CERTIFICATE OF NEED APPLICATION
INTERMEDIATE CARE FACILITY
Matter No. 22-02-2459

Pascal Crisis Stabilization Center
43 Community Place
Crownsville, Maryland 21032

Response to MHCC Letter of August 25, 2022
Request for additional information.

September 23, 2022

PASCAL
Crisis Stabilization Center

Pascal Crisis Services, Inc.
Robert A. Pascal Youth & Family Services, Inc. • Pascal Crisis Stabilization Center
1215 Annapolis Road, Suite 204, Odenton, MD 21113
(410) 975-0067

September 20, 2022

VIA Email & Hard Copy Delivered

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
Attn: Ms. Ruby Potter

Re: Pascal Crisis Services, Inc.
Establish a Track Two ICF
Matter No. 22-02-2459

Dear Ms. Ruby Potter,

After consultation with our medical and clinical team, Pascal has decided to modify the initially requested number of Track Two ICF beds from 25 to 20. This change will allow Pascal to reduce the number of patients per room, which will provide a better overall use of space and enable greater observation of the patients while being provided 3.7/3.7WM services. All references to 25 ICF Track Two beds in the initial application will now reflect the modification to 20 ICF Track Two beds. This modification requires Pascal to update the responses to the following sections in their CON application:

Part I Project Identification and General Information
- 8.B. Compréhensive Project Description
  - (1) Construction, renovation, and demolition plans
  - (2) Changes to square footage of departments and units
  - (5) Outline the project schedule

Part II Project Budget
- MHCC Tables

Updates to these sections will be given at the end of this response.

On behalf of applicant Pascal Crisis Services, Inc., per Commission Staff's standing request, we are submitting four copies of Pascal's response to MHCC request for additional information letter of August 25, 2022. Updated and related exhibits will be provided in a searchable PDF file and a native Excel spreadsheet of the revised MHCC tables will be emailed to yourself by the end of the day.

I hereby certify that the information contained within this application is true and accurate to best of my knowledge.

Katherine Bonincontri, M.H.R., M.S., LCPC-S
President and Executive Director

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Table of Exhibits

MHCC Request for Additional Information

The following responses address the MHCC request for information dated August 25, 2022.

Part I: Project Identification and General Information

1. Will the 3.7/3.7WM patients be managed in a separate unit, or cohoused with the existing crisis stabilization patients?

Applicant Response 1:
All 3.7/3.7WM patients will be managed on the 2nd floor of the Pascal Crisis Stabilization Center and will occupy the entire second floor as a separate unit. Currently, the second floor is utilized for the State Opioid Response (SOR) Crisis Stabilization Services (CSS) beds and Low Intensity Residential (ASAM 3.1/3.1WM) beds. The 3.7/3.7WM ICF beds, if approved, will replace the SOR CSS and Low Intensity Residential (3.1/3.1WM) beds on the 2nd floor of the Pascal Crisis Stabilization Center. The 3.7/3.7WM patients will have dedicated access to showers, toilets and sinks at a ratio of 4:1 respectfully.

All floors have access control points that can only be opened using a FOB to prevent patients from traveling between floors, or into unauthorized areas. These control points will deactivate in the event of a fire alarm or emergency.

2. How many patients are currently housed per room? How will this change after implementation of project?

Applicant Response 2:
Currently, SOR CSS patients are housed on the 2nd floor in the following breakout:

Room 201: 5 patient beds
Room 203: 3 patient beds
Room 205: 5 patient beds
Room 206: 5 patient beds
Room 209: 2 patient beds

The current use of the 2nd floor will transition immediately to 3.7/3.7WM upon application approval and implementation of a new 20 bed track two ICF.

3. Please submit revised floor plan that provides existing bed placement, showers, and toilets and the square footage for the rooms. In addition, please identify all other areas including nursing stations, recreation space, commercial kitchen and dining areas.

Applicant Response 3:
In order to maintain a 4 bed per room requirement, Pascal has since redesigned the 2nd floor to maximize the care provided and to ensure rooms have adequate space for care and monitoring. In addition, to maintain patient availability to showers, toilets and sinks, Pascal has adjusted the floor plan to meet the regulatory requirements for one shower, one sink and one toilet for every four patients. The updated building plan includes all four levels of the Pascal Crisis Stabilization Center.

Pascal maintains a Food Service License for a commercial kitchen located in the lower level of the site, in close proximity with the center's dining area. The commercial kitchen utilizes contracted food preparation and service personnel who prepare, cook and serve food to all patients.

The revised plans include a new room/bed breakout with additional shower/toilet and sink areas to support the patients on the 2nd floor. The **NEW** breakout is identified in the **Exhibit 1** Revised Building Plan and Project Layout is follows:

Room 200 Nursing Station and Medication Room
Room 201 Semi-private 2 beds
Room 202 Semi-private 2 beds
Room 202A toilet, sink
Room 202B toilet, sink
Room 203 Semi-private 3 beds
Room 204 Shower Room (3) showers, sinks (1) toilet
Room 205 Semi-private 3 beds
Room 206 Semi-private 4 beds
Room 207 Semi-private 4 beds
Room 208 Shower Room (3) showers, toilets, sinks
Room 209 Semi-private 2 beds
Room 210 TV Room
Room 211 Recreation/Group
Room 212 Activity Room

The project plan has been updated with the appropriate labels to identify room numbers, nursing stations, recreational space, commercial kitchen, and dining areas with associated square footage.

4. Please explain how five patients in a room meets the quality and architectural standards for ASAM Level 3.7 and 3.7WM (medically monitored intensive inpatient services)? How many patients will there be per toilet?

Applicant Response 4:
Pascal has reduced the number of requested ICF beds in our application to 20. All patients located on the 2nd floor have access to showers, toilets and sinks, with a ratio of one toilet per every four patients. Please see the new site plan in **Exhibit 1.**

5. Policies and Procedures: Please include the following information:

a. 05I(1), provide more detail about how admissions, length of stay, referral and discharge planning will be managed for level 3.7/3.7WM.

Applicant Response 5a. 05I(1):
Pascal's process regarding admissions, length of stay, referral and discharge planning is outlined in our CARF Accredited policies and procedures see **Exhibit 2, Policies, Procedures and Protocols**

All CARF accredited policies and procedures regarding the admissions, length of stay, referral discharge planning across multiple programs and will be utilized to manage the 3.7/3.7WM program. Pascal's success in achieving accreditation across nine other

licensed behavioral health programs has provided the foundation from which to build a successful 3.7/3.7WM program.

b. 05I(2), provide more detail about how a minimum of one year follow-up care and aftercare will be provided, and how discharged patients' follow-up care will be monitored.

Applicant Response 5b. 05I(2):
Upon intake, patients provide Pascal with their phone number, email, and physical address if applicable. Upon discharge, whether to another facility or to another level of care within Pascal, patients are scheduled for follow up appointments between fourteen and thirty days after discharge. Depending on the level of care transition, Pascal's administration, IOP and care coordination staff will contact patients with referral information for linkages upon discharge and again two weeks later. After thirty days, administrations and care coordination staff contact patients monthly and follow up via telephone for one year following discharge. Pascal also maintains ROIs for other facilities to keep Pascal's Care Coordination Team aware of mutual patient's progress. These follow ups are documented in the EMR (ICANotes).

Need

6. Provide additional information on the projected client population. Will the majority of clients be those who originate from the Safe Stations Program?

Applicant Response 6:
The Safe Station Program staff continues to refer to and access Pascal Crisis Stabilization Center beds through a combination of SOR, RCS or Crisis Response System resolution beds based on their initial assessment. Due to the nature and purpose of the Safe Stations Program, ICF Track Two beds may be filled by this population; however, this is not the main source. Pascal is CARF accredited and licensed in nine separate behavioral health programs and has just completed our tenth accreditation survey for Partial Hospitalization Program services. Continuous outreach and service to patients across all programs has allowed for Pascal's reputation as a quality provider to be shared with hospitals, health departments, and other provider agencies all throughout the state of Maryland. In addition, former clients themselves have encouraged others to contact Pascal directly when in crisis as an alternative to the emergency departments which would require lengthy wait times or the possibility of being denied access to care.

7. Define the service area for the proposed project. Will the facility accept patients from outside of Anne Arundel County?

Applicant Response 7:
Pascal's immediate service area is the Central Region; however, we continue to receive patients statewide. In some cases, Pascal has accepted patients that are out of state i.e. residents here locally due to a family member's military status. Pascal prides itself as the agency that always says "yes" to care. Pascal's focus is filling the gap between the need for psychiatric urgent care and providing an alternative to emergency departments and no other options, regardless of the patient's county of residence.

8. Describe the transportation services which will be provided to patients. Does this include patients from outside of Anne Arundel County? If so, how is this budgeted?

Applicant Response 8:
Pascal's transportation services are an integral part of Pascal's continuum of care philosophy in providing point-to-point transportation for the patient in order to support access to treatment, giving the patient the highest opportunity of success. Our transportation program removes the barriers to care that often result in a patient failing to meet basic requirements for which they then lose access to the limited number of, (often unavailable) follow-on recovery beds because they are unable to find adequate and timely transportation.

Pascal leases vans and utilizes Pascal staff as drivers to transport patients statewide to assist the patient in obtaining health care insurance, government services, e.g. identification card and vital records, medical necessities and discharge to follow-on care. Care coordination also utilizes the transportation service, in cooperation with local, state and out-of-state recovery agencies, to transport patients to bus or rail stations, ensuring the patient departs safely and arrives at the desired final destination.

The funding for the transportation service is part of the agency's overhead budget and costs are split across multiple program lines whose revenue is obtained from reimbursement claims for fee for services.

9. Provide an overview of existing ASAM Level 3.7/3.7 WM services in the jurisdiction, the region, and the state.

Applicant Response 9:
The following grid is found in the Avenues Recovery Center's Prince Frederick active CON application (pg. 34-35), which cites the information was provided by MHCC Program Manager, Moira Lawson, on February 7, 2022. This is the most up to date information that can be found on the ICF providers in Maryland and their bed counts. Listed in red are providers within Anne Arundel County.

On page 35, Avenues noted "According to the MHCC inventory, RCA is the only Track 1 facility in the region. While the table states that RCA has only 3.7 capability, not 3.7 WM, Avenues at Prince Frederick believes that it may be in error, as it was on the Eastern Shore."

Pascal has also identified calculations in the table below (see footnotes) that were not tabulated correctly and updated the Track Two region total for Western MD and Eastern Shore bringing the overall total down to 808 beds.

TRACK 1				
Central MD	Provider	Location	Levels of Care	Beds
	Maryland House Detox, LLC	Linthicum	3.7 & 3.7WM	40
	Baltimore Detox Center	Baltimore	3.7WM	24
	Ashley, Inc.	Havre de Grace	3.7 & 3.7WM	121
			Region Total	185
Eastern Shore	Provider	Location	Levels of Care	Beds
	RCA at Bracebridge Hall	Earleville	3.7	123

	Warwick Manor Behavioral Health, Inc.	East New Market	3.7 & 3.7WM	16
	Hudson Health Services, Inc.	Salisbury	3.7 & 3.7WM	9
	Avenues Recovery Center of Chesapeake Bay	Cambridge	3.7 & 3.7WM	20
			Region Total	168
Montgomery & Southern MD	Provider	Location	Levels of Care	Beds
	RCA Capital Region	Waldorf	3.7	64
			Region Total	64

Total Number of Track 1 ICF Beds in Maryland: 417

TRACK 2				
Central MD	Provider	Location	Levels of Care	Beds
	Hope House Treatment Centers	Crownsville	3.7 & 3.7WM	49
	Pathways	Annapolis	3.7 & 3.7WM	40
	Gaudenzia Crownsville	Crownsville	3.7 & 3.7WM	27
	Pyramid Walden	Joppa	3.7 & 3.7WM	50
	Gaudenzia Park Heights	Baltimore	3.7WM	124
	Mountain Manor	Baltimore	3.7 & 3.7WM	68
	Tuerk House	Baltimore	3.7 & 3.7WM	29
	Baltimore Crisis Response	Baltimore	3.7	7
	Shoemaker	Sykesville	3.7 & 3.7WM	40
			Region Total	434
Western MD	Provider	Location	Levels of Care	Beds
	Joseph S. Massie Unit	Cumberland	3.7	74
	Maryland Treatment Centers	Emmitsburg	3.7 & 3.7WM	118
			Region Total	192[1]
Eastern Shore	Provider	Location	Levels of Care	Beds
	A.F. Whitsitt Center	Chestertown	3.7 & 3.7WM	26
			Region Total	26[2]
Montgomery & Southern MD	Provider	Location	Levels of Care	Beds
	Maryland Treatment Centers	Rockville	3.7 & 3.7WM	70
	Hope House Treatment Centers	Laurel (2 locations)	3.7 & 3.7WM	59 total
	Pyramid Walden, LLC.	Charlotte Hall	3.7 & 3.7WM	27
			Region Total	156

Total Number of Track 2 ICF Beds in Maryland: 808[3]

10. How did you determine a 7 day ALOS for Level 3.7 patients? Will the ALOS be the same for both level 3.7 and 3.7 WM patients? How does this compare to similar Track Two facilities in the state?

