Pyramid Healthcare
AN INTEGRATED BEHAVIORAL HEALTHCARE SYSTEM

CORPORATE OFFICE
P.O. Box 967
Duncansville, PA 16635
P: 814-940-0407
F: 814-946-1402
pyramidhc.com

Pyramid Healthcare, Inc.

Certificate of Need Application-Prince George Facility
March 23, 2022

SUBMISSION COPY
Application and Exhibits

Pyramid
Healthcare, Inc.

CORPORATE OFFICE
P.O. Box 967
Duncansville, PA 16635
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1-888-694-9996

September 26, 2021

Eric Baker
Program Manager
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Baker,

Please accept this letter as evidence of Pyramid Walden, LLC's intent to file a Certificate of Need application to establish a new, Track 2 Intermediate Care Facility offering Medically Monitored Inpatient treatment for individuals with Substance Use Disorder.

The proposed project will convert a former day services program for developmentally delayed individuals in Bowie, Prince George County, MD into a 100-bed residential treatment facility, which will include fifty (50) beds licensed and designated for Withdrawal Management and Medically Monitored Inpatient (Level III.7WM and Level III.7), and an additional 50 beds licensed for Clinically Managed High Intensity Residential treatment (Level III.5).

The specific address of the facility is 3000 Lottsford Vista Road Bowie, MD 20721-4001 and falls in the Capitol Region in Maryland.

As we have met with and received the support of the Prince George County Health Department, and because we expect the facility to be licensed and operational in March, 2023, we intend to submit our application for docketing immediately following submission of this LOI.

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

Sincerely,

Jonathan Wolf, President

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Prince George County - Certificate of Need

Table of Contents

STATE OF MARYLAND

MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO. _____

DATE DOCKETED _____

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

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

Required Format:

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

The Table of Contents must include:

- **Responses to PARTS I, II, III, and IV of the this application form**
- **Responses to PART IV must include responses to the standards in the State Health Plan chapter that apply to the project being proposed.**
  - All Applicants must respond to the Review Criteria listed at 10.24.14.05(A) through 10.24.14.05(F) as detailed in the application form.
- **Identification of each Attachment, Exhibit, or Supplement**

Application pages must be consecutively numbered at the bottom of each page. Exhibits attached to subsequent correspondence during the completeness review process shall use a consecutive numbering scheme, continuing the sequencing from the original

application. (For example, if the last exhibit in the application is Exhibit 5, any exhibits used in subsequent responses should begin with Exhibit 6. However, a replacement exhibit that merely replaces an exhibit to the application should have the same number as the exhibit it is replacing, noted as a replacement.

SUBMISSION FORMATS:

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

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

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

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

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

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

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

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

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

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: Pyramid Healthcare Inc.

Address:

3000 Lottsford Vista Rd. Bowie, MD 20721-4001

Street City Zip County

2. Name of Owner

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

Please see attached.

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

Legal Name of Project Applicant (Licensee or Proposed

Address:

Street	City	Zip	State	County
Telephone:				

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

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

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

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☐	
	(2) For-profit	☒	
	(3) Close	☐	State & Date of Incorporation
			[X] PA, May 13, 1999
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited Liability Partnership	☐	
	Limited Liability Limited Partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☐	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	☐	

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

A. Lead or primary contact:

Name and Title: Brandon Golder, VP of Operations

Company Name Pyramid Healthcare, Inc

Mailing Address:

Street 270 Lakemont Park Blvd. City Altoona Zip 16602 State PA

Telephone: 240-298-1698

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

Fax:

If company name is different than applicant briefly describe the relationship

B. Additional or alternate contact:

Name and Title: Jonathan Wolf , Chief Executive Officer

Company Name

Mailing Address:

270 Lakemont Park Blvd.	Altoona	PA	16602
Street	City	Zip	State

Telephone:

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

Fax:

If company name is different than applicant briefly describe the relationship

7. TYPE OF PROJECT

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

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

(1) A new health care facility built, developed, or established
(2) An existing health care facility moved to another site ☒
(3) A change in the bed capacity of a health care facility ☐
(4) A change in the type or scope of any health care service offered by a health care facility ☐
(5) A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfscon/documents/con capital threshold 20140301.pdf ☐

8. PROJECT DESCRIPTION

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

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

Pyramid proposes to establish an intermediate care/residential treatment facility for the treatment and rehabilitation of individuals with substance use disorders
This project will require new construction/renovation and the design/construction of the building will be completed specifically for the efficient and safe treatment of adult men and women in a respectful, comfortable, engaging environment. Pyramid currently operates over 20 residential behavioral healthcare treatment facilities in the United States and is well versed in the physical space needs of this population.
Pyramid has a longstanding history of serving individuals suffering from substance use disorders. In this project, Pyramid's proposed facility will include 100 intermediate care facility substance use disorder treatment beds, which initially will be used for both acute detoxification and residential treatment services. Approval of this project will improve access to much needed substance use disorder treatment services for residents in the surrounding areas.
The size, shape, contour, and location of the proposed project will be adequate for the proposed use. The building will be serviced by municipal

sewer and water. Solid waste will be provided by Waste Management services.
This project is a cost-effective approach to introducing an intermediate care facility for substance abuse treatment. The proposed project will be a combination of newly constructed space/renovation of existing space using modern construction materials to house the proposed facility. The additions to the single story building will be built on a green field available site to meet the needs of the proposed project with design elements incorporated that have been used in other Pyramid buildings. The unique design allows for efficient and optimal patient care. The layout and building features will contribute to enhanced operational efficiencies resulting in a more cost-effective project.
The proposed project and space allocations have been designed to efficiently and safely accommodate the proposed use, taking advantage of Pyramid's extensive experience designing, renovating and operating similar residential substance abuse treatment facilities. The facility will be constructed to ensure all spaces are appropriate for the residential treatment of substance use disorders. The design of the facility is consistent with Life Safety Code 101 requirements as well as FGI Design Guidelines and national and local building codes.
The total costs to implement this project is $8,833,000

B. Comprehensive Project Description: The description should include details regarding:

(1) Construction, renovation, and demolition plans (Exhibit 3)
(2) Changes in square footage of departments and units
(3) Physical plant or location changes (Exhibit 3)
(4) Changes to affected services following completion of the project
(5) Outline the project schedule.

Answer- This project takes an existing building previous used as a Development Disability Program and converts the use to a Pyramid intermediate care/residential treatment facility for the treatment and rehabilitation of individuals with substance use disorders. Very little demolition exists to convert this building as the Pyramid design has been able to utilize most of the original floor plan. Thereby reducing the cost of demolition and rebuild.

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

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: ___5___ acres

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

Zoning - Prince George's County Final Zoning is forth coming although the 100 bed building/property is a permitted use under Sub Title 27 of the applicable ordinance of Prince George's County.....Site Plan Approval By 7/2022

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

(1) Owned by: Owned by: Pyramid-Walden, LLC _____

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

(3) Land Lease held by: _____
Please provide a copy of the land lease as an attachment.

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

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

11. PROJECT SCHEDULE

(Instructions: In completing this section, please note applicable performance requirement time frames set forth in Commission Regulations, COMAR 10.24.01.12)

For new construction or renovation projects.

Project Implementation Target Dates

A. Obligation of Capital Expenditure __1 Month_____ months from approval date.

B. Beginning Construction _____1 Month_____ months from capital obligation.

C. Pre-Licensure/First Use _____N/A_____ months from capital obligation.

D. Full Utilization _____11 Months_____ months from first use.

~~**For projects not involving construction or renovations.**~~

~~Project Implementation Target Dates~~

~~A. Obligation or expenditure of 51% of Capital Expenditure _____ months from CON approval date.~~

~~B. Pre-Licensure/First Use _____ months from capital obligation.~~

~~C. Full Utilization _____ months from first use.~~

~~**For projects not involving capital expenditures.**~~

~~Project Implementation Target Dates~~

~~A. Obligation or expenditure of 51% Project Budget _____ months from CON approval date.~~

~~B. Pre-Licensure/First Use _____ months from CON approval.~~

~~C. Full Utilization _____ months from first use.~~

12. PROJECT DRAWINGS

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

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

A. Floor plans for each floor affected with all rooms labeled by purpose or function, number of beds, location of bath rooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as "shell space". (Exhibit 3)

B. For projects involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project. (Exhibit 3)

C. Specify dimensions and square footage of patient rooms. (Exhibit 3)

13. AVAILABILITY AND ADEQUACY OF UTILITIES

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

Gas-Accounts	BG&E
Water/Sewer - Accounts	WSSC-Water/Sewer
Electric-Accounts	BG&E

PART II - PROJECT BUDGET

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

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

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

1. List names and addresses of all owners and individuals responsible for the proposed project. Please see attached Ownership Control.

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

   No

3. In the last 5 years, has the Maryland license or certification of the applicant facility, or the license or certification from any state or the District of Columbia of any of the facilities listed in response to Question 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) ? If yes, provide a written explanation of the

facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

No

4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) ever received inquiries from a federal or any state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with Maryland, another state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

   No

5. Has any applicant, owner, or responsible individual listed in response to Question 1, above, ever pled guilty to, received any type of diversionary disposition, or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

   No

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

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

3/23/22
Date

Signature of Owner or Board-designated Official

President / CEO
Position/Title

Printed Name

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

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

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

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

10.24.01.08G(3)(a). The State Health Plan.

Every applicant must address each applicable standard in the chapter of the State Health Plan for Facilities and Services[1]. Commission staff can help guide applicants to the chapter(s) that applies to a particular proposal.

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

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

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

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

(2) The Commission will approve a Certificate of Need application for a new intermediate care facility only if the facility will have no more than 40

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

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

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

Applicant Response:
Standard .05A (1) does not apply: applicant seeks a total of 50 ICF beds.
Standard .05A (2) does apply: applicant will have 50 Adult ICF beds.
Standard .05A (3) does not apply: Applicant is proposing a new facility

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

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

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

Applicant Response: Standard .058(1)(a) does not apply as Applicant proposes to establish a Track 2 ICF with 50 beds.

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

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

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

Applicant Response: Standard 05(8)(1)(b): Applicant proposes to establish a Track 2 ICF with 50 beds for adults. Applicant will serve all persons in need at the ICF facility, including those indigent / gray area persons, and no beds will be reserved for private-pay patients. Applicant is a credentialed Medicaid provider in the state of Maryland and will

serve the indigent population, including Medicaid recipients, court referrals, and county-funded persons in this facility. Applicant will ensure that it provides at least 50% of its annual patient days to indigent and gray area patients. As evidence of its commitment, Pyramid Walden can show a history of serving indigent and gray area patients at its existing ICF located in St. Mary's and Harford County. At that location, Walden Charlotte Hall and Joppa Inpatient more than 85% of patient days are provided to persons funded by Medicaid, Federal Probation and Parole, and County contracts.

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

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

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

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

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

Applicant Response: Standard .05(B)(2)(a) Applicant is proposing the addition of fifty (50) Track 2 ICF beds in Prince George County, which is part of the Southern Region Maryland region (comprised of Prince George, Frederick Counties) as outlined in the Stale Health Plan (See Exhibit 5, State Health Plan for Facilities and Services: Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services, COMAR 10/24/14, Supplement 1 Effective February 18, 2013, page 25). According to the most recent available State Health Plan for Facilities and Services, referenced above as Exhibit 5, in 2005 the Southern Maryland Region was in need of between 101 and 121 ICF beds for adults (see Exhibit 5, Table 2 Gross and Net Private ICR Bed Need Projections for Adults Ages 18+ 2005). According to the document, that projection was based on a total 2005 Maryland projected Adult population of 4,568,305. It is our assertion that the need for ICF beds, and specifically Track 2 ICF beds that serve the indigent population, has increased commensurate with the population increase since that date. The US Census Bureau projects Maryland's 2021 Total Population to be 6,177,224. Assuming that each Maryland Region's population as a percentage of the Slate population remained stable, and using the State Plan's previous assumptions to estimate the rate of Substance Abusers (8.64%), Target Population (25%), and Range Requiring Treatment (95%); we have estimated the current Gross Private Bed Need Range for the State of Maryland to be

between to be between 781 and 941; we have estimated the current Gross Private Bed Need Range for the Southern Region to be between 143 and 172 (see Table 1 below)

	Western Maryland (9.75%)	Montgomery County (14.93%)	Southern Maryland (18.3%)	Central Maryland (50.53%)	Eastern Shore (6.53%)	Total
Projected Population - 2021	602,279	922,260	1,130,432	3,121,351	403,373	6,177,224
Indigent Population	31,499	31,818	55,843	175,108	29,245	323,513
Non-indigent Population	570,780	890,442	1,074,589	2,946,243	374,128	5,856,182
Est. No of Substance Abusers (8.64%)	49,315	76,934	92,844	254,555	23,913	497,562
Estimated Annual Target Population (25%)	12,329	19,234	23,211	63,639	5,978	124,390
Estimated Range Requiring Treatment (95%)	11,712	18,272	22,051	60,457	5,679	118,171
Estimated Range Requiring Intermediate Care (12.5% - 15%)						-
Minimum	1,464	2,284	2,756	7,557	1,420	15,481
Maximum	1,757	2,741	3,308	9,069	1,988	18,862
Estimated Range Requiring Readmission (10%)						-
Minimum	146	228	276	756	142	1,548
Maximum	176	274	331	907	199	1,886
Total Discharges from Out-of-State		-				-
Range Requiring Intermediate Care						
Minimum	1,610	2,512	3,032	8,313	1,562	17,030
Maximum	1,933	3,015	3,638	9,975	2,187	20,748
Gross Private Bed Need Range (14 ALOS - 85% Occupy)						-
Minimum	73	113	137	375	70	768
Maximum	87	136	164	450	99	936
Existing Private ICF Inventory (Track 2)	272	60	86	337	26	781
Net Intermediate Private Bed Need Range Track 2						-
Minimum	(199)	53	51	38	44	(13)
Maximum	(185)	76	78	113	73	155

Table 2 Below: displays the current number of Track 2 ICF beds by Region, using information provided by the Maryland Health Care Commission in October 2019. (Exhibit 6) Currently, there are 86 Track 2 Beds in the Southern Region (**only 10 beds in PG County**), indicating that the range of current need of additional Track 2 ICF beds to serve the Central Region is between 38 to 113 beds. Currently there are 755 Track 2 Beds in the State of Maryland (excluding Eastern Shore), indicating that the range of current need of additional Track 2 ICF beds to serve the State of Maryland is between -13 and 155 beds.

Region / Facility Name (Maryland-October 2021)	Adult Track 2 ICF Beds
TOTAL BEDS	**755**
Prince George County	**10**
WESTERN MARYLAND	**272**
Allegheny County Health Dept (Massie & Jackson Unit)	114
Mountain Manor Treatment Center	118
Shoemaker Center	40
MONTGOMERY COUNTY	**60**
Avery Road Treatment Center	60
SOUTHERN MARYLAND	**86**
Anchor of Walden	27
Hope House Treatment Centers	59
CENTRAL MARYLAND	**327**
Hope House Treatment Center	39
Pathways	40
Baltimore Crisis Response	7
Gaudenzia at Park Heights	67
Mountain Manor	68
Turek House	29
PHC Harford County	50
Gaudenzia Crownsville	27

In addition to the above estimates, Applicant has specific internal referral data to support a number of Track 2 ICF beds in Capital Region of Maryland. Pyramid Walden has been

tracking the needs and outcomes of Maryland residents contacting Pyramid Walden's Central Call Center requesting medically monitored residential treatment (111.7 and III.7WM) that we were unable to serve at our Charlotte Hall and Harford locations due to lack of beds (this metric will be referred to as "Turndowns" through the remainder of the application). Attached in Exhibit 7 is a grid showing the number of Turndowns during the 12-month period from January 2021 through December 2021. This data is provided as an illustration of our process of collecting this information. Our turndown data shows significant need throughout Maryland. This data is extracted and shown in the below Tables: ICF Turndowns by County for January 2021-December, 2021 (see below).

Row Labels	Count of Turn Down Code CY 2021
Accomack	6
Albemarle	2
Allegany	246
Allegheny	4
Anne Arundel	398
Atlantic	2
Baltimore	657
Baltimore City	205
Bedford	2
Bergen	2
Berks	2
Buckingham	2
Bucks	2
Calvert	290
Campbell	2
Caroline	37
Carroll	173
Cecil	245
Centre	2
Charles	532
Chester	4
Cumberland	3
Delaware	2
Dorchester	72
Fauquier	2
Franklin	4
Frederick	282
Garrett	60
Harford	547
Hartford	2
Howard	135
Kent	63
King George	2
Lackawanna	2
Lee	2
Lehigh	2
Luzerne	4
Monmouth	2
Montgomery	153
N/A	6
Northumberland	2
Perry	2
Prince George's	491
Queen Anne's	75
Somerset	60
Spotsylvania	3
St. Mary's	1274
Talbot	22
Vanango	2
Washington	102
Wicomico	184
Worcester	60
Total	6433

Although Pyramid Walden currently operates ICF services in Southern Maryland and Harford County, the above table shows that our Call Center receives and accepts calls

from individuals and referral sources from throughout the State of Maryland. The highlighted areas are the Counties in the South-Central Maryland Region. Using the State Plan's assumed Length of Stay of 14 Days, we have identified that in order to provide access to the individuals who contacted our Call Center during this 120-day period of lime would require additional Track 2 ICF beds as follows:

• Entire State of Maryland: Treating the **6433 persons Turned Down** would require 750.8 additional beds.
• South-Central Maryland: Treating the **926 persons Turned Down** would require 108 additional beds.

Applicant is requesting the maximum allowed 50 Track 2 ICF beds due to the demonstrated need for 750.8 additional beds in the State of Maryland, just to serve the 6433 persons turned down by Pyramid Walden. As demonstrated by our Call Center data and Pyramid Walden's commitment to ensure immediate access to treatment through 24-hour admissions and transportation, we anticipate these additional 50 beds serving and providing access to not only the South-Central Region of Maryland, but those persons in other parts of Maryland that are unable to find a bed closer to home. With 3 ICF facilities in different regions of the State, a 24-hour Central Call Center and a transportation system, it will be Pyramid Walden's goal lo serve every person who contacts us in need of ICF treatment at the time of their call.

Standard .05(8)(2)(b) Applicant agrees to serve indigent and gray area patients, and will serve all individuals in the same groups and treatment locations. All patients will be respected and treated together (comingled), regardless of ability to pay.

Standard .05(8)(2)(c) Applicant agrees to ensure that indigents, including court-referrals, receive preference for care. Pyramid Walden currently provides access to Medically Monitored treatment at our Charlotte Hall ICF using a centralized Call Center, with admission available 24-hours per day. The Call Center monitors bed availability using a real-time electronic bedboard, and persons are offered a bed according to availability when they call. This has resulted in a stable finding that more than 85% of persons admitted to ICF in Charlotte Hall and Joppa have been indigent/gray area patients. As further demonstration of this commitment, applicant agrees to prioritize the indigent person in the event that two persons are referred at the same time for only one remaining bed.

Standard .05(8)(2)(d) Applicant agrees that if the facility license or Medicaid enrollment is terminated, applicant will notify the Commission and the Office of Health Care Quality immediately and agrees not to use its ICF beds for private pay patients without obtaining a new Certificate of Need .

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

The facility will utilize a sliding fee scale for uninsured and unfunded persons consistent

with the individual's ability to pay. The fee schedule is summarized as follows, and represents discount percentages from the standard billing rate charged to insurance carriers for each service: 100% of Federal Poverty Level 50% 150% of Federal Poverty Level 25% (Exhibit 20)

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

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

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

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

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

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

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

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

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

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

Applicant Response: Standard .050(1-4) does not apply. Applicant seeks to establish a new Track 2 ICF.

.05E. Information Regarding Charges. An applicant must agree to post information concerning charges for services, and the range and types of services provided, in

a conspicuous place, and must document that this information is available to the public upon request.

Applicant Response: Applicant agrees to post a fee schedule describing the range and types of services, and their charges, in a prominent place in the registration area. Standard registration information will include a statement that this information is available to the public upon request.

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

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

- MedStar Washington Hospital Center 13.2 miles (26 minutes)
- UM Bowie Health Center 7.3 miles (15 minutes)
- University of Maryland Capital Region Medical Center 3.3 miles (7 minutes)

.05G. Age Groups.

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

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

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

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

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

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

.05H. Quality Assurance.

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

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

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

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

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

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

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

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

Applicant Response: Applicant will be certified by the Office of Health Care Quality

before it begins operation and will maintain that certification as a condition of continuing authority to operate an ICF for substance abuse treatment in Maryland.

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

If Applicant loses its State certification, Applicant will notify the Commission in writing within fifteen days of receiving notice, and will cease operation until the Office of Health Care Quality notifies the Commission that deficiencies have been corrected.

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

.05I. Utilization Review and Control Programs.

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

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

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

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

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

a. Providing Outpatient treatment in close proximity to our residential treatment

programs, and providing same-day/ next-day appointments after discharge.

b. When aftercare is provided by another entity, attempting to obtain the first appointment as quickly after discharge as possible, and coordinating support with the individual's Care Coordinator to provide a Warm Handoff to the next level of care.

As described below in Standard .05(0), Applicant intends to establish an outpatient office near Prince George County within 12 months of opening the ICF. Exhibit 10 is an Agreement to Cooperate signed by the Prince George County BHA that delineates all levels of care that will be licensed at the facility.

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

.05J. Transfer and Referral Agreements.

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

Applicant Response:
Throughout the last few years Pyramid Walden has had numerous conversations with local and nearby stakeholders regarding SUD inpatient services within Prince George County. We will be including the agreement to cooperate in addition to numerous letters of support and transfer agreements to validate such support.

We will continue to establish rapport with local providers to ensure the community needs are being met as we serve the SUD population in PG County. All transfer agreements, letters of support, etc. will be included in this document.

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

(a) Acute care hospitals;
(b) Halfway houses, therapeutic communities, long-term care facilities, and local alcohol and drug abuse intensive and other outpatient programs;
(c) Local community mental health center or center(s);
(d) The jurisdiction's mental health and alcohol and drug abuse authorities;

(e) The Alcohol and Drug Abuse Administration and the Mental Hygiene Administration;
(f) The jurisdiction's agencies that provide prevention, education, driving-while-intoxicated programs, family counseling, and other services; and,
(g) The Department of Juvenile Justice and local juvenile justice authorities, if applying for beds to serve adolescents.

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

.05K. Sources of Referral.

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

Applicant Response: Pyramid Walden's Call Center has been accepting referrals from Maryland County residents since January, 2019. In that time, the majority of referrals for medically monitored residential treatment have been from self, hospitals, emergency rooms, and opiate crisis centers. We can demonstrate our commitment to serve this population through our referrals by referral source from January 2021 – May 2021 attached in Exhibit 12. Of those referrals, the Pyramid Walden ICF programs located in Charlotte Hall, MD and Joppa, MD were able to admit approximately 130 patient per month. The percentage of these persons who were indigent/gray area consistently exceeded 85% each month. Because the referrals are from throughout the state of Maryland, we expect to serve those same individuals with the Prince George County facility.

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

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

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

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

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

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

Please refer to Exhibit 14 for Detox Protocols as follows:

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

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

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

Policies listed in Exhibit 15 are as follows:

- PHC - HIV Admission Medication Procedure
- PHC HIV Procedure
- PHC 3.8 - Confidentiality: HIV AIDS

.05O. Outpatient Alcohol & Drug Abuse Programs.

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

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

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

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

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

Applicant Response: Pyramid Walden is committed to ensuring access to the entire continuum of care to persons in our ICF. We plan to establish and license an outpatient office on the grounds of the Pyramid Walden Prince George County facility. We have secured the support of the Prince George County BHA in licensing the location for Outpatient - see Exhibit 10 Agreement to Cooperate. This office will provide, at a minimum, individual needs assessment and evaluation; aftercare; and information and referral for at least one year after each patient's discharge from the ICF. In addition to the outpatient office on site, Pyramid Walden plans to lease space and open a larger outpatient facility within 30 minutes of Prince George County ICF location within one year of the ICF opening. This office will provide access to services in the evening and weekends and will have specialized treatment for different populations. In the meantime, Applicant has obtained written Referral Agreements with several agencies who provide Outpatient Services.

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

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

.06 Preferences for Certificate of Need approval.

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

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

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

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

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

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

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

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

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

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

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

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

B. NEED

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

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

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

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

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

Applicant Response: Standard .05(8)(2)(a) Through the responses above, Applicant has demonstrated our commitment to serving all individuals in the State of Maryland in need of treatment for Substance Use Disorder, particularly those who are indigent, through our continuum of care. We currently provide an ICF facility in the Southern Maryland Region and Harford County that is unable to serve everyone who contacts us in need of ICF treatment. We have identified through our Call Center's Turndown data that there is a need in the Southern Region of Maryland for Track 2 ICF beds that are able to serve the indigent population, and specifically Prince George County, which has O Track 2 ICF beds. Our method of estimating this need was detailed above in Section .05B and is documented again below: 11 is our assertion that the need for ICF beds, and specifically Track 2 ICF beds that serve the indigent population, has increased commensurate with the population increase since that date. The US Census Bureau projects Maryland's 2021 Total Population to be 6,177,224. Assuming that each Maryland Region's population as a percentage of the State population remained stable, and using the State Plan's previous assumptions to estimate the rate of Substance Abusers (8.64%), Target Population (25%), and Range Requiring Treatment (95%); we have estimated the current Gross Private Bed Need Range for the State of Maryland to be between to be between 768 and 936; we have estimated the current Gross Private Bed Need Range for the Southern Region to be between -13 and 155 (see Table 1 below)

	Western Maryland (9.75%)	Montgomery County (14.93%)	Southern Maryland (18.3%)	Central Maryland (50.53%)	Eastern Shore (6.53%)	Total
Projected Population - 2021	602,279	922,260	1,130,432	3,121,351	403,373	6,177,224
Indigent Population	31,499	31,818	55,843	175,108	29,245	323,513
Non-indigent Population	570,780	890,442	1,074,589	2,946,243	374,128	5,856,182
Est. No of Substance Abusers (8.64%)	49,315	76,934	92,844	254,555	23,913	497,562
Estimated Annual Target Population (25%)	12,329	19,234	23,211	63,639	5,978	124,390
Estimated Range Requiring Treatment (95%)	11,712	18,272	22,051	60,457	5,679	118,171
Estimated Range Requiring Intermediate Care (12.5% - 15%)						-
Minimum	1,464	2,284	2,756	7,557	1,420	15,481
Maximum	1,757	2,741	3,308	9,069	1,988	18,862
Estimated Range Requiring Readmission (10%)						-
Minimum	146	228	276	756	142	1,548
Maximum	176	274	331	907	199	1,886
Total Discharges from Out-of-State		-				-
Range Requiring Intermediate Care						
Minimum	1,610	2,512	3,032	8,313	1,562	17,030
Maximum	1,933	3,015	3,638	9,975	2,187	20,748
Gross Private Bed Need Range (14 ALOS - 85% Occupy)						-
Minimum	73	113	137	375	70	768
Maximum	87	136	164	450	99	936
Existing Private ICF Inventory (Track 2)	272	60	86	337	26	781
Net Intermediate Private Bed Need Range Track 2						-
Minimum	(199)	53	51	38	44	(13)
Maximum	(185)	76	78	113	73	155

Table 2 Below, displays the current number of Track 2 ICF beds by Region, using information provided by the Maryland Health Care Commission in October 2019. (Exhibit 6) Currently, there are 86 Track 2 Beds in the Southern Region, indicating that the range of current need of Track 2 ICF beds to serve the Southern Region is between 137 and 164 beds. Currently there are 755 Track 2 Beds in the State of Maryland, indicating that the range of current need of Track 2 /CF beds to serve the State of Maryland is between 13 and 155 beds.

