,106,394	(920,524)
Income tax (benefit) expense	$ 2,241,821	$ (555,584)

A reconciliation of income tax benefit at the statutory rate to the Company's actual income tax benefit is shown below for the years ended June 30, 2018 and 2017:

	2018	2017
Computed at the statutory rate of 27.5% for 2018 and 34% for 2017	$ (2,555,092)	$ (1,168,552)
Increase (decrease) resulting from		
Nontaxable income	(754,492)	(530,792)
Nondeductible expenses and acquisition cost	64,631	37,155
Nondeductible goodwill amortization	481,835	595,725
State income taxes	(800,416)	94,372
Impact of federal rate change	1,297,067	-
Changes in the deferred tax asset valuation allowance	4,486,000	190,000
Other	22,288	226,508
Actual tax (benefit) expense	$ 2,241,821	$ (555,584)

The tax effects of temporary differences related to deferred taxes shown on the consolidated balance sheets at June 30, 2018 and 2017 were:

	2018	2017
Deferred tax assets		
Allowance for doubtful accounts	$ 1,750,467	$ 2,803,995
Accrued expenses	947,268	1,155,330
Net operating loss carryforward	5,671,922	3,768,099
Other	153,050	263,222
	8,522,707	7,990,646
Deferred tax liabilities		
Property and equipment	(1,152,231)	(2,284,632)
Intangible assets	(1,849,476)	(2,564,620)
	(3,001,707)	(4,849,252)
Net deferred tax asset before valuation allowance	5,521,000	3,141,394
Valuation allowance - state operating loss carryforward		
Beginning balance	(1,035,000)	(845,000)
Increase during the period	(4,486,000)	(190,000)
Ending balance	(5,521,000)	(1,035,000)
Net deferred tax asset (liability)	$ -	$ 2,106,394

At June 30, 2018, the Company has $7,900,000 of net operating loss carryforwards expiring in 2036. Additionally, Onward has federal net operating loss carryforwards of approximately $3,200,000 expiring in 2034. The future utilization of Onward's carryforwards is subject to annual limitations pursuant to the Internal Revenue Code, Section 382.

On December 22, 2017, the United States enacted tax reform legislation through the *Tax Cuts and Jobs Act*, which significantly changes the existing U.S. tax laws, including a reduction in the corporate tax rate from 35% to 21% as well as other changes. The Company's effective tax rate for 2018 is 27.5%, which is a calculated blended rate derived from the tax rates in effect during the fiscal year. As a result of enactment of the legislation, the Company incurred additional one-time income tax expense of $1,297,067 during 2018 related to the remeasurement of certain deferred tax assets and liabilities.

Note 11: Employee Profits Interest Units

The Company's 2011 Profits Interest Plan (Plan) permits the grant of Class B units of the Company to its employees. The Company has granted 175,000 and 110,000 Class B membership units as of June 30, 2018 and 2017, respectively. The Class B units vest over a three to four-year term and are subject to certain restrictions and minimum capital components that are withheld from future distributions based on the Company's operating agreement. The grant date fair value of the Class B units was zero. The Plan provides for accelerated vesting if there is a change in control (as defined in the Plan). During 2018, 65,000 shares were granted. During 2016, 30,000 units were forfeited by a terminated employee. As of June 30, 2018 and 2017, 115,000 and 86,250 units were vested under the Plan, respectively.

Note 12: Related Party Transactions

The Company pays management fees and acquisition transaction fees to Clearview Capital, LLC, a company related through common ownership. During the years ended June 30, 2018 and 2017, acquisition transaction fees paid to Clearview Capital, LLC totaled $0 and $56,300, respectively. Management fee expense was $431,905 and $500,000 for the years ended June 30, 2018 and 2017, respectively, and is included with professional fees in the consolidated statements of operations. Accrued management fees approximated $0 and $68,700 at June 30, 2018 and 2017, respectively.

The Company rents various facilities from related parties. Rental expense paid to related parties totaled $481,340 for the years ended June 30, 2018 and 2017. Total annual rental payments due to related parties are $481,340 per year over the next five years.

Note 13: Contingencies and Commitments

In the normal course of business, the Company is, from time to time, subject to allegations that may or do result in claims and litigation. Some of these allegations may be in areas not covered by the Company's commercial insurance policies. The Company evaluates such allegations by conducting investigations to determine the validity of each potential claim. Based upon the advice of counsel, management records an estimate of the amount of ultimate expected loss, if any, for each of these matters. Management is of the opinion that the ultimate resolution of any known claims, either individually or in the aggregate, will not have a material adverse impact on the Company's consolidated financial position or results of operations or cash flows. Events could occur that would cause the estimate of ultimate loss to differ materially in the near term.