Applicant Response 10:
Pascal determined an average length of stay of seven days for both 3.7/3.7 WM programs in order to allow for the patient to safely detox utilizing a four-to-seven-day medication taper in conjunction with comfort medication. This timeframe may increase to ten days on an as needed basis after initial taper completion to allow for

[1] Calculation on Avenues grid was 26, which is incorrect
[2] Calculation on Avenues grid was 244, which is incorrect
[3] Because of the other two miscalculations, the calculation on Avenues grid was 860, which is incorrect

further comfort medications and evaluation. Multiple other track two facilities in the state of Maryland utilize this same timeframe of the four-to-seven-day time period.

According to the Maryland Department of Health's report on Substance Use Disorder (SUD) Treatment Limitations in the Medicaid Program, July 19, 2021, The Maryland Department of Health reported the average length of stay for residential SUD was 5.6 days based on Beacon paid claims from July 1, 2017 - December 31, 2019 which supports Pascal's Length of Stay calculations.

11. Additional information on the Pascal call center is needed as follows:

a. Provide a breakdown of calls by jurisdiction and level of care requested.

b. Provide information on how calls are evaluated to determine the level of care needed, and how staff are trained to evaluate callers.

c. What percentage of those offered a bed are admitted to the stabilization center?

Applicant Response 11:

a. Pascal is unable to provide a breakdown of incoming calls to the Pascal Call Center by jurisdiction because Pascal does not receive accurate data from the callers. Further, callers are typically homeless and often move around different areas of the state and have an incorrect, or out of date, last known address listed in their insurance profile. Similarly, Pascal does not ask callers their requested level of care, but rather will ask them what their "need" is for help. Responses vary, making this difficult to measure. In a sampling of a recent 48-hour period during the month of September 2022, there were 27 incoming calls made to the Pascal Call Center requesting a bed. Two calls requested mental health only; three calls did not have a clear plan in mind for their next steps in treatment; and one call simply stated a desire and need to "get stabilized." Of the remaining 21 calls, one stated a need to "detox," seven stated a desire to "detox then inpatient [substance use treatment]," and 13 stated a need for "inpatient [substance use treatment]". This sampling provides an accurate representation of Pascal's average call volume. This sampling does not include incoming calls from providers, crisis response, hospitals or others; it represents self-referred clients only.

b. Information on how calls are evaluated to determine level of care needed can be found in policies PRG-029 Screening Procedure and PRG-010 Admission & Screening Criteria. (**see Exhibit 2)** Staff taking phone calls are not trained to evaluate for a level of care as they are non-clinical staff. Staff are trained to determine if a potential client is appropriate for services (for example, is a person calling because they simply want a shelter bed, or for clinical services for behavioral health concerns). If the patient requests services not offered by Pascal, the patient is given the appropriate referral of services.

c. Upon completion of an incoming call and screening, if the prospective patient meets criteria and a bed is available, it is **always** offered; however, the person requesting the bed initially may have accepted the bed, but sometimes does not arrive at Pascal for reasons only known to the patient. When this occurs, Pascal releases the bed being held and updates Pascal staff and external referral sources notifying them of updated bed availability. **This ongoing admission flow throughout a given 24-hour period is precisely how Pascal differs from every other program in their**

jurisdiction. Pascal's process agility and rapid communication, both internal and external to the agency, provides the greatest level of access to treatment and simultaneously provides diversion from hospitals and other higher than necessary levels of care.

12. How will the applicant monitor the percentage of grey area patients served by the program? How will the facility recruit grey area patients if the percentage of this population falls below 50 percent?

Applicant Response 12:
At the Crownsville location, the Pascal Crisis Stabilization Center, and at the 1226 Annapolis Rd, Odenton MD location, 97.3% of patient days are provided to persons funded by Medicaid, Federal Probation and Parole, and County contracts. Pascal currently tracks intake demographics which include grey area patient statistical information. In the unlikely event that grey area patient days drop below 50%, Pascal is CARF accredited and licensed in Assertive Community Treatment (Mobile Treatment) that services grey area patients in the field and would be a key component in recruitment for an ICF bed as needed. Pascal is an active provider in Anne Arundel County and throughout the State of Maryland. Pascal provides a unique combination of services that enhance the total care continuum in support of co-occurring patient needs.

Pascal is predominantly a Medicaid provider with a current overall rate of 90% Medicaid patients. Pascal utilizes quality assurance and EHR tracking to monitor this population. Due to these statistics, Pascal does not foresee a drop below 50% with regards to grey area patients. However, if there is a drop, Pascal will offer community services by taking the mobile treatment program into areas where this population lives and connecting with them to maintain continuity of care.

Availability of More Cost-Effective Alternatives

13. Describe the goals or objectives developed by PASCAL staff for the 3.7/3.7WM project.

Applicant Response 13:
Pascal's goal is to provide persons in need high quality, medically managed detoxification services in a caring, compassionate, supervised setting. Pascal strives to determine a baseline for each client in order to properly evaluate them for the appropriate level of care. Pascal follows the National Guidelines for Behavioral Health Crisis Care published by the Substance Abuse and Mental Health Services Administration (SAMHSA). Pascal is committed to the following:

- Accept all referrals to determine if a person meets criteria for admission
- Not require medical clearance prior to admission, but rather provide an assessment and support for medical stability while in the program
- Address mental health and substance use crisis issues
- Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges in order to transfer the individual to more medically staffed services if needed

- Be staffed at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community; including:
    - Psychiatrists or psychiatric nurse practitioners
    - Nurses
    - Licensed and/or credentialed clinicians capable of completing assessments
    - Peers with lived experience similar to the experience of the population served.
- Offer walk-in and first responder drop-off options
- Be structured in a manner that offers capacity to accept all referrals, understanding that facility capacity limitations may result in occasional exceptions when full, with a no rejection policy for first responders
- Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated; *and*
- Screen for the recovery needs of the individual in order to move beyond their mental health and/or their substance use challenges to become stabilized prior to discharge.

14. Describe how existing facilities meet/cannot meet the demand. Then describe how and why PASCAL will be able to offer a more cost-effective alternative approach.

Applicant Response 14:
Pascal believes that the approval of twenty (20) Track 2 ICF beds will provide a state-wide benefit for Marylanders and yield a positive impact, as it will provide additional capacity for those in need of immediate 3.7 and 3.7WM services, help reduce the wait time experienced by individuals for urgently needed beds, and ultimately assist in the effort to reduce the amount of overdose deaths.

This unique capability to provide mental health services, residential crisis services and substance use withdrawal management in sequence or combination, sets Pascal apart from existing facilities that only offer substance use treatment. Pascal's expertise and experience in addressing co-occurring needs and crisis stabilization services provides a high level of return to the patient and the community.

Pascal provides a unique service delivery model due to the 24/7/365 Admission policy of the Pascal Crisis Stabilization Center, which simultaneously offers immediate mental health care by Licensed Behavioral Health Clinicians for even the high mental health acuity clients upon an individual's arrival, in addition to other needed services. This service delivery is a main driver that differentiates Pascal from other providers in the jurisdiction as other providers restrict admission windows to a limited set of hours Monday through Friday. **In contrast, Pascal will admit 3.7/3.7WM patients 24/7/365 exactly as hospital emergency departments are available without specified admission time constraints to all who are in need of care.**

Licensed Behavioral Health Clinicians are not mandated for 3.7/3.7WM services, yet Pascal maintains a Licensed Behavioral Health Clinician ratio of 8:1. If an individual requires continued treatment for mental health after completion of 3.7 and/or 3.7WM services, the co-located Residential Crisis Services beds can be utilized, and no transportation to an alternate location is needed. In addition, Pascal's Care Coordination team works with the patient daily to enhance service delivery connecting patients to all basic entitlements and benefits, e.g assisting the patient to obtain health care insurance, government services, identification cards and vital records, medical necessities, and discharge to follow-on care.

The cost-effectiveness of services with the unique emphasis on admission for those in crisis and the availability to access immediate treatment for persons in need of high mental health acuity care presents a unique, affordable alternative to hospitalization for those in need of immediate detox and/or fully co-occurring behavioral health services.

In addition, Pascal follows SAMHSA's guidance for *Safety/Security for Staff and People in Crisis,* as safety for both individuals served and staff is a foundational element for all crisis service settings. Crisis settings are also on the front lines of assessing and managing suicidality and possibly violent thoughts or aggressive behaviors, issues with life and death consequences. While ensuring safety for people using crisis services is paramount, the safety for staff cannot be compromised. Keys to safety and security in crisis delivery settings include:

- Evidence-based crisis training for all staff;
- Role-specific staff training and appropriate staffing ratios to number of clients being served;
- A non-institutional and welcoming physical space and environment for persons in crisis
- Policies that include the roles of clinical staff for management of incidents of behavior that places others at risk

Pascal's ethos maintains that a client's needs come first, and the agency has shown the commitment to provide "radical compassion", driven by hope, and will continue to grow through innovation and collaboration in the pursuit of excellence.

Viability of the Proposal

15. Describe the continuum of care, and how applying for 3.7/3.7WM will improve the services offered.

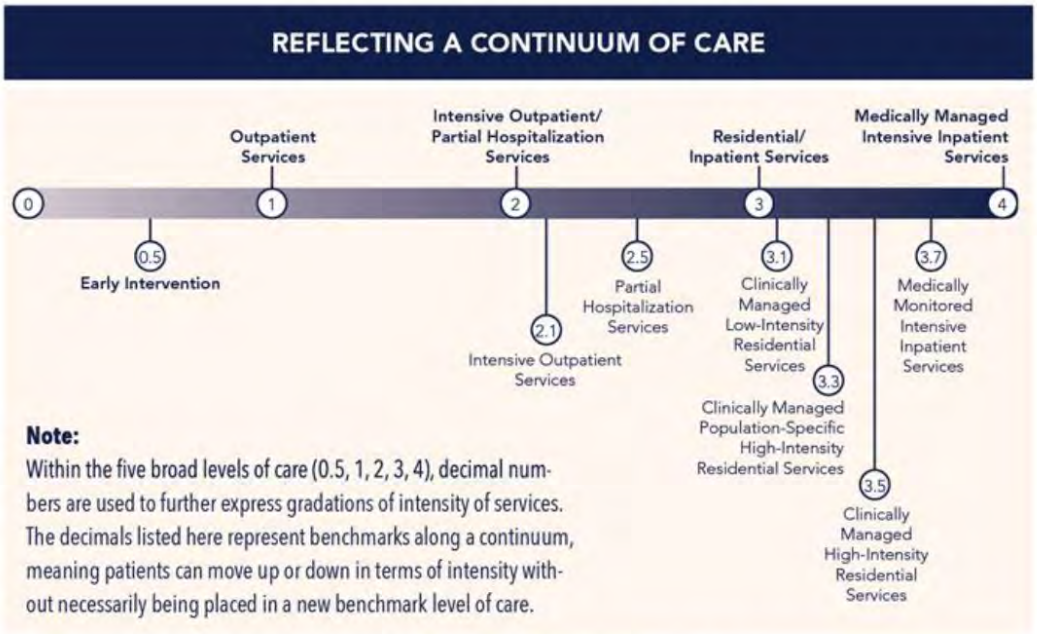
Applicant Response 15:
The "Continuum of Care" is a concept involving a system that guides patients over time through a comprehensive array of behavioral health and substance use services spanning all levels and intensity of care. Another term for continuum of care in the behavioral health and substance use continuum is a "Recovery-Oriented System of Care" (ROSC). According to SAMHSA, the definition of a ROSC is "a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families and communities to achieve

abstinence and improved health, wellness and quality of life for those with or at a risk of alcohol and drug problems".