Region / Facility Name (Maryland-October 2021)	Adult Track 2 ICF Beds
TOTAL BEDS	**755**
Prince George County	**10**
WESTERN MARYLAND	**272**
Allegheny County Health Dept (Massie & Jackson Unit)	114
Mountain Manor Treatment Center	118
Shoemaker Center	40
MONTGOMERY COUNTY	**60**
Avery Road Treatment Center	60
SOUTHERN MARYLAND	**86**
Anchor of Walden	27
Hope House Treatment Centers	59
CENTRAL MARYLAND	**327**
Hope House Treatment Center	39
Pathways	40
Baltimore Crisis Response	7
Gaudenzia at Park Heights	67
Mountain Manor	68
Turek House	29
PHC Harford County	50
Gaudenzia Crownsville	27

In addition to the above estimates, Applicant has specific internal referral data to support a number of Track 2 ICF beds in the Southern Region of Maryland. Pyramid Walden has

been tracking the needs and outcomes of Maryland residents contacting Pyramid's Central Call Center requesting medically monitored residential treatment (111.7 and III.7WM) that we were unable to serve at our Charlotte Hall and Harford ICF due to lack of beds (this metric will be referred to as "Turndowns" through the remainder of the application). Attached in Exhibit 7 is a grid showing the number of Turndowns during the 12-month period from January 2021 through - December 2021. This data is provided as an illustration of our process of collecting this information.

Row Labels	Count of Turn Down Code CY 2021
Accomack	6
Albemarle	2
Allegany	246
Allegheny	4
Anne Arundel	398
Atlantic	2
Baltimore	657
Baltimore City	205
Bedford	2
Bergen	2
Berks	2
Buckingham	2
Bucks	2
Calvert	290
Campbell	2
Caroline	37
Carroll	173
Cecil	245
Centre	2
Charles	532
Chester	4
Cumberland	3
Delaware	2
Dorchester	72
Fauquier	2
Franklin	4
Frederick	282
Garrett	60
Harford	547
Hartford	2
Howard	135
Kent	63
King George	2
Lackawanna	2
Lee	2
Lehigh	2
Luzerne	4
Monmouth	2
Montgomery	153
N/A	6
Northumberland	2
Perry	2
Prince George's	491
Queen Anne's	75
Somerset	60
Spotsylvania	3
St. Mary's	1274
Talbot	22
Vanango	2
Washington	102
Wicomico	184
Worcester	60
Total	6433

Although Pyramid Walden currently only operates ICF services in Southern Maryland and

Harford County the above table shows that our Call Center receives and accepts calls from individuals and referral sources from throughout the State of Maryland. The highlighted areas are the Counties in the Central Maryland Region. Using the State Plan's assumed Length of Stay of 14 Days, we have identified that in order to provide access to the individuals who contacted our Call Center during this 120-day period of time would require additional Track 2 ICF beds as follows:

- Entire State of Maryland: Treating the **6433 persons Turned Down** would require 750.8 additional beds
- South-Central Maryland: Treating the **926 persons Turned Down** would require 108 additional beds.

Applicant is requesting the maximum allowed 50 Track 2 ICF beds due to the demonstrated need for 751 additional beds in the State of Maryland, just to serve the persons turned down by Pyramid Walden. As demonstrated by our Call Center data and Pyramid Walden's commitment to ensure immediate access to treatment through 24-hour admissions and transportation, we anticipate these additional 50 beds serving and providing access to not only the Southern Region of Maryland, but those persons in other parts of Maryland that are unable to find a bed closer to home. With two ICF facilities in different regions of the State, a 24-hour Central Call Center and a transportation system, it will be Pyramid Walden's goal to serve every person who contacts us in need of ICF treatment at the time of their call.

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

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

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

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

C. AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

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

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

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

Applicant Response: The proposed project involves renovating an existing structure to create a new Intermediate Care Facility for Alcohol and Drug Abuse treatment. Pyramid Walden has selected the proposed site based on the shortage of Track 2 ICF beds throughout the State of Maryland, in the Southern Region, Prince George County. Applicant's turndown data demonstrates that existing providers do not have enough capacity to meet the immediate treatment needs of persons needing withdrawal management and medically intensive rehabilitation for Substance Use Disorder. The new resources provided by Applicant's proposed ICF brings a very rapid solution to this problem. As an alternative to approving a new ICF facility, the Commission could approve bed increases at existing facilities. However, this would not result in needed Track 2 beds in Prince George County (which has only 10 beds) (with a need of up to 172) and where stakeholders have identified a need. Accordingly, Applicant proposes to renovate a facility of a scope that could begin to address the need in Prince George County and the Southern Region of Maryland. The repurposing of an existing building also provides this resource in a very cost-effective manner.

D. VIABILITY OF THE PROPOSAL

COMAR 10.24.01.08G(3)(d) Viability of the Proposal. The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set

forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

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

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

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

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

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

Applicant Response: See Table G, attached in Exhibit 18

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

Applicant Response: See Exhibit 19 for Audited Financial Statements.

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

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

- Describe and document relevant community support for the proposed project. (reference letters)

Applicant Response: Throughout the last few years Pyramid Walden has had numerous conversations with local and nearby stakeholders regarding SUD inpatient services within Prince George County. We will be including the agreement to cooperate in addition to numerous letters of support and transfer agreements to validate such support.

We will continue to establish rapport with local providers to ensure the community needs are being met as we serve the SUD population in PG County. All transfer agreements, letters of support, etc. will be included in this document.

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

Applicant Response: Applicant has access to an internal Engineering team to lead our new facility projects. That team identified the location, completed the project design, and obtained all relevant State and local land use permits and approvals. At the time of this submission, the building has been purchased and renovations are beginning, and Applicant is awaiting the Certificate of Occupancy in order to proceed with licensure. Assuming the licensure process takes 60 days, we expect to be providing 111.5 Residential Treatment in the facility by March 1, 2023. No additional modifications are necessary in order to provide 111.7 and 111.7WM, so there is minimal risk that the project will be completed within the described time frame.

E. COMPLIANCE WITH CONDITIONS OF PREVIOUS CERTIFICATES OF NEED

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

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

Applicant Response: Pyramid Walden, INC currently operates two ICF facilities one in St. Mary's County (Walden, Charlotte Hall) and the other in Harford County (Joppa Inpatient) The Charlotte Hall facility received its Certificate of Need more than 15 years ago, and has provided the ICF treatment programs meeting all conditions identified in that CON. Joppa Inpatient received its CON 2 years ago and is meeting all conditions identified in that CON.

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

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

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

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

Applicant Response: There is several Track 1 ICF providers in PG County, and one Track 2 ICF provider. Because the vast majority of our admissions will be indigent and Medicaid recipients, we anticipate minimal impact on the volume of service provided by the track 1 ICF. We anticipate that, due to the introduction of our Call Center, transportation, and the ability to walk-in the facility and receive assessment, the local Emergency Rooms will experience a reduction in the volume of individuals presenting lo the Emergency Room seeking referrals to treatment of Substance Use Disorder.

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

Applicant Response: There is one Track 1 ICF provider in Prince George County, and 10 Track 2 beds in PG County. Because the vast majority of our admissions will be indigent and Medicaid recipients, we anticipate minimal impact on the payer mix of service provided by the track 1 ICF.

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

Applicant Response: We anticipate that access to ICF services will improve for individuals throughout the state. Using a projected LOS of 14 days (assumption is from the Maryland State Health Plan), the additional 50 ICF beds will provide immediate access to 1303 additional individuals each year needing medically monitored treatment of SUD. Our internal Turndown data indicates that 6433 people requested that service in the 12-month period from January - December, 2021. It is reasonable to assume that the 1303 additional admissions to an ICF each year will not ensure access to every person seeking care.

d) On costs to the health care delivery system.

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

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

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

Exhibit 1

Ownership and Control Information

1. Ownership and Control Information for Disclosing Entity, 42 C.F.R. §455.104
List any individual who has any ownership or controlling interest in this provider entity or in any subcontractor. List the name, title, (e.g., CEO, President), address, Tax ID Number of any organization, corporation or entity having any ownership or controlling interest in this provider entity. The ownership or controlling interest is an ownership interest of 5% or more in this provider entity.

Pyramid Healthcare Inc.

- **23-3006202**
- **PO Box 967 Duncansville, PA 16635**
- Direct Percent = **100%**
- Indirect Percent = **0%**
- Name of Entity Owned = **Pyramid Walden LLC.**
- Does the corporate entity listed above have an ownership or control interest in "other disclosing entities"? = **Yes, Please see questions 4.**

Pyramid Healthcare Acquisition Corp.

- **86-2563330**
- **50 Kennedy Plaza, 17th Floor**
  Providence, RI 02903
- Direct Percent = **100%**
- Indirect Percent = **0%**
- Name of Entity Owned = **Pyramid Healthcare, Inc.**
- Does the corporate entity listed above have an ownership or control interest in "other disclosing entities"? = **NO**

Pyramid Healthcare Intermediate Holdings Corp.

- **86-2593921**
- **50 Kennedy Plaza, 17th Floor**
  Providence, RI 02903
- Direct Percent = **0%**
- Indirect Percent = **100%**
- Name of Entity Owned = **Pyramid Healthcare Acquisition Corp.**
- Does the corporate entity listed above have an ownership or control interest in "other disclosing entities"? = **NO**

Pyramid Healthcare Holding Company, LLC.

- **86-2567283**
- **50 Kennedy Plaza, 17th Floor**
  Providence, RI 02903
- Direct Percent = **0%**
- Indirect Percent = **100%**
- Name of Entity Owned = **Pyramid Healthcare Intermediate Holdings Corp.**
- Does the corporate entity listed above have an ownership or control interest in "other disclosing entities"? = **NO**

Nautic Partners IX, L.P.

- **83-3353461**
- **50 Kennedy Plaza, 17th Floor**

Ownership and Control Information

Providence, RI 02903

- Direct Percent = **0%**
- Indirect Percent = **37.442%**
- Name of Entity Owned = **Pyramid Healthcare Holding Company, LLC.**
- Does the corporate entity listed above have an ownership or control interest in "other disclosing entities"? = **YES. As follows:**
- **Carepath Rx Holdings, LLC.** 9808 N. Mercer Way, Mercer Is. WA 98040
- **IRC Holdco, LLC** 3102 West End Ave. Suite 1100 Nashville, TN 37203

Nautic Partners IX-A, L.P.

- **83-3374613**
- **50 Kennedy Plaza, 17th Floor,**
  Providence, RI 02903
- Direct Percent = **0%**
- Indirect Percent = **21.852%**
- Name of Entity Owned = **Pyramid Healthcare Holding Company, LLC.**
- Does the corporate entity listed above have an ownership or control interest in "other disclosing entities"? = **YES. As follows:**
- **Carepath Rx Holdings, LLC.** - 9808 N. Mercer Way, Mercer Is. WA 98040
- **IRC Holdco, LLC** - 3102 West End Ave. Suite 1100 Nashville, TN 37203

PEF 2020-2021 PASS, C.V.

c/o APG Asset Management US Inc.

- **98-1520385**
- **666 Third Avenue, Second Floor**
  New York, NY 10017
- Direct Percent = **0%**
- Indirect Percent = **9.519%**
- Name of Entity Owned = **Pyramid Healthcare Holding Company, LLC.**
- Does the corporate entity listed above have an ownership or control interest in "other disclosing entities"? = **NO**

Nautic Partners VIII, L.P.

- **81-0850534**
- **50 Kennedy Plaza, 17th Floor,**
  Providence, RI 02903
- Direct Percent = **0%**
- Indirect Percent = **7.541%**
- Name of Entity Owned = **Pyramid Healthcare Holding Company, LLC.**
- Does the corporate entity listed above have an ownership or control interest in "other disclosing entities"? = **YES. As follows:**
  - **Carepath Rx Holdings, LLC.** - 9808 N. Mercer Way, Mercer Is. WA 98040
  - **IHCS/CMS Holdings, LLC** - 3700 Commercial Parkway, Miramar FL 33025
  - **IRC Holdco, LLC** - 3102 West End Ave Suite 1100 Nashville TN 37203
  - **Nystrom Holdings Company, LLC** - 1900 Silver Lake Rd, New Brighton MN 55112

University of Notre Dame du Lac

- **35-0868188**
- **1251 N. Eddy Street, Suite 400**

Ownership and Control Information

South Bend, IN 46617

- Direct Percent = **0%**
- Indirect Percent = **5.553%**
- Name of Entity Owned = **Pyramid Healthcare Holding Company, LLC.**
- Does the corporate entity listed above have an ownership or control interest in "other disclosing entities"? = **YES As Follows:**
- **Nautic Carepath Co-invest, LP** - 50 Kennedy Plaza, 17th Floor, Providence RI 02903
- **IRC Superman Aggregator, LLC** - 50 Kennedy Plaza 17th Floor, Providence RI 02903

Exhibit 2

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

INSTRUCTIONS: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project in accordance with the definition of physical capacity noted below. Applicants should add columns and recalculate formulas to address rooms with 3 and 4 bed capacity. NOTE: Physical capacity is the total number of beds that could be physically set up in space without significant renovations. This should be the maximum operating capacity under normal, non-emergency circumstances and is a physical count of bed capacity, rather than a measure of staffing capacity. A room with two headwalls and two sets of gasses should be counted as having capacity for two beds, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough from a square footage perspective to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain no headwalls or a single headwall, but are normally used to accommodate one or more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms should be counted as they are currently used.

Before the Project						After Project Completion					
Service Location (Floor/Wing)	Current Licensed Beds	Based on Physical Capacity				Service Location (Floor/Wing)	Location (Floor/ Wing)*	Based on Physical Capacity			
		Room Count			Bed Count			Room Count			Bed Count
		Private	Semi-Private	Total Rooms	Physical Capacity			Semi-Private	Triple Rooms	Total Rooms	Physical Capacity
III.7 AND III.7D						III.7 AND III.7D					
1st Floor	0	0		0	0	1st Floor		2	32	34	100
				0	0					0	0
				0	0					0	0
				0	0					0	0
				0	0					0	0
Subtotal III.7 AND III.7D	**0**	**0**	**0**	**0**	**0**	**Subtotal III.7 and III.7 D**		**2**	**32**	**34**	**100**
RESIDENTIAL						RESIDENTIAL					
				0	0					0	0
				0	#VALUE!					0	0
Subtotal Residential	**0**	**0**	**0**	**0**	**#VALUE!**	**Subtotal Residential**		**0**	**0**	**0**	**0**
TOTAL	**0**	**0**	**0**	**0**	**#VALUE!**	**TOTAL**		**2**	**32**	**34**	**100**
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	**0**	**0**	**0**	**0**	**#VALUE!**	**FACILITY TOTAL**		**2**	**32**	**34**	

Exhibit 3

PYRAMID PROPOSED FLOOR PLAN

Dwg. No.	Operations Approval:		REV	DESCRIPTION	DATE
P-K-101	***		1	ISSUED TO OPERATIONS FOR REVIEW	12-14-21
	E.V.P. of Engineering:		2	REVISED PER OPERATIONS COMMENTS (BG)	12-17-21
	***		3		
	Project Mgr.:	Cad:	4		
	JSD	TP	5		

PYRAMID HEALTHCARE
3000 LOTTSFORD VISTA ROAD
BOWIE, MD. 20721

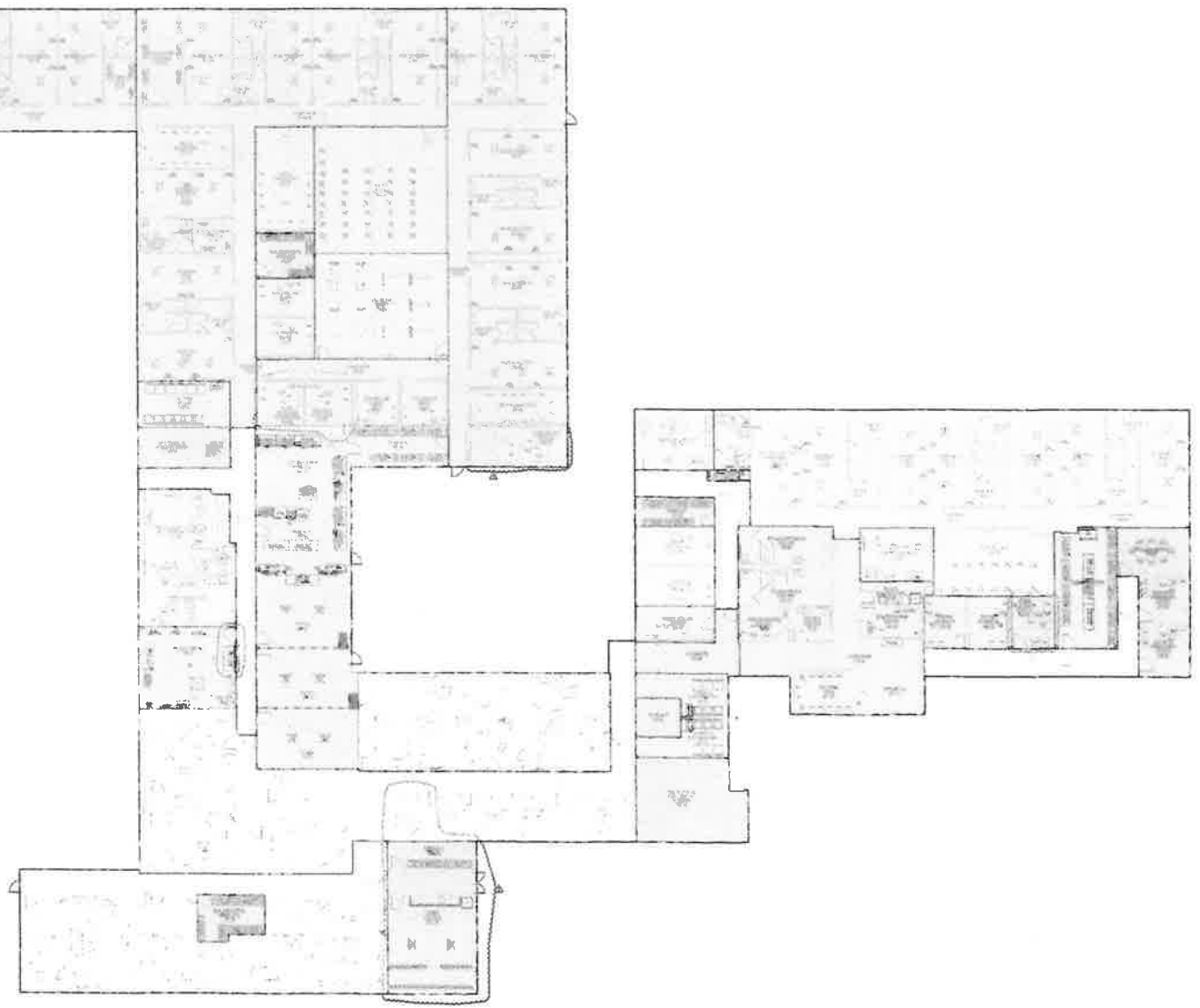
BUILDING ADDITIONS - PLAN

Pyramid Healthcare

270 LAKEMONT PARK BLVD.
ALTOONA, PA. 16602

- [ ] INTAKE (2725 SQ. FT.)
- [ ] 21 BED DETOX (2964 SQ. FT.)
- [ ] 33 BED WOMENS (6863 SQ. FT.)
- [ ] 47 BED MENS (10901 SQ. FT.)
- [ ] GENERAL SERVICES (4002 SQ. FT.)
- [ ] CLINICAL AREAS (1262 SQ. FT.)
- [ ] ADMINISTRATION (2720 SQ. FT.)
- [ ] COMMON AREAS (1252 SQ. FT.)

TOTAL GROSS AREA (33709 SQ. FT.)
TOTAL NET AREA (32457 SQ. FT.)



PYRAMID PROPOSED FLOOR PLAN

Pyramid Healthcare

270 LAKEMONT PARK BLVD.

PYRAMID HEALTHCARE
3000 LOTTSFORD VISTA ROAD
BOWIE, MD. 20721

REV	DESCRIPTION	DATE
1	ISSUED TO OPERATIONS FOR REVIEW	13-Jul

Operations Approval ***
E.V.P. of Engineering ***
Project Mgr. | Date

Dwg. No.
P-K-10

SPACE TABULATION			
Type of Space	Number of Spaces	Total Square Footage	
		Net	Gross
Intake	14	2,725	2,725
Detox	19	3,964	3,964
Women's Inpatient	30	6,883	6,883
Men's Inpatient	49	10,901	10,901
General Services	12	4,002	4,002
Clinical Areas	5	1,262	1,262
Administration	14	2,720	2,720
Common Areas	3	0	1,252
Totals		32,457	33,709

LEGAL DESCRIPTION

All that certain lot or parcel of land, with the improvements and appurtenances thereunto belonging, situate in the 13th Election District of Prince George's County, Maryland, and more particularly described as follows:

Parcel A, in the subdivision known as "Parcel A, Ardmore Developments Center", as per plat recorded in Plat Book 89 at Plat No. 8, among the Land Records of Prince George's County, Maryland.

NOTE FOR INFORMATIONAL PURPOSES ONLY:
Tax I.D. No.: 13-1530837

Being the same tract of land described in a Title Report provided by Fidelity National Title Insurance Company, Commitment No. 0020002373, dated December 3, 2020 at 8:00 A.M.

SCHEDULE B EXCEPTIONS

Fidelity National Title Insurance Company, Commitment No. 0020002373, dated December 3, 2020 at 8:00 A.M.

(B) The following matters shown and/or noted on the plat recorded in Plat Book 89 at Plat No. 8:

A. Terms, conditions, restrictions, minimum building restrictions line(s), and easements in the Owners Dedication and —NOT PLOTTED, BLANKET IN NATURE

B. Easement for roadway purposes. —PLOTTED ON SURVEY

(E) Terms, conditions, and easements granted to Consolidated Gas Electric Light and Power Company of Baltimore by instrument dated August 8, 1938 and recorded August 25, 1938 in Liber 343 at folio 341. —NOT PLOTTED, POLES NUMBERS NOT OBSERVED AT TIME OF SURVEY.

(10) Terms, conditions, and easements granted to Consolidated Gas Electric Light and Power Company of Baltimore by instrument dated April 16, 1943 and recorded May 22, 1943 in Liber 509 at folio 484. —NOT PLOTTED, EXACT LOCATION CANNOT BE DETERMINED FROM RECORD DOCUMENT.

(11) Terms, conditions, and easements granted to Consolidated Gas Electric Light and Power Company of Baltimore by instrument dated April 27, 1945 and recorded May 3, 1945 in Liber 909 at folio 182. —NOT PLOTTED, DOES NOT FALL ON SUBJECT PROPERTY.

(12) Terms, conditions, and easements granted to Consolidated Gas Electric Light and Power Company of Baltimore by instrument dated April 3, 1950 and recorded April 20, 1951 in Liber 1266 at folio 12. —NOT PLOTTED, DOES NOT FALL ON SUBJECT PROPERTY.

(13) Terms, conditions, covenants, and easements as contained in Right of Way with Washington Suburban Sanitary Commission dated February 7, 1958 and recorded February 23, 1958 in Liber 2284 at folio 864. —NOT PLOTTED, DOES NOT FALL ON SUBJECT PROPERTY.

(14) Terms, conditions, covenants, and easements as contained in Right of Way with Washington Suburban Sanitary Commission dated September 3, 1970 and recorded September 23, 1970 in Liber 3671 at folio 404. —NOT PLOTTED, DOES NOT FALL ON SUBJECT PROPERTY.

(15) Terms, conditions, covenants, restrictions, easements, and reversionary interest as contained in Deed dated November 13, 1974 and recorded December 6, 1974 in Liber 4363 at folio 262, as affected by Corrective Deed dated August 3, 1977 and recorded August 25, 1977 in Liber 4812 at folio 240. —PLOTTED ON SURVEY.

(16) Terms, conditions, covenants, stipulations, agreements, easements, and provisions as contained in Declaration of Covenants by Storm and Surface Water Facility and Option Maintenance dated March 17, 2009 and recorded April 2, 2009 in Liber 30602 at folio 205. —NOT PLOTTED, PLANS REFERENCED IN DOCUMENT NOT PROVIDED.

(17) Terms and conditions as contained in Notice of Right of Recovery dated January 20, 2010 and recorded January 27, 2010 in Liber 31382 at folio 401. —NOT PLOTTED, BLANKET IN NATURE.

(18) Terms, conditions, and covenants as contained in Deed of Easement with the Mayor and Council of Prince George's, Maryland dated May 26, 2010 and recorded August 6, 2010 in Liber 31812 at folio 326. —PLOTTED ON SURVEY.

UTILITY NOTES

ONE CALL TICKET NUMBER: 20851456. CALL DATE 12/08/2020.