Note 14: Professional Liability Claims

The Company purchases medical malpractice insurance under a claims-made policy. Under such a policy, only claims made and reported to the insurer during the policy term, regardless of when the incidents giving rise to the claims occurred, are covered. Based upon the Company's claims experience, no accrual has been made for the Company's estimated medical malpractice costs as of June 30, 2018 and 2017.

Note 15: Self-Insured Medical Plan

Substantially all of the Company's employees and their dependents are eligible to participate in the Company's employee health insurance plan. The Company began self-insuring for health claims of participating employees and dependents of the different consolidated operating entities at various dates beginning August 1, 2014. Newly acquired entities are expected to be added to the plan subsequent to acquisition. Costs resulting from noninsured losses are charged to income when incurred including both claims reported and claims incurred but not yet reported.

The Company has purchased insurance that limits its exposure for individual claims to $150,000 per occurrence, with no cap per person per plan year. As of June 30, 2018 and 2017, the Company has recorded a receivable of $185,400 and $1,025,400, respectively, related to health care claims that are expected to be in excess of aggregate exposure amounts.

At June 30, 2018 and 2017, the Company's accrual for incurred but not recorded medical expense was $528,200 and $448,200, respectively, which was net of any refunds expected from the reinsurance provider.

Note 16: Significant Estimates

Accounting principles generally accepted in the United States of America require disclosure of certain significant estimates and current vulnerabilities due to certain concentrations. Those matters include the following:

Allowance for Net Patient Service Revenue Adjustments

Estimates of allowances for adjustments included in net patient service revenue are described in *Notes 1 and 2.*

Note 17: Future Changes in Accounting Principles

Revenue Recognition

The Financial Accounting Standards Board amended its standards related to revenue recognition. This amendment replaces all existing revenue recognition guidance and provides a single, comprehensive revenue recognition model for all contracts with customers. The amendment also requires additional disclosure about the nature, amount, timing and uncertainty of revenue and cash flows arising from customer contracts, including significant judgments and changes in those judgments and assets recognized from costs incurred to fulfill a contract. The standard allows either full or modified retrospective adoption effective for nonpublic entities for annual periods beginning after December 15, 2018, and any interim periods within annual reporting periods that begin after December 15, 2019. The Company is in the process of evaluating the impact the amendment will have on the consolidated financial statements.

Leases

The Financial Accounting Standards Board amended its standard related to the accounting for leases. Under the new standard, lessees will now be required to recognize substantially all leases on the balance sheet as both a right-of-use asset and a liability. The standard has two types of leases for income statement recognition purposes: operating leases and finance leases. Operating leases will result in the recognition of a single lease expense on a straight-line basis over the lease term similar to the treatment for operating leases under existing standards. Finance leases will result in an accelerated expense similar to the accounting for capital leases under existing standards. The determination of lease classification as operating or finance will be done in a manner similar to existing standards. The new standard also contains amended guidance regarding the identification of embedded leases in service contracts and the identification of lease and nonlease components in an arrangement. The new standard is effective for annual periods beginning after December 15, 2019, and any interim periods within annual reporting periods that begin after December 15, 2019. The Company is evaluating the impact the standard will have on the consolidated financial statements; however, the standard is expected to have a material impact on the consolidated financial statements due to the recognition of additional assets and liabilities for operating leases.

Note 18: Subsequent Events

In June 2018, the Company entered into an agreement to purchase substantially all assets of a business. The purchase price is $10,500,000, subject to a net working capital adjustment at closing. The Company expects to close the acquisition during October 2018 and is working with its lender to provide the necessary financing for the purchase price.

Subsequent events have been evaluated through October 1, 2018, which is the date the consolidated financial statements were available to be issued.