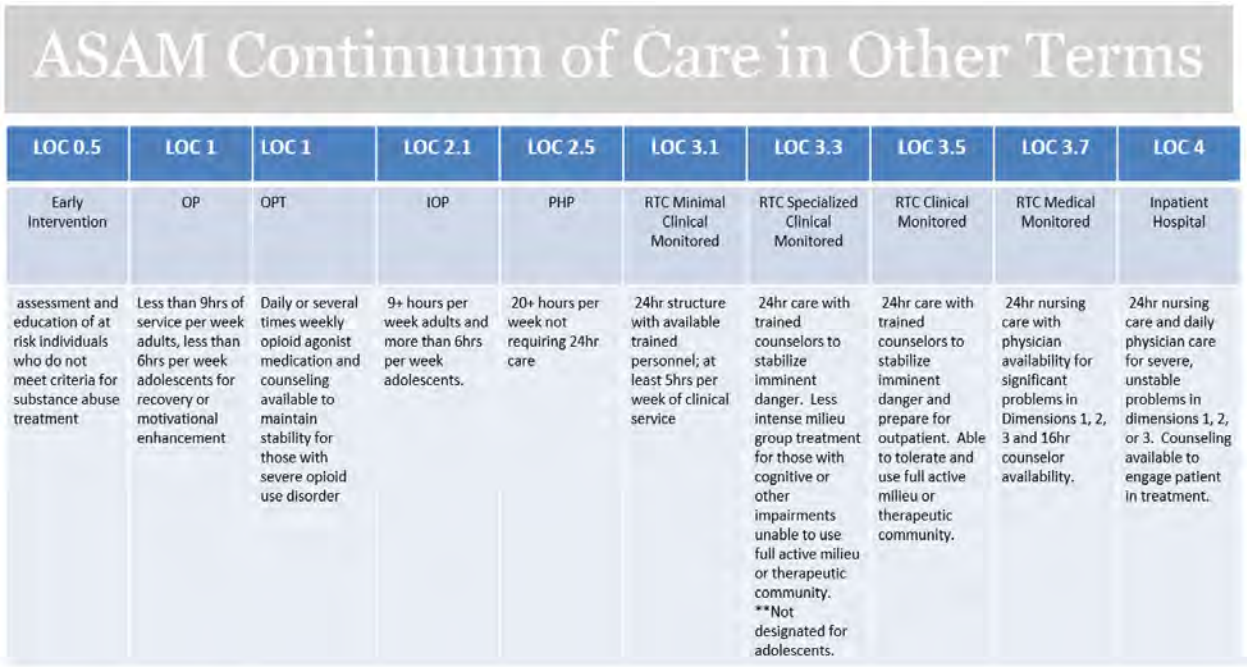
Pascal will utilize the ASAM Dimensions for Addiction Symptomatology in the evaluation of patients for 3.7/3.7WM treatment.

1. Intoxication and Withdrawal Potential
2. Biomedical Conditions
3. Emotional, Cognitive, Behavioral Conditions
4. Readiness to Change
5. Relapse Potential
6. Recovery and Living Environment

Pascal is licensed to provide services across both the outpatient and inpatient levels of care for mental health and substance use services, to include withdrawal management. Services will be enhanced with the ability to provide medically monitored detox as the need for immediate access to this critically important service can be lifesaving for persons in need.



Source: The ASAM Criteria, Third Edition, p. 105



ASAM Continuum of Care in Other Terms

LOC 0.5	LOC 1	LOC 1	LOC 2.1	LOC 2.5	LOC 3.1	LOC 3.3	LOC 3.5	LOC 3.7	LOC 4
Early Intervention	OP	OPT	IOP	PHP	RTC Minimal Clinical Monitored	RTC Specialized Clinical Monitored	RTC Clinical Monitored	RTC Medical Monitored	Inpatient Hospital
assessment and education of at risk individuals who do not meet criteria for substance abuse treatment	Less than 9hrs of service per week adults, less than 6hrs per week adolescents for recovery or motivational enhancement	Daily or several times weekly opioid agonist medication and counseling available to maintain stability for those with severe opioid use disorder	9+ hours per week adults and more than 6hrs per week adolescents.	20+ hours per week not requiring 24hr care	24hr structure with available trained personnel; at least 5hrs per week of clinical service	24hr care with trained counselors to stabilize imminent danger. Less intense milieu group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community. **Not designated for adolescents.	24hr care with trained counselors to stabilize imminent danger and prepare for outpatient. Able to tolerate and use full active milieu or therapeutic community.	24hr nursing care with physician availability for significant problems in Dimensions 1, 2, 3 and 16hr counselor availability.	24hr nursing care and daily physician care for severe, unstable problems in dimensions 1, 2, or 3. Counseling available to engage patient in treatment.

16. Will PASCAL only focus on withdrawal management (pg. 31), or will the program offer medically managed level 3.7 services after completion of level 3.7WM care?

Applicant Response 16:
Currently, Pascal provides withdrawal management services by way of medication; however, the agency's licensure does not allow for an authorization for a patient to comfortably undergo full detox services. Applying and becoming licensed for 3.7/3.7WM will add to the overall services and enable Pascal's medical team to offer medically managed detoxification services in a caring, compassionate, supervised setting to patients in active detox. This will support patients both physically and mentally, making them ready for the next stage in their recovery process once detox is complete.

17. Page 32 states Exhibit 8 provides two years of audited financial data, but actually includes the letters of support. Please provide the most recent two years of audited financial data.

Applicant Response 17:
Pascal has provided a letter from their accountant stating that Pascal has received an unmodified opinion of our financial records for the years 2018, 2019, 2020, and 2021. The letter continues to stipulate that based on past performance; the agency has the financial viability to sustain the project as outlined in the application presented. The accountant's letter is attached as **Exhibit 4 Financial Audit Letter.**

<u>Impact on Existing Providers</u>

18. Please provide a list of other providers in the primary service area who offer similar services to PASCAL.

Applicant Response 18:
Below is a list of other providers in the primary service area who offer similar services to Pascal, specifically with regards to adult residential substance use and withdrawal management programs. **There is no other provider in the jurisdiction that offers all of the behavioral health services and ASAM levels of care in one location with 24/7/365 admissions providing access to care and immediate treatment similar to Pascal.**

Provider	Location	Levels of Care	Beds
Hope House Treatment Centers	Crownsville	3.7 & 3.7WM	49
Pathways	Annapolis	3.7 & 3.7WM	40
Gaudenzia Crownsville	Crownsville	3.7 & 3.7WM	27

19. Provide the following information on current and projected referrals from the crisis stabilization center in the chart below:

Applicant Response 19:
The table below reflects the number of patients currently referred to Level 3.7/3.7WM programs and the number of patients referred to area hospital emergency departments when other ICF program admissions are either closed or beds are full. All local Medicaid 3.7/3.7WM, have communicated to Pascal's Care Coordination team their operating hours for admissions as 10am – 3pm, Monday through Friday. In most cases, even when a bed is available, these licensed 3.7/3.7WM ICF(s) cannot admit a patient same-day and admission time frames can be as soon as 24-hours or more than a week.

The Pascal Crisis Stabilization Center is a 24/7/365 agency and admissions are always open regardless of time or day. Pascal currently treats walk-in patients with medially assisted withdrawal management; however, during the initial assessment, when it is determined that the patient requires a 3.7/3.7WM, and currently licensed intermediate care facilities are closed for admissions and/or beds are full, Pascal has no choice but to immediately transport the patient to the first available emergency department or contact 911 for emergency services. This referral data is included in the table.

Hospital emergency department diversion is a high priority for the state of Maryland. Pascal's request for 20 Track Two ICF beds for 3.7/3.7WM services will immediately provide additional access to ICF beds, ease the burden on emergency departments and reduce overall costs.

The table below captures data from a 12-month period of 7/1/2021 – 6/30/2022. During that period, there were 2,716 admissions to the Pascal Crisis Stabilization Center. This includes 941 SOR CSS patients. Of these admissions, 234 patients were sent to 3.7/3.7WM for detox treatment or to local area hospital emergency departments.

Discharges 7/1/2021 - 6/30/2022	Level 3.7/3.7 WM Program	# of patients currently referred	Estimated 25% # of patients to be referred after program implementation	Difference
TRACK TWO	WALDEN	41	10	31
	GAUDENZIA CV	10	3	8
	HHCV	33	8	25
	HHL	14	4	11
	PATHWAYS	15	4	11
	MT MANOR	6	2	5
	SHOEMAKER	3	1	2
TRACK ONE	HUDSON	1	0	1
	WARWICK	4	1	3
	RCA	11	3	8
HOSPITAL EMERGENCY DEPARTMENTS	AAMC	80	20	60
	BWMC	15	4	11
	MERCY	0	0	0
	BAYVIEW	1	0	1

20. How will the additional services impact other providers regarding staffing availability and costs?

Applicant Response 20:
The impact on other providers will be negligible considering the recent increase in substance use and overdose with the added spike in fentanyl related deaths. The need for beds is so great that any additional beds will only serve to provide greater access to care to those desperately in need of detox and follow-on treatment.

Staffing is a global challenge that all employers are mitigating through higher levels of pay and broader use of incentives and benefits to both hire and retain qualified personnel and as such costs across the industry have risen. Staffing has been challenging since the pandemic, but Pascal has maintained core employees and continues to have an average employee count of 89 staff members. Pascal's medical staff has been a constant throughout the pandemic and Pascal has recently added two additional CRNP(s) and a RN.

Pascal must remain vigilant in the effort to provide a safe and caring environment for patients and staff through continuous support and enhanced employment incentives and benefits. Other providers must make every effort to do the same for their clients and staff to maximize access to care and retain highly qualified people.

Upon approval and implementation of Pascal's 3.7/3.7WM for 20 Track Two bed ICF, area hospital emergency departments may experience a reduction in costs as patients desiring treatment will have access to Pascal 24/7/365 as an alternative. Pascal's cost-effective approach offers availability to access immediate medically monitored intensive inpatient services for patients also in need of high mental health acuity

care. Ultimately, approving Pascal's request for 20 Track Two ICF beds will provide an affordable alternative to hospitalization.

Tables

21. Please resubmit Table A with the current and projected bed count by floor and service type.

Applicant Response 21:
Table A. Physical Bed Capacity (**see Exhibit 3 Revised MHCC Tables**) has been modified listed the title of the service provided on the 2nd floor and 3rd floor of the Pascal Crisis Stabilization Center. The 2nd floor currently houses twenty State Opioid Response beds and eight Low Intensity Residential (ASMA 3.1/3.1WM) beds. The 3rd floor houses sixteen Residential Crisis Services beds and has surge capacity for six Crisis Response System resolution beds.

Table B. has been updated to reflect additional costs for renovation which includes adding two showers, toilets and sinks. The total cost for the project budget is now $60,500.