UTILITIES SHOWN ARE BASED ON LIMITED DATA. THERE IS NO GUARANTEE AS TO THEIR LOCATION OR SIZE. PLEASE CONTACT RESPECTIVE UTILITY COMPANIES PRIOR TO CONSTRUCTION. POSSIBLE CONTACTS IN THIS AREA ARE:

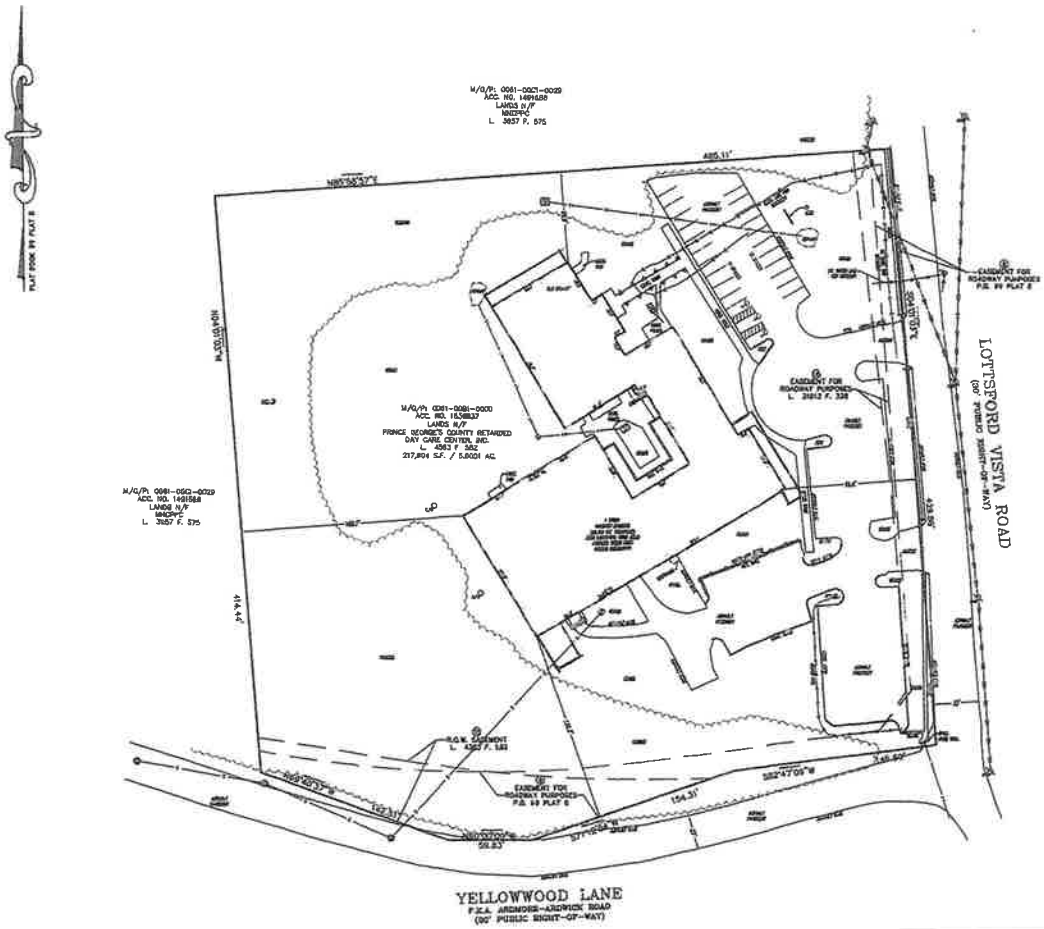
BGE ELECTRIC-USIC: (800) 778-9140
BGE GAS-USIC: (800) 778-9140
PEPCO/ DCI UTILITY LOCATING: (844) 605-1189
VERIZON: (301) 210-0355
WASHINGTON GAS-UTILISCAN: (301) 210-0355
WSSC - PINPOINT LIC: (301) 668-6803

ZONING

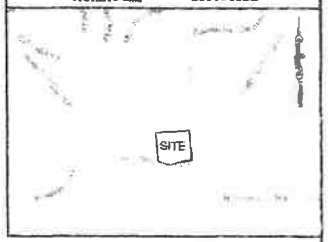
The surveyor was not provided with zoning information by the insurer pursuant to Table A item 6 (a)(b.)

SIGNIFICANT OBSERVATIONS

NONE OBSERVED.



VICINITY MAP — NOT TO SCALE



SITE DATA

1. PROPERTY IS KNOWN AS MAP 0061 GRID 0021 PARCEL 0029, ACCOUNT NO. 1538837 IN THE 13TH ELECTION DISTRICT OF PRINCE GEORGE'S COUNTY, MARYLAND

2. LOT AREA = 217,804 S.F. OR 5.0001± AC.

3. PARKING PROVIDED –
REGULAR – 33 SPACES
HANDICAP – 3 SPACES
TOTAL SPACES PROVIDED = 36

4. NO CHANGES IN STREET RIGHT OF WAY LINES EITHER COMPLETED OR PROPOSED KNOWN TO THIS SURVEYOR, NO OBSERVABLE EVIDENCE OF RECENT STREET OR SIDEWALK CONSTRUCTION OR REPAIRS.

5. THE EXISTENCE OF UNDERGROUND STORAGE TANKS, IF ANY, WAS NOT KNOWN AT THE TIME OF THIS SURVEY.

6. THIS PLAN IS VALID ONLY WHEN SIGNED IN COLORED INK AND EMBOSSED WITH A RAISED IMPRESSION SEAL AND WAS PREPARED IN ACCORDANCE WITH THE MINIMUM STANDARD OF ACCURACY OF THE STATE IN WHICH THE PROJECT IS LOCATED.

7. THE WORD "IDENTIFY" OR "IDENTIFICATE" AS SHOWN AND USED HEREIN MEANS AN EXPRESSION OF PROFESSIONAL OPINION REGARDING THE FACTS OF THIS SURVEY AND DOES NOT CONSTITUTE A WARRANTY OR GUARANTEE, EXPRESSED OR IMPLIED.

8.

9. IN RESPONSE TO ALTA/NSPS TABLE A ITEM 11, THE LOCATION OF UTILITIES SHOWN HEREON ARE FROM OBSERVED EVIDENCE OF ABOVE GROUND APPURTENANCES AND SURFACE MARKINGS AS PURSUANT TO ONE CALL REQUEST FOR GROUND MARKINGS OF UNDERGROUND UTILITY LINES.

10. IN RESPONSE TO ALTA/NSPS TABLE A ITEM 16, THERE WAS NO OBSERVABLE EVIDENCE OF EARTH MOVING WORK, BUILDING CONSTRUCTION OR BUILDING ADDITIONS WITHIN RECENT MONTHS.

11. IN RESPONSE TO ALTA/NSPS TABLE A ITEM 17, THERE ARE NO KNOWN CHANGES IN STREET RIGHT OF WAY LINES EITHER COMPLETED OR PROPOSED, AND AVAILABLE FROM THE CONTROLLING JURISDICTIONS. THERE IS NO OBSERVABLE EVIDENCE OF RECENT STREET OR SIDEWALK CONSTRUCTION OR REPAIRS.

12. IN RESPONSE TO ALTA/NSPS TABLE A ITEM 18, THE SURVEYOR DID NOT OBSERVE ANY MARKERS DELINEATING WETLANDS ON THE SUBJECT PROPERTY AT THE TIME OF THE FIELD SURVEY.

13. IN RESPONSE TO ALTA/NSPS TABLE A ITEM 19, THERE ARE NO OFFSITE EASEMENTS OR SERVITUDES BENEFITING THE SUBJECT PROPERTY AS DISCLOSED BY THE TITLE COMMITMENT PROVIDED FOR THIS SITE.

FLOOD NOTE

BY GRAPHICAL REPRESENTATION ONLY THIS PROPERTY IS LOCATED IN FLOOD HAZARD ZONE X UNSHADED AS SHOWN ON FLOOD INSURANCE RATE MAP, 24033C0035E, COMMUNITY PANEL No. 240208 WHICH HAS AN EFFECTIVE DATE OF 09/16/2016 AND IS NOT IN A SPECIAL FLOOD HAZARD AREA. FIELD SURVEYING WAS NOT PERFORMED TO DETERMINE THIS ZONE. AN ELEVATION CERTIFICATE MAY BE NEEDED TO VERIFY THIS DETERMINATION OR APPLY FOR AN AMENDMENT FROM THE FEDERAL EMERGENCY MANAGEMENT AGENCY

TYPE OF SURVEY: ALTA / NSPS LAND TITLE SURVEY

SYMBOLS

(ONLY IF A STANDARD LEGEND, NOT ALL ITEMS ARE ON THE SURVEY)

- MONUMENT FOUND
- MONUMENT TO BE SET
- BENCHMARK TOPO
- RECORD DATA
- SURVEYED DATA
- R/W RIGHT OF WAY
- BRL BUILDING RESTRICTION LINE
- SBRL SIDE BUILDING RESTRICTION LINE
- RCP REINFORCED CONCRETE PIPE
- CMP CORRUGATED METAL PIPE
- PVC PLASTIC PIPE
- HDPE HIGH DENSITY POLYETHYLENE
- CIP CAST IRON PIPE
- DIP DUCTILE IRON PIPE
- L/S LANDSCAPING
- DECIDUOUS TREE
- EVERGREEN TREE
- P — POWERLINE
- C — CABLE TELEVISION LINE
- E — ELECTRICAL LINE
- G — GAS LINE
- T — TELEPHONE LINE
- W — WATER LINE
- OHP — OVERHEAD ELECTRIC WIRE
- SPOT LIGHT
- FIRE HYDRANT
- LIGHT POLE
- STREET LIGHT POLE
- ELEC. TRANSFORMER
- AIR CONDITIONER
- ELEC. MANHOLE
- ELECTRIC METER
- CABLE BOX
- UNDERGROUND CABLE MARKER
- TRAFFIC POLES
- TRAFFIC SIGNAL
- TRAFFIC MANHOLE
- TRAFFIC WARNAL BOX
- SEWER MANHOLE
- CLEAN OUT
- STORM DRAIN MANHOLE
- STORM INLET
- CURB INLET
- ROUND STORM INLET
- UNKNOWN MANHOLE
- U.G. UNDER GROUND
- WATER MANHOLE
- WATER VALVE
- SEWER METER
- HYDRANT / FDC
- GAS MANHOLE
- GAS VALVE
- GAS METER
- UNDERGROUND GAS MARKER
- PAY PHONE
- TELEPHONE BOX
- UNDERGROUND TELEPHONE MARKER
- FLAG POLE
- BOLLARD
- SIGNS HOLE
- MONITORING WELL
- MAN. SOIL
- SIGN
- METAL TANK COVER
- AIR COMPRESSOR
- ADA PARKING

SURVEYOR'S CERTIFICATION

TO: Pyramid Manager, LLC, Fidelity National Title Insurance Company:

This is to certify that this map or plat and the survey on which it is based, was made in accordance with the 2016 Minimum Standard Detail Requirements for ALTA/NSPS Land Title Surveys, jointly established and adopted by ALTA and NSPS, and includes items 1, 2, 3, 4, 6a, 7a, 7b1, 7c, 8, 9, 11, 13, 14, 16, 17, 18, 19 and 20 of Table A thereof.

The fieldwork was completed on December 31, 2020.

Surveyor's Signature
Jack B. Shumacher
Professional Land Surveyor 21043 exp. 11/23/2022
In the State of Maryland
Date of Survey: December 31, 2020
Date of Last Revision: January 8, 2021

Survey Performed by
First Order, LLC
4383 Hecktown Road, Suite B
Bethlehem, PA 18020
Phone: 610-365-2907
Fax: 866-382-1935
Email: jshumacher@firstorderllc.net
Project No. 19259

FIRST ORDER, LLC
4383 HECKTOWN ROAD
BETHLEHEM, PA 18020
Phone (610) 365-2907 Fax (610) 365-2908

SITE ADDRESS: 5000 LOTTSFORD VISTA ROAD
BOWIE, PRINCE GEORGE'S COUNTY, MARYLAND

CLIENT: PYRAMID MANAGER, LLC

JOB NO: 19259	DRAWN BY: JV	APPROVED BY: JBM

DATE:
REVISIONS:

NO.	DATE	DESCRIPTION
1	01/08/21	ADDED TITLE COMMITMENT INFORMATION

SCALE: 1" = 40'

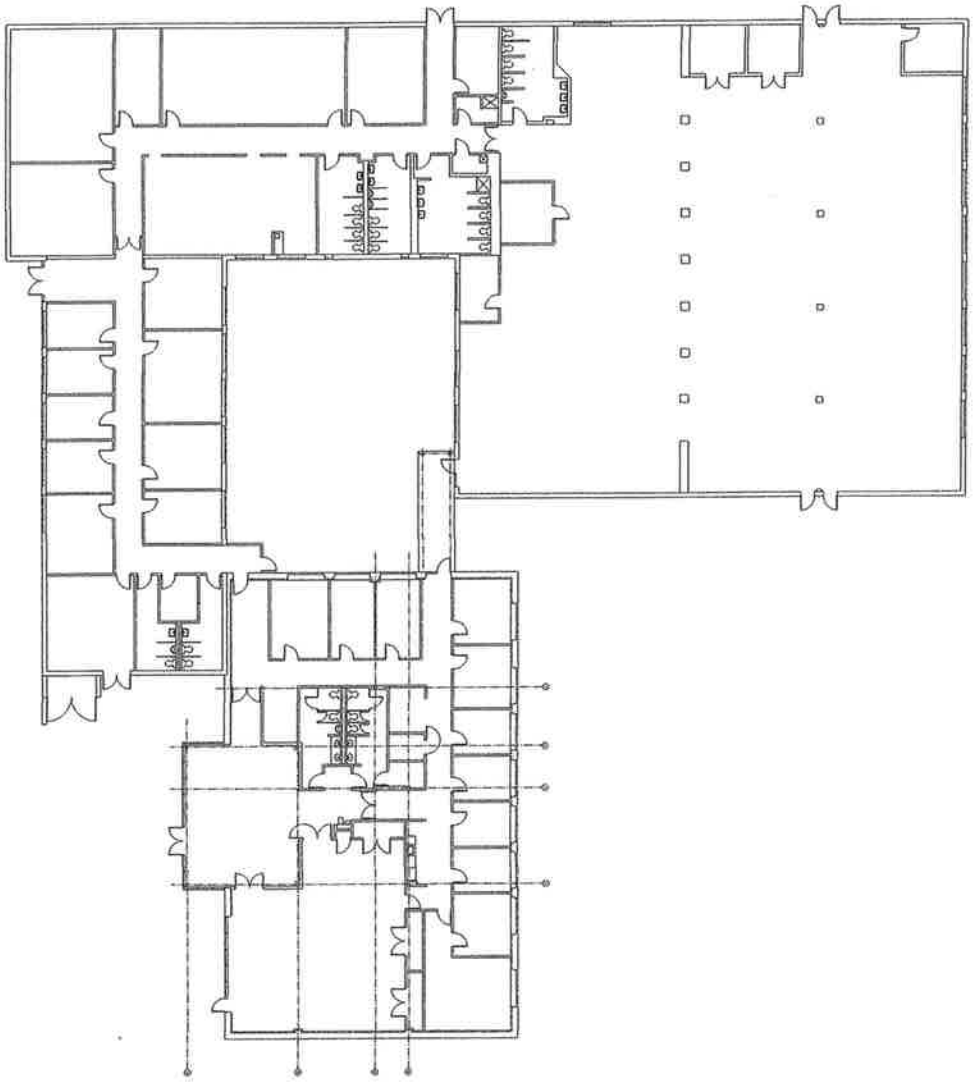
SHEET 1 OF 1

PYRAMID PROPOSED FLOOR PLAN

Operations Approval:	...	REV	DESCRIPTION	DATE	PYRAMID HEALTHCARE 3000 LOTTSFORD VISTA ROAD BOWIE, MD. 20721	Pyramid Healthcare 270 LAKEMONT PARK BLVD. ALTOONA, PA. 16602
E.V.P. or Engineering:	***	1	ISSUED TO OPERATIONS FOR REVIEW	12-4-21	ARCHITECTURAL PLAN	
Project Mgr.:	Cad:					
JSD	TP					

Dwg. No. P-A-100

EXISTING FLOOR PLAN



Dwg. No.:	Operations Approval:	Project Mgr.:	Cad:	REV	DESCRIPTION	DATE
P-A-101	***	JSD	TP	1	***	***

PYRAMID HEALTHCARE
3000 LOTTSFORD VISTA ROAD
BOWIE, MD. 20721

EXISTING ARCHITECTURAL PLAN

Pyramid Healthcare

270 LAKEMONT PARK BLVD.
ALTOONA, PA. 16602

Exhibit 4

TABLE B. PROJECT BUDGET

INSTRUCTION: Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application. If the project involves services other than level III.7 and III.7D explain the allocation of costs between the levels. NOTE: Inflation should only be included in the Inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.d as a use of funds and on line B.8 as a source of funds

	III.7 and III.7D	RESIDENTIAL	TOTAL
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building		$1,970,000	$1,970,000
(2) Fixed Equipment		$197,000	$197,000
(3) Site and Infrastructure		$95,000	$95,000
(4) Architect/Engineering Fees		$65,000	$65,000
(5) Permits (Building, Utilities, Etc.)		$12,000	$12,000
SUBTOTAL	**$0**	**$2,339,000**	**$2,339,000**
b. Renovations			
(1) Building		$5,135,000	$5,135,000
(2) Fixed Equipment (not included in construction)		$168,000	$168,000
(3) Architect/Engineering Fees		$205,000	$205,000
(4) Permits (Building, Utilities, Etc.)		$15,000	$15,000
SUBTOTAL	**$0**	**$5,523,000**	**$5,523,000**
c. Other Capital Costs			
(1) Movable Equipment		$389,000	$389,000
(2) Contingency Allowance		$507,000	$507,000
(3) Gross interest during construction period		$597,800	$597,800
(4) Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$0***	***$1,493,800***	**$1,493,800**
TOTAL CURRENT CAPITAL COSTS	**$0**	**$9,355,800**	**$9,355,800**
d. *Land Purchase*		**$375,000**	**$375,000**
e. Inflation Allowance			$0
TOTAL CAPITAL COSTS	**$0**	**$9,730,800**	**$9,730,800**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			$0
b. Bond Discount			$0
c CON Application Assistance			
c1. Legal Fees			$0
c2. Other (Specify/add rows if needed)			
d. Non-CON Consulting Fees			
d1. Legal Fees		**$131,000**	$131,000
d2. Other (Specify/add rows if needed)			$0
e. Debt Service Reserve Fund			$0
i. Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$0***	***$131,000***	**$131,000**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$0***	***$9,861,800***	***$9,861,800***
B. Sources of Funds			
1. Cash			$0
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds			$0
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS			**$0**
	III.7 and III.7D	***RESIDENTIAL***	***TOTAL***
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

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

Exhibit 5

Craig Tanio, M.D.
Chairman

Ben Steffen
Executive Director

STATE OF MARYLAND

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

STATE HEALTH PLAN FOR FACILITIES AND SERVICES:

ALCOHOLISM AND DRUG ABUSE INTERMEDIATE CARE FACILITY TREATMENT SERVICES

COMAR 10.24.14

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

Table of Contents

APPENDIX

Page

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

.01 Incorporation by Reference.

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

.02 Introduction.

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

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

The State Health Plan serves two purposes:

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

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

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

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

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

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

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

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

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

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

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

C. Organizational Setting of the Commission.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Applicability and Plan Content.

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

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

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

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

.03 Alcohol and Drug Abuse Treatment Services

A. Introduction

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

B. Statement of Issues and Policies

1. Access To Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Funding for Alcohol and Drug Treatment Services

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

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

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

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

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

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

3. Quality of Care

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

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

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

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

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

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

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

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

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

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

4. **Data Collection Systems**

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

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

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

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

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

5. The Continuum of Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Areas of cooperation and shared responsibilities; and

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

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

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

(i) Treat mildly mentally ill substance abusers;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) A existing Track One intermediate care facility may propose an alternative to the standards in Regulation D(1) that would increase the availability of alcoholism and drug abuse

treatment to indigent or gray area patients in its health planning region.

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

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

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

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

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

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

G. **Age Groups.**

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

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

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

***H.* Quality Assurance.**

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

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

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

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

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

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

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

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

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

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

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

J. **Transfer and Referral Agreements.**

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

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

(a) Acute care hospitals;

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

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

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

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

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

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

K. **Sources of Referral.**

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

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

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

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

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

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

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

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

(3) Outpatient programs must identify special populations as defined in

Regulation. 08, in their service areas and provide outreach and outpatient services to meet their needs.

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

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

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

.06 Preferences for Certificate of Need Approval.

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

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

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

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

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

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

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

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

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

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

.07 Bed Need Projection Methodologies.

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

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

(1) Period of Time Covered.

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

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

(2) Age Groups.

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

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

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

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

(b) Montgomery County;

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

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

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

(4) Assumptions.

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

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

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

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

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

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

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

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

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

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

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

(j) Projected need is for Maryland facilities only.

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

(5) **Data Sources.**

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

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

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

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

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

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

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

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

(6) **Revisions.**

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

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

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

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

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

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

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

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

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

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

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

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

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

(8) Mathematical Formulas.

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

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

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

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

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

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

.08 Definitions.

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

B. **Terms Defined.**

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

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

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

(4) Charity Care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX

TABLES

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

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

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

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

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

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

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

Source: Maryland Health Care Commission (Data on ALOS and discharges from out-of-state are from the Substance Abuse Management Information System; data on the indigent population is from the Maryland Medical Assistance Program, June 2000; population

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

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

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

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

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

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

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

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

(*) Negative bed need is tabulated as zero.

Source: Maryland Health Care Commission, October 2000

Exhibit 6

Region / Facility Name (Maryland-October 2021)	Adult Track 2 ICF Beds
TOTAL BEDS	**755**
Prince George County	**10**
WESTERN MARYLAND	**272**
Allegheny County Health Dept (Massie & Jackson Unit)	114
Mountain Manor Treatment Center	118
Shoemaker Center	40
MONTGOMERY COUNTY	**60**
Avery Road Treatment Center	60
SOUTHERN MARYLAND	**86**
Anchor of Walden	27
Hope House Treatment Centers	59
CENTRAL MARYLAND	**327**
Hope House Treatment Center	39
Pathways	40
Baltimore Crisis Response	7
Gaudenzia at Park Heights	67
Mountain Manor	68
Turek House	29
PHC Harford County	50
Gaudenzia Crownsville	27

Exhibit 7

January 2021 to December 2021

Turndown Data

Row Labels	Count of Turn Down Code CY 2021
Accomack	6
Albemarle	2
Allegany	246
Allegheny	4
Anne Arundel	398
Atlantic	2
Baltimore	657
Baltimore City	205
Bedford	2
Bergen	2
Berks	2
Buckingham	2
Bucks	2
Calvert	290
Campbell	2
Caroline	37
Carroll	173
Cecil	245
Centre	2
Charles	532
Chester	4
Cumberland	3
Delaware	2
Dorchester	72
Fauquier	2
Franklin	4
Frederick	**282**
Garrett	60
Harford	547
Hartford	2
Howard	135
Kent	63
King George	2
Lackawanna	2
Lee	2
Lehigh	2
Luzerne	4
Monmouth	2
Montgomery	**153**
N/A	6
Northumberland	2
Perry	2
Prince George's	**491**
Queen Anne's	75
Somerset	60
Spotsylvania	3
St. Mary's	1274
Talbot	22
Vanango	2
Washington	102
Wicomico	184
Worcester	60
Total	6433

Exhibit 8

carf INTERNATIONAL

March 23, 2022

To Whom It May Concern:

It is CARF's understanding that Pyramid Healthcare Inc., in Baltimore, MD would like to expand the following CARF Accredited programs to 300 Lottsford Vista Rd. Bowie, MD 20721:

- Outpatient Treatment
- Intensive Outpatient Treatment
- Residential Treatment
- Inpatient Treatment
- Withdrawal Management

These programs are part of their active accreditation #143105. The attached Survey Accreditation Detail report will indicate all current accredited programs and locations.

It is CARF's policy that the organization notify CARF within 30 days of the occurrence for all relocations, expansions, or eliminations of an accredited program or location. This notification would be by means of an Ongoing Communication Form that can be located in the organizations Customer Connect account.

Please direct any questions about the matter to the undersigned.