Supplementary Information

Clearview Pyramid Acquisition Company, LLC

Consolidating Schedule - Balance Sheet Information

June 30, 2018

Assets	Clearview Pyramid Acquisition Company, LLC	Pyramid Healthcare, Inc.	American Day CD Centers, LLC	October Road, Inc.	Onward Behavioral Health, Inc.	Silvermist, LLC	Foundations Medical Services, LLC	Real Recovery of Asheville, Inc.	Mazziti & Sullivan Counseling Services, Inc.	Quest Services, Inc.	Twelve Oaks Holdings, LLC	Meadow Haven Recovery Services, LLC	Eliminations	Consolidated Totals
Current Assets														
Cash and cash equivalents	$ -	$ 182,625	$ 901,558	$ 283,039	$ 399,749	$ 342,733	$ 32,879	$ 229,140	$ 367,845	$ 48,664	$ 245,041	$ 15,286	$ -	$ 3,053,359
Patient accounts receivable, net of allowance of $4,729,740	-	6,781,835	2,643,079	414,408	1,537,953	1,299,000	61,920	333,000	113,819	36,435	930,000	363,625	-	14,717,072
Other receivables	-	1,199,537	-	-	-	-	5,000	-	-	2,000	-	-	(382,141)	824,396
Due from affiliates	-	20,947,043	23,648,948	-	-	853,386	3,128	-	(18,135)	-	-	-	(45,434,370)	-
Refundable income taxes	-	921,644	-	-	(219,340)	-	-	-	15,906	69,345	-	112,705	(465,807)	408,453
Prepaids and other current assets	-	396,712	191,406	6,463	15,474	1,598	3,888	809	9,388	-	1,509	2,393	-	629,640
Total current assets	-	30,429,396	27,384,991	703,910	1,733,836	2,501,717	106,815	562,949	688,823	156,444	1,176,550	494,009	(46,282,318)	19,632,920
Property and Equipment, net	-	31,976,488	675,888	3,180,926	8,010,789	3,060,969	239,287	221,688	122,767	27,590	2,829,410	453,480	-	50,799,782
Other Assets														
Goodwill, net	-	5,532,577	4,670,193	896,247	1,991,695	-	-	1,468,607	5,382,738	1,053,542	-	3,639,232	-	23,084,831
Other intangible assets, net	-	8,182,060	13,661,375	1,401,583	4,304,167	-	-	-	-	-	-	-	-	27,550,085
Other long-term assets	-	81,080	241,866	5,225	94,441	702	35,110	10,400	21,363	-	-	-	-	490,187
Deferred income tax benefit	-	-	-	-	(2,593)	-	-	48,243	208,964	-	-	7,648	(262,262)	-
Investment in subsidiaries	36,069,172	69,901,141	-	-	-	-	-	-	-	-	-	-	(105,970,313)	-
	36,069,172	83,697,758	18,573,434	2,303,055	6,387,710	702	35,110	1,527,250	4,063,065	1,053,542	-	3,646,880	(106,232,575)	51,125,103
	$ 36,069,172	$ 146,103,642	$ 46,634,313	$ 6,187,891	$ 16,132,335	$ 5,563,388	$ 381,712	$ 2,313,887	$ 4,874,655	$ 1,211,374	$ 4,005,960	$ 4,594,369	$ (152,514,893)	$ 121,557,805
Liabilities and Members' Equity														
Current Liabilities														
Checks in excess of bank balance	$ -	$ 507,158	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 507,158
Current maturities of long-term debt	-	2,464,463	-	-	-	-	-	-	-	-	-	-	-	2,464,463
Accounts payable	-	3,511,482	78,680	36,275	66,302	15,704	401,241	11,265	25,929	754	10,582	8,979	(382,143)	3,788,050
Accrued expenses	-	10,127,568	947,690	383,061	922,964	-	10,312	(16,039)	221,973	-	979	(63,627)	-	12,514,881
Income tax payable	-	-	-	319,283	-	-	-	146,524	-	-	-	-	(465,807)	-
Due to affiliates	-	20,027,065	-	2,727,438	18,113,352	1,531,258	-	310,322	-	445,189	1,539,689	768,694	(45,463,007)	-
Total current liabilities	-	36,637,736	1,026,370	3,466,057	19,085,618	1,546,962	411,553	452,072	247,902	445,943	1,551,250	714,046	(46,310,957)	19,274,552
Long-Term Liabilities														
Line of credit	-	2,000,000	-	-	-	-	-	-	-	-	-	-	-	2,000,000
Long-term debt	-	89,844,897	-	-	-	-	-	-	-	-	-	-	-	89,844,897
Deferred income tax liability	-	-	-	244,706	-	-	-	-	-	17,499	-	-	(262,262)	-
	-	91,844,897	-	244,706	-	-	-	-	-	17,499	-	-	(262,262)	91,844,897
Members' Equity														
Members' capital	36,069,172	-	-	-	-	-	-	-	-	-	-	-	-	36,069,172
Common stock	-	-	-	1,000	-	-	-	-	-	-	-	-	(1,000)	-
Additional paid-in capital	-	35,659,410	40,877,333	2,977,974	8,955,404	599,001	1,286,175	2,078,241	4,973,072	1,371,859	(147,213)	4,303,055	(102,954,688)	-
Retained earnings (accumulated deficit)	-	(18,038,401)	4,730,610	(821,703)	(11,908,964)	3,416,825	(1,316,016)	(216,426)	(346,319)	(625,927)	2,601,923	(422,712)	(3,302,148)	(25,946,978)
Total Clearview Pyramid Acquisition Company, LLC members' equity	36,069,172	17,621,009	45,607,943	2,477,071	(2,953,283)	4,016,426	(29,841)	1,861,815	4,626,753	747,932	2,454,710	3,880,323	(106,257,836)	10,122,194
Noncontrolling interests	-	-	-	-	-	-	-	-	-	-	-	-	316,162	316,162
Total members' equity	36,069,172	17,621,009	45,607,943	2,477,071	(2,953,283)	4,016,426	(29,841)	1,861,815	4,626,753	747,932	2,454,710	3,880,323	(105,941,674)	10,438,356
Total liabilities and members' equity	$ 36,069,172	$ 146,103,642	$ 46,634,313	$ 6,187,891	$ 16,132,335	$ 5,563,388	$ 381,712	$ 2,313,887	$ 4,874,655	$ 1,211,374	$ 4,005,960	$ 4,594,369	$ (152,514,893)	$ 121,557,805