22. Explain why the sources of cash do not match the expenses on Table B.

Applicant Response 22:
Table B has been updated. The line item for sources of cash, $60,500, originates from the agency's overhead account for maintenance and renovation. This cash is reserved for expansion and is obtained through sound fiscal budgeting and execution. All revenue is received through fee for service billing of private and public insurance and excess is saved from year to year for contingencies. (**see Exhibit 3 Revised MHCC Tables**)

23. Please resubmit Tables C, D with the current revenue and expenses for the existing crisis stabilization facility, and projections for the facility after implementation of the new program.

Applicant Response 23:
Table C & D have been updated to include all services within the Pascal Crisis Stabilization Center. Data for the SOR Grant in CY 2024 and 2025 cannot be forecasted. Pascal's SOR Grant contract expires in 2023 and further extension is not certain as Maryland may consider direct funding reimbursed to providers through fee for service billing. (**see Exhibit 3 Revised MHCC Tables**)

24. Identify what is included in "Other Expenses" on Table E, Row 2j.

Applicant Response 24:
Table E does not have a row labeled "Other Expenses"; however, Table F does. The other expenses include fuel for transportation, unexpected repairs and maintenance and unplanned supplies as well as a $50,000 reserve for unplanned expenses. (**see Exhibit 3 Revised MHCC Tables**)

25. Please resubmit Table G with both the current workforce at the stabilization center and projections of the workforce after addition of the new services.

Applicant Response 25:
Table G. Work Force has been updated. (**see Exhibit 3 Revised MHCC Tables**)

Due to the modification of Pascal's request of 25 Track Two ICF beds to 20 Track Two ICF beds, updates to the following initial application sections are as follows:

Part I Project Identification and General Information

8.A.(3) Project Description: Total cost of implementing the proposed project.

Applicant Update 8.A.(3):
The revised project budget is increased to $60,500 to complete renovations and plumbing additions to ensure Pascal meets the quality and architectural standards for ASAM Level 3.7 and 3.7WM (medically monitored intensive inpatient services). The project will add two toilets, two sinks and two showers to the 2nd floor and minor adjustments to existing rooms to maximize the service area.

8.B. Comprehensive Project Description
(1) Construction, renovation, and demolition plans
(2) Changes to square footage of departments and units
(5) Outline the project schedule

Applicant Update 8.B.(1),(2),(5):
The project plans (**Exhibit 1**) have been updated to reflect the changes needed. The square footage, room identification labels and other areas of the entire building have been updated. The schedule for implementation remains unchanged. All improvements will be completed within the next 90 days of this response.

12. Project Drawings

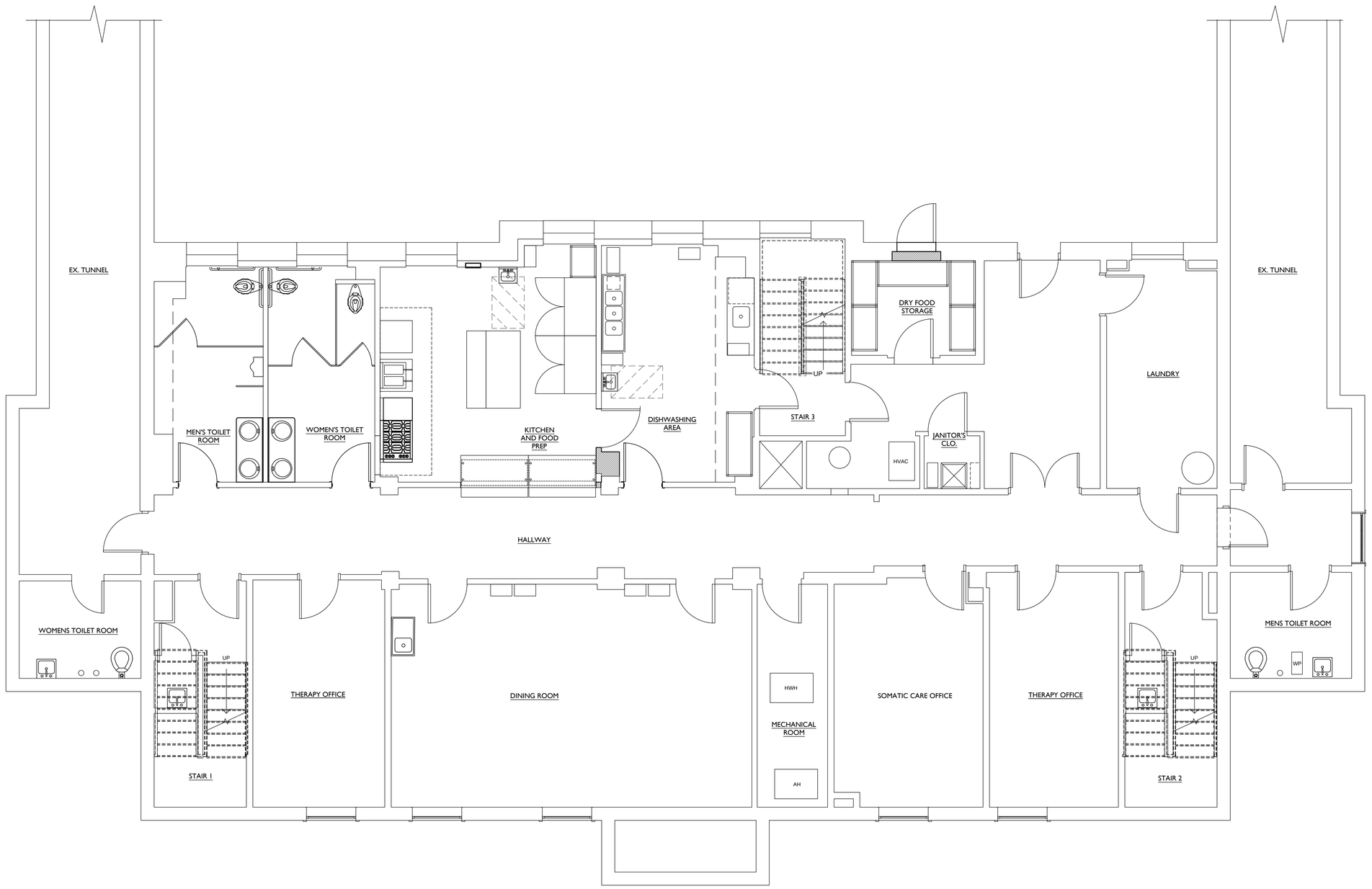
Applicant update 12:
Revised project drawings have been included in **Exhibit 1**.

Part II Project Budget
MHCC Tables, Table B has been updated to reflect the increase cost of renovation for the project. The applicant project cost has been adjusted to $60,500. The funding for this project is provided by Pascal and there is no special financing needed. **See Exhibit 3, Revised MHCC Tables**

Part IV D Viability of the Proposal

Applicant Update:
Assumptions and Explanations remain constant with the only variable being the requested number of Track Two ICF beds reducing from 25 to 20. All calculations recorded in the MHCC tables have been updated to reflect this variable change.

EXHIBIT 1



1 / A-101 BASEMENT FLOOR PLAN

SCALE: 1/4"=1'-0"

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CUSTOM DESIGNS. FLAT FEES.

7612 Browns Bridge Road
Highland, MD 20777
301-776-2666
301-776-2886 fax
info@TransformingArchitecture.com
www.TransformingArchitecture.com

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I CERTIFY THAT THESE DOCUMENTS WERE PREPARED OR APPROVED BY ME, AND THAT I AM A DULY LICENSED ARCHITECT UNDER THE LAWS OF THE STATE OF MARYLAND, LICENSE NUMBER 13662, EXPIRATION 10-22-2021.

PROJECT PHASE

PERMIT

PROJECT TITLE

Robert A. Pascal Youth and Family Services, Inc.

43 Community Place
Crownsville, MD 21032

REVISIONS

SYMBOL	DATE	ISSUED FOR

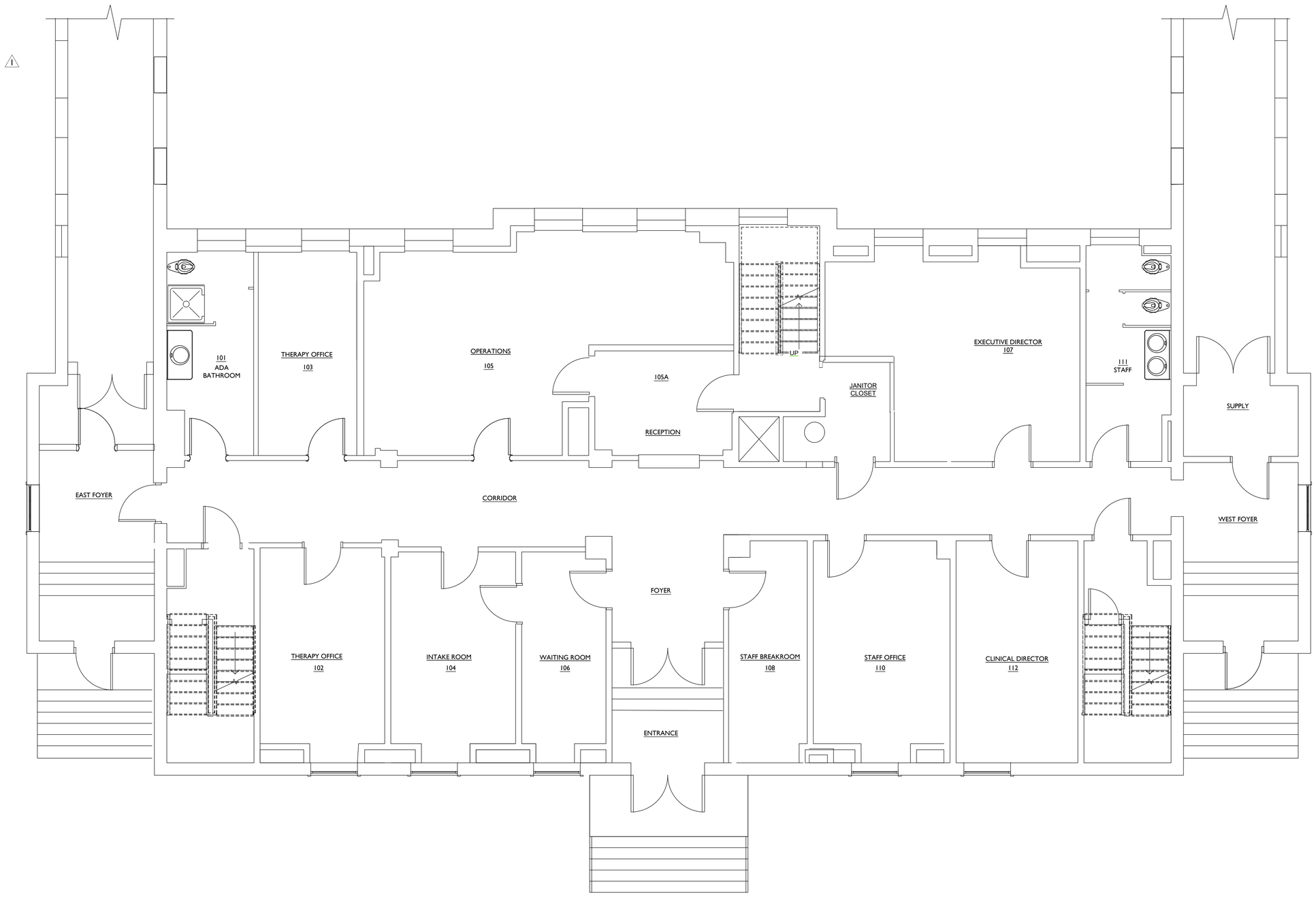
PROJECT NUMBER	20-495
DATE	09/21/2022
SCALE	AS NOTED

DRAWING TITLE

BASEMENT FLOOR PLAN

SHEET NUMBER

A-101



1 / A-102 FIRST FLOOR PLAN

SCALE: 1/4"=1'-0"

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PROJECT PHASE

PERMIT

PROJECT TITLE

Robert A. Pascal Youth and Family Services, Inc.