Sincerely,

Michelle Nevarez-Sandy, MA

Michelle Nevarez-Sandy
Resource Specialist
1-888-281-6531 Ext 7083
mnevarezsandy@carf.org

CARF International Headquarters
6951 E. Southpoint Road
Tucson, AZ 85756-9407, USA

www.carf.org

carf INTERNATIONAL

Companies & Programs

Pyramid Walden Recovery Harbor
44871 Saint Andrew's Church Road
California MD 20619

- Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Adults
- Outpatient Treatment - Substance Use Disorders/Addictions - Adults

Pyramid Walden Lexington Park
21770 Franklin Delano Roosevelt Boulevard Suite B
Lexington Park MD 20653

- Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Adults
- Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents
- Office-Based Opioid Treatment - Addictions Pharmacotherapy - Adults
- Outpatient Treatment - Substance Use Disorders/Addictions - Adults
- Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents
- Partial Hospitalization - Substance Use Disorders/Addictions - Adults

Pyramid Walden Charlotte Hall
30007 Business Center Drive
Charlotte Hall MD 20622

- Detoxification/Withdrawal Management - Inpatient - Substance Use Disorders/Addictions - Adults
- Inpatient Treatment - Substance Use Disorders/Addictions - Adults
- Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Adults
- Outpatient Treatment - Substance Use Disorders/Addictions - Adults
- Partial Hospitalization - Substance Use Disorders/Addictions - Adults
- Residential Treatment - Substance Use Disorders/Addictions - Adults

Pyramid Healthcare, Inc.
270 Lakemont Park Boulevard
Altoona PA 16602-5944

- Administrative Location Only

Pyramid Walden Waldorf
85 High Street Suite 4
Waldorf MD 20602

- Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Adults
- Office-Based Opioid Treatment - Addictions Pharmacotherapy - Adults
- Outpatient Treatment - Substance Use Disorders/Addictions - Adults

Walden Saint Mary's County Detention Center Services
41880 Baldridge Street
Leonardtown MD 20650

- Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Criminal Justice
- Outpatient Treatment - Substance Use Disorders/Addictions - Criminal Justice

Duncansville Inpatient
1894 Plank Road
Duncansville PA 16635-8380

- Detoxification/Withdrawal Management - Inpatient - Substance Use Disorders/Addictions - Adults
- Residential Treatment - Substance Use Disorders/Addictions - Adults

Belleville Inpatient
3893 West Main Street

Belleville PA 17004-9252

Residential Treatment - Substance Use Disorders/Addictions - Adults

Hillside Inpatient
420 Supreme Court
East Stroudsburg PA 18302

Detoxification/Withdrawal Management - Inpatient - Substance Use Disorders/Addictions - Adults
Residential Treatment - Substance Use Disorders/Addictions - Adults

Pyramid Pittsburgh Inpatient
306 Penn Avenue
Pittsburgh PA 15221-2134

Detoxification/Withdrawal Management - Inpatient - Substance Use Disorders/Addictions - Adults
Residential Treatment - Substance Use Disorders/Addictions - Adults

Altoona Outpatient
2 Sellers Drive
Altoona PA 16601

Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Adults
Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents
Office-Based Opioid Treatment - Addictions Pharmacotherapy - Adults
Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents
Outpatient Treatment - Substance Use Disorders/Addictions - Adults

Allentown Outpatient
1605 North Cedar Crest Boulevard Suite 602, Roma Corporate Center
Allentown PA 18104

Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents
Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Adults
Office-Based Opioid Treatment - Addictions Pharmacotherapy - Adults
Outpatient Treatment - Mental Health - Adults
Outpatient Treatment - Mental Health - Children and Adolescents
Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents
Outpatient Treatment - Substance Use Disorders/Addictions - Adults

Chambersburg Outpatient
124 Chambers Hill Drive
Chambersburg PA 17201

Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents
Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Adults
Office-Based Opioid Treatment - Addictions Pharmacotherapy - Adults
Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents
Outpatient Treatment - Substance Use Disorders/Addictions - Adults

Erie Outpatient
2409 State Street Suite C
Erie PA 16503

Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents
Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Adults
Office-Based Opioid Treatment - Addictions Pharmacotherapy - Adults
Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents
Outpatient Treatment - Substance Use Disorders/Addictions - Adults

Pittsburgh Outpatient
1401 Forbes Avenue Suite 200
Pittsburgh PA 15219

Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Adults

Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents
Office-Based Opioid Treatment - Addictions Pharmacotherapy - Adults
Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents
Outpatient Treatment - Substance Use Disorders/Addictions - Adults

Gratitude House (Halfway House)
901 Sixth Avenue
Altoona PA 16602-2503

Residential Treatment - Substance Use Disorders/Addictions - Adults

Tradition House (Halfway House)
830 Sixth Avenue
Altoona PA 16602-2502

Residential Treatment - Substance Use Disorders/Addictions - Adults

Pine Ridge Manor (Halfway House)
13505 South Eagle Valley Road
Tyrone PA 16686-7817

Residential Treatment - Substance Use Disorders/Addictions - Adults

Waynesboro Outpatient
626 North Grant Street
Waynesboro PA 17268

Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents
Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Adults
Office-Based Opioid Treatment - Addictions Pharmacotherapy - Adults
Outpatient Treatment - Mental Health - Adults
Outpatient Treatment - Mental Health - Children and Adolescents
Outpatient Treatment - Substance Use Disorders/Addictions - Adults
Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents

Langhorne Inpatient
1990 Woodbourne Road
Langhorne PA 19047

Detoxification/Withdrawal Management - Inpatient - Substance Use Disorders/Addictions - Adults
Residential Treatment - Substance Use Disorders/Addictions - Adults

Quakertown Inpatient
2705 Old Bethlehem Pike
Quakertown PA 18951-4047

Residential Treatment - Substance Use Disorders/Addictions - Adults

Ridgeview Inpatient
4447 Gibsonia Road
Gibsonia PA 15044-7998

Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents
Residential Treatment - Substance Use Disorders/Addictions - Adults

Bartonsville Outpatient
3180 Route 611 Suite 19, Fountain Court
Bartonsville PA 18321

Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Adults
Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents
Office-Based Opioid Treatment - Addictions Pharmacotherapy - Adults
Outpatient Treatment - Substance Use Disorders/Addictions - Adults
Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents
Outpatient Treatment - Mental Health - Children and Adolescents

Outpatient Treatment - Mental Health - Adults

Quest - Phillipsburg
9 West Pine Street
Philipsburg PA 16866

Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Adults
Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents
Office-Based Opioid Treatment - Addictions Pharmacotherapy - Adults
Outpatient Treatment - Substance Use Disorders/Addictions - Adults
Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents

Quest - Bellefonte
210 Suite 1 West High Street
Bellefonte PA 16866

Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Adults
Intensive Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents
Office-Based Opioid Treatment - Addictions Pharmacotherapy - Adults
Outpatient Treatment - Substance Use Disorders/Addictions - Adults
Outpatient Treatment - Substance Use Disorders/Addictions - Children and Adolescents

Pyramid Walden Compass
44863 Saint Andrew's Church Road
California MD 20619

Residential Treatment - Substance Use Disorders/Addictions - Adults

Pyramid Healthcare, Inc. @ Allentown OP: Dieruff High School
815 North Irving Street
Allentown PA 18109

Outpatient Treatment - Mental Health - Children and Adolescents

Pyramid Healthcare, Inc. @ Allentown OP: William Penn Alternative School
401 Allen Street
Allentown PA 18102

Outpatient Treatment - Mental Health - Children and Adolescents

Pyramid Healthcare, Inc. @ Allentown OP: William Allen High School
106 North 17th Street
Allentown PA 18102

Outpatient Treatment - Mental Health - Children and Adolescents

Pyramid Healthcare, Inc. @ Allentown OP: Raub Middle School
102 South St. Cloud Street
Allentown PA 18104

Outpatient Treatment - Mental Health - Children and Adolescents

Lehigh Valley Inpatient Treatment Center
124 Bridge Street
Catasauqua PA 18032

Residential Treatment - Substance Use Disorders/Addictions - Adults

York Pharmacotherapy Services
104 Davies Drive
York PA 17402

Outpatient Treatment - Substance Use Disorders/Addictions - Adults

Pyramid Walden Dockside

44867 Saint Andrew's Church Road
California MD 20619

Residential Treatment - Substance Use Disorders/Addictions - Adults

Pyramid Healthcare Dallas
100 Upper Demunds Road
Dallas PA 18612

Detoxification/Withdrawal Management - Inpatient - Substance Use Disorders/Addictions - Adults
Residential Treatment - Substance Use Disorders/Addictions - Adults

Pyramid Healthcare York Inpatient
5849 Lincoln Highway
York PA 17406

Residential Treatment - Substance Use Disorders/Addictions - Adults

Pyramid Walden Harford
1015 Pulaski Highway
Joppa MD 21085

Detoxification/Withdrawal Management - Inpatient - Substance Use Disorders/Addictions - Adults
Inpatient Treatment - Substance Use Disorders/Addictions - Adults
Residential Treatment - Substance Use Disorders/Addictions - Adults

Pyramid Healthcare, Inc. @ Allentown OP: Trexler Middle School
851 North 15th Street
Allentown PA 18102

Outpatient Treatment - Mental Health - Children and Adolescents

Exhibit 9

Pyramid Healthcare Treatment Facilities

POLICY/PROCEDURE

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

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

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

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

PROCEDURE:

I. Purpose

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

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

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

II. Organization:

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

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

4. Support staff

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

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

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

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

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

III. Admission and Continued Stay Reviews:

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

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

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

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

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

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

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

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

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

Pyramid Healthcare Treatment Facilities

POLICY/PROCEDURE

Section:	Assessment
Policy Name:	Admission Criteria
Policy Number:	PHC 1.3

Date Issued:	7/1/1999
Date Reviewed:	
Date Revised:	2/23/00; 1/29/07; 7/1/10; 8/13/12; 6/3/15; 6/15/15; 8/1/16; 6/22/18; 11/30/18, 1/1/19

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

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

PROCEDURE:

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

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

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

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

V. Each program adheres to the following additional criteria:

A. **ADULT DETOXIFICATION**

1. Admission criteria include:

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

2. Exclusions from admission are:

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

g. Any person with an open warrant

B. **ADULT RESIDENTIAL OR INPATIENT**

1. Admissions must:

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

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

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

C. **ADOLESCENT RESIDENTIAL**

1. Admissions must:

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

2. Exclusions:

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

D. **HALFWAY HOUSE**

1. Admissions must:

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

2. Exclusions from admission are:

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

3. Special Considerations:

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

E. **ADULT PARTIAL HOSPITAL PROGRAMS**

1. Admissions must:

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

2. Exclusions from admission are:

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

F. **ADOLESCENT PARTIAL HOSPITAL PROGRAMS**

1. Admissions must:

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

2. Exclusions from admission are:

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

G. **ADULT INTENSIVE OUTPATIENT AND OUTPATIENT**

1. Admissions must:

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

2. Exclusions from admission are:

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

H. ADOLESCENT INTENSIVE OUTPATIENT AND OUTPATIENT

1. Admissions must:

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

2. Exclusions from admission are:

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

Pyramid Healthcare Treatment Facilities

POLICY/PROCEDURE

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

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

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

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

PROCEDURE:

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

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

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

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

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

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

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

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

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

B. Coordination with Primary Care Physician

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

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

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

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

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

C. Coordination with other Behavioral Health Providers

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

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

D. Referrals to Aftercare Services with Internal Agencies

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

2. Documentation will be shared through current EMR.

E. Referrals to Aftercare Services with External Agencies

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

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

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

Pyramid Healthcare Treatment Facilities

POLICY/PROCEDURE

Section:	Provision of Care
Policy Name:	Discharge and Transfer Criteria
Policy Number:	PHC 2.2

Date Issued:	7/1/1999
Date Reviewed:	8/13/2012
Date Revised:	11/1/2001; 8/7/2003; 7/1/2010; 6/18/2018

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

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

PROCEDURE:

I. Types of client discharge statuses:

A. Successful

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

B. Partially Successful

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

C. Against Medical Advice

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

D. Against Facility Advice

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

E. Behavioral

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

F. Transfer

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

G. Deceased/death of client

II. The requirements for successful completion of treatment are:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Imminent safety concerns such as:

a. Illicit substance distribution

b. Physical altercations or threats to do bodily harm to other clients or staff

c. Sexual boundary violation

2. Violations of a safety, behavioral, or motivational contract such as:

a. Continued use of contraband

b. Ongoing boundary concerns

c. Continued use of illegal/non-prescribed substances while in treatment, if verified or and/or admitted by client

d. Ongoing failure to participate in programming

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

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

1. The primary counselor or the nursing staff may develop a behavioral contract to clarify behavioral expectations and consequences. The contract is reviewed and signed by the client.

2. A decision is then made as to whether or not the client may remain in the program based on their response and compliance the behavioral contract, when applicable.

3. Safe treatment or disposition options are put in place.

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

1. The medical physician on-call must be consulted on all behavioral discharges from the detox unit.

2. The client is assessed by nursing staff to determine if the inappropriate behavior is a complication of the withdrawal process, including:

a. Is the behavior a result of a delusional/hallucinatory process that requires acute psychiatric treatment?

b. Is the behavior related to a delirium process that requires acute medical treatment?

c. Is the behavior willful?

3. The Counselor, Detox Specialist or Nurse documents the necessary information in the clinical record.

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

1. A **Notice of Involuntary Discharge** is presented to the client.

a. The Notice includes a listing of the specific reasons for the behavioral discharge.

b. Treatment recommendations post discharge are identified.

c. The Counselor, Program Director and client, when available, sign the Notice.

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

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

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

A. Internal Transfers

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

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

B. External Transfers

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

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

b. The client is incarcerated

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

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

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

f. Funding issue

g. Referred to external higher level of care

h. Referred to external lower level of care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Exhibit 10

HEALTH DEPARTMENT
Prince George's County

Local Behavioral Health Authority

March 23, 2022

Mr. Brandon Golder
Pyramid Healthcare, Inc.
3000 Lottsford Vista Road
Bowie, Maryland 20721

Dear Mr. Golder:

Thank you for submitting a request for an Agreement to Cooperate to operate services in Prince George's County. As per COMAR 10.63, attached is the signed letter.

While COMAR stipulates the regulations concerning the Agreement to Cooperate, local Behavioral Health Authorities (LBHAs) are tasked with developing, planning, monitoring and managing a system of care for their local jurisdiction. Authority to perform this system oversight role is granted to LBHAs through a Memorandum of Understanding (MOU) with the Department of Health (DOH), Behavioral Health Administration (BHA). As per this MOU, the Prince George's County Health Department is asking you to cooperate with the below additional items.

- Attend and participate in provider meetings hosted by the LBHA.
- Maintain a Disaster Preparedness and Response Plan. Participate in regional or county specific Behavioral Health Disaster Preparedness and Response activities as needed and able; encourage staff registration with Maryland Responds Volunteers Corps.
- Support and encourage appropriate utilization of emergency department and behavioral health crisis response services, if available.
- Ensure program after hours emergency support services and execute consumer specific crisis intervention plans as part of the treatment process.
- Ensure program listing in the resource directory is updated at least annually each December, to include names of relevant staff.
- Participate in collaborative problem solving on behalf of identified high service utilizers to support community stabilization, improved quality of life and system cost efficiency.
- Cooperate with all complaint investigations.

Angela D. Alsobrooks
County Executive

Local Behavioral Health Authority
Dyer Regional Center
9314 Piscataway Road, Suite 150, Clinton, Maryland 20735
301-856-9500
www.goprincegeorgescounty.com

- Cooperate with all Program Improvement Plan (PIP) obligations and follow-up resulting from site visits by the ASO, Office of Health Care Quality (OHCQ) or BHA's Office of Compliance as delegated to the LBHA.
- Report critical incidents/sentinel events as defined by COMAR 10.63.
- Collaborate in the planning and development of services to be delivered in the jurisdiction.
- Notify the LBHA 60 days prior to closure, and cooperate in finding appropriate alternative services for consumers.
- Make available any financial, treatment, personnel or service records needed for the purpose of assessing an individual's quality of care or investigating a complaint or grievance.
- Cooperate with all site visits and audits from the ASO, OHCQ and Office of Compliance.
- Make staff and/or service recipients available for complaint or grievance investigation.
- Provide access for announced or unannounced visits to the program site.

Thank you for providing services in Prince George's County. The success of our jurisdiction is dependent upon the collaborative work we all do within our respective roles. The Prince George's County Health Department looks forward to our ongoing partnership.

Sincerely,

O'Tilia V. Hunter, Ph.D., NCC, LCPC-S, LCADC-S
Manager

MARYLAND
Department of Health

BEHAVIORAL HEALTH ADMINISTRATION
Catonsville, MD 21228

AGREEMENT TO COOPERATE

Before applying for licensure under Subtitle 10.63 - *Community-Based Behavioral Health Programs and Services*, behavioral health programs in Maryland must enter into an Agreement to Cooperate with the CSA, LAA, or LBHA in each of the relevant counties or Baltimore City in which the program operates. Agreements are required when submitting an initial application, renewal application, or when a change to a program's license is requested (e.g., change in service array or locations). When submitting this agreement for signature, please attach page 2, all applicable pages 3-4, and proof of accreditation, if applicable, of the "Application for Licensure Under COMAR 10.63" packet. Please note that separate agreements are not required per site, unless there is a change to the program's existing license, such as adding a new location.

Program Information

Program Name (should match the corporate/business name included on the application for licensure): **Pyramid Healthcare, Inc**
Primary Program Address: **3000 Lottsford Vista Rd Bowie, Maryland 20721**
Primary Contact Name: **Brandon Golder**
Primary Contact Phone: **240-298-1698**
Primary Contact Email: **bgolder@pyramidhc.com**

Local Behavioral Health Authority Information

Local Jurisdiction: **Prince George's County**
Primary Contact Name: **Dr. O'Tilia V. Hunter**
Primary Contact Phone: **301-856-9500**
Primary Contact Email: **OVHunter@co.pg.md.us**

Type of Program

Non-Accredited Program Types	
☐ DUI Education	☐ Substance-Related Disorder Assessment and Referral
☐ Early Intervention Level 0.5	

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

DHMH #4781 (Revised June 29, 2017)

Accredited Services	
☐ Opioid Treatment	☒ Withdrawal Management

As required under COMAR 10.63.01.05, Pyramid Healthcare, Inc. enters into the following agreement with Prince George's County Health Department, Behavioral Health Services to provide for coordination and cooperation between the parties in carrying out behavioral health activities in the jurisdiction, including complaint investigation and the transition of services if the program closes.

Behavioral Health Program

Signature

3/25/22
Click here to enter a date.
Date

Click here to enter text. Brandon Bowden
Print Name

Local Behavioral Health Authority

Signature

3/23/2021
Date

O'Tilia V. Hunter, Ph.D., NCC, LCPC-S, LCADC-S
Print Name

Regulatory Authority

COMAR 10.63.01.02B(5)

B. Terms Defined.

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

COMAR 10.63.01.05E

E. Agreement to Cooperate.

(1) Before applying for licensure, a program shall enter into an agreement to cooperate with the CSA, LAA, or LBHA that operates in the relevant county or Baltimore City.

(2) The agreement to cooperate shall provide for coordination and cooperation between the parties in carrying out behavioral health activities in the jurisdiction, including but not limited to facilitating:

(a) A complaint investigation; and

(b) The transition of services if the program closes.

(3) The agreement to cooperate may not include a provision that authorizes the CSA, LAA, or LBHA to prohibit a program from offering services at any location

Exhibit 11

Pyramid Healthcare
AN INTEGRATED BEHAVIORAL HEALTHCARE SYSTEM

One Team. One Purpose. Making a Difference Together
3000 Lottsford Vista Rd, Bowie, MD 20721
P: (301) 997-1300 F: (301) 290-0280

TRANSFER AND REFERRAL AGREEMENT

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

Grassroots Crisis Intervention Center

Both institutions agree that:

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

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

C. The patient shall agree to the referral.

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

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

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

BL MA 3/8/22

Brandon Golder, Vice President of Development Date
Pyramid Healthcare

Vicki Scofield 3/16/2022

Facility Representative Date

Pyramid Healthcare
AN INTEGRATED BEHAVIORAL HEALTHCARE SYSTEM

One Team. One Purpose. Making a Difference Together
3000 Lottsford Vista Rd, Bowie, MD 20721
P: (301) 997-1300 F: (301) 290-0280

TRANSFER AND REFERRAL AGREEMENT

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

ADDICTION CONNECTIONS RESOURCE

Both institutions agree that:

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

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

C. The patient shall agree to the referral.

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

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

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

3/18/22

Brandon Golder, Vice President of Development — Date
Pyramid Healthcare

Linda Williams — 3/18/22

Facility Representative — Date

Pyramid Healthcare
AN INTEGRATED BEHAVIORAL HEALTHCARE SYSTEM

One Team. One Purpose. Making a Difference Together
3000 Lottsford Vista Rd, Bowie, MD 20721
P: (301) 997-1300 F: (301) 290-0280

TRANSFER AND REFERRAL AGREEMENT

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

Suburban Hospital – John Hopkins Medicine

Both institutions agree that:

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

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

C. The patient shall agree to the referral.

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

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

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

BL MA 3/15/22

Brandon Golder, Vice President of Development Date
Pyramid Healthcare

Latonia Roth 3-16-2022

Facility Representative Date

Effective Date March 1 2022

Pyramid Healthcare
AN INTEGRATED BEHAVIORAL HEALTHCARE SYSTEM

One Team. One Purpose. Making a Difference Together
3000 Lottsford Vista Rd, Bowie, MD 20721
P: (301) 997-1300 F: (301) 290-0280

TRANSFER AND REFERRAL AGREEMENT

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

Voices of Hope, Inc Maryland

Both institutions agree that:

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

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

C. The patient shall agree to the referral.

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

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

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

3/11/22

[redacted], Vice President of Development, Pyramid Healthcare — Date

3/17/2022

[redacted] — Date

Pyramid Healthcare
AN INTEGRATED BEHAVIORAL HEALTHCARE SYSTEM

One Team. One Purpose. Making a Difference Together
3000 Lottsford Vista Rd, Bowie, MD 20721
P: (301) 997-1300 F: (301) 290-0280

TRANSFER AND REFERRAL AGREEMENT

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

Ashley Addiction Treatment

Both institutions agree that:

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

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

C. The patient shall agree to the referral.

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

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

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

3/17/22

Brandon Golder, Vice President of Development — Date
Pyramid Healthcare

3/16/22

Facility Representative — Date

Effective Date March 1 2022

Dear Maryland Health Care Commission,

It's my absolute pleasure to recommend Pyramid Healthcare for their Pyramid Healthcare's application for a Certificate of Need for an ICF for Substance Use Disorder. Pyramid Walden and I have worked together professionally for the past few years and I have had nothing but great experiences. Pyramids knowledge of treating individuals and expertise in alcoholism and substance abuse disorder is a huge advantage to our community residents and the population they serve.

Along with their undeniable passion for helping clients, Pyramid Healthcare has always been an absolute joy to work with. They work alongside referents, and always foster positive discussions to produce the best outcomes for those they serve.

Without a doubt, I confidently recommend Pyramid Healthcare's application for their facility in Prince George County. As a dedicated and knowledgeable organization and I know that they will be a beneficial addition to needed treatment services in our state.

Please feel free to contact me at my information below if you want to discuss Pyramid's qualifications and experience further. I'd be happy to expand on my recommendation.

Best wishes,

Erin Knight

Erin Knight

Deputy Director – Consumer Quality Team

Mental Health Association

610-324-8126

SUMMIT
BHC

Dear Maryland Health Care Commission,

It is with pleasure that I write this letter of support on behalf of Walden and Pyramid Healthcare In their development of a Detox and Residential facility in Prince George County to serve adults with Substance Use Disorder. I have lived in Prince George County and worked in mental health and substance abuse treatment for the past 10 years. Our community lacks resources currently to meet the need of clients that critically need inpatient treatment services. I have been referring clients to Pyramids facility in Harford County as well as Charlotte Hall for some time now, and have had nothing but great results and positive interactions with their staff.

Pyramid has always gone above and beyond to help the clients I am working with, and has taken every measure possible to ensure the best care and outcomes for those they serve. It would be such an asset to have their resources available to us locally and have their services become a part of our community in helping to treat those who struggle with alcoholism and substance abuse disorder. Thank you for your consideration of Pyramid Healthcare's application for a Certificate of Need for an ICF for Substance Use Disorder. We are eager to have access to this needed treatment In Prince George County and recommend Pyramid's treatment model without hesitation.

For any further questions please feel free to reach out to me.

Sincerely,

Morgan Pagels

Morgan Pagels
National Outreach Manager / Peer Support
Email: morgan.pagels@summitbhc.com
Phone: 443-307-7256

NEW LIFE
ADDICTION COUNSELING & MENTAL HEALTH SERVICES

Date: 3/18/22

To Whom This May Concern,

My name is Michael Darling and I am proud to offer my recommendation of Pyramid Healthcare to whom I have professionally known and worked with for several years as my priority choice for inpatient detox and residential services.

During my time working as an outpatient provider in the Prince George and Anne Arundel area, I have worked with Pyramid Healthcare endlessly with treating and caring for the our clients that are in need of inpatient services. I have experienced an organization who shows up whenever they are need, works hard, and carries themselves in a polite, respectable manner. In addition Pyramid Healthcare has always utilized the best client centered practices when treating our population and treated them with the utmost respect.

We are excited for your consideration of Pyramid Healthcare's application for a Certificate of Need for an ICF for Substance Use Disorder. Having access to their services locally would be highly beneficial for our local professional and personal community.

Please do not hesitate to contact me if you should require any further information.

All the best,

Michael Darling
Director of Clinical Outreach
Discovery Healthcare / New Life
609-284-5533

Exhibit 12

January 2021 to May 2021

Referral Data by Referral Type

Referral Type	01/2021	02/2021	03/2021	04/2021	05/2021
	Scheduled for Admit:				
Crisis	5	1	4	11	6
External Detox / Rehab	2	4	6	5	6
External Halfway House / Sober Living			2	2	
External Mental Health Inpatient		1	1	1	
External Outpatient / Private Practice	23	34	43	46	34
External Outpatient/Private Practice	1				1
Friend / Family		1	2	4	5
Hospital	19	25	57	46	28
Hotline / Social Services			2	3	2
Insurance / EAP				1	
Internal Detox / Rehab	11	9	18	14	8
Internal Marketer		1			
Internal Outpatient	5	4	1	4	3
Internet	73	64	92	62	82
Legal	11	11	19	18	15
NA	14	14	21	15	15
Probation	2	1	2	1	2
Unknown		4	3	5	11
Grand Total	138	144	232	197	185

Exhibit 13

Clearview Pyramid Acquisition Company, LLC.

POLICY/PROCEDURE

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

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

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

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

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

SCOPE: Organization-wide.

PROCEDURE:

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

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

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

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

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

employee's personnel file.

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

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

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

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

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

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

one year, full certification must be completed again.

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

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

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

TRAINING HOUR REQUIREMENTS (PER CALENDAR YEAR):

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

New Hire Orientation Agenda

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

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

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

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

Presenter: Courtney Thacker

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

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

Presenter: Courtney Thacker

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

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

Presenter: Jesse Hertzler or Eric Raley

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

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

Presenter: Lindsay Laundermilch or Bartonsville Staff

Exhibit 14

Pyramid Healthcare Treatment Facilities

POLICY/PROCEDURE

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

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

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

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

Restrictions include:

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

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

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

PROCEDURE:

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

II. The responsibilities of the Medical Director include:

A. Formulate, order and revise detoxification protocols

B. Issue verbal orders pertaining to patient care

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

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

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

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

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

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

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

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

2. Determining diagnosis and determining narcotic dependence

3. Reviewing treatment plans

4. Discussing cases with the treatment team

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

6. Assessing coexisting medical and psychiatric disorders

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

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

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

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

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

1. The consultation is documented in the medical record.

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

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

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

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

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

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

F. Revise medications as warranted by client condition.

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

H. Discuss cases with treatment team.

I. Issue verbal orders pertaining to patient care.

J. Assess coexisting medical and psychiatric disorders.

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

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

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

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

   1. The consultation is documented in the medical record.

C. Order medications for clients as appropriate.

   1. Only a physician may prescribe buprenorphine.

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

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

E. Revise medications as warranted by client condition.

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

G. Discuss cases with treatment team.

H. Assess coexisting medical and psychiatric disorders.

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

V. Staffing and job responsibilities:

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

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

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

      b. Photograph of client in the MAR for visual comparison

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

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

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

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

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

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

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

      a. The name of the medication

      b. The date the medication was prescribed

      c. The dosage

      d. The frequency

e. The route of administration

f. The date and time of administration

g. The name of the person administering the medication

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

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

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

   b. The name and amount of each product is documented

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

9. Drug reactions and Medication Errors:

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

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

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

   d. The reaction or error is documented on the MAR and in the client record.

   e. The appropriate staff members involved in the administration of buprenorphine are informed about the error and the plans to prevent a similar error from occurring in the future.