Clearview Pyramid Acquisition Company, LLC

Consolidating Schedule - Statement of Operations Information

Year Ended June 30, 2018

	Clearview Pyramid Acquisition Company, LLC	Pyramid Healthcare, Inc.	American Day CD Centers, LLC	October Road, Inc.	Onward Behavioral Health, Inc.	Silvermist, LLC	Foundations Medical Services, LLC	Real Recovery of Asheville, Inc.	Mazziti & Sullivan Counseling Services, Inc.	Quest Services, Inc.	Twelve Oaks Holdings, LLC	Meadow Haven Recovery Services, LLC	Eliminations	Consolidated Totals
Revenues														
Patient service revenue, net of allowances and contractual adjustments	$ -	$ 85,486,474	$ 35,417,784	$ 5,892,597	$ 18,458,878	$ 6,250,892	$ 1,403,765	$ 2,376,213	$ 4,286,629	$ 461,815	$ 7,025,760	$ 1,868,673	$ (328,416)	$ 168,641,064
Provision for uncollectible accounts, net of recoveries	-	(5,129,188)	(2,479,245)	(530,334)	(1,845,888)	(2,102,041)	(50,652)	(124,013)	(252,975)	(50,464)	(1,905,147)	(220,852)	-	(14,690,799)
Net patient service revenue less provision for uncollectible accounts	-	80,357,286	32,938,539	5,362,263	16,612,990	4,148,851	1,353,113	2,252,200	4,033,654	411,351	5,120,613	1,647,821	(328,416)	153,950,265
Operating Expenses														
Salaries	-	46,079,697	16,544,833	2,938,357	12,264,201	1,428,155	584,065	522,191	2,363,936	304,656	1,010,919	767,298	-	84,798,308
Employee benefits	-	10,189,029	3,022,662	632,414	2,037,908	292,719	128,569	125,923	374,856	64,907	219,786	89,235	-	17,177,036
Purchased services and professional fees	-	10,163,364	1,343,228	793,254	1,665,875	396,642	436,534	71,398	26,082	2,446	172,654	179,308	(328,416)	14,922,566
Food, clothing, drugs and supplies	-	4,372,690	261,941	187,877	337,656	203,468	98,187	144,111	243,297	10,736	187,875	21,174	-	6,089,012
Property leases and other rentals	-	2,627,236	1,847,457	79,969	1,693,114	8,514	64,529	175,981	304,709	24,649	75,821	106,102	-	7,005,065
Repairs and maintenance	-	1,453,084	369,767	73,220	65,833	36,262	6,654	23,843	8,961	5,507	36,541	23,214	-	2,104,916
Utilities	-	2,594,971	310,214	109,330	322,067	79,688	47,319	10,927	83,408	14,394	27,799	35,799	-	3,635,916
Travel	-	1,764,806	375,921	111,585	147,049	136,474	19,270	31,431	106,525	21,034	26,313	91,169	-	2,827,577
Insurance	-	722,665	52,284	26,368	-	45,287	9,811	-	5,741	6,306	-	-	-	868,292
Property and local taxes	-	505,794	35,299	32,432	16,338	14,573	7,479	19,136	8,495	1,098	21,689	7,180	-	669,513
Depreciation and amortization	-	5,333,417	2,081,361	379,669	1,690,858	75,620	49,533	260,582	541,038	143,568	148,957	430,354	-	11,035,097
Gain on capital lease	-	(420,035)	-	-	-	-	-	-	-	-	-	-	-	(420,035)
Loss on disposal of property and equipment	-	234,874	-	-	-	-	-	-	-	-	-	-	-	234,874
Other operating expenses	-	1,395,058	972,804	85,582	723,818	849,753	13,250	84,571	106,809	13,947	40,870	224,434	-	4,510,100
Total operating expenses	-	86,515,650	27,217,771	5,450,057	20,964,717	3,567,209	1,463,651	1,490,289	4,170,680	603,248	1,969,224	1,975,267	(328,416)	155,458,147
Operating Income (Loss)	-	(6,158,364)	5,720,768	(87,794)	(4,351,727)	621,642	(109,938)	761,911	(136,426)	(191,897)	3,151,389	(327,446)	-	(1,507,882)
Other Income (Expense)														
Interest expense	-	(7,876,409)	-	-	-	-	-	-	-	-	-	-	-	(7,876,409)
Other	-	6,250,178	(4,079,905)	(242,155)	(465,077)	(709,949)	-	(106,869)	(225,399)	(22,901)	(269,536)	(95,338)	-	93,049
Equity in earnings of subsidiaries	-	3,361,171	-	-	-	-	-	-	-	-	-	-	(3,361,171)	-
Total other income (expense)	-	1,734,940	(4,079,905)	(242,155)	(465,077)	(709,949)	-	(106,869)	(225,399)	(22,901)	(269,536)	(95,338)	(3,361,171)	(7,783,360)
Income (Loss) Before Income Taxes	-	(4,423,424)	1,640,863	(329,949)	(4,816,804)	(88,307)	(109,938)	655,042	(361,825)	(214,798)	2,941,853	(422,784)	(3,361,171)	(9,291,242)
Income Tax (Benefit) Expense	-	950,685	-	(71,414)	1,271,791	-	-	319,393	(140,706)	(27,305)	-	(60,623)	-	2,241,821
Net Income (Loss)	-	(5,774,109)	1,640,863	(258,535)	(6,088,595)	(88,307)	(109,938)	335,649	(221,119)	(187,493)	2,941,853	(362,161)	(3,361,171)	(11,533,063)
Less: Net Income Attributable to Noncontrolling Interests	-	-	-	-	-	-	-	-	-	-	-	-	121,980	121,980
Net Income (Loss) Attributable to Clearview Pyramid Acquisition Company, LLC	$ -	$ (5,774,109)	$ 1,640,863	$ (258,535)	$ (6,088,595)	$ (88,307)	$ (109,938)	$ 335,649	$ (221,119)	$ (187,493)	$ 2,941,853	$ (362,161)	$ (3,483,151)	$ (11,655,043)