43 Community Place
Crownsville, MD 21032

REVISIONS

SYMBOL	DATE	ISSUED FOR

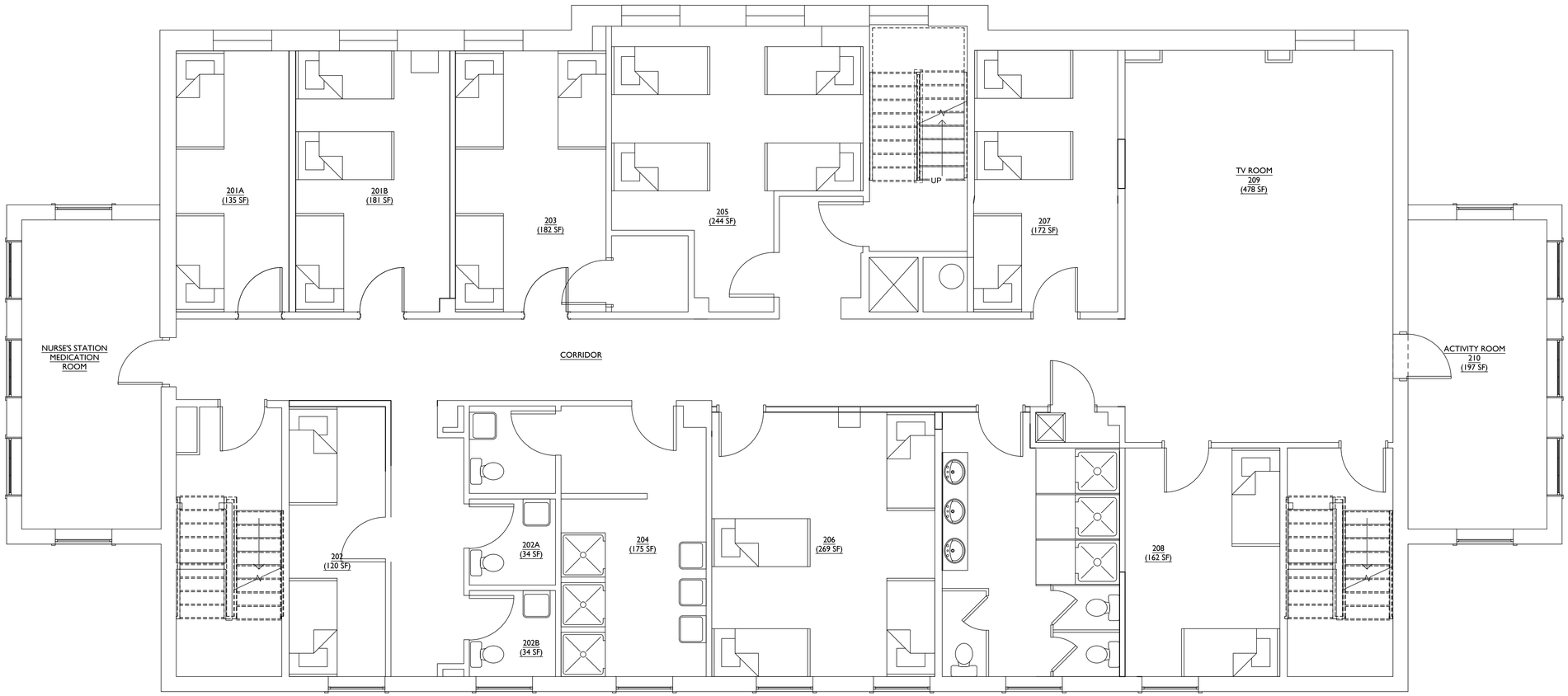
PROJECT NUMBER	20-495
DATE	09/21/2022
SCALE	AS NOTED

DRAWING TITLE

FIRST FLOOR PLAN

SHEET NUMBER

A-102



1 A-103 SECOND FLOOR PLAN
SCALE: 1/4"=1'-0"

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PROJECT PHASE
PERMIT

PROJECT TITLE
Robert A. Pascal Youth and Family Services, Inc.

43 Community Place
Crownsville, MD 21032

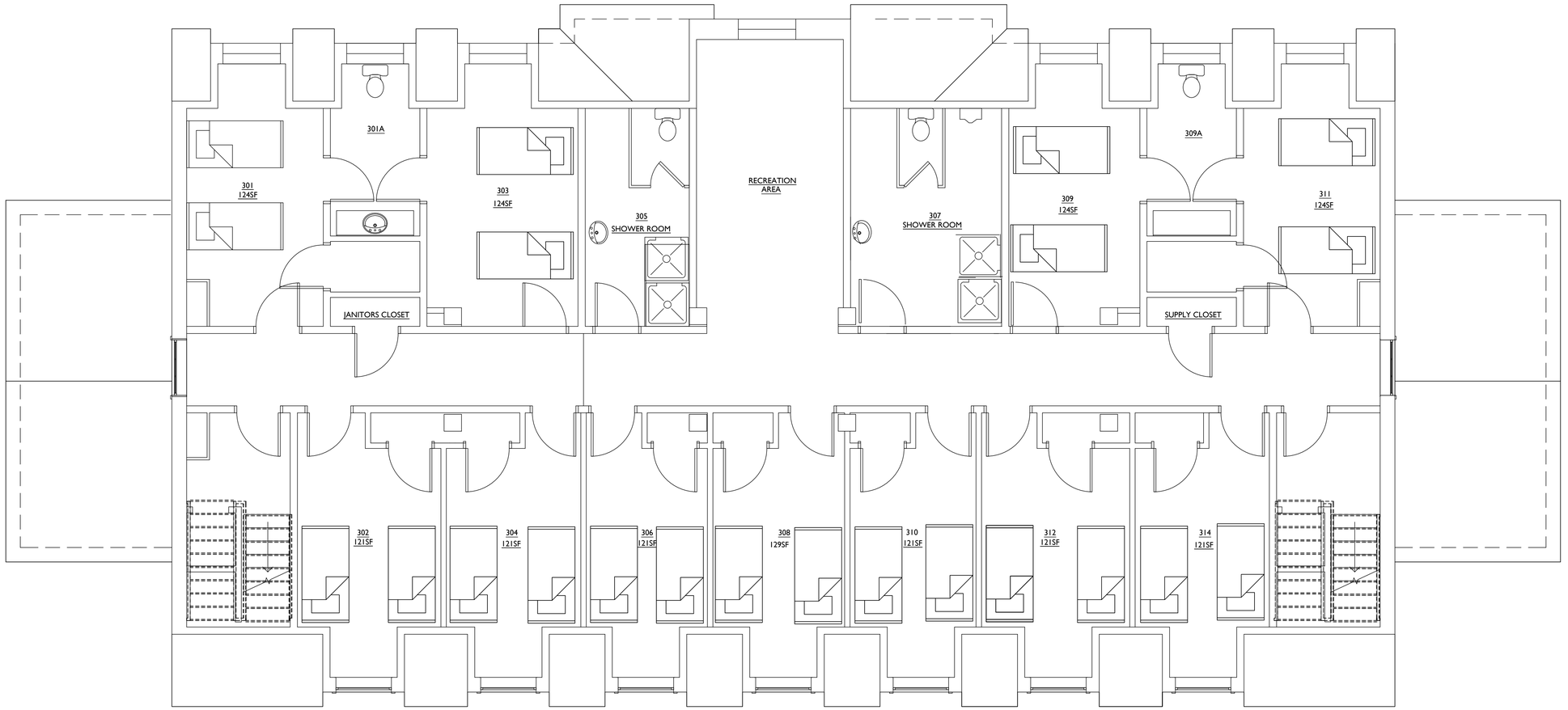
REVISIONS

SYMBOL	DATE	ISSUED FOR

PROJECT NUMBER	20-495
DATE	09/21/2022
SCALE	AS NOTED

DRAWING TITLE
SECOND FLOOR PLAN

SHEET NUMBER
A-103



1 A-104 THIRD FLOOR PLAN
SCALE: 1/4"=1'-0"

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PROJECT PHASE

PERMIT

PROJECT TITLE

Robert A. Pascal Youth and Family Services, Inc.

43 Community Place
Crownsville, MD 21032

REVISIONS

SYMBOL	DATE	ISSUED FOR

PROJECT NUMBER	20-495
DATE	09/21/2022
SCALE	AS NOTED

DRAWING TITLE

THIRD FLOOR PLAN

SHEET NUMBER

A-104

EXHIBIT 2

Pascal Crisis Services, Inc.
Robert A. Pascal Youth & Family Services, Inc. • Pascal Crisis Stabilization Center
1215 Annapolis Road, Suite 204, Odenton, MD 21113
(410) 975-0067

2.A.9 3.7 Program Description

Our clinical team prides itself on ensuring your comfort from the moment you walk in. Our goal is to help cleanse your mind, body, land, and soul in order to aid you in your recovery process.

Medically managed detox helps cleanse and stabilize your body and mind from alcohol, benzodiazepines, opioids, or any other drug lingering in your system. We make your withdrawal as comfortable as possible to ensure your medical safety. Pascal Crisis Services, Inc., (Pascal) follows standards developed by the National Institute on Drug Abuse (NIDA) which is one of the leading establishments on addiction treatment.

Our team of physicians, nurses, and other clinicians deliver a customized alcohol and drug withdrawal management program in order to meet your physical and psychological needs. Supervised withdrawal management can help reduce the severity of your discomfort with withdrawal symptoms.

Pascal operates on a 24/7, 365 days per year basis.

This medically supervised withdrawal process provides you with a safe start to your new, sober life.

FEES
Pascal accepts the following forms of payment:
Medicaid
Blue Cross Blue Shield
Care First
United Health Care (with out of network benefits)
Tri Care

PRE-SCREENING
Prior to being admitted into the withdrawal management program, patients will typically receive a referral from mobile crisis or their local hospital. The information below is then obtained by Pascal staff prior to patient admitting to the unit. Pascal clinical staff reserves the right to deem a patient ineligible for services or requiring medical clearance from a hospital prior to admission based off of the prescreening information.

Referral Source
Name
DOB
SSN
Insurance
Photo ID
Allergies
Medical
Psych
Current meds
Substance used, length of use, route of use, last use time/date
Prior treatment
Plan

ASSESSMENT
The first step is a nursing assessment, followed by a medical evaluation in order to determine your medical, physical, psychological and emotional needs.

WITHDRAWAL MANAGEMENT
Our clinical team will place the patient under 24-hour supervision in order to ensure your safety. The full withdrawal management process takes 4 to 7 days to complete on average.

ALCOHOL WITHDRAWAL
As the most dangerous physical withdrawal, alcohol detox needs to take place in a medically-supervised and closely monitored environment. Although most drug withdrawals are very uncomfortable, abruptly stopping alcohol consumption can cause heart attacks, strokes, and seizures in patients considered high risk. Without professional medical intervention, alcohol detox could be fatal.

Additional complications of alcohol withdrawal can include:

Grand mal seizures	Hallucinations
Heart Attacks	Delirium Tremens
Strokes	

ALCOHOL WITHDRAWAL TIMELINE
Timelines for detoxification depend on the person. For example, people who smoke, suffer from liver or kidney disease, and various other health factors can alter the timeline. But generally, most alcohol detoxification timelines look like this:

- 6-12 hours: Mild symptoms begin about 6-12 hours after the last drink. This could include anxiety, nausea, insomnia or abdominal pain.
- 12-24 hours: About 12-24 hours after the last drink, hallucinations, increased body temperature, confusion and unusual heart rate can occur during this time.
- 24-48 hours: While alcohol withdrawal seizures aren't common, they can happen in as little as 2 hours after a drink but can take up to 24-48 hours to happen.
- 48-72 hours: If DTs (delirium tremens) are going to happen, it will likely occur 48-72 hours after stopping alcohol intake.

While these symptoms may seem daunting, they can be controlled and managed in a professional, medically-supervised setting.