B. The clinical staffing ratio for the detox unit is:

   1. 1 licensed nurse (RN or LPN) to every 7 detox clients 24 hours a day

   2. 1 Detox Specialist/Detox tech for every 12 detox clients during primary care hours

   3. 1 RN on call 24 hours a day

   4. 1 Narcotic Treatment Physician on-call at all times

C. Buprenorphine is administered only by order of a physician, after the physician completes a face-to-face determination of current dependence, within established time frames and parameters.

   1. Clonidine detox protocols are initiated upon the arrival if the physician is not on site to perform the initial face-to-face evaluation.

   2. Once current dependence has been determined, buprenorphine may be ordered.

      a. Buprenorphine is initiated per valid order of a physician registered to prescribe buprenorphine.

      b. The standing clonidine protocol is discontinued upon initiation of buprenorphine.

   3. Buprenorphine may not be administered until the client's age and identity have been verified.

   4. Buprenorphine may not be administered until after an initial urine drug screen is collected.

D. A licensed nurse (RN or LPN) is available in the detox area at all times to medicate detox clients as needed.

E. Buprenorphine is administered within 15 minutes of the client arriving at the dispensing station.

VI. Intake and admission

A. The admissions staff will screen each individual for appropriateness prior to admission to the detox program.

1. Information obtained and verified will include, but is not limited to:

a. The individual is at least 18 years of age or older

b. The individual's name, address, date of birth, social security number and any other pertinent identifying information

c. The opiate dependent female client is not currently known to be pregnant

d. A current drug use status is obtained

e. A current medical status and history is obtained

f. An attempt is made to obtain emergency contact, referral contact, Primary Care Physician contact, behavioral healthcare contact and funding contact information.

g. If the client is requesting detoxification from methadone, the daily dosage is verified with the narcotic treatment provider to be no more than 30mg per day, unless reviewed and approved by the Medical Director.

2. If a client was previously discharged from treatment at another narcotic treatment program, the admitting narcotic treatment program, with client authorization and consent, will contact the previous facility for the treatment and dosage history.

3. The admissions staff determines eligibility for admission based on information gathered, utilizing the following criteria:

a. PCPC criteria for non-hospital detoxification

b. Admission criteria

c. Bed availability

4. All information obtained by the admissions staff is documented on the appropriate forms, which include, but are not limited to:

a. The personal data form

b. The pre-admission assessment form

B. The nursing staff completes an initial triage assessment of the client within 1 hour of arrival at the facility.

1. Clonidine protocols are initiated for the opiate dependent client until a physician examines the client and buprenorphine use is approved and ordered.

2. A urine drug screen is obtained and sent to the contracted laboratory for a complete toxicological evaluation.

a. A staff member will accompany the client to the bathroom to ensure that the urine collected is unadulterated.

b. Staff will perform the observational duties in a professional manner that demonstrates respect for the client's rights to privacy, dignity and respect.

c. All urine specimens are handed directly to the staff member, who:

1) Labels the specimen with the client name and number
2) Places the labeled specimen jar in a specimen collection bag
3) Labels the specimen bag with the client's name and number

d. A random urine drug screen may be collected and sent to the contracted laboratory for testing at any time during treatment.

e. A urine or serum drug test may be ordered to screen for any particular substance of abuse that is known to be abused in the local area or is identified in the client's drug and alcohol history as a drug of abuse or use.

f. A body and property search is conducted upon admission to prevent contraband from entering the facility.

3. If a client is assessed to be medically or psychiatrically unstable for admission to the non-hospital detox program, arrangements are made to have the client evaluated at the local hospital ER or Crisis Unit.

C. Verbal orders for short term use of buprenorphine during **urgent** situations **only**:

1. A verbal order for buprenorphine can only be given if the following **three** criteria are met:

a. The client must be physiologically dependent on opioids and experiencing significant withdrawal symptoms that potentially put the client at risk for negative outcomes.

b. The RN/CRNP completing the assessments/instruments concludes that there is no appropriate alternative treatment other than buprenorphine available to adequately stabilize the client. Documentation of the effect of non-opiold medication, such as Clonidine, on the client condition and evaluate the need for opioid medication.

c. There is no significant sedative-hypnotic physical dependence present. If the client is dependent on alcohol or other sedative-hypnotics, such as benzodiazepines, the client must be assessed personally by the physician.

2. The physician approves or disapproves administration of buprenorphine. If a verbal order is given, the physician determines the initial dose. Only a single dose, or a dose divided in two, may be ordered verbally, and the verbal dose may not exceed 8mg.

3. The physician must see the client within 24 hours and sign off on the verbal medication order. The physician must co-sign the various assessments/instruments when he signs the verbal order.

4. The physician must be registered with the DEA to prescribe Buprenorphine.

5. Assessments/Instruments used to determine if client is eligible to receive Buprenorphine to be completed **only** by a Registered Nurse/CRNP. After Completion the RN/CRNP calls the physician and reviews the assessment findings with the physician.

a. Nursing assessment/H&P to include:

1) Documentation of past and current drug dependency
2) Treatment history
3) Drug use status and history
4) Current medications (licit or illicit) that may be contraindicated for Buprenorphine (sedative-hypnotics)
5) Biographical data
6) Medical history including current health and illness
7) Documentation of the psychological support given to the client

b. Clinical Opiate Withdrawal Scale that must be completed and client must be in Mild to Moderate withdrawal.

c. Urine Toxicology results

d. All applicable consent forms are completed and filed in the client record.

D. A nursing assessment is completed within 8 hours of admission to the detox program. This assessment includes, but is not limited to:

1. A complete drug and alcohol history

2. A medical history

3. The client's current and past narcotic dosage level

4. Other drugs prescribed to the client and the reasons for their use

E. A preliminary treatment plan is initiated within 8 hours of admission to the detox program.

F. A history and physical examination is completed by the physician, PA or CRNP within 24 hours of admission to the detox program.

G. The prescribing physician makes a face-to-face determination of current dependency prior to the prescription or administration of any buprenorphine.

1. The physician documents in the client's record the basis for the determination of current dependency.

2. If a PA, CRNP or other physician completes the history and physical evaluation, the prescribing physician will consult with the licensed professional prior to the prescription or administration of any buprenorphine and document the consultation in the medical record.

3. No buprenorphine is administered prior to the completion of a complete history and physical, a face-to-face determination of current dependency and a valid order is obtained except in urgent situations only (see page 8).

VII. Continued stay documentation

A. A licensed nurse writes a progress note every shift while the client is in detox.

B. A detox record of service is completed to reflect treatment services provided to/attended by the client throughout his/her stay.

C. Individual and group therapy notes are completed by the staff member providing those services, to reflect the client's level of participation and progress in treatment.

D. All laboratory-testing results are filed in the client's record.

E. All treatment plans, reviews and updates are documented and included in the record.

1. The treatment plan will outline realistic short and long-term goals, which are mutually acceptable to the client and the treatment staff.

2. The treatment plan will identify the behavioral tasks a patient will perform to complete each short-term goal.

F. A psychosocial evaluation is completed and entered into the client record upon completion of all preliminary evaluations.

G. The results of any psychiatric, psychological or other evaluations are included in the record.

H. Any referrals made to other projects or services are documented in the client record

I. If a client requests Buprenorphine Maintenance treatment while being treated for opiate detoxification and requests discharge to Pyramid OP, the client will meet with the Physician to discuss options. If determined that

the client will discharge to Outpatient Buprenorphine Maintenance, the physician will initiate the transition from Subutex to Suboxone. This will occur prior to discharge to ensure stability. Coordination of care between physicians and Pyramid OP providers will occur.

VIII. Transfer

A. Any client who requests a transfer to another narcotic treatment program for continued detoxification services will be transferred within 7 days of their request.

1. The transfer will be coordinated with the referral and/or funding sources as applicable.

2. All attempts to arrange transfer will be documented in the client record.

B. Information to be provided, with appropriate client authorization and consent, to the receiving treatment program will include:

1. Date of admission

2. Medical summary

3. Psychosocial summary

4. Buprenorphine dosage and schedule

5. Urinalysis and laboratory reports

6. Exception requests

7. Current client status

C. Confidentiality of client records will be maintained in accordance with all state and federal confidentiality regulations.

D. A transfer note is written, including a description of all materials that were sent to the receiving narcotic treatment program.

E. The transferring treatment program will notify the receiving treatment program of the admission and the MAR/client record regarding doses given to the client. This information will be documented in the client record.

IX. Discharge documentation

A. The aftercare plan is completed prior to discharge and is signed by the client and staff member.

1. A copy of the aftercare plan is provided to the client.

2. The original aftercare plan is maintained in the client record.

B. A discharge summary is completed within 48hours of discharge by the Physician, PA or CRNP and is counter-signed by the Medical Director.

C. The licensed nurse writes a transfer note when a client transfers directly from the detox program into the inpatient program in the same facility.

D. Follow-up calls are documented on the aftercare plan and are maintained as a permanent part of the client record.

E. Involuntary termination of treatment will occur when all other efforts to retain the client in the program have failed.

1. A client will be involuntarily discharged if it is deemed that the termination would be in the best interests of the health or safety of the client and others.

2. A client may be involuntarily discharged from the detox program if any of the following conditions exist:

    a. The client has committed or threatened to commit acts of violence in or around the program premises.

    b. The client possessed a controlled substance without a prescription or sold or distributed a controlled substance, in or around the program premises.

    c. The client leaves the program premises without staff accompaniment or approval.

    d. The client has failed to follow treatment plan objectives.

3. If a client is terminated involuntarily, except a client who commits or threatens to commit acts of physical violence, the client will be offered the opportunity to receive detoxification of at least 7 days if appropriate.

    a. The client may be referred to another narcotic treatment program or hospital licensed and approved by the Department for detoxification to complete the detox if appropriate.

    b. The rationale for not providing a referral is documented in the client's file (i.e. if the client committed or threatened to commit violence on the premises).

X. Any grievance filed by a client is documented in the medical record, including the results of the investigation and the final determination.

A. The investigation will allow for the client to be heard, to question, and confront persons and evidence used against them to have a fair review.
B. If the grievance is filed against the narcotic treatment Program Director, the administrative team will conduct the initial investigation.
C. No penalty may be initiated prior to final resolution.
D. The client may, at his or her own expense, seek legal counsel at any time during the treatment process.

XI. Inspection of Medication Storage Areas:

A. Buprenorphine is stored in a double locked designated area.

B. An inspection of the medication storage area is conducted monthly by a representative from the contracted pharmacy and a nursing staff representative.

C. The results of the inspection are documented on the medication area checklist.

1. The inspection form is forwarded to the Director of Nursing/ Assistant Director of Nursing/ Nurse Manager for review and intervention.

2. The Performance Improvement Committee monitors issues and resolution of these issues identified in the monthly inspections.

3. The inspection documentation includes verification that:

    a. Disinfectants and drugs for external use are stored separately from oral or injectable drugs.

    b. Drugs requiring special conditions for storage to insure stability are properly stored.

    c. Outdated and contaminated drugs are removed and destroyed according to Federal and State regulations.

    d. Administration of controlled substances is documented.

    e. Controlled substances and other abusable drugs are stored in accordance with Federal and State regulations.

XII. Loss, theft or misuse of buprenorphine:

A. Any loss, theft, or misuse of buprenorphine, is immediately reported to the Program Director and to the Director of Nursing/ Assistant Director of Nursing/ Nurse Manager so that an appropriate investigation can be initiated.

1. In the event of loss or suspected theft or diversion of buprenorphine:

a. A search of the medication storage area is conducted immediately to determine if there are any obvious breeches to the security system.

b. A search of the facility and facility grounds is conducted if there is suspicion that the buprenorphine may be in the possession of clients, staff or is otherwise hidden on the premises.

c. Staff interviews are conducted as a routine part of the investigation and a review of staff schedules and assignments relative to the time period of the suspected loss or theft is also completed by the Program Director and/or the Director of Nursing/ Assistant Director of Nursing/ Nurse Manager.

d. A review of the narcotic administration records and inventories is conducted to determine the date and time of the suspected loss or theft, the amount of buprenorphine missing, and/or the staff members involved in the security and administration of the buprenorphine during the period of the suspected loss or theft.

e. The local police are notified of any suspected theft or crime against the premises and a police report is filed.

2. In the event that a client has an emesis that contains the buprenorphine, or otherwise spits out or expels the undigested buprenorphine tablet:

a. The presence of the undissolved buprenorphine tablet is verified by a licensed nurse.

b. The licensed nurse disposes of the buprenorphine tablet per facility policy.

1) A second staff member witnesses the disposal of all narcotic medications.

2) The licensed nurse documents the entire incident, including the disposal of the medication in the presence of a staff witness, in the medical record.

c. The physician is contacted and orders are obtained and initiated.

1) No additional buprenorphine is administered unless the initial dose of buprenorphine is obtained, verified and disposed of by a licensed nurse, **and** an order to re-administer the buprenorphine dose is obtained from a physician registered with the DEA to prescribe buprenorphine.

2) If the client has repeated episodes of emesis or inability to tolerate the buprenorphine, the physician is consulted and alternative medications are considered.

3. In the event of an adverse reaction or medication error, follow the procedures as outlined previously in this policy regarding Drug Reactions and Medication Errors.

4. In the event that a client is suspected of cheeking, pocketing or otherwise not ingesting the buprenorphine dose:

a. A body and property search is conducted immediately by facility staff in compliance with facility body and property search policy and procedure.

b. The Program Director/Nurse Manager is contacted immediately and further actions are determined based on the results of the body/property search.

c. Clients who are found to be misusing buprenorphine in any manner may be subject to immediate involuntary discharge from the facility.

d. A police report may be filed and criminal charges may result if a client is found to be diverting buprenorphine to other clients within the facility or from the premises.

B. All loss, theft or misuse of buprenorphine is:

1. Documented on an incident report and is reported to the Safety Committee.

2. Reported to DDAP, Division of Licensing via an unusual incident report as defined in the Incident and Sentinel Event Reporting policy.

C. A root cause analysis is performed within 24 hours to identify areas requiring action to prevent loss, theft or misuse in the future.

D. Action plans are developed, implemented and evaluated for effectiveness based on the findings of the root cause analysis.

XIII. Community Responsiveness

A. The program director of each respective detox program is identified as the community liaison.

B. The community liaison will attend pertinent meetings in the community, respond to questions or concerns brought by community members, evaluate treatment services, design new services, and redesign existing services to meet the needs of the community whenever possible.

C. A Community Outreach plan is developed by each program and updated annually

Pyramid Healthcare Treatment Facilities

POLICY/PROCEDURE

Section:	Provision of Care	**Date Issued:**	1/15/13
Policy Name:	Detox Observation	**Date Reviewed:**	8/13/17
Policy Number:	PHC 2.32	**Date Revised:**	6/22/18

POLICY: Pyramid Healthcare, Inc. will establish parameters and principles for direct observation of clients in the Detox Unit.

A. To ensure client safety, comfort and staff accountability by regularly observing all clients.
B. To note the mental status and behavior of clients.
C. To provide a level of observation which correlate to the levels of client acuity and risk.

SCOPE: The Executive Director and Director of Nursing are responsible for adherence to this policy.

PROCEDURE:

Staff will conduct direct observation rounds observing each client, with notation of whereabouts, at intervals of 30 minutes or less, daily without interruption.

A. Each staff member is responsible for completing direct observation rounds on all clients at their assigned times. The nurse on duty will be responsible for assignments and assuring that client rounds have been completed.
B. At the time of rounds, the staff member is to locate the client face-to-face.
C. While making observation rounds, staff will check the environment for safety and security risks including any unusual client behaviors. Any observation of unusual behaviors or change in the client's physical condition will be reported to the nurse on duty.
D. If staff is unable to complete rounds during their assigned time they must communicate this to nurse and hand off rounds documentation to the nurse on duty.
E. The client's whereabouts will be documented on the Client Observation Form utilizing the legend provided. The staff's initials will be affixed to form with each observation noted.
F. When completed the Client Observation Form will become a permanent part of the client's medical record.
G. Nurse Manager or designee will assure adherence to this policy.

Exhibit 15

Subject: HIV Admission Medication Procedure		
Issued: 6/1/00 Revised: 2.1.17	Policy & Procedures Manual Category: Anchor/Medical	Page 1 of 1

Purpose:
To provide a procedure for admission medications process.

Procedure:

1. On pre-admission, if a client identifies positive HIV testing with medications, the Supervisor/Nurse must be notified prior to admission.

2. With appropriate client release, the Medical Department must contact the Regional HIV manager for Southern Maryland at the Charles County Health Department, if the client is from Charles, St. Mary's, or Calvert County. If the client is not from Charles, St. Mary's, or Calvert County, the client's case manager must be contacted. This must be done prior to admission.

3. An evaluation of Medication/HIV status follow-up meeting must occur with the Supervisor of Anchor ICF, Walden/Sierra, Inc., and the Medical Staff of Anchor prior to admission.

Subject: HIV Procedure		
Issued: 6/1/2000 Revised: 2.1.17	Policies & Procedures Manual Category: Anchor Medical, Northstar, Compass	Page 1 of 1

Purpose:
To provide initial counseling, risk assessment, and referral support for testing, post-test counseling, appropriate treatment and related needs to clients re: HIV/AIDS.

Procedure:

1. Staff will complete an HIV/AIDS Risk Assessment on admission.

2. Staff will see that appropriate linkages with the county Health Department or client's healthcare provider are made for HIV/AIDS testing as appropriate, including tests to diagnose the extent of the deficiency in the immune system and tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease.

3. Staff will refer clients as appropriate to the county Health Department or client's healthcare provider for pre and post-test counseling.

4. Staff will provide referrals, primarily via relationship with the local Health Department, to make available therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease.

5. Staff maintains established linkages with a comprehensive community resource network of related health and social services organizations to ensure a wide-based knowledge of the availability of these services and to facilitate referral.

6. The program ensures that HIV early intervention services are undertaken voluntarily, provided with patients' informed consent, and are not required as a condition of receiving substance abuse treatment or any other services.

7. When medications are needed and with appropriate client release, staff will contact the Regional HIV manager for Southern Maryland at the Charles County Health Department, if the client is from Charles, St. Mary's, or Calvert County. If the client is not from Charles, St. Mary's, or Calvert County, the client's case manager must be contacted. This must be done prior to admission.

SUBJECT: CONFIDENTIALITY: HIV/AIDS RELATED INFORMATION

POLICY: PYRAMID Healthcare, Inc. strictly maintains the confidentiality of all HIV/AIDS-related information.

HIV/AIDS-related information is defined as any information which is in the possession of a person who provides one or more health or social services or who obtains the information pursuant to a release of confidential HIV/AIDS-related information and which concerns whether an individual:

1. Has been the subject of an HIV-related test
2. Is HIV positive
3. Has HIV-related illness
4. Has AIDS
5. Or any of the information which identifies or reasonably could identify a person as having one or more of these conditions, including information pertaining to the individual's contacts

PROCEDURE:

I. HIV/AIDS-related information is only disclosed to the following persons:

A. The client

B. The physician who ordered the test, or the physician designee

C. Any persons specifically designated in a written authorization and consent

1. Every disclosure made pursuant to a written release is accompanied by a written statement detailing the limitations of the release

D. Medical staff members of a health care provider that have already received confidential HIV/AIDS-related information provided they are currently involved in the medical care of the client.

E. Federal or State government agencies with oversight responsibilities over health care providers.

F. Health care providers providing emergency care to the client when the information is necessary to provide that care.

G. An insurer, to the extent necessary to reimburse health care providers or to make any payment of a claim submitted to an insured person's policy.

H. The Commonwealth Department of Health and persons authorized to collect vital statistics

I. The Commonwealth Department of Health and local boards and departments of health authorized to collect information pursuant to the Disease and Prevention Law.

J. Persons granted access pursuant to a court order.

- **If a court order requesting HIV/AIDS-related information is received, consult legal counsel before disclosing information, as there are prerequisites to the release of such information.**
- **Release the information only upon direction of legal counsel.**

K. Funeral Directors

L. Employees of county mental health agencies, county children and youth agencies, county juvenile probation departments, county or state facilities for delinquent youth, and contracted residential providers for the above named entities receiving or contemplating residential placement of a minor consumer who:

1. Generally are authorized to receive medical information

2. Are responsible for ensuring that the minor consumer receives proper health care.

3. Have a need to know HIV/AIDS-related information in order to ensure such care is given

- The above named entities may release the information to a court in the course of a dispositional proceeding under 42 PA C.S. §6351 (relating to the dispositions of a child) and §6352 (relating to the disposition of a delinquent child) when it is determined that such information is necessary to meet the medical needs of the minor client.

II. Re-disclosure of confidential HIV/AIDS-related information is generally prohibited unless a written consent is obtained or the above provisions authorize the release.

III. Every disclosure of HIV/AIDS-related information includes a statement regarding the prohibition of re-disclosure of the information.

IV. HIV/AIDS-related information is released when a separate authorization and consent for the release of HIV/AIDS-related information is signed and maintained in the clients file.

A. In order to release the information the authorization/consent must:

1. Cover the information requested
2. Be current

B. The authorization/consent contains the following information:

1. The client's name
2. The name of the person, agency, or organization to whom the disclosure will be made
3. The specific information requested
4. The purpose of the disclosure
5. Dated signature of the client or the legal guardian (if necessary)
6. The expiration of the consent
7. The name of the program disclosing the information
8. Revocation statement
9. Written notice of prohibition of re-disclosure

V. If the information requested is for the purpose of a medical emergency, the following is done immediately:

A. Any person seeking information will identify themselves and provide proof of status as a person who can obtain information without a signed release or court order:

- For example: obtain a badge number if a police officer is requesting the information.

B. Provide only the information necessary to alleviate an emergency

C. Immediately document in the file what information was provided, to whom, and why.

D. Notify the client as soon as possible that the information was released

VI. If a subpoena is received requesting confidential HIV/AIDS-related information:

A. Fax a copy of the subpoena to the corporate office and obtain legal counsel.

B. Do not release any information until directed to do so by legal counsel.

C. Notify the client that the confidential information has been subpoenaed.

VII. If a court order is received directing that confidential HIV/AIDS-related information be released:

A. Fax a copy of the court order to the corporate office and obtain legal counsel.

B. Do not release any information until directed to do so by legal counsel.

Exhibit 16

TABLE E. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY				FY'23 (March-June)	FY'24	FY'25				
1. DISCHARGES										
a. Residential				65	715	742				
b. III.7 and III.7D				39	433	450				
c. Other (Specify)										
TOTAL DISCHARGES	***0***	***0***	***0***	***104***	***1,148***	***1,191***	***0***	***0***	***0***	***0***
2. PATIENT DAYS										
a. Residental				1,838	20,315	21,060				
b. III.7 and III.7D				788	8,697	9,041				
c. Other (Specify)										
TOTAL PATIENT DAYS	***0***	***0***	***0***	***2,626***	***29,012***	***30,101***	***0***	***0***	***0***	***0***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. Residental	#DIV/0!	#DIV/0!	#DIV/0!	28.4	28.4	28.4	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. III.7 and III.7D	#DIV/0!	#DIV/0!	#DIV/0!	20.1	20.1	20.1	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Other (Specify)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	#DIV/0!	#DIV/0!	#DIV/0!	25.3	25.3	25.3	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
4. NUMBER OF LICENSED BEDS										
f. Rehabilitation				20	20	20				
g. Comprehensive Care				80	80	80				
h. Other (Specify)										
TOTAL LICENSED BEDS	***0***	***0***	***0***	***100***	***100***	***100***	***0***	***0***	***0***	***0***
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. Residential	#DIV/0!	#DIV/0!	#DIV/0!	85.0%	85.0%	85.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. III.7 and III.7D	#DIV/0!	#DIV/0!	#DIV/0!	85.0%	85.0%	85.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Other (Specify)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	***#DIV/0!***	***#DIV/0!***	***#DIV/0!***	***7.2%***	***79.5%***	***82.5%***	***#DIV/0!***	***#DIV/0!***	***#DIV/0!***	***#DIV/0!***
6. OUTPATIENT VISITS										
a. Residential										
b. III.7 and III.7D										
c. Other (Specify)										
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***

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

Exhibit 17

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

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table F should reflect current dollars (no 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 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 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 gen revenues over total expenses consistent with the Financial Feasibility standard.