Exhibit 20

Mental Health & Addictions Advisory Council

Public Health
Prevent. Promote. Protect.
Harford County Health Department

HARFORD COUNTY
LHIC

Mental Health and Addictions Advisory Council (MHAAC)
Local Health Improvement Coalition (LHIC) Behavioral Health Workgroup
Harford County OOCC Opioid Intervention Team (OIT)

Meeting Agenda | September 24, 2019 | 8:00-10:00 AM
Location: Harford County Emergency Operations Center (EOC)
2220 Ady Road, Forest Hill, MD 21050

Call to Order & Introductions: Mary Bunch, MHAAC Council Chair

Old Business: N/A

Special Topics:

- Emergency Services & Naloxone – Edward Hopkins
- Harford Crisis Hotline – Michael Clancy

Updates:

- Health Officer Report – Dr. Russell Moy
- Office of Mental Health/Core Service Agency – Jessica Kraus
- Department of Community Services/Office of Drug Control Policy – Tara Lathrop
- UMUCH & Harford Crisis Center – Rod Kornrumpf
- HCHD Behavioral Health– Andrea Pappas
- Local Addictions Authority (LAA) – Shawn Martin
- Other Updates

Community Announcements: All

Upcoming Meetings:

- November 26th
- January 28th

Harford County Health Department
Division of Behavioral Health
120 S. Hays Street
Bel Air, MD 21014
410-877-2340

Harford County Government
Department of Community Services - ODCP
125 N. Main Street
Bel Air, MD 21014
410-638-3333

Office on Mental Health
Core Service Agency of Harford County
2231 Conowingo Road, Suite A
Bel Air, MD 21015
410-803-8726