BENZODIAZEPINE WITHDRAWAL

Benzodiazepines are usually prescribed for anxiety and are like alcohol in the way they act on the central nervous system. Withdrawal from benzodiazepines can be extremely dangerous and need medical detoxification.

Much like alcohol and other drugs, the timeline and symptoms can change depending on the person, especially because benzodiazepines have different half-lives. Generally, symptoms include:

Irritability	Heart Palpitations	Anxiety
Upset Stomach	Tremors	
Weight Loss	Insomnia	

BENZODIAZEPINE WITHDRAWAL TIMELINE

As for the timeline of detox from benzodiazepines, it depends. For example, alprazolam (like Xanax) has an average of an 11-hour half-life, so the system is rid of it quickly. On the other hand, the half-life of clonazepam (Klonopin) can be 30-40 hours, which means it takes longer to get out of the patient's system. Therefore, the patient is likely to start experiencing withdrawal symptoms for Xanax within a few hours of taking the last dose. However, it may be a few days before the patient starts feeling symptoms of withdrawal from clonazepam (Klonopin).

A lot of other elements are factored into a benzodiazepine withdrawal timeline, such as how long the patient has been taking the drug, how much, how often, and various other health factors. Because it can take a month or two before physical symptoms completely reside.

OPIOIDS AND HEROIN WITHDRAWAL

Being addicted to opioids and heroin is more dangerous than the withdrawal; regardless, the symptoms of withdrawal can be extremely rough. Luckily, a clinician coupled with a successful treatment program can help ease the symptoms of opioid withdrawal, cutting back on the uncomfortable feelings that come along with it.

If a patient is detoxing from opioids and heroin, the patient may experience:

Agitation and Anxiety	Nausea and Vomiting
Muscle Aches	Goosebumps
Sweating	Insomnia
Restless Legs	Yawning

OPIOIDS AND HEROIN WITHDRAWAL TIMELINE

Symptoms of opiate or heroin withdrawal usually start around 12-30 hours after the last exposure. The earliest symptoms will usually include aches and pain, fatigue, extreme nausea, sweating, anxiety and insomnia. These symptoms may get worse as time goes on, and new symptoms may pop up, such as stomach pain, chills and digestive issues.

Because these symptoms can last several weeks or longer, long-term replacement medication given by medical staff may be given in order to help symptoms.

When someone goes on a binge and uses a stimulant drug, like methamphetamine or cocaine, the withdrawal is commonly called coming down or a crash. This form of withdrawal comes in different stages.

Regardless of the substance issue the patient is struggling with, Pascal focuses treatment around the patient's comfort.

Pascal Crisis Services, Inc. Robert A. Pascal Youth & Family Services, Inc.	**POLICY AND PROCEDURE MANUAL**	**Section:** General Program Standards
		Policy No: PRG-010
	Policy Name: Admission & Screening Criteria	**Effective Date:** 3/1/2018
		CARF BH 2.B.3.

Policy

General Admission Criteria

The following criteria for admission to Pascal Crisis Services, Inc. (Pascal) Residential and Outpatient Programs is subject to the following criteria:

- The client will have a history of mental health diagnosis or symptoms, substance use and concerns, or is in active crisis
- The client will not have a diagnosis of mental retardation or significant cognitive impairment
- The client will be medically stable and physically able to participate in the program, if physically disabled, the disability must not prohibit them from participation in the program
- If non-English speaking, Pascal will make every effort to accommodate the client (at no additional charge) within program guidelines. If unable to accommodate a language difference, the client will be referred to an alternative location where he/she will be best served.

In addition to the aforementioned criteria, the following specific criteria for admission to specific programs will be:

Admission Criteria for Residential Crisis Services

- The client will be 18 years or older, male or female
- The client may be referred by area hospitals, local health department, behavioral health agencies, Crisis Response System, judiciary system representatives, or a self-referral
- The client is experiencing an acute crisis episode, may have SPMI and/or a priority population diagnosis

Admission Criteria for Substance Use Services (Outpatient and Residential)

- The client will be 18 years or older, male or female
- The client may be referred by area hospitals, local health department, behavioral health agencies, Crisis Response System, judiciary system representatives, or a self-referral
- a self-referral client who calls in for assistance completes a phone screening by trained staff on a 24/7 basis which is then sent to the clinical team via secure email to review and respond as to whether the client is appropriate for the referral and request any follow up information needed. If the client is not found to be appropriate, the clinical team will provide additional resources for them.
- Upon arrival, the client is immediately assessed by a licensed clinician and nursing staff to identify ASAM dimension criteria, after which the clinical team makes an

appropriate level of care recommendation, and the client is admitted to the appropriate program (IOP/2.1, PHP/2.5, 3.1, 3.3, 3.5, 3.7, 3.7WM)
- if the clinician's level of care recommendation for a client does not fall under a level of care that is already provided by agency, an appropriate referral will be made to the recommended level of care.

Admission Criteria for Outpatient Mental Health Programs

- The client can either be male or female
- The client can be a child, adolescent, or adult for OMHC
- For any other outpatient mental health program, client must be an adult

Reviews: Pascal has a policy of inclusion, and due to the open nature of the program and the limited medical and psychiatric staffing, Pascal staff will individually review clients in clinical team meetings.
Each client being considered for admission to Pascal shall be advised of the following:
1. Criteria for Admission
2. Criteria for Completion of Treatment
3. Criteria for Involuntary/Therapeutic Discharge
4. Grievance Procedure
5. HIPAA/ Client Rights Disclosure shall be made through the provision of a packet of orientation materials for each client, to be given out during' the first intake meeting. The materials will be reviewed verbally with the client by the Counselor or Nurse performing the intake and an opportunity for client questions will be provided. Documentation of the disclosure of these items is verified by the client's signature on the Consent to Treatment form.

Applicable to All Programs:

Termination/Discharge
Criteria Termination/Discharge is an extremely serious measure to be utilized only as a last resort, when all other reasonable measures to retain the client in treatment have been exhausted. Decisions regarding termination will be made by the clinical team and always after careful consideration as to whether or not the client would continue to benefit from further treatment. These considerations must also be balanced against concerns of safety – of the individual client, other clients, staff members, and the community as a whole.

Due to our belief in individualized treatment, it is not the policy of Pascal to impose a single corrective model for infractions. Rather, each case will be judged on the merit of the individual client and the relevant circumstances.

The following circumstances may be grounds for termination from treatment:

Non-Compliant Discharge
A non-compliant discharge may occur due to the following reasons:
- The client has committed or threatened to commit acts of physical violence in or around the program premises
- The client has engaged in unauthorized substance use
- The client has failed to follow treatment plan objectives
- The client has engaged in flagrant violation of program rules

Therapeutic Discharge
A therapeutic discharge may occur due to the following reasons:
- The client has manifested behavior that is deemed by the clinical team to be psychologically or physically dangerous to themselves or others
- The client has manifested behavior which the clinical team believes to warrant a different (typically higher) level of care
- Failure to make satisfactory adjustment to treatment

Other Discharge:
- Transfer to a hospital due to an unstable medical or psychiatric condition
- Incarceration
- Death

If it is determined that all reasonable clinical interventions have been exhausted and an individual is no longer able to benefit from further treatment at the facility, the client's treatment will be terminated.

The Clinical Supervisor/Director will notify the individual orally and/or in writing using the discharge documentation found in the EMR detailing the reason(s) for termination. As appropriate, family, significant others, referral sources, and/or other relevant bodies (i.e., court, PO), will be notified. A copy of this notice shall be maintained in the client's record.

In all cases, every effort to discharge the client with appropriate aftercare will be made.

Note – During the intake process, all clients are informed of their right to appeal termination as outlined in the Client Rights and the Grievance and Appeal Procedure sections of the Client Orientation Manual.

Aftercare:
In an effort to promote continued growth of the progress made while in treatment, Pascal programs complete an individualized aftercare plan with each and every client.

Follow Up

All Pascal programs will make reasonable follow up attempts regarding all clients after discharge from any Pascal program (unless the client has made a specific request to not receive a follow up). This is done to ensure that a client who has been referred to another program or service is successfully connected with that program or service. It is also done in order to document the discharged client's progress and well-being, and if necessary and appropriate, provide an opportunity for re-admission to the program or referral to another appropriate service. Only after such an attempt has been made and documented as described below will Pascal consider its obligation to the individual fulfilled. If the client is referred to another program or service, Pascal will, having obtained the written consent of the client, attempt via telephone to contact the program to which the client was referred in order to determine the disposition of the referral. This will be completed no later than 7 days after the date of the client's referral appointment.

In instances when the client either refuses a referral to another program or service, or circumstances otherwise prevent such a referral (e.g., the client leaves against staff advice, declines referral to services after discharge, etc.) an attempt will still be made to follow up with the client within 30 days after the date of discharge.

Upon intake, patients provide Pascal with their phone number, email and physical address if applicable. Upon discharge, whether to another facility or to another level of care within Pascal, patients are scheduled for follow up appointments between fourteen and thirty days after discharge. Depending on the level of care transition, Pascal's administration, IOP and care coordination staff will contact patients with referral information for linkages upon discharge and again two weeks later. After thirty days, administrations and care coordination staff contact patients monthly and follow up via telephone for one year following discharge. Pascal also maintains ROIs for other facilities to keep Pascal's Care Coordination Team aware of mutual patient's progress. These follow ups are documented in the EMR (ICAN).

Information obtained during follow-up shall include:

- The client's status with the program or service to which they were referred
- Ensuring clients are in a safe environment and provide resources to help them if otherwise
- The client's overall progress with aftercare goals

In instances where the client refuses follow-up, such refusal shall be documented in the clients EMR, with note as to the client's stated reason for refusal.

Pascal Crisis Services, Inc. Robert A. Pascal Youth & Family Services, Inc.	**POLICY AND PROCEDURE MANUAL**	**Section:** General Program Standards
		Policy No: PRG-013
	Policy Name: Transition Planning	**Effective Date:** 3/1/2018
		CARF BH 2.D.3.

Policy

The following is a policy of Robert A. Pascal Youth and Family Services, inc.

Procedures for Referrals

- Referral forms will be filled out by primarily by care coordinators. Therapists and Nurse Practitioners may include additional information if applicable.

Transfer to Another Level of Care or Services

- The appearance of new problems may require services that can be provided effectively only at a more or less intensive level of care.
- A discharge summary must be completed when a client is transferring to another level of care, another service or from one provide to another. Discharge summary must include a reasoning for the transfer and start date. It should also include a SNAP (Strengths, Needs, Abilities and Preferences)

Discharge

- Termination of treatment may result from achievement of individual planning outcomes.
- All written discharge plans must include date of admit, description of treatment received, discharge location, date of discharge and information on how the client was transportation. It should also include details on client's progress of their treatment goals. Discharge Plan to include SNAP (Strengths, Needs, Abilities and Preferences). A list of health and safety concerns should also be included.
- If a client opposes termination of treatment services, the client in question has the right to send a written appeals form requesting a review of the decision. This should be sent within less than 10 days of discharge date.

Follow-up

- After-care planning must be integrated into the treatment plan. This should be addressed in the discharge plan as well. Clients will need to be informed about the possibility of them following-up with outpatient services for individual therapy, IOP groups and medication management. If client expresses interest in beginning after care plan with another agency, care coordinator and therapist will need to work on a written plan and referral with clients.
- Every client must be given an appointment card with all information needed to follow-up. Such required information includes date, time, address, telehealth link.

Timing of Transition Planning

- Transition Planning should be first introduced during the initial meeting between the client and care coordinator. During admission process, client should be aware of a potential discharge date and understand it is subject to change depending on progress or lack of. This should also be addressed between the client and their assigned therapist. Once a discharge plan is set and scheduled, transition planning should begin no later than 10 days prior to discharge (given there is that amount of time left).