Indicate CY or FY	FY'23 (March to June'23)	FY'24	FY'25			
1. REVENUE						
a. Inpatient Services	$ 814,013	$ 8,992,777	$ 9,357,371			
b. Outpatient Services						
Gross Patient Service Revenues	***$ 814,013***	***$ 8,992,777***	***$ 9,357,371***	$ -	$ -	$ -
c. Allowance For Bad Debt	$ 40,701	$ 449,639	$ 467,869			
d. Contractual Allowance						
e. Charity Care						
Net Patient Services Revenue	***$ 773,312***	***$ 8,543,138***	***$ 8,889,502***	$ -	$ -	$ -
f. Other Operating Revenues (Specify)						
NET OPERATING REVENUE	***$ 773,312***	***$ 8,543,138***	***$ 8,889,502***	$ -	$ -	$ -
2. EXPENSES						
a. Salaries & Wages (including benefits)	$ 901,716	$ 5,304,403	$ 5,394,000			
b. Contractual Services	$ 12,000	$ 100,000	$ 39,000			
c. Interest on Current Debt						
d. Interest on Project Debt						
e. Current Depreciation						
f. Project Depreciation	$ 119,612	$ 358,836	$ 358,836			
g. Current Amortization						
h. Project Amortization						
i. Supplies	$ 16,280	$ 179,856	$ 187,147			
j. Other Expenses (Specify)	$ 328,126	$ 1,942,623	$ 1,994,077			
TOTAL OPERATING EXPENSES	***$ 1,377,735***	***$ 7,885,717***	***$ 7,973,060***	$ -	$ -	$ -
3. INCOME						
a. Income From Operation	$ (604,422.75)	$ 657,421.53	$ 916,442.24	$ -	$ -	$ -
b. Non-Operating Income						
SUBTOTAL	***$ (604,422.75)***	***$ 657,421.53***	***$ 916,442.24***	$ -	$ -	$ -
c. Income Taxes	$ (207,549.00)	$ 117,148.00	$ 192,874.00			
NET INCOME (LOSS)	***$ (396,873.75)***	***$ 540,273.53***	***$ 723,568.24***	$ -	$ -	$ -
4. PATIENT MIX						
a. Percent of Total Revenue						
1) Medicare						
2) Medicaid	85.0%	85.0%	85.0%			
3) Blue Cross						
4) Commercial Insurance	12.0%	12.0%	12.0%			
5) Self-pay	3.0%	3.0%	3.0%			

Exhibit 18

TABLE G. WORKFORCE INFORMATION

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

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table D, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table D)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Program Director			$0	1.0	$120,000	$120,000			$0	1.0	$120,000
Clinical Director			$0	1.0	$90,000	$90,000			$0	1.0	$90,000
Medical Director			$0	0.2	$250,000	$50,000			$0	0.2	$50,000
			$0			$0			$0	0.0	$0
Total Administration			$0	2.2	$460,000	$260,000			$0	2.2	$260,000
Direct Care Staff *(List general categories, add rows if needed)*											
Behavioral Technician			$0	33.0	$31,200	$1,029,600			$0	33.0	$1,029,600
Behavioral Technician Supervisor			$0	4.0	$40,000	$160,000			$0	4.0	$160,000
RN			$0	7.0	$73,000	$511,000			$0	7.0	$511,000
LPN			$0	11.0	$58,000	$638,000			$0	11.0	$638,000
Counselor			$0	11.0	$55,000	$605,000			$0	11.0	$605,000
Clinical Supervisor			$0	2.0	$80,000	$160,000			$0	2.0	$160,000
CRNP			$0	2.0	$130,000	$260,000			$0	2.0	$260,000
Total Direct Care			$0	70.0	$467,200	$3,363,600			$0	70.0	$3,363,600
Support Staff *(List general categories, add rows if needed)*											
Administrative Assistant			$0	3.0	$31,200	$93,600			$0	3.0	$93,600
Case Managers			$0	4.0	$40,000	$160,000			$0	4.0	$160,000
Maintenance/Kitchen			$0	10.0	$40,000	$400,000			$0	10.0	$400,000
			$0			$0			$0	0.0	$0
Total Support			$0			$0			$0	0.0	$0
REGULAR EMPLOYEES TOTAL			$0	***17.0***	***$111,200***	$653,600			$0	17.0	$653,600
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff			$0			$0			$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL			$0			$0			$0	0.0	$0
Benefits *(State method of calculating benefits below):*											
TOTAL COST	***0.0***		***$0***	***89.2***		***$4,277,200***	***0.0***		***$0***		***$4,277,200***

Exhibit 19

Clearview Pyramid Acquisition Company, LLC

Independent Auditor's Report and Consolidated Financial Statements

June 30, 2020 and 2019

Clearview Pyramid Acquisition Company, LLC

June 30, 2020 and 2019

Contents

BKD
CPAs & Advisors

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Independent Auditor's Report

Board of Directors
Clearview Pyramid Acquisition Company, LLC
Altoona, Pennsylvania

We have audited the accompanying consolidated financial statements of Clearview Pyramid Acquisition Company, LLC and its subsidiaries, which comprise the consolidated balance sheets as of June 30, 2020 and 2019, and the related consolidated statements of operations, members' equity and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Clearview Pyramid Acquisition Company, LLC and its subsidiaries as of June 30, 2020 and 2019, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidated information listed in the table of contents is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

BKD, LLP

Indianapolis, Indiana
October 12, 2020

Clearview Pyramid Acquisition Company, LLC

Consolidated Balance Sheets
June 30, 2020 and 2019

Assets

	2020	2019
Current Assets		
Cash	$ 28,493,887	$ 1,769,807
Patient accounts receivable, net of allowance of $10,133,230 and $6,666,936, respectively	12,[illegible]139	17,187,213
Other receivables	[illegible]440	381,531
Refundable income taxes	[illegible]967	137,154
Prepaids and other current assets	[illegible]018,20[illegible]	553,581
Total current assets	43,014,[illegible]	20,029,286
Property and Equipment, net	[illegible]972	59,963,368
Other Assets		
Goodwill, net	24,[illegible]917	24,245,077
Other intangible assets, net	[illegible]	25,369,751
Other long-term assets	[illegible]784	787,297
Total other assets	[illegible]176,956	50,402,125
Total assets	$ 159,189,561	$ 130,394,779

Liabilities and Members' Equity

Current Liabilities		
Current maturities of long-term debt	$ 2,774,195	$ 2,926,450
Accounts payable	6,498,671	2,599,090
Advanced payments from third-party payers	4,402,734	-
Accrued expenses	15,067,986	16,794,237
Total current liabilities	28,743,586	22,319,777
Long-Term Liabilities		
Paycheck Protection Program term loans	15,915,900	-
Long-term debt	125,369,673	111,057,245
Deferred employer payroll expenses	1,847,482	-
	143,133,055	111,057,245
Members' Equity		
Members' capital	34,893,044	34,893,044
Accumulated deficit	(48,044,664)	(37,943,963)
Total Clearview Pyramid Acquisition Company, LLC members' equity	(13,151,620)	(3,050,919)
Noncontrolling interest (deficit)	464,540	68,676
Total members' equity (deficit)	(12,687,080)	(2,982,243)
Total liabilities and members' equity	$ 159,189,561	$ 130,394,779

Clearview Pyramid Acquisition Company, LLC

Consolidated Statements of Operations
Years Ended June 30, 2020 and 2019

	2020	2019
Revenues		
Patient service revenue, net of allowances and contractual adjustments	$ 205,815,224	$ 190,234,053
Provision for uncollectible accounts, net of recoveries and adjustments	(14,856,878)	(18,187,994)
Net patient service revenue, less provision for uncollectible accounts	190,958,346	172,046,059
Operating Expenses		
Salaries	103,709,238	94,146,845
Employee benefits	20,151,068	19,546,961
Purchased services and professional fees	16,085,378	15,197,921
Food, clothing, drugs and supplies	8,599,612	7,396,744
Property leases and other rentals	7,947,368	7,982,528
Repairs and maintenance	1,426,652	1,768,905
Utilities	4,800,439	4,592,078
Travel	3,056,667	3,157,676
Insurance	2,414,603	1,043,114
Property and local taxes	951,445	959,306
Depreciation and amortization	13,176,535	12,834,163
Loss on disposal of property and equipment	362,244	234,652
Other operating expenses	7,216,917	5,025,779
Total operating expenses	189,278,356	173,886,672
Operating Income (Loss)	1,679,990	(1,840,613)
Other Income (Expense)		
Interest expense	(11,194,175)	(10,311,349)
Other	14,649	179,915
Total other expense	(11,179,526)	(10,131,434)
Loss Before Income Taxes	(9,499,536)	(11,972,047)
Income Tax Expense	205,301	197,436
Net Loss	(9,704,837)	(12,169,483)
Less: Net Income (Loss) Attributable to Noncontrolling Interests	395,864	(172,498)
Net Loss Attributable to Clearview Pyramid Acquisition Company, LLC	$ (10,100,701)	$ (11,996,985)

Clearview Pyramid Acquisition Company, LLC

Consolidated Statements of Members' Equity
Years Ended June 30, 2020 and 2019

	Total	Clearview Pyramid Acquisition Company, LLC		Noncontrolling Interests
		Members' Capital	Accumulated Deficit	
Balance July 1, 2019	$ 10,438,356	$ 36,069,172	$ (25,946,278)	$ 316,162
Distribution	(1,251,116)	(1,176,128)		(74,988)
Net loss	(12,169,483)		(11,996,985)	(172,498)
Balance June 30, 2019	(2,982,243)	34,893,044	(37,943,263)	68,676
Net loss	(9,704,837)		(10,100,701)	395,864
Balance June 30, 2020	$ (12,687,080)	$ 34,893,044	$ (48,044,664)	$ 464,540

Clearview Pyramid Acquisition Company, LLC

Consolidated Statements of Cash Flows
Years Ended June 30, 2020 and 2019

	2020	2019
Operating Activities		
Net loss	$ (9,704,837)	$ (12,169,483)
Items not requiring (providing) cash		
Depreciation	7,084,347	6,507,280
Amortization of intangible assets and goodwill	6,899,358	6,326,883
Amortization of deferred finance cost - (interest expense)	706,428	979,428
(Gain) loss on disposal of property and equipment	362,244	234,652
Gain on capital leases upon termination	(31,644)	(41,017)
Provision for uncollectible accounts, net of recoveries and adjustments	14,856,878	18,187,994
Changes in		
Patient accounts receivable	(10,891,884)	(20,299,393)
Advance claim payments from insurance payers	4,402,734	-
Other receivables	73,091	(34,731)
Accounts payable and other payables	4,615,391	(361,299)
Prepaids and other assets	(377,080)	(213,240)
Accrued expenses	116,471	4,267,954
Refundable income taxes	(124,813)	271,299
Net cash provided by operating activities	17,456,594	3,656,327
Investing Activities		
Purchase of property and equipment	(12,445,372)	(11,395,556)
Cash paid for business acquisition, net of cash acquired	(7,200,000)	(10,196,121)
Net cash used in investing activities	(19,645,372)	(21,591,677)
Financing Activities		
Change in checks outstanding in excess of bank balance	-	(507,158)
Proceeds from issuance of senior debt	16,000,000	23,350,000
Proceeds from issuance of Paycheck Protection Program term loans	15,915,900	-
Finance cost paid	(322,710)	(420,570)
Principal payments on senior debt	(1,264,744)	(1,034,622)
Principal payments on installment sale note payable	-	(76,310)
Principal payments on capital lease	(1,415,590)	(1,408,426)
Borrowings under line of credit agreement	8,227,750	10,500,000
Repayments under line of credit agreement	(8,227,750)	(12,500,000)
Distribution	-	(1,251,116)
Net cash provided by financing activities	28,912,856	16,651,798
Increase (Decrease) in Cash	26,724,078	(1,283,552)
Cash, Beginning of Year	1,769,807	3,053,359
Cash, End of Year	$ 28,493,885	$ 1,769,807
Supplemental Cash Flows Information		
Interest paid, net of capitalized interest	$ 10,260,358	$ 10,367,893
Interest paid, capitalized within property and equipment	413,586	582,361
Income taxes paid, net of refunds	332,257	(99,232)
Capital asset acquisitions in accounts payable	-	715,810
Capital asset acquisition through capital lease	491,433	325,852

Clearview Pyramid Acquisition Company, LLC

Notes to Consolidated Financial Statements
June 30, 2020 and 2019

Note 1: Nature of Operations and Summary of Significant Accounting Policies

Nature of Operations

Clearview Pyramid Acquisition Company, LLC (Company or Parent) was formed on May 2, 2011 for the purpose of effecting the acquisition of Pyramid Healthcare, Inc. (Pyramid). The Parent and operating subsidiaries are collectively referred to as the "Company." The acquisition was led by the Parent's primary investor, Clearview Capital, L.P. and affiliates (Clearview).

The Company is based in Altoona, Pennsylvania and King of Prussia, Pennsylvania with operations throughout Pennsylvania, New Jersey, North Carolina, Maryland and Georgia. The Company provides drug and alcohol inpatient and outpatient treatment programs for adults and adolescents and other mental health services. The Company contracts with commercial insurance payers and, in certain markets, contracts with state and county authorities in addition to managed care behavioral health medical assistance organizations (Medicaid).

Pyramid Healthcare, Inc. acquired 100% of the stock of October Road, Inc. on April 30, 2012 and acquired 100% of the membership units of American Day CD Centers, LLC (High Focus Centers) on October 1, 2012. In 2014, Pyramid contributed capital for a 97% ownership in Foundations Medical Services, LLC (Foundations) of which it previously held a minority interest. Pyramid acquired 100% of the stock of Onward Behavioral Health, Inc. (Onward) on May 1, 2014. On December 9, 2013, Parent formed Silvermist, LLC and contributed capital for a 94% ownership. On July 3, 2015, Parent formed Twelve Oaks Holdings, LLC (Silver Ridge) and holds 94% ownership. Pyramid acquired 100% of the outstanding stock ownership of Real Recovery of Asheville, Inc. (effective March 23, 2016), Mazzitti & Sullivan Counseling Services, Inc. (effective April 21, 2016), Quest Services, Inc. (effective May 2, 2016) and Meadow Haven Recovery Services, LLC (Tapestry - effective June 30, 2017) in separate acquisitions. Pyramid acquired 100% of the membership interests in Meadow Haven Recovery Services, LLC (Tapestry) effective June 30, 2017. On October 12, 2018, Pyramid acquired the assets of Walden/Sierra Corporation (Pyramid Walden, LLC). On October 4, 2019, Pyramid acquired the equity units of Aspen Investment Group, LLC (D/B/A Freedom Detox). The results of operations include the acquired entities from the date of acquisition.

Limited Liability Company

Clearview Pyramid Acquisition Company, LLC was formed as a limited liability company. Each member's interest in the Company is divided into and represented by Class A and Class B units. Voting rights are held only by Class A unit holders. Class B units that were granted to employees vest over a three to four year period from the date of grant. Class A units are entitled to a preference in the allocation and distribution of profits in the amount of their unrecovered capital. Profit allocation and distributions to Class B unit holders is pro-rata with Class A unit holders once the capital component assigned to such Class B units has been satisfied as a result of reduced distributions.

The capital component amount of the Class B units issued during July 2011 varies with respect to the tranche the units were issued according to the limited liability company agreement, with per unit minimums that range from 15% to 75% of the Class A unit capital contributions. All other Class B units have a capital component equal to fair value as determined by the board of directors at issuance. All members' equity and accumulated deficit amounts are allocated to Class A unit holders. The personal liability of a member is limited to the amount of the member's capital contribution, less any distributions.

The operating agreement includes certain restrictions on the transfer and sale of the member units including drag along and tag along rights. In addition, certain members have preemptive rights to purchase additional member units under certain instances. The operating agreement has no termination date.

Principles of Consolidation

The consolidated financial statements include the accounts of the Company, its wholly-owned subsidiaries, Pyramid Healthcare, Inc.; American Day CD Centers, LLC; October Road, Inc.; Onward Behavioral Health, Inc.; Real Recovery of Asheville, Inc.; Mazzitti & Sullivan Counseling Services, Inc.; Quest Services, Inc.; Meadow Haven Recovery Services, LLC; Pyramid Family Behavior Healthcare, Inc.; Pyramid Walden, LLC; Aspen Investment Group, LLC; and its majority-owned subsidiaries, Foundations Medical Services, LLC; Silvermist, LLC; and Twelve Oaks Holdings, LLC. All significant intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Noncontrolling Interest

Noncontrolling interest represents the minority ownership interest in Foundations (43%), Silvermist (6%), and Silver Ridge (6%), that the Company does not own. Losses attributable to the noncontrolling interest are allocated to the noncontrolling interest even if the carrying amount of the noncontrolling interest is reduced below zero.

Cash

At June 30, 2020, the Company's cash accounts exceeded federally insured limits by approximately $24,162,000.

Net Patient Service Revenue

The Company has agreements with third-party payers that provide for payments to the Company at amounts different from its established rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payers and others for services rendered and includes estimated retroactive revenue adjustments. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered and such estimated amounts are revised in future periods as adjustments become known.

Patient Accounts Receivable

Accounts receivable are reduced by an allowance for doubtful accounts and allowances for contractual adjustments with third-party payers. In evaluating the collectability of accounts receivable, the Company analyzes its past history and identifies trends for each of its major payer sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for uncollectible accounts. Management regularly reviews data about these major payer sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts.

For receivables associated with services provided to patients who have third-party coverage, the Company analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for uncollectible accounts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payer has not yet paid, or for payers who are known to be having financial difficulties that make the realization of the full amounts due unlikely).

For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Company records a significant provision for uncollectible accounts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated or provided by policy) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The Company's allowance for doubtful accounts and adjustments for both insured and self-pay patients was $10,133,230 and $6,666,936 at June 30, 2020 and 2019, respectively. This change was the result of changes in volumes and timing of write-offs.

Property and Equipment

Property and equipment acquisitions are stated at cost, less accumulated depreciation and amortization. Depreciation and amortization are charged to expense on the straight-line basis over the estimated useful life of each asset. Assets under capital lease obligations and leasehold improvements are amortized over the shorter of the lease term or their respective estimated useful lives.

The estimated useful lives for each major depreciable classification of property and equipment are as follows:

Buildings and improvements	27-30 years
Leasehold improvements	5-15 years
Equipment and vehicles	3-10 years
Furniture and fixtures	5-10 years
Software	3 years

The Company capitalizes interest costs as a component of construction in progress, based on the rates paid for long-term borrowing. The following table summarizes capitalized interest in 2020 and 2019. Interest expense in the table below does not include amortization of deferred financing fees, which is included in interest expense and was $708,428 and $979,428 in 2020 and 2019, respectively.

	2020	2019
Total interest incurred	$ 10,904,333	$ 9,914,282
Capitalized interest	(413,586)	(582,361)
Interest expensed	$ 10,490,747	$ 9,331,921

Goodwill

The Company has elected the private company accounting alternative for the subsequent measurement of goodwill. Under this alternative, goodwill is amortized on a straight-line basis over ten years. Amortization of goodwill totaled $4,720,892 and $4,146,549 in 2020 and 2019, respectively.

The Company evaluates the recoverability of the carrying value of goodwill at the entity level whenever events or circumstances indicate the carrying amount may not be recoverable. In testing goodwill for impairment, the Company has the option first to perform a qualitative assessment to determine whether it is more likely than not that goodwill is impaired or the entity can bypass the qualitative assessment and proceed directly to the quantitative test by comparing the carrying amount, including goodwill, of the entity with its fair value. The goodwill impairment loss, if any, is measured as the amount by which the carrying amount of the reporting unit, including goodwill, exceeds its fair value. Subsequent increases in goodwill value are not recognized in the consolidated financial statements.

The Company also elected the private company accounting alternative provided for identifiable intangible assets in a business combination. Under this alternative, certain customer-related intangible assets and noncompetition agreements are subsumed into goodwill and are no longer required to be recognized separately in the accounting for a business combination.

Other Intangible Assets

The Company has other intangible assets including noncompete agreements, payer contracts, network patient referrals and other intangibles. Amortization for these items is computed using the straight-line method with lives ranging from 2 to 20 years. Such assets are periodically evaluated as to the recoverability of their carrying values.

Trade names and licenses associated with Pyramid and its subsidiaries have indefinite lives. These intangible assets are evaluated annually for impairment or more frequently if impairment indicators are present. A qualitative assessment is performed to determine whether the existence of events or circumstances leads to a determination that it is more likely than not the fair value of the indefinite-lived intangible asset is less than the carrying amount. If, based on the evaluation, it is determined to be more likely than not that the fair value is less than the carrying value, then the indefinite-lived intangible asset is tested further for impairment. If the implied fair value of the indefinite-lived intangible asset is lower than its carrying amount, an impairment loss is recognized for the difference. Subsequent increases in the indefinite-lived intangible asset values are not recognized in the consolidated financial statements.

Long-Lived Asset Impairment

The Company evaluates the recoverability of the carrying value of long-lived assets whenever events or circumstances indicate the carrying amount may not be recoverable. If a long-lived asset is tested for recoverability and the undiscounted estimated future cash flows expected to result from the use and eventual disposition of the asset is less than the carrying amount of the asset, the asset cost is adjusted to fair value and an impairment loss is recognized as the amount by which the carrying amount of a long-lived asset exceeds its fair value.

No material asset impairment was recognized during the years ended June 30, 2020 and 2019.

Income Taxes and Uncertain Tax Positions

The Parent is not directly subject to income taxes under the provisions of the Internal Revenue Code and applicable state laws. Taxable income or loss is allocated to its members in accordance with their respective percentage ownership for inclusion in their respective tax returns.

The Parent's wholly owned subsidiary, Pyramid Healthcare, Inc., is subject to federal and state income taxes. Deferred tax assets and liabilities are recognized for the tax effects of differences between the financial statements and tax basis of assets and liabilities of the subsidiary. A valuation allowance is established to reduce deferred tax assets if it is more likely than not that a deferred tax asset will not be realized.

The Company recognizes the benefit or expense of an uncertain tax position in accordance with the Financial Accounting Standards Board Accounting Standards Codification (ASC) Topic 740, *Income Taxes*, after considering if it is more likely than not, based on the technical merits, that a tax position will be realized and sustained upon examination. For tax positions meeting a "more-likely-than-not" threshold, the amount recognized in the consolidated financial statements is the largest amount expected to be realized upon settlement with the tax authority. The Company's income tax returns filed subsequent to 2016 are still subject to federal and state examinations by tax authorities. As of June 30, 2020, the Company had no material uncertain tax positions.

Self Insurance

The Company has elected to self-insure certain costs related to employee health benefit programs. Costs resulting from noninsured losses are charged to income when incurred, as the Company accrues for incurred but not reported claims. The Company has purchased insurance that limits its exposure for individual claims to $200,000 per occurrence, with no cap per person per plan year.

Liquidity and Going Concern

As discussed in Note 8, the Company's credit agreement governing the revolving line of credit, senior and delayed draw term loans matured on August 22, 2020. Management has addressed this condition and has amended the credit facility on comparable terms with a new maturity date of August 21, 2022.

Note 2: Net Patient Service Revenue

The Company recognizes patient service revenue associated with services provided to patients who have third-party payer coverage on the basis of contractual rates or historical collection history for the services rendered. For uninsured patients that do not qualify for hardship discounts, the Company recognizes revenue on the basis of its standard charges for services provided and amounts expected to be paid in exchange for providing patient care. The Company records a significant provision for uncollectible amounts related to these patients and patient co-pays and deductibles for patients with third-party coverage in the period the services are provided. This provision for uncollectible accounts is presented on the statements of operations as a negative component of net patient service revenue.

The Company has agreements with third-party payers that provide for payments to the Company at amounts different from its established rates. These payment arrangements include:

Medicaid

Services rendered to Medicaid program beneficiaries are reimbursed at established rates based on the type of service provided. Laws and regulations governing Medicaid programs are complex and subject to interpretation and change. As a result, it is reasonably possible that recorded estimates could change materially in the near term.

County and Other Government Funding

The Company is contracted through certain counties and state-sponsored government agencies to provide services to eligible individuals. The Company is reimbursed by the various agencies at contracted rates.

Other Third-Party Payers

The Company has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations and preferred provider organizations. The basis for payment to the Company under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

Patient service revenue, net of contractual allowances and discounts but before the provision for uncollectible accounts recognized in the years ended June 30, 2020 and 2019 was:

	2020	2019
Medicaid	$ 97,386,645	$ 88,191,365
County and other government funding	12,127,881	12,093,299
Other third-party payers	85,110,453	82,006,310
Self-pay and other	11,190,245	7,943,079
	$ 205,815,224	$ 190,234,053

The following is a summary of net patient service revenue for 2020 and 2019:

	2020	2019
Gross patient service revenue	$ 619,666,200	$ 541,367,629
Deductions from revenue		
Contractual allowance and adjustments	(413,850,976)	(351,133,576)
Provision for uncollectible accounts, net of recoveries and adjustments	(14,856,878)	(18,187,994)
Total deductions from revenue	(428,707,854)	(369,321,570)
Net patient service revenue, less provision for uncollectible accounts	$ 190,958,346	$ 172,046,059

Note 3: Concentration of Credit Risk

The Company grants credit without collateral to its patients, of which many are insured under third-party payer agreements. The mix of net receivables from patients and third-party payers at June 30, 2020 and 2019, is:

	2020	2019
Medicaid	30%	20%
County and other government funding	15%	11%
Other third-party payers	46%	60%
Self-pay and patient co-pays and deductibles	9%	9%
	100%	100%

Note 4: Business Combinations

The Company acquired 100% of the outstanding equity units of Aspen Investment Group, LLC (d/b/a Freedom Detox) and certain real estate assets held by Bluebrooke, LLC, a majority owned subsidiary of Freedom (collectively "Freedom" or "Sellers" or "the business"), effective October 4, 2019. The Company paid $7,300,000 in cash consideration for the business. The Company executed the acquisition as part of the overall investment strategy of the Company and its investor group, which considered several factors, including industry growth and market presence. Under the terms of the purchase agreement, the Sellers were entitled to all closing date accounts receivable balances collected for 180 days after the closing and the Sellers were, also, responsible for the payment of most liabilities incurred as of the closing date.

In connection with the purchases, the Company incurred purchase transaction costs of approximately $170,000, which were expensed and included in other operating expenses during the year ended June 30, 2020. Approximately $126,000 of the transaction expense were paid to related parties. The operations of Freedom have been included in the 2020 consolidated financial statements from the acquisition date.

The Company previously adopted the alternative accounting for business combinations provided in ASU 2014-18, *Business Combinations (Topic 805): Accounting for Identifiable Intangible Assets in a Business Combination*. Under this guidance, the Company does not recognize apart from goodwill the intangible assets related to certain customers and non-competition agreements. The consideration paid for the goodwill was primarily attributable to the expected future cash flows and growth of the business. Goodwill is deductible for income tax purposes.

The following table summarizes the consideration paid in addition to the assets acquired and liabilities assumed at the acquisition date.

Fair Value of Consideration	
Cash paid to sellers	$ 7,300,000
Recognized Amounts of Identifiable Assets Acquired	
Assets Acquired	
Cash	100,000
Property and equipment	2,260,000
Other assets	3,028
Total assets	2,363,028
Liabilities Assumed - accrued expenses	14,760
Net Assets Acquired	2,348,268
Goodwill	$ 4,951,732

The Company acquired certain assets of Walden/Sierra Corporation and Walden Property, LLC (Collectively Walden) effective October 12, 2018. The Company paid approximately $10,674,000 in consideration for the business assets. The Company executed the acquisition as part of the overall investment strategy of the Company and its investor group, which considered several factors including industry growth and market presence. In connection with the purchases, the Company incurred purchase transaction costs of approximately $285,000, which were expensed and included in other operating expenses during the year ended June 30, 2019. Approximately $184,000 of the transaction expense were paid to related parties. The operations of Walden have been included in the consolidated financial statements from the acquisition date.

The consideration paid for the goodwill was primarily attributable to the expected future cash flows and growth of the business. Goodwill for this is deductible for income tax purposes.

The following table summarizes the consideration paid in addition to the assets acquired and liabilities assumed at the acquisition date.

Fair Value of Consideration	
Cash paid to sellers	$ 10,196,121
Estimated purchase price adjustment due to sellers	477,596
Total	10,673,717
Recognized Amounts of Identifiable Assets Acquired and Liabilities Assumed	
Assets Acquired	
Accounts receivable	358,742
Property and equipment	5,011,771
Other assets	7,811
Total assets	5,378,324
Liabilities Assumed	(11,402)
Total identifiable net assets	5,366,922
Goodwill	$ 5,306,795

The fair value of the accounts receivable includes gross amounts of approximately $458,000 of which $100,000 was expected to be uncollectible.

Note 5: Property and Equipment

Property and equipment consist of the following at June 30, 2020 and 2019:

	2020	2019
Land	$ 3,219,450	$ 2,692,850
Buildings and leasehold improvements	63,264,009	53,139,004
Equipment, vehicles and software	19,863,498	17,846,893
Furniture and fixtures	1,098,200	699,448
Construction in progress	2,876,051	2,678,221
Total cost	90,321,208	77,056,416
Accumulated depreciation	(23,323,236)	(17,093,048)
Total	$ 66,997,972	$ 59,963,368

Note 6: Goodwill and Other Intangible Assets

The carrying basis and accumulated amortization of recognized goodwill and other intangible assets at June 30, 2020 and 2019 were:

	2020			
	Amortization Period (Years)	Gross Carrying Amount	Accumulated Amortization	Net Carrying Value
Amortized intangible assets				
Network patient referrals	10 - 20	$ 25,090,000	$ (10,592,745)	$ 14,497,255
Payer contracts	4 - 5	13,160,000	(13,160,000)	-
Noncompete agreement	3 - 5	930,000	(930,000)	-
Licenses and certifications	2 - 3	354,000	(354,000)	-
Goodwill	10	47,299,455	(23,523,538)	24,475,917
		$ 87,333,455	$ (48,560,283)	$ 38,973,172
Unamortized intangible assets				
Trade names		$ 5,955,000	$ -	$ 5,955,000
Licenses and providers numbers		3,546,000	-	3,546,000
		$ 9,501,000	$ -	$ 9,501,000

	2019			
	Amortization Period (Years)	Gross Carrying Amount	Accumulated Amortization	Net Carrying Value
Amortized intangible assets				
Network patient referrals	10 - 20	$ 25,090,000	$ (9,221,249)	$ 15,868,751
Payer contracts	4 - 5	13,160,000	(13,160,000)	-
Noncompete agreement	3 - 5	930,000	(930,000)	-
Licenses and certifications	2 - 3	354,000	(354,000)	-
Goodwill	10	43,047,723	(18,802,646)	24,245,077
		$ 82,581,723	$ (42,467,895)	$ 40,113,828
Unamortized intangible assets				
Trade names		$ 5,955,000	$ -	$ 5,955,000
Licenses and providers numbers		3,546,000	-	3,546,000
		$ 9,501,000	$ -	$ 9,501,000

Amortization expense related to goodwill and intangible assets for the years ended June 30, 2020 and 2019 was $6,092,388 and $6,326,883, respectively. Estimated amortization expense for each of the following five years is as follows:

2021	$ 5,676,772
2022	5,676,772
2023	5,676,772
2024	3,270,459
2025	2,898,098

Changes in goodwill for the years ended June 30, 2020 and 2019 were as follows:

	2020	2019
Balance as of July 1	$ 24,245,077	$ 23,084,831
Acquired goodwill in business combination	4,951,732	5,306,795
Amortization expense	(4,720,892)	(4,146,549)
Balance as of June 30	$ 24,475,917	$ 24,245,077

Note 7: COVID-19 Pandemic and CARES Act Funding

On March 11, 2020, the World Health Organization designated COVID-19 as a global pandemic. Patient volumes and the related revenues for the Company's services were significantly impacted by COVID-19 as various policies were implemented by federal, state and local governments in response to the pandemic that have caused many people to remain at home and forced the transition to telehealth services due to temporary closure of the majority of the Company's facilities.

While some of these policies have been eased, some restrictions remain in place, and some state and local governments are re-imposing certain restrictions due to increasing rates of COVID-19 cases.

The Company's pandemic response plan has multiple facets and continues to evolve as the pandemic unfolds. The Company has taken precautionary steps to enhance its operational and financial flexibility, and react to the risks the COVID-19 pandemic presents to its business, including the following:

- Implemented numerous safety programs to minimize the impact of COVID-19 on the Company's staff and clients
- Purchased Personal Protective Equipment
- Implemented certain cost reduction initiatives;
- Reduced certain planned projects and capital expenditures; and
- Obtain additional liquidity through traditional financing and programs made available through government relief programs

The extent of the COVID-19 pandemic's adverse impact on the Company's operating results and financial condition has been and will continue to be driven by many factors, most of which are beyond the Company's control and ability to forecast. Such factors include, but are not limited to, the scope and duration of stay-at-home practices and restrictions, government-imposed or recommended closures, continued declines in patient volumes for an indeterminable length of time, increases in the number of uninsured and underinsured patients as a result of higher sustained rates of unemployment, incremental expenses required for supplies and personal protective equipment, increased costs in the Company's self insured health programs for claims related to the treatment and testing of COVID-19 and changes in professional and general liability exposures.

Because of these and other uncertainties, the Company cannot estimate the length or severity of the impact of the pandemic on the Company's business. Decreases in cash flows and results of operations may have an impact on debt covenant compliance and on the inputs and assumptions used in significant accounting estimates, including allowances for patient receivables, and potential impairments of goodwill and long-lived assets.

Third-Party Payer Accelerated and Advanced Payment Programs

During the year ended June 30, 2020, certain third-party payers moved to alternative payment models to accelerate payments to providers and compensate organizations for declines in volumes. The extent of these models ranged from temporary rate increases to capitated level payments measured against baselines from previous periods. Certain payers continued to adjudicate claims for certain of their services and reconcile activity to the baseline payments. Others have not provided enough information that would allow the Company to identify and measure amounts to determine the extent of any over-funding and potential repayment. At June 30, 2020, the Company has recognized $4,482,734 from these accelerated and advance payment programs in third-party payer advance payments liability within the consolidated balance sheets as amounts are either expected to be repaid or sufficient information is not yet available to reasonably determine a settlement amount.

The Company continues to evaluate these accelerated and advanced payments against known payment terms and reconcile payment amounts with payers where payment terms are unknown. To the extent that information becomes available where the Company can reasonably estimate amounts that will not be subject to repayment, these accelerated and advanced payments will be recognized as patient service revenues in the period known. Given the complexities and uncertainties of these program, it is reasonably possible that recorded estimates will change materially in the near term.

Payroll Tax Credits

The CARES Act provides for a deferral of payments of the employer portion of payroll tax incurred during the pandemic, allowing half of such payroll taxes to be deferred until December 31, 2021 and the remaining half until December 31, 2022. At June 30, 2020, the Company had deferred $1,847,482 of payroll taxes in the accompanying consolidated balance sheets.

Paycheck Protection Program (PPP) Loan

During April 2020, the Company's subsidiaries applied for Paycheck Protection Program (PPP) Loans and received seven term loans totaling $15,915,900 under the Paycheck Protection Program (PPP), which was established under the CARES Act. The loans are forgivable based on actual payroll cost and certain other costs paid or incurred during an eight or twenty-four week covered period. The Company's twenty-four week covered period ends over a range of dates commencing on October 12, 2020. The application for forgiveness is due within ten months from the end of the covered period and no principal or interest payments are required until the forgiveness amount is remitted to the lender by the Small Business Administration. Interest accrues at 1% under the PPP loans and is fully forgivable with the principal balance. The PPP note agreements have a maturity date of two years from the loan date which is generally April 30, 2022. Monthly payments of principal are required for amount not otherwise forgiven through the maturity date.

The Company has classified the PPP loans as long-term debt at June 30, 2020. Management expects the Company to receive full forgiveness for the loans, however, the gain on loan forgiveness will be recorded in the period the Company receives forgiveness and the debt is legally extinguished.

Provider Relief Funds

Subsequent to June 30, 2020, the Company received $3,110,993 from the phase two general distribution of the CARES Act Provider Relief Fund. This distribution from the Provider Relief Fund is not subject to repayment, provided the Company is able to attest to and comply with the terms and conditions of the funding, including demonstrating that the distributions received have been used for healthcare-related expenses or lost revenue attributable to COVID-19.

Note 8: Long-Term Debt and Line of Credit

On August 22, 2014, the Company entered into a credit agreement with a group of lenders. The agreement provides a $51,000,000 term note facility and a $4,000,000 revolving credit facility. The agreement has been amended through October 2017 to increase the revolving credit limit to $6,000,000 and increase the term loan credit facility to $69,282,750.

Effective October 12, 2018, the credit agreement was amended to provide an additional $10,350,000 incremental term loan on the term loan credit facility. Total outstanding balance on the term note was $86,428,875 and $78,310,875 at June 30, 2020 and 2019, respectively. At June 30, 2020 and 2019, there was $0 borrowed against the revolving credit facility.

The credit agreement provides for an additional $15,000,000 senior term note commitment through an incremental senior delayed draw term loan commitment (DDTL). The DDTL was available through the 18-month anniversary of the amendment closing date and is available for purposes of financing growth through capital expenditure projects subject to funding conditions outlined in the credit agreement. Total outstanding balance under the original DDTL was $4,500,000 and $0 at June 30, 2020 and 2019.

Effective October 10, 2017, the credit agreement was amended to extend an additional commitment under the DDTL of $10,000,000 and established a new tranche for future outstanding delayed draw term loan (DDTL-1). The additional delayed draw term loan (DDTL-1) had an outstanding balance of $14,561,500 and $14,711,500 at June 30, 2020 and 2019, respectively.

Effective October 12, 2018, the credit agreement was amended to allow for an additional commitment of $10,000,000 via subsequent DDTL. DDTL-2 had an outstanding balance of $9,805,591 and $9,905,253 at June 30, 2020 and 2019, respectively. DDTL-3 had and outstanding balance of $7,401,250 and $7,476,250 outstanding at June 30, 2020 and 2019, respectively.

Effective October 4, 2019, the credit agreement was amended to allow for an additional commitment of $9,000,000 via subsequent DDTL. DDTL-4 had an outstanding balance of $2,481,250 at June 30, 2020.

The credit agreement contains certain restrictive covenants including the maintenance of certain financial ratios. The facility is collateralized by substantially all assets of the Company and contains prepayment penalties through the loan maturity date.

Interest is payable quarterly on the term, DDTLs and revolving facilities at a LIBOR-based rate or a prime base rate, plus applicable margin. The interest rate at June 30, 2020 on the various borrowings ranged from 7.5% to 8.5%; whereas, the interest rate at June 30, 2019 ranged from 8.83% to 9.10%. Principal payments for the term note facility and DDTLs are made quarterly in equal aggregate installments of $324,791 at June 30, 2020, with the balance of the notes due at maturity. Additional principal payments are due annually based on the Company's excess cash flow as defined in the credit agreement.

Subsequent to June 30, 2020, the Company amended the senior credit facility to extend the maturity date to August 22, 2022. In addition, the credit agreement was amended in early June to allow for the PPP loans and provide for a limited guaranty from the Company's private equity sponsor based on an event of default under the PPP loans or if the amounts unforgiven exceed $2,000,000. The maximum amount of the PPP guarantee is $15,915,900. The private equity sponsor also provided a guarantee if certain liquidity levels fall below $3,000,000, which guarantee amount is limited to $3,000,000.

On October 1, 2014, the Company entered into an installment sales agreement for the acquisition of property and equipment for the operation of a single drug addiction recovery and rehabilitation center. The agreement calls for 240 monthly installment payments of $8,500 for the first 60 months and $4,087 for the remaining 180 months. The discount rate utilized for this sales agreement was 4.25%, which is reflected as imputed interest.

The Company leases various vehicles through capital lease arrangements. The leases expire at various times through 2024 and include interest ranging from 5.6% to 10.0%. The Company is obligated for the residual value of the vehicle, which is included within the present value of lease payments. Should the prevailing market value exceed the residual value at the term of the lease, the Company will receive credit or be refunded the difference. During 2020 and 2019, the Company realized net lease termination gain of $31,644 and $41,017, respectively.

Refer to Note 7 for information regarding the Company's PPP loans payable at June 30, 2020.

Long-term debt consists of the following at June 30, 2020 and 2019:

	2020	2019
Senior term note payable, bank	$ 86,428,875	$ 78,310,875
Delayed draw term note payable, bank	4,500,000	-
Delayed draw term note payable - 1, bank	14,561,500	14,711,500
Delayed draw term note payable - 2, bank	9,805,591	9,905,253
Delayed draw term note payable - 3, bank	7,401,250	7,476,250
Delayed draw term note payable - 4, bank	2,481,250	-
Capital lease payable	2,444,790	3,400,591
Installment sale note payable	562,827	562,859
	128,146,783	114,367,328
Less unamortized debt issuance costs	(2,915)	(383,633)
Less current maturities	(2,774,195)	(2,926,450)
	$ 125,369,673	$ 111,057,245

Aggregate annual maturities of long-term debt and capital leases at June 30, 2020 are:

	Long-Term Debt (Excl. Capital Leases)	Capital Lease Obligations
2021	$ 1,327,667	$ 1,537,442
2022	1,328,903	695,427
2023	122,611,169	291,604
2024	31,029	56,650
2025	33,776	-
Thereafter	369,449	-
	$ 125,701,993	2,581,123
Less amount representing interest		(136,333)
Present value of future minimum lease payments		$ 2,444,790

Property and equipment include the following property under capital leases:

	2020	2019
Equipment and vehicles	$ 6,465,981	$ 6,602,050
Less accumulated depreciation	(4,000,842)	(3,070,131)
	$ 2,465,139	$ 3,531,919

Note 9: Operating Leases

The Company leases various treatment facilities and certain other equipment under operating leases. The leases expire in various periods through 2026. The terms of the facility leases generally allow for extension of the lease terms and require the Company to pay insurance, utilities, maintenance and property taxes in addition to monthly rental amounts.

Minimum annual rental payments required under facility operating leases, which have remaining terms in excess of one year as of June 30, 2020, are as follows:

2021	$ 6,282,589
2022	5,120,441
2023	3,003,108
2024	982,128
2025	346,900
Thereafter	199,469
	$ 15,934,635

Total rental expense was $7,008,881 and $7,141,164 during the years ended June 30, 2020 and 2019, respectively. See Note 13 for rental expenses paid to related parties.

Note 10: Employee Benefits

The Company offers a 401(k) plan covering all eligible employees. The Company provides a matching contribution of 100% of employee contributions, up to 1% of eligible employee compensation under the 401(k) plan, plus 50% of salary deferrals for the next 5% of eligible employee compensation. For the years ended June 30, 2020 and 2019, the Company had contribution expense of $1,819,865 and $1,814,751, respectively. The Company suspended its match temporarily effective June 7, 2020.

Note 11: Income Taxes

The income tax expense includes these components for the years ended June 30, 2020 and 2019:

	2020	2019
Taxes currently payable	$ 205,301	$ 197,436
Income tax expense	$ 205,301	$ 197,436

A reconciliation of income tax expense at the statutory rate to the Company's actual income tax expense is shown below for the years ended June 30, 2020 and 2019:

	2020	2019
Computed at the statutory rate of 21% for 2020 and 2019	$ (1,994,903)	$ (2,514,130)
Increase (decrease) resulting from		
Nontaxable income	90,914	(442,889)
Nondeductible expenses and acquisition cost	40,005	36,027
Nondeductible goodwill amortization	367,948	367,947
State income taxes	(389,134)	(928,000)
Changes in the deferred tax asset valuation allowance	2,049,408	3,691,091
Other	41,063	(12,610)
Actual tax expense	$ 205,301	$ 197,436

The tax effects of temporary differences related to deferred taxes shown on the consolidated balance sheets at June 30, 2020 and 2019 were:

	2020	2019
Deferred tax assets		
Allowance for doubtful accounts	$ 830,913	$ 1,334,726
Accrued expenses	1,785,706	1,010,072
Net operating loss carryforward	8,249,645	7,761,614
Interest expense limitation - carryforward	3,019,426	2,120,360
Other		28,603
	13,885,690	12,255,375
Deferred tax liabilities		
Property and equipment	(904,898)	(1,337,514)
Intangible assets	(1,488,661)	(1,705,770)
Other	(470,032)	-
	(2,863,591)	(3,043,284)
Net deferred tax asset before valuation allowance	11,261,499	9,212,091
Valuation allowance - state operating loss carryforward		
Beginning balance	(9,212,091)	(5,521,000)
Increase during the period	(2,049,408)	(3,691,091)
Ending balance	(11,261,499)	(9,212,091)
Net deferred tax asset (liability)	$ -	$ -

At June 30, 2020, the Company has approximately $23,900,000 of net operating loss carryforwards expiring through 2040.

The Company was limited during 2020 and 2019 in its interest deduction and has an interest carryforward of approximately $10,064,000 that does not expire.

Note 12 - Employee Profits Interest Units

The Company's 2011 Profits Interest Plan (Plan) permits the grant of Class B units of the Company to its employees. The Company has granted 180,000 Class B membership units as of June 30, 2020. The Class B units vest over a four-year term and are subject to certain restrictions and minimum capital components that are withheld from future distributions based on the Company's operating agreement. The grant date fair value of the Class B units was zero. The Plan provides for accelerated vesting if there is a change in control (as defined in the Plan). During 2019, 5,000 units were granted. As of June 30, 2020 and 2019, 143,750 and 126,250 units were vested under the Plan, respectively.

Note 13: Related Party Transactions

The Company pays management fees and acquisition transaction fees to Clearview Capital, L.P., a company related through common ownership. During the years ended June 30, 2020 and 2019, acquisition transaction fees paid to Clearview Capital, L.P. totaled $90,000 and $131,250, respectively. Management fee expense was $500,000 for the years ended June 30, 2020 and 2019, respectively, and is included with professional fees in the consolidated statements of operations. Accrued management fees recorded at June 30, 2019 was $125,000. Additionally, the Company reimburses Clearview Capital, L.P. for various board member expenses throughout the year. Reimbursed expenses paid for the years ended June 30, 2020 and 2019 was $50,610 and $13,472, respectively.

The Company rents various facilities from related parties. Rental expense paid to related parties totaled $572,161 and $569,090 for the years ended June 30, 2020 and 2019, respectively.

The Company had accounts payable to related parties in the amount of $170,036 as of June 30, 2020.

Note 14: Contingencies and Commitments

In the normal course of business, the Company is, from time to time, subject to allegations that may or do result in claims and litigation. Some of these allegations may be in areas not covered by the Company's commercial insurance policies. The Company evaluates such allegations by conducting investigations to determine the validity of each potential claim. Based upon the advice of counsel, management records an estimate of the amount of ultimate expected loss, if any, for each of these matters. Management is of the opinion that the ultimate resolution of any known claims, either individually or in the aggregate, will not have a material adverse impact on the Company's consolidated financial position or results of operations or cash flows. Events could occur that would cause the estimate of ultimate loss to differ materially in the near term.

The Company signed a real estate purchase agreement during 2019 which closed during August 2020. The purchase price related to real estate was $3,515,000 at June 30, 2020.

Note 15: Professional Liability Claims

The Company purchases medical malpractice insurance under a claims-made policy. Under such a policy, only claims made and reported to the insurer during the policy term, regardless of when the incidents giving rise to the claims occurred, are covered. Based upon the Company's claims experience, no accrual has been made for the Company's estimated medical malpractice costs as of June 30, 2020 and 2019.

Note 16: Self-Insured and Liability Retention Plans

Substantially all of the Company's employees and their dependents are eligible to participate in the Company's employee health insurance plan, subject to the eligibility requirements and waiting periods. The Company began self-insuring for health claims of participating employees and dependents of the different consolidated operating entities at various dates beginning August 1, 2014. Newly acquired entities are expected to be added to the plan subsequent to acquisition. Costs resulting from noninsured losses are charged to income when incurred including both claims reported and claims incurred but not yet reported.

At June 30, 2020 and 2019, the Company's accrual for incurred but not reported medical expense was $1,133,240 and $684,520, respectively, which was net of any refunds expected from the reinsurance provider. The Company has purchased insurance that limits its exposure for individual claims to $200,000 per occurrence, with no cap per person per plan year.

During the fiscal year ended June 30, 2020, the Company has certain liability retention arrangements for workers' compensation, general liability and automobile liability insurance coverage. Under the terms of the agreements, the Company pays a fixed premium for insurance coverage and participates in actual claims cost up to certain maximum deductible levels. The workers' compensation per occurrence deductible is $250,000, the auto liability per occurrence deductibles is $100,000 and the general liability per occurrence deductible is $100,000. The Company accrues based on calculations from its insurance broker management consultant's projected retention amounts. The maximum aggregate deductible cost for workers' compensation and automobile liability insurance was approximately $1,900,000 for 2020. As of June 30, 2020, the Company has accrued approximately $393,000 in connection with claims incurred in connection with the retention portion of the insurance policies.

The Company is subject to claims and lawsuits that arise primarily in the ordinary course of business. It is the opinion of management that the disposition or ultimate resolution of such claims and lawsuits will not have a material adverse effect on the consolidated financial position, results of operations and cash flows of the Company. The Company's insurance carrier is providing legal defense in various matters. As of June 30, 2020, the Company has accrued approximately $291,000 related to the estimated liability.

Note 17: Significant Estimates

Accounting principles generally accepted in the United States of America require disclosure of certain significant estimates and current vulnerabilities due to certain concentrations. Those matters include the following:

Allowance for Net Patient Service Revenue Adjustments

Estimates of allowances for adjustments included in net patient service revenue are described in *Notes 1 and 2.*

Third-Party Payer Accelerated and Advanced Payment Programs

Refer to Note 7 for estimates related to payer advanced payment programs.

Note 18: Future Changes in Accounting Principles

Revenue Recognition

The Financial Accounting Standards Board amended its standards related to revenue recognition. This amendment replaces all existing revenue recognition guidance and provides a single, comprehensive revenue recognition model for all contracts with customers. The amendment also requires additional disclosure about the nature, amount, timing and uncertainty of revenue and cash flows arising from customer contracts, including significant judgments and changes in those judgments and assets recognized from costs incurred to fulfill a contract. The standard allows either full or modified retrospective adoption effective for nonpublic entities for annual periods beginning after December 15, 2019. The Company is in the process of evaluating the impact the amendment will have on the consolidated financial statements.

Leases

The Financial Accounting Standards Board (FASB) amended its standard related to the accounting for leases. Under the new standard, lessees will now be required to recognize substantially all leases on the balance sheet as both a right-of-use asset and a liability. The standard has two types of leases for income statement recognition purposes: operating leases and finance leases. Operating leases will result in the recognition of a single lease expense on a straight-line basis over the lease term similar to the treatment for operating leases under existing standards. Finance leases will result in an accelerated expense similar to the accounting for capital leases under existing standards. The determination of lease classification as operating or finance will be done in a manner similar to existing standards. The new standard also contains amended guidance regarding the identification of embedded leases in service contracts and the identification of lease and nonlease components in an arrangement. The new standard is effective for annual periods beginning after December 15, 2021. The Company is evaluating the impact the standard will have on the consolidated financial statements; however, the standard is expected to have a material impact on the consolidated financial statements due to the recognition of additional assets and liabilities for operating leases.

Note 19: Subsequent Events

Subsequent events have been evaluated through October 12, 2020, which is the date the consolidated financial statements were available to be issued.

Refer to Note 7 for the Provider Relief Funds received subsequent to June 30, 2020.