Person Responsible for Coordinating Transfer or Discharge

- Each client will be assigned to a care coordinator staff member. The client and designated staff member will work collaboratively to ensure client's goals and expectations are met to best of ability.
- Client also have the possibility to discuss transfer and discharge plans with their primary clinician. This clinician will then relay information to the client's designated care coordinator.

Actions to be Taken to ensure Coordination with External Organizations

- Care coordinator and discharge coordinator will be in immediate contact with the appropriate staff member at the next facility/service client is being discharged or transferred to.

Where to Locate Documentation

- All discharge summaries and transitional plans must be in client's paper and electronic chart.
- All documentation must have a listed of medication attached.

Addendum to Transition Planning: Transfer and Referral Policies

<u>Referral Policy Update:</u>

The clinical team receives and reviews all referrals in order to determine if the referred client is appropriate for each particular program. See program specific admission criteria. Ultimately, the Clinical Director signs off on all referrals.

<u>Transfer Policy Update:</u>

Internal transfers occur from higher level programs to lower-level programs within the agency. When this occurs, discharge summaries will be included in the EMR. However, if a client is not discharged from a program, yet receiving ancillary

services elsewhere, a ROI will be completed, and the clinician will communicate, and document as needed with the other provider(s) in order to provide the best care to that client.

External transfers occur when the client's ongoing care will be provided by another provider or entity, whether that be a higher-level or lower-level program, or continuation of the current level of care. Examples include: client's request to transfer, client is incarcerated, a conflict of interest arises, or the recommended level of care is not a program provided by Pascal.

Pascal Crisis Services, Inc. Robert A. Pascal Youth & Family Services, Inc.	**POLICY AND PROCEDURE MANUAL**	**Section:** General Program Standards
		Policy No: PRG-029
	Screening Procedures	**Effective Date:** 1/1/2020
		CARF BH 2.A.2.

Policy

A self-referral client who calls in for assistance completes a phone screen by trained staff on a 24/7 basis which is then sent to the clinical team via secure email to review and respond as to whether the client is appropriate for the referral and request any follow up information needed. If client is not found appropriate, clinical team will provide additional resources for them.

Procedures

1. The staff member taking the call utilizes the screening form, asks questions in detail, documents answers.
2. The staff member creates a new chart in the EHR (if no chart exists already), puts screening information into the chart and sends to the clinical team via secure email.
3. Typical response time from clinical team may take one to three hours for response, if not sooner.
4. After a response from the clinical team, that staff member is delegated to contact the client and ask any follow up questions or share any relevant information. If that staff member is no longer on shift, the clinical team will delegate to another trained staff member on shift.
5. That staff member will let the client know the decision of the clinical team and any information regarding admission or resources.

For program-specific eligibility, refer to PRG-010 Admission & Screening Criteria

Definitions/Acronyms:

Referenced Standards and Regulations

Pascal Crisis Services, Inc. Robert A. Pascal Youth & Family Services, Inc.	**POLICY AND PROCEDURE MANUAL**	**Section:** General Program Standards
		Policy No: PRG-016
	Policy Name: Termination Procedure	**Effective Date:** 3/1/2018
		CARF BH 2.D.1.

Policy

The following is a policy of Robert A. Pascal Youth and Family Services, inc.

For effective treatment to occur, an individual must be appropriate for the program, be willing and able to participate in treatment and be motivated to allow for changes in attitude and behavior. Robert A. Pascal Youth & Family Services, Inc. believes that a formal process succinctly describing reasons for terminating an individual from treatment can be useful to the person for future treatment experiences. This allows the client to put into effect the adage of "learning from one's mistakes".

Criteria for Termination:

1. The client leaves against staff advice
2. Incarceration or moving to another state
3. Acting out destructive behavior on other people or property within the facility
4. Client's own insistence to leave treatment (if not willing to change their decision, every effort will be made to refer to an alternative program for continued treatment. Co-occurring clients will be given a week's medication and a referral to a Mental Health Center
5. Inappropriateness of treatment level following extensive review and clinical consensus for termination
6. Hospitalization requiring extended stay beyond policy

Termination is an extremely serious measure and, as such, shall be utilized as a therapeutic tool with the utmost care. Treatment will be terminated if an individual demonstrates destructive behavior toward other individuals and/or property or has broken one of the agency rules. While Robert A. Pascal Youth & Family Services, Inc. is governed by a strict set of regulations, we do not superimpose a single corrective mode for infractions. Due to our belief in individualized treatment, most cases of agency rule breaking will be judged on its individual merit. Decisions for termination will always be determined from the context of whether the client can benefit from treatment.

Discharge Summary:

Within one week after discharge, a discharge summary should be entered into the client's chart describing the reasons for treatment, services offered, response to treatment, and the client's status or condition upon discharge. The client's strengths, needs, abilities, and preferences shall be reviewed at this time. A discharge summary shall be completed on all clients who have been officially admitted to the program, regardless of the length of the treatment episode or the status of the discharge.

Procedures

Definitions/Acronyms:

Referenced Standards and Regulations

EXHIBIT 3

Table Number	Table Title	Instructions
Table A	**Physical Bed Capacity Before and After Project**	All applicants whose project impacts any nursing unit, regardless of project type or scope, must complete Table A.
Table B	**Project Budget**	All applicants, regardless of project type or scope, must complete Table B.
Table C	**Statistical Projections - Entire Facility**	Existing facility applicants must complete Table C. All applicants who complete this table must also complete Table D.
Table D	**Revenues & Expenses, Uninflated - Entire Facility**	Existing facility applicants must complete Table D. The projected revenues and expenses in Table D should be consistent with the volume projections in Table C.
Table E	**Statistical Projections - New Facility or Service**	Applicants who propose to establish a new facility, existing facility applicants who propose a new service, and applicants who are directed by MHCC staff must complete Table E. All applicants who complete this table must also complete Table F.
Table F	**Revenues & Expenses, Uninflated - New Facility or Service**	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant who complete a Table F must complete Table F. The projected revenues and expenses in Table F should be consistent with the volume projections in Table E.
Table G	**Work Force Information**	All applicants, regardless of project type or scope, must complete Table G.

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

INSTRUCTIONS: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project in accordance with the definition of physical capacity noted below. Applicants should add columns and recalculate formulas to address rooms with 3 and 4 bed capacity. 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	4 Bed	Total Rooms	Physical Capacity
State Opioid Response Grant Beds						**III.7 AND III.7D**					
2nd Floor SOR Grant		0	5	5	20	**2nd Floor III.7 AND III.7D**		5	2	7	20
2nd Floor Low Intensity Residential			3	3	8					0	0
				0	0					0	0
				0	0					0	0
				0	0					0	0
Pascal Crisis Stabilization Center		**0**	**8**	**8**	**28**	**Subtotal III.7 and III.7 D**		**5**	**2**	**7**	**20**
Residential Crisis Services						**RESIDENTIAL**					
3rd Floor RCS Beds	**16**		8	8	16	**3rd Floor RCS Beds**		8		8	16
3rd Floor CRS Beds			3	3	6	**3rd Floor CRS Beds**		3		3	6
Subtotal Residential	**16**	**0**	**11**	**11**	**22**	**Subtotal Residential**		**11**	**0**	**11**	**22**
TOTAL	**16**	**0**	**19**	**19**	**50**	**TOTAL**		**16**	**2**	**18**	**42**
Other *(Specify/add rows as needed)*				0	0	**Other** *(Specify/add rows as needed)*				0	0
TOTAL OTHER	**0**	**0**	**0**	**0**	**0**	**TOTAL NON-ACUTE**		**0**	**0**	**0**	**0**
FACILITY TOTAL	**16**	**0**	**19**	**19**	**50**	**FACILITY TOTAL**		**16**	**2**	**18**	**42**

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
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building	$0		$0
(2) Fixed Equipment	$0		$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	$35,000		$35,000
(2) Fixed Equipment (not included in construction)	$0		$0
(3) Architect/Engineering Fees	$3,500		$3,500
(4) Permits (Building, Utilities, Etc.)	$1,500		$1,500
SUBTOTAL	**$40,000**	**$0**	**$40,000**
c. Other Capital Costs			
(1) Movable Equipment	$5,500		$5,500
(2) Contingency Allowance	$15,000		$15,000
(3) Gross interest during construction period	$0		$0
(4) Other *(Specify/add rows if needed)*	$0		$0
SUBTOTAL	***$20,500***	***$0***	**$20,500**
TOTAL CURRENT CAPITAL COSTS	**$60,500**	**$0**	**$60,500**
d. *Land Purchase*	**$0**		
e. Inflation Allowance	$0		$0
TOTAL CAPITAL COSTS	**$60,500**	**$0**	**$60,500**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees	**$0**		$0
b. Bond Discount	**$0**		$0
c CON Application Assistance	**$0**		
c1. Legal Fees	**$0**		$0
c2. Other (Specify/add rows if needed)	**$0**		
d. Non-CON Consulting Fees	**$0**		
d1. Legal Fees	**$0**		$0
d2. Other (Specify/add rows if needed)	**$0**		$0
e. Debt Service Reserve Fund	**$0**		$0
i. Other *(Specify/add rows if needed)*	**$0**		$0
SUBTOTAL	***$0***	***$0***	**$0**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$60,500***	***$0***	***$60,500***
B. Sources of Funds			
1. Cash	**$60,500**		$60,500
2. Philanthropy (to date and expected)	$0		$0
3. Authorized Bonds	**$0**		$0
4. Interest Income from bond proceeds listed in #3	**$0**		$0
5. Mortgage	**$0**		$0
6. Working Capital Loans	**$0**		$0
7. Grants or Appropriations			
a. Federal	**$0**		$0
b. State	**$0**		$0
c. Local	**$0**		$0
8. Other *(Specify/add rows if needed)*	$0		$0
TOTAL SOURCES OF FUNDS	***$60,500***		**$60,500**
	III.7 and III.7D	***RESIDENTIAL***	***TOTAL***
Annual Lease Costs (if applicable)			
1. Land	**$0**		$0
2. Building	**$1**		$1
3. Major Movable Equipment	**$0**		$0
4. Minor Movable Equipment	**$0**		$0
5. Other *(Specify/add rows if needed)*	**$0**		$0

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

TABLE C. STATISTICAL PROJECTIONS - ENTIRE FACILITY (Pascal Crisis Stabilization Center - 43 Community Place, Crownsville MD only)

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			**2022**	**2023**	**2024**	**2025**				
1. DISCHARGES										
a. Residential Crisis Services			1,100	1,100	1,100	1,100				
b. III.7 and III.7D			0	1,200	1,236	1,273				
c. Other (SOR Grant)			980	400	UNK	UNK				
TOTAL DISCHARGES	***0***	***0***	***2,080***	***2,700***	***2,336***	***2,373***	***0***	***0***	***0***	***0***
2. PATIENT DAYS										
a. Residental				7,700	7,700	7,700				
b. III.7 and III.7D				7,284	7,284	7,284				
c. Other (Specify/add rows of needed)			3,920	1,600	0	0				
TOTAL PATIENT DAYS	***0***	***0***	***3,920***	***16,584***	***14,984***	***14,984***	***0***	***0***	***0***	***0***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. Residental			7.0	7.0	7.0	7.0				
b. III.7 and III.7D				6.1	5.9	5.7				
c. Other (Specify/add rows of needed)			4.0	4.0	0.0	0.0				
TOTAL AVERAGE LENGTH OF STAY				6.1	6.4	6.3				
4. NUMBER OF LICENSED BEDS										
f. Rehabilitation			16	16	16	16				
g. Comprehensive Care				20	20	20				
h. Other (Specify/add rows of needed)				0	0	0				
TOTAL LICENSED BEDS	***0***	***0***	***16***	***36***	***36***	***36***	***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				131.8%	131.8%	131.8%				
b. III.7 and III.7D				99.8%	114.0%	114.0%				
c. Other (Specify/add rows of needed)										
TOTAL OCCUPANCY %				**126.2%**	**114.0%**	**114.0%**				
6. OUTPATIENT VISITS										
a. Residential			4,400	4,400	4,400	4,400				
b. III.7 and III.7D				2,400	2,400	2,400				
c. Other (SOR Grant)			600	200						
TOTAL OUTPATIENT VISITS	***0***	***0***	***5,000***	***7,000***	***6,800***	***6,800***	***0***	***0***	***0***	***0***