Supplementary Information

Clearview Pyramid Acquisition Company, LLC

Consolidating Schedule - Balance Sheet Information

June 30, 2020

	Clearview Pyramid Acquisition Company, LLC	Pyramid Healthcare, Inc.	American Day CD Centers, LLC	October Road, Inc.	Onward Behavioral Health, Inc.	Silvermist, LLC	Foundations Medical Services, LLC	Real Recovery of Asheville, Inc.	Mazzitti & Sullivan Counseling Services, Inc.	[illegible]	Twelve Oaks Holdings, LLC	[illegible] Recovery Services, LLC	Pyramid Family Behavioral Healthcare, LLC	Wilderness Corporation	Aspen Investment Group, LLC	Eliminations	Consolidated Totals
Assets																	
Current Assets																	
Cash and cash equivalents	$ -	$ 5,539,592	$ 4,131,794	$ 1,830,168	$ 8,455,809	$ 942,502	$ 186,080	$ 832,620	$ [illegible]	$ 28,943	$ [illegible]	1,145,212	$ 284,798	$ 2,179,798	$ 938,913	$ -	$ 28,493,885
Patient accounts receivable, net of allowance of $10,133,230	-	4,204,834	2,293,196	211,833	1,266,946	644,006	54,249	347,224	[illegible]	304	[illegible]	635,254	266,444	1,673,574	501,394	331,000	12,932,139
Other receivables	-	514,085	-	-	29,915	-	-	-	-	-	-	-	-	-	-	(264,560)	308,440
Due from affiliate	-	204,830,728	45,221,443	4,375,854	(2,718,755)	6,572,967	1,205,205	2,053,541	[illegible]	735,705	[illegible]	1,325,937	381,329	3,071,821	1,873,884	(275,403,111)	-
Refundable income taxes	-	224,815	530	-	21,118	-	-	3,919	-	-	-	(976)	16,000	-	-	3	261,967
Prepaids and other current assets	-	870,509	530	3,500	74,567	1,007	6,221	-	[illegible]	45,499	-	-	-	74	-	14,287	1,018,202
Total current assets	-	316,194,563	51,647,403	6,421,347	7,128,630	8,160,482	1,451,755	3,237,304	[illegible]	3,971,236	[illegible]	4,842,819	3,122,403	872,571	7,121,928	3,274,191	(275,392,381)	43,974,633
Property and Equipment, net	-	31,122,832	587,383	3,472,662	11,738,865	3,077,987	229,704	[illegible]	[illegible]	106,258	[illegible]	2,827,921	369,526	89,671	10,803,968	2,337,019	-	66,997,977
Other Assets																	
Goodwill, net	-	3,290,859	2,802,116	537,748	1,308,828	-	-	[illegible]	2,854,166	[illegible]	-	-	2,863,982	-	4,363,701	4,580,352	-	24,475,917
Other intangible assets, net	-	7,681,135	11,978,375	1,312,582	3,025,833	-	-	-	-	-	-	-	-	-	330	-	-	23,998,255
Other long-term assets	-	230,332	306,080	5,650	86,941	702	15,272	14,900	-	2,775	-	-	-	13,745	1,600	-	-	702,784
Investment in subsidiaries	34,893,044	86,955,061	-	-	-	-	-	-	-	-	-	-	-	-	-	-	(121,848,105)	-
	34,893,044	98,157,387	15,086,571	1,855,980	4,421,602	702	15,272	[illegible]	[illegible]	[illegible]	-	[illegible]	2,863,982	13,745	4,365,631	4,580,352	(121,848,105)	49,176,956
	$ 34,893,044	$ 345,474,782	$ 67,321,356	$ 11,749,989	$ 23,289,087	$ 11,239,171	$ [illegible]	$ 4,728,632	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ 6,355,911	$ 975,987	$ 22,291,527	$ 10,191,562	$ (397,150,486)	$ 159,189,561
Liabilities and Members' Equity																	
Current Liabilities																	
Current maturities of long-term debt	-	2,774,195	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2,774,195
Accounts payable	-	5,636,945	99,412	126,829	93,298	[illegible]	5,979	[illegible]	[illegible]	99,116	[illegible]	13,409	18,343	4,991	35,145	9,696	328,845	6,498,671
Advanced payments from third-party payers	-	3,965,207	-	15,019	29,080	-	-	-	-	358,137	-	-	-	-	56	-	-	4,462,734
Accrued expenses	-	11,165,776	1,256,186	392,538	1,247,182	[illegible]	276,528	[illegible]	[illegible]	132,000	15,290	20,898	65,173	28,186	450,679	64,148	(249,057)	13,087,986
Due to affiliate	-	175,609,063	13,253,366	9,320,139	34,961,068	[illegible]	1,261,726	[illegible]	[illegible]	3,197,810	[illegible]	4,263,384	2,618,151	1,241,998	16,596,948	2,628,426	(275,431,746)	-
Total current liabilities	-	199,151,186	14,608,964	9,854,531	35,870,588	[illegible]	1,546,233	[illegible]	[illegible]	3,696,781	[illegible]	4,296,891	2,711,647	1,275,175	17,082,828	2,706,223	(275,351,938)	28,743,586
Long-Term Liabilities																	
Long-term debt	-	141,285,573	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	141,285,573
Other payroll deferrals	-	1,115,407	239,275	105,372	[illegible]	35,238	-	5,427	[illegible]	[illegible]	-	5,782	7,435	2,077	96,841	8,236	-	1,847,482
	-	142,400,980	239,275	105,372	[illegible]	35,238	-	5,427	[illegible]	[illegible]	-	5,782	7,435	2,077	96,841	8,236	-	143,133,055
Members' Equity																	
Members' capital	34,893,044	35,659,410	40,877,333	2,998,774	[illegible]	375,994	[illegible]	[illegible]	[illegible]	4,973,072	1,371,859	(1,174,679)	4,383,035	-	6,000,000	7,200,000	(114,904,572)	34,893,044
Retained earnings (accumulated deficit)	-	(31,736,794)	11,595,764	(1,208,688)	[illegible]	[illegible]	[illegible]	(1,116,122)	246,558	(1,342,258)	(854,731)	4,342,746	(666,206)	(301,265)	(888,140)	277,104	(7,358,496)	(48,044,664)
Total Clearview Pyramid Acquisition Company, LLC members' equity	34,893,044	3,922,616	52,473,117	1,790,086	[illegible]	[illegible]	150,053	[illegible]	[illegible]	3,230,814	517,128	3,168,067	3,636,829	(301,265)	5,111,860	7,477,104	(122,263,068)	(13,151,620)
Noncontrolling interests	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	464,540	464,540
Total members' equity	34,893,044	3,922,616	52,473,117	[illegible]	[illegible]	[illegible]	150,053	[illegible]	[illegible]	3,230,814	517,128	3,168,067	3,636,829	(301,265)	5,111,860	7,477,104	(121,798,528)	(12,687,080)
Total liabilities and members' equity	$ 34,893,044	$ 345,474,782	$ 67,321,356	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ [illegible]	$ 6,956,392	$ 1,705,861	$ 7,470,740	$ 6,355,911	$ 975,987	$ 22,291,527	$ 10,191,562	$ (397,150,486)	$ 159,189,561

Clearview Pyramid Acquisition Company, LLC

Consolidating Schedule - Statement of Operations Information

Year Ended June 30, 2020

	Clearview Pyramid Acquisition Company, LLC	Pyramid Healthcare, Inc.	American Day CD Centers, LLC	October Road, Inc.	Onward Behavioral Health, Inc.	Silvermist, LLC	Foundations Medical Services, LLC	Real Recovery of Asheville, Inc.	Mazziotti & Sullivan Counseling Services, Inc.	[illegible]	Twelve Oaks Holdings, LLC	[illegible] Recovery Services, LLC	Pyramid Family Behavioral Healthcare, LLC	Walden/Sierra Corporation	Aspen Investment Group, LLC	Eliminations	Consolidated Totals
Revenues																	
Patient service revenue, net of allowances and contractual adjustments	$ -	$ 95,629,342	$ 37,180,082	$ 7,870,157	$ 29,046,097	$ 4,692,275	$ 1,282,471	$ 2,292,250	$ [illegible]	$ 753,404	$ [illegible]	$ 4,177,489	$ 1,099,872	$ 9,662,956	$ 2,816,942	$ -	$ 205,815,224
Provision for uncollectible accounts, net of recoveries	-	(2,758,909)	(2,559,059)	(1,202,014)	(3,525,988)	(1,318,723)	21,396	(24,276)	[illegible]	(126,747)	[illegible]	(1,049,409)	(40,688)	(544,082)	44,864	-	(14,856,878)
Net patient service revenue less provision for uncollectible accounts	-	92,870,433	34,621,023	6,668,143	25,520,109	3,373,552	1,303,867	2,267,974	3,963,700	[illegible]	3,574,944	3,128,080	1,059,184	9,118,874	2,861,806	-	190,958,346
Operating Expenses																	
Salaries	-	55,064,035	17,022,150	3,358,930	14,868,009	2,491,462	472,762	[illegible]	1,765,025	[illegible]	406,239	1,137,468	505,959	4,407,797	1,010,529	-	103,709,233
Employee benefits	-	10,152,643	3,284,901	753,591	3,183,003	444,852	97,335	[illegible]	408,073	[illegible]	175,944	247,507	118,521	893,878	135,826	-	20,151,863
Purchased services and professional fees	-	(466,326)	4,082,631	1,643,968	4,135,548	717,722	277,685	410,188	1,030,917	[illegible]	643,056	445,326	254,716	2,403,543	704,048	-	16,385,578
Food, clothing, drugs and supplies	-	5,607,546	238,311	229,053	809,314	192,292	[illegible]	241,594	[illegible]	[illegible]	163,296	89,634	11,068	855,456	136,914	-	8,699,612
Property leases and other rentals	-	3,042,097	1,723,506	181,047	1,889,110	16,187	[illegible]	[illegible]	[illegible]	26,883	8,991	167,052	114,803	218,142	4,875	-	7,947,368
Repairs and maintenance	-	874,002	149,448	51,916	97,439	3,548	[illegible]	38,032	[illegible]	2,845	[illegible]	18,746	4,962	130,795	10,422	-	1,426,652
Utilities	-	2,967,002	412,726	120,255	544,121	75,607	[illegible]	45,410	[illegible]	[illegible]	68,221	16,145	279,080	30,974	-	4,800,439
Travel	-	857,979	211,445	140,186	342,953	236,606	[illegible]	20,212	[illegible]	[illegible]	2,601	7,324	5,151	101,285	24,212	-	2,056,667
Insurance	-	1,297,848	390,178	71,458	292,840	48,588	[illegible]	27,366	[illegible]	[illegible]	42,241	32,508	16,184	92,364	36,012	-	2,414,603
Property and local taxes	-	625,152	17,764	52,134	71,653	14,783	[illegible]	[illegible]	[illegible]	[illegible]	22,745	24,104	300	57,017	11,528	-	931,445
Depreciation and amortization	-	6,402,894	1,949,072	415,695	1,439,389	100,756	[illegible]	[illegible]	526,178	[illegible]	133,902	496,148	36,952	810,257	440,710	-	13,176,535
Gain on capital lease	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Loss on disposal of property and equipment	-	358,344	1,646	-	2,254	-	-	-	-	-	-	-	-	-	-	-	362,244
Other operating expenses	-	3,893,352	788,026	148,913	829,852	[illegible]	7,482	28,778	136,687	6,215	19,632	32,110	49,510	274,790	38,721	-	7,216,917
Total operating expenses	-	90,676,568	30,271,804	7,167,139	28,604,485	[illegible]	1,114,482	[illegible]	4,489,549	716,086	1,686,483	2,766,140	1,134,271	10,524,404	2,584,771	-	189,278,356
Operating Income (Loss)	-	2,193,865	4,349,219	(498,995)	(3,084,376)	[illegible]	189,385	31,991	(525,849)	(89,429)	1,888,461	361,940	(75,087)	(1,405,530)	277,035	-	1,679,990
Other Income (Expense)																	
Interest expense	-	(11,194,171)	-	(4)	-	-	-	-	-	-	-	-	-	-	-	-	(11,194,175)
Other	-	614,867	(1,213)	9,878	-	203,972	-	-	28	183	(813,135)	-	-	-	69	-	14,649
Equity in earnings of subsidiaries	-	3,840,948	-	-	-	-	-	-	-	-	-	-	-	-	-	(3,840,948)	-
Total other income (expense)	-	(6,738,356)	(1,213)	9,874	-	203,972	-	-	28	183	(813,135)	-	-	-	69	(3,840,948)	(11,179,526)
Income (Loss) Before Income Taxes	-	(4,544,491)	4,348,006	(489,121)	[illegible]	[illegible]	189,385	31,991	(525,821)	(89,246)	1,075,326	361,940	(75,087)	(1,405,530)	277,104	(3,840,948)	(9,499,536)
Income Tax (Benefit) Expense	-	140,541	715	10,520	36,613	[illegible]	[illegible]	3,556	-	5,076	515	6,427	823	515	-	-	205,301
Net Income (Loss)	-	(4,685,032)	4,347,291	(499,641)	(3,120,989)	[illegible]	189,385	28,435	(525,821)	(94,322)	1,074,811	355,513	(75,910)	(1,406,045)	277,104	(3,840,948)	(9,704,837)
Less: Net Income Attributable to Noncontrolling Interests	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	395,864	395,864
Net Income (Loss) Attributable to Clearview Pyramid Acquisition Company, LLC	$ -	$ (4,685,032)	$ [illegible]	$ (499,641)	$ (3,120,989)	$ [illegible]	$ 189,385	$ 28,435	$ (525,821)	$ (94,322)	$ 1,074,811	$ 355,513	$ (75,910)	$ (1,406,045)	$ 277,104	$ (4,236,812)	$ (10,100,701)

Pyramid Healthcare Acquisition Corp.

Independent Auditor's Report and Consolidated Financial Statements

June 30, 2021 (Successor) and June 30, 2020 (Predecessor)

Pyramid Healthcare Acquisition Corp.

June 30, 2021 (Successor) and June 30, 2020 (Predecessor)

Contents

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Independent Auditor's Report

Board of Directors
Pyramid Healthcare Acquisition Corp.
Altoona, Pennsylvania

We have audited the accompanying consolidated financial statements of Pyramid Healthcare Acquisition Corp., and its subsidiaries, which comprise the consolidated balance sheets as of June 30, 2021 (Successor Period) and June 30, 2020 (Predecessor Period), and the related statements of operations, stockholder's and members' equity and cash flows for the period from May 10, 2021 to June 30, 2021 (Successor Period) and the period from July 1, 2020 to May 9, 2021 and the year ended June 30, 2020 (Predecessor Period), and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Pyramid Healthcare Acquisition Corp. and its subsidiaries as of June 30, 2021 (Successor Period) and June 30, 2020 (Predecessor Period), and the results of their operations and their cash flows for the period from May 10, 2021 to June 30, 2021 (Successor Period) and the period from July 1, 2020 to May 9, 2021 and the year ended June 30, 2020 (Predecessor Period) in accordance with accounting principles generally accepted in the United States of America.

BKD, LLP

Indianapolis, Indiana
November 5, 2021

Pyramid Healthcare Acquisition Corp.

Consolidated Balance Sheets
June 30, 2021 (Successor) and June 30, 2020 (Predecessor)

Assets	Successor June 30, 2021	Predecessor June 30, 2020
Current Assets		
Cash	$ 16,910,600	$ 28,493,885
Patient accounts receivable, net of allowance - 2020 - $10,133,230	13,282,378	12,952,134
Other receivables	1,027,469	308,440
Escrow claim receivable	7,386,000	-
Refundable income taxes		261,967
Prepaids and other current assets	1,303,081	1,018,202
Total current assets	39,909,930	43,014,633
Property and Equipment, net	79,853,274	66,997,972
Other Assets		
Goodwill, net	246,370,935	24,475,917
Other intangible assets, net	77,452,380	23,998,255
Other long-term assets	2,338,311	702,784
Total other assets	326,141,626	49,176,956
Total assets	$ 445,804,230	$ 159,189,561
Liabilities and Equity		
Current Liabilities		
Current maturities of long-term debt	2,838,385	$ 2,774,195
Accounts payable	5,323,891	6,167,671
Consideration payable - purchase price adjustment	2,613,718	-
Patient refunds payable	1,950,853	331,000
Other estimated third-party settlements	861,816	-
Deferred revenue, grants and other supplemental funding	7,776,014	4,402,734
Accrued expenses	19,744,768	15,067,986
Total current liabilities	41,109,445	28,743,586
Long-Term Liabilities		
Deferred income tax liability	8,457,174	-
Paycheck Protection Program term loans	-	15,915,900
Long-term debt, net of deferred financing fees	169,407,319	125,369,673
Deferred employer payroll expenses	2,139,095	1,847,482
	180,003,588	143,133,055
Stockholder's and Members' Equity		
Common stock, $.001 par value	227,930,000	
Members' capital		34,893,044
Additional paid-in capital (Equity Compensation)	69,016	
Accumulated deficit	(3,307,819)	(48,044,664)
Total stockholder's and members' equity (deficit)	224,691,197	(13,151,620)
Non-controlling interest	-	464,540
Total stockholder's and members' equity (deficit)	224,691,197	(12,687,080)
Total liabilities, stockholder's and members' equity	$ 445,804,230	$ 159,189,561

Pyramid Healthcare Acquisition Corp.

Consolidated Statements of Operations
Period Ended June 30, 2021 (Successor)
Period Ended May 9, 2021 and Year Ended June 30, 2020 (Predecessor)

	Successor	Predecessor	
	Period From May 10, 2021 Through June 30, 2021	Period From July 1, 2020 Through May 9, 2021	Year Ended June 30, 2020
Revenues			
Patient service revenue, net of allowances and contractual adjustments			$ 205,815,224
Provision for uncollectible accounts, net of recoveries and adjustments			(14,856,878)
Net patient service revenue, less provision for uncollectible accounts	$ 32,[illegible]2,679	$ 185,[illegible]7,922	190,958,346
Operating Expenses			
Salaries	13,542,976	89,111,794	102,923,168
Employee benefits	2,578,335	15,914,020	19,301,234
Purchased services and professional fees	2,490,[illegible]	13,799,705	17,157,257
Food, clothing, drugs and supplies	1,446,[illegible]60	7,615,084	9,248,204
Property leases and other rentals	177,831	6,407,689	7,947,368
Repairs and maintenance	236,445	1,198,847	1,426,652
Utilities	597,101	4,044,930	4,762,138
Travel	217,1[illegible]6	978,399	2,056,667
Insurance	4[illegible]7,353	2,277,373	2,414,603
Property and local taxes	130,[illegible]90	910,202	931,445
Depreciation and amortization	5,158,[illegible]82	10,267,782	13,176,535
(Gain) loss on disposal of property and equipment	(7,183)	(371,773)	362,244
Acquisition related expenses	2,543,021	-	-
Other operating expenses	707,102	9,437,749	7,570,841
Total operating expenses	33,297,436	161,591,801	189,278,356
Operating Income (Loss)	(385,357)	22,367,121	1,679,990
Other Income (Expense)			
Interest expense	(1,774,045)	(8,804,328)	(11,194,175)
Other	-	39,072	14,649
Total other expense	(1,774,045)	(8,765,256)	(11,179,526)
Income (Loss) Before Income Taxes	(2,159,402)	13,601,865	(9,499,536)
Income Tax Expense	1,148,417	1,105,329	205,301
Net Income (Loss)	(3,307,819)	12,496,536	(9,704,837)
Less: Net Income (Loss) Attributable to Non-Controlling Interests	-	54,580	395,864
Net Income (Loss) Attributable to Controlling Interest	$ (3,307,819)	$ 12,441,956	$ (10,100,701)

See Notes to Consolidated Financial Statements

Pyramid Healthcare Acquisition Corp.

Consolidated Statements of Stockholder's and Members' Equity
Period Ended June 30, 2021 (Successor)
Period Ended May 9, 2021 and Year Ended June 30, 2020 (Predecessor)

	Successor			Predecessor			
	Common Stock		Additional Paid-in Capital	Members' Capital	Accumulated Deficit	Non-Controlling Interests	Total
	Shares	Amount					
Balance July 1, 2019 (Predecessor)	-	$ -	$ -	34,893,044	$ (37,943,963)	$ 68,676	$ (2,982,243)
Net loss	-	-	-	-	(10,100,701)	395,864	(9,704,837)
Balance June 30, 2020 (Predecessor)	-		-	34,893,044	(48,044,664)	464,540	(12,687,080)
Distribution	-		-	(557,932)	-	-	(557,932)
Contribution of non-controlling interest				367,188		(367,188)	-
Net income	-	-	-	-	12,441,956	54,580	12,496,536
Balance, May 9, 2021 (Predecessor)	-	$ -	$ -	$ 34,702,300	$ (35,602,708)	$ 151,932	$ (748,476)
Balance, May 10, 2021 (Successor)		$	$ -	$ -	$ -	$ -	$ -
Issuance of common stock	3,000	227,930,000	-	-	-	-	227,930,000
Equity-based compensation			69,016	-	-	-	69,016
Net loss			-	-	(3,307,819)	-	(3,307,819)
Balance June 30, 2021 (Successor)	3,000	$ 227,930,000	$ 69,016	$ -	$ (3,307,819)	$ -	$ 224,691,197

Pyramid Healthcare Acquisition Corp.

Consolidated Statements of Cash Flows
Period Ended June 30, 2021 (Successor)
Period Ended May 9, 2021 and Year Ended June 30, 2020 (Predecessor)

	Successor	Predecessor	
	Period From May 10, 2021 Through June 30, 2021	Period From July 1, 2020 Through May 9, 2021	Year Ended June 30, 2020
Operating Activities			
Net income (loss)	$ (3,307,819)	12,496,536	(9,704,837)
Items not requiring (providing) cash			
Depreciation	752,020	4,920,[illegible]	7,084,147
Amortization of intangible assets and goodwill	4,406,[illegible]62	[illegible]	6,092,388
Amortization of deferred finance cost - (interest expense)	1[illegible],331	494,[illegible]42	703,428
Equity-based compensation	[illegible]	-	-
(Gain) loss on disposal of property and equipment	-	(63,335)	362,244
Deferred income tax expense	73,174	-	-
Gain on capital leases upon termination	(7,183)	(308,438)	(31,644)
Provision for uncollectible accounts, net of recoveries and adjustments	-	-	14,856,878
Changes in			
Patient accounts receivable	72,[illegible]	(422,622)	(10,601,804)
Patient refunds and other third-party settlements	[illegible]76,[illegible]	2,304,866	-
Other receivables	([illegible]1,[illegible])	(217,899)	73,091
Accounts payable and other payables	([illegible]91,413)	[illegible],995,567)	4,615,391
Prepaids and other assets	([illegible]28,627)	(701,776)	(377,080)
Accrued expenses	1,369,672	6,016,597	106,471
Deferred revenue, grants and other supplemental funding	389,[illegible]12	3,289,632	4,402,734
Refundable income taxes		261,967	(124,813)
Net cash provided by operating activities	2,292,60[illegible]	30,421,885	17,456,594
Investing Activities			
Purchase of property and equipment	([illegible],663,928)	(10,763,205)	(12,445,372)
Cash paid for business acquisition, net of cash acquired	(369,271,949)	-	(7,200,000)
Net cash used in investing activities	(370,937,877)	(10,763,205)	(19,645,372)
Financing Activities			
Proceeds from issuance of senior debt	175,000,000	-	16,000,000
Proceeds from issuance of Paycheck Protection Program term loans	-	-	15,915,900
Finance cost paid	(5,025,427)	(1,422,074)	(322,710)
Principal payments on senior debt	-	(25,649,582)	(1,264,744)
Principal payments on installment sale note payable	(2,321)	(24,999)	-
Principal payments on capital lease	(116,376)	(839,466)	(1,415,590)
Principal payments on Paycheck Protection Program term loans	-	(15,915,900)	-
Borrowings under line-of-credit agreement	-	-	8,227,750
Repayments under line-of-credit agreement	-	-	(8,227,750)
Proceeds from issuance of common stock	215,700,000	-	-
Distribution	-	(557,932)	-
Net cash provided by (used in) financing activities	385,555,876	(44,409,953)	28,912,856
Increase (Decrease) in Cash	16,910,600	(24,751,273)	26,724,078
Cash, Beginning of Period	-	28,493,885	1,769,807
Cash, End of Period	$ 16,910,600	$ 3,742,612	$ 28,493,885
Supplemental Cash Flows Information			
Interest paid, net of capitalized interest	$ 135,964	$ 7,694,048	$ 10,260,358
Interest paid, capitalized within property and equipment	-	-	413,586
Income taxes paid, net of refunds	386,708	254,770	332,257
Capital asset acquisitions in accounts payable	2,417,205	1,453,227	-
Capital asset acquisition through capital lease	293,358	188,909	491,433
Equity issued in exchange for seller's equity	12,230,000	-	-
Estimated business acquisition purchase price adjustment due to seller	2,613,718	-	-

Pyramid Healthcare Acquisition Corp.

Notes to Consolidated Financial Statements
June 30, 2021 (Successor) and June 30, 2020 (Predecessor)

Note 1: Nature of Operations and Summary of Significant Accounting Policies

Reporting Entity and Reporting Periods

Pyramid Healthcare Acquisition Corp. (Successor Entity) was formed on February 25, 2021 for the purpose of effecting the acquisition of Pyramid Healthcare, Inc. (Pyramid), CV Twelve Oaks Holding, Inc. (Silver Ridge) and CV Silvermist Holdings, Inc. (Silvermist). The acquisition closed effective May 10, 2021 and as a result, the financial statements reflect the results from operations and cash flows of the Successor Entity for the period from the date of acquisition, May 10, 2021 to June 30, 2021 (Successor Period).

Prior to the consummation of the acquisition, Clearview Pyramid Acquisition Company, LLC (Predecessor Entity) was the 100% owner of Pyramid. The Predecessor Entity also was the approximate 94% owner in both Twelve Oaks, LLC and Silvermist, LLC, which reorganized prior to the acquisition to become wholly owned by the Predecessor Entity. As a result, the non-controlling interest was reflected as a capital contribution by the Predecessor. The previously issued 2020 financial statements and the result of operations from July 1, 2020 to May 9, 2021 (Predecessor Period) have been presented on a basis consistent with a change in reporting entity as the Predecessor Entity was replaced by the Successor Entity resulting from the business combination.

Nature of Operations

The Successor Entity and Predecessor Entity (collectively, the Company) is based in Altoona, Pennsylvania and King of Prussia, Pennsylvania with operations throughout Pennsylvania, New Jersey, North Carolina, Maryland, Connecticut, Georgia and Virginia. The Company provides drug and alcohol inpatient and outpatient treatment programs for adults and adolescents, autism educational services and other mental health services. The Company contracts primarily with commercial insurance payors, state and county authorities, managed care behavioral health medical assistance organizations (Medicaid) and school districts.

Principles of Consolidation

The consolidated financial statements include the accounts of the Company, its wholly-owned subsidiaries, Pyramid Healthcare, Inc.; American Day CD Centers, LLC (High Focus); October Road, Inc. (October Road); Onward Behavioral Health, Inc. (Onward); Silvermist, LLC; CV Silvermist Holdings, Inc. (majority owned under Predecessor Entity); Twelve Oaks, LLC; CV Twelve Oaks Holdings Inc. (majority owned under Predecessor Entity); Real Recovery of Asheville, Inc (Real Recovery).; Mazzitti & Sullivan Counseling Services, Inc. (Mazzitti & Sullivan); Quest Services, Inc. (Quest); Meadow Haven Recovery Services, LLC (Tapestry); Pyramid Family Behavior Healthcare, Inc. (PFBH); Pyramid Online Counseling, LLC (Online Counseling); Pyramid Walden, LLC (Walden); Aspen Investment Group, LLC (Freedom Detox) and its majority-owned subsidiary, Foundations Medical Services, LLC (Foundations); All significant intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Non-Controlling Interest

Successor Entity non-controlling interest represents the minority ownership interest in Foundations (43.5%), that the Company does not own, which was not material in connection with the Successor Period financial statements. Predecessor entity non-controlling interest represents the minority ownership interest in Foundations (43.5%), Silvermint (6%), and Silver Ridge (6%), that the Company does not own. Losses attributable to the non-controlling interest are allocated to the non-controlling interest even if the carrying amount of the non-controlling interest is reduced below zero.

Cash

At June 30, 2021, the Company's cash accounts exceeded federally insured limits by approximately $15,440,000.

Patient Accounts Receivable

Patient accounts receivable reflects the outstanding amount of consideration to which the Company expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs) and others. As a service to the patient, the Company bills third-party payors directly and bills the patient when the patient's responsibility for copays, coinsurance and deductibles is determined. Patient accounts receivable are due in full when billed.

Contract Assets and Liabilities

Amounts related to services provided to patients which have not been billed and that do not meet the conditions of an unconditional right to payment at the end of the reporting period are contract assets. Contract assets consist primarily of health care services provided to patients who are still receiving inpatient and residential care at the end of the year. The majority of these services are billed daily or monthly to respective payors.

The Company had no contract assets at June 30, 2021. There were no amounts at June 30, 2020, related to health care services provided to patients which had not been billed and did not meet the conditions of an unconditional right to payment as of the year then ended.

Amounts received related to health care services that have not yet been provided to patients are contract liabilities. Contract liabilities consist of payments made by patients and third-party payors for services not yet performed.

Contract liabilities totaling $335,894 are included in deferred revenue, grants and other supplemental funding at June 30, 2021. At June 30, 2020, amounts totaling $338,876 related to payments received for future health care services are included on the consolidated balance sheet in deferred revenue, grants and other supplemental funding.

Property and Equipment

Property and equipment acquisitions are stated at cost, less accumulated depreciation and amortization. Depreciation and amortization are charged to expense on the straight-line basis over the estimated useful life of each asset. Assets under capital lease obligations and leasehold improvements are amortized over the shorter of the lease term or their respective estimated useful lives.

The estimated useful lives for each major depreciable classification of