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

TABLE D. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY (Pascal Crisis Stabilization Center - 43 Community Place, Crownsville MD only)

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY			**2022**	**2023**	**2024**	**2025**				
1. REVENUE										
a. Inpatient Services			$ 2,677,213	$ 2,757,529	$ 2,840,255	$ 2,925,432				
b. Outpatient Services			$ 1,410,220	$ 1,452,527	$ 1,496,103	$ 1,540,986				
Gross Patient Service Revenues	***$ -***	***$ -***	***$ 4,087,433***	***$ 4,210,056***	***$ 4,336,358***	***$ 4,466,418***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt				$ -	$ -	$ -				
d. Contractual Allowance				$ -	$ -	$ -				
e. Charity Care				$ -	$ -	$ -				
Net Patient Services Revenue	***$ -***	***$ -***	***$ 4,087,433***	***$ 4,210,056***	***$ 4,336,358***	***$ 4,466,418***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)										
NET OPERATING REVENUE	***$ -***	***$ -***	***$ 4,087,433***	***$ 4,210,056***	***$ 4,336,358***	***$ 4,466,418***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)			$ 2,146,680	$ 2,211,080	$ 2,277,412	$ 2,345,735				
b. Contractual Services			$ 705,110	$ 726,263	$ 748,051	$ 770,492				
c. Interest on Current Debt				**$ -**						
d. Interest on Project Debt				$ -						
e. Current Depreciation				$ -						
f. Project Depreciation				$ -						
g. Current Amortization				**$ -**						
h. Project Amortization				$ -						
i. Supplies			$ 83,200	$ 85,000	$ 87,500	$ 90,000				
j. Other Expenses (Specify/add rows if needed)			$ 102,000	$ 102,000	$ 102,000	$ 102,000				
TOTAL OPERATING EXPENSES	***$ -***	***$ -***	***$ 3,036,990***	***$ 3,124,343***	***$ 3,214,963***	***$ 3,308,227***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME										
a. Income From Operation	**$ -**	**$ -**	**$ 1,050,443**	**$ 1,085,713**	**$ 1,121,395**	**$ 1,158,191**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income										
SUBTOTAL	***$ -***	***$ -***	***$ 1,050,443***	***$ 1,085,713***	***$ 1,121,395***	***$ 1,158,191***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ -***	***$ -***	***$ 1,050,443***	***$ 1,085,713***	***$ 1,121,395***	***$ 1,158,191***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE D. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY (Pascal Crisis Stabilization Center - 43 Community Place, Crownsville MD only)

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY			**2022**	**2023**	**2024**	**2025**				
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare										
2) Medicaid			93.0%	93.0%	93.0%	93.0%				
3) Blue Cross										
4) Commercial Insurance			6.8%	6.9%	6.9%	6.9%				
5) Self-pay										
6) Other (SOR Grant 2022)			0.2%	0.1%	0.1%	0.1%				
TOTAL	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
1) Medicare										
2) Medicaid			93.0%	93.0%	93.0%	93.0%				
3) Blue Cross										
4) Commercial Insurance			6.8%	6.9%	6.9%	6.9%				
5) Self-pay										
6) Other			0.2%	0.1%	0.1%	0.1%				
TOTAL	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE E. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE (Pascal Crisis Stabilization Center - 43 Community Place, Crownsville MD)

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				**CY 2023**	**CY 2024**	**CY2025**				
1. DISCHARGES										
a. Residential				1,100	1,100	1,100				
b. III.7 and III.7D				1,200	1,236	1,273				
c. Other (SOR Grant)				400	0	0				
TOTAL DISCHARGES	***0***	***0***	***0***	***2,700***	***2,336***	***2,373***	***0***	***0***	***0***	***0***
2. PATIENT DAYS										
a. Residental				7,700	7,700	7,700				
b. III.7 and III.7D				7,284	7,284	7,284				
c. Other (Specify)				400	0	0				
TOTAL PATIENT DAYS	***0***	***0***	***0***	***15,384***	***14,984***	***14,984***	***0***	***0***	***0***	***0***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. Residental				7.0	7.0	7.0				
b. III.7 and III.7D				6.1	5.9	5.7				
c. Other (Specify)										
TOTAL AVERAGE LENGTH OF STAY				5.7	6.4	6.3				
4. NUMBER OF LICENSED BEDS										
f. RCS				16	16	16				
g. Comprehensive Care				20	20	20				
h. Other (Specify)										
TOTAL LICENSED BEDS	***0***	***0***	***0***	***36***	***36***	***36***	***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										
b. III.7 and III.7D				99.8%	99.5%	99.8%				
c. Other (Specify)										
TOTAL OCCUPANCY %	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**117.1%**	**114.0%**	**114.0%**				
6. OUTPATIENT VISITS										
a. Residential										
b. III.7 and III.7D										
c. Other (Specify)										
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***

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

TABLE F. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE (Pascal Crisis Stabilization Center - 43 Community Place, Crownsville MD only

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	**CY 2023**	**CY 2024**	**CY 2025**				
1. REVENUE							
a. Inpatient Services (Facility)	$ 3,553,200	$ 3,659,796	$ 3,769,590				
b. Outpatient Services	$ 681,420	$ 701,862	$ 722,918				
Gross Patient Service Revenues	***$ 4,234,620***	***$ 4,361,658***	***$ 4,492,508***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt							
d. Contractual Allowance							
e. Charity Care							
Net Patient Services Revenue	***$ 4,234,620***	***$ 4,361,658***	***$ 4,492,508***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify)							
NET OPERATING REVENUE	***$ 4,234,620***	***$ 4,361,658***	***$ 4,492,508***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 2,185,000	$ 2,250,550	$ 2,318,067				
b. Contractual Services	$ 105,000	$ 108,150	$ 111,395				
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 83,200	$ 85,000	$ 87,500				
j. Other Expenses (Specify)	$ 152,600	$ 157,178	$ 161,893				
TOTAL OPERATING EXPENSES	**$ 2,525,800**	**$ 2,600,878**	**$ 2,678,854**	**$ -**	**$ -**	**$ -**	**$ -**
3. INCOME							
a. Income From Operation	**$ 1,708,820.00**	**$ 1,760,780.00**	**$ 1,813,653.54**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ 1,708,820.00***	***$ 1,760,780.00***	***$ 1,813,653.54***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ 1,708,820.00***	***$ 1,760,780.00***	***$ 1,813,653.54***	***$ -***	***$ -***	***$ -***	***$ -***
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare							
2) Medicaid	93.0%	93.0%	93.0%				
3) Blue Cross							
4) Commercial Insurance	6.8%	7.0%	7.0%				
5) Self-pay							

TABLE F. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE (Pascal Crisis Stabilization Center - 43 Community Place, Crownsville MD only

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	**CY 2023**	**CY 2024**	**CY 2025**				
6) Other SOR Grant	0.2%						
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare							
2) Medicaid	92.1%	94.6%	94.6%				
3) Blue Cross							
4) Commercial Insurance	6.9%	5.4%	5.4%				
5) Self-pay							
6) Other SOR Grant	1.0%						
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE G. WORKFORCE INFORMATION

INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables F and G.

	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)*											
Clinical Director	1.0	$120,000	$120,000	1.0	$120,000	$120,000			$0	1.0	$120,000
Intake/Case Management	4.0	$51,000	$51,000	4.0	$51,000	$204,000			$0	8.0	$255,000
Substance Use Counselor(s)	1.0	$52,000	$52,000	4.0	$52,000	$208,000			$0	5.0	$260,000
Administrative Staff	3.0	$40,000	$120,000	2.0	$40,000	$80,000			$0	2.0	$80,000
Total Administration	9.0	$263,000	***$343,000***	***11.0***	***$263,000***	***$612,000***			***$0***	***20.0***	***$955,000***
Direct Care Staff *(List general categories, add rows if needed)*											
Psychiatrist / Medical Director	1.0	$182,000	$182,000	1.0	$182,000	$182,000			$0	1.0	$182,000
CRNP	4.0	$120,000	$480,000	2.0	$120,000	$240,000			$0	5.0	$240,000
LCPC, LCSW-C	7.0	$70,000	$490,000	4.0	$70,000	$280,000			$0	11.0	$770,000
RN	2.0	$104,000	$104,000	4.0	$104,000	$416,000			$0	6.0	$520,000
LPN	3.0	$60,000	$60,000	1.0	$60,000	$60,000			$0	4.0	$240,000
Behavioral Health Supervisor	1.0	$60,000	$60,000	2.0	$60,000	$120,000			$0	3.0	$180,000
Total Direct Care	18.0	$596,000	***$1,376,000***	***14.0***	***$596,000***	***$1,298,000***			***$0***	***30.0***	***$2,132,000***
Support Staff *(List general categories, add rows if needed)*											
Peer Recovery Specialist / Driver	5.0	$35,000	$35,005	4.0	$35,000	$140,000			$0	9.0	$175,005
Facilities Maintenance	1.0	$60,000	$60,000	0.5	$60,000	$30,000			$0	1.5	$90,000
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support			$0			$0			$0	0.0	$0
REGULAR EMPLOYEES TOTAL	***6.0***	***$95,000***	***$95,006***	***4.5***	***$95,000***	***$170,000***			***$0***	***10.5***	***$265,006***
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
			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
Psych Techs	24.0	$35,000	$35,024			$0			$0	24.0	$35,024
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff	24.0	$35,000	$35,024			$0			$0	24.0	$35,024
Support Staff *(List general categories, add rows if needed)*											
Chef	1.0	$50,000	$50,000	1.0	$50,000	$50,000			$0	1.0	$50,000
Food Service Tech	0.5	$40,000	$20,000	0.5	$40,000	$20,000			$0	0.5	$20,000
Billing Services	1.0	$35,000	$35,000	1.0	$35,000	$35,000			$0	1.0	$35,000
			$0			$0			$0	0.0	$0
Total Administration			$0	2.5	$125,000	$105,000			$0	2.5	$105,000
CONTRACTUAL EMPLOYEES TOTAL	***2.5***	***$125,000***	***$105,000***	***2.5***	***$125,000***	***$105,000***	***0.0***	***$0***	***$0***	***2.5***	***$105,000***
Benefits *(State method of calculating benefits below)***:**											
TOTAL COST	***59.5***		***$1,954,030***	***32.0***		***$2,185,000***	***0.0***		***$0***		***$3,492,030***

EXHIBIT 4

ANDERSON
DAVIS

Reference: Robert A Pascal Youth and Family Services, Inc.
D.B.A. Pascal Crisis Services, Inc.

Subject: Certificate of Need Application

To: Maryland Health Care Commission

Please be advised Anderson, Davis & Associates, CPA, PA has audited the financial statements of Robert A Pascal Youth and Family Services, Inc. (the Organization) for the years ended June 30, 2021, 2020, 2019 and 2018 and issued an unmodified opinion for each year. Anderson, Davis & Associates, CPA, PA has also prepared and efiled the Organization's IRS Form 990 for each of those same years.

Please be further advised that the AICPA precludes Anderson, Davis & Associates, CPA, PA from issuing comfort letters and therefore, we are not issuing such a letter.

The Organization's management has represented to us that the Board of Directors for this agency has appointed the management representatives and charged them with the responsibility of ensuring the revenue collected is allocated in such a manner that ensured financial viability in previous years and based on review of the audited financial documents, the entity's projected cash flow is sufficient to support funding of this project.

Please feel free to contact us should you have any questions.

Anderson, Davis & Associates, CPA

Anderson, Davis & Associates, CPA, PA

Anderson, Davis & Associates, Certified Public Accountants, PA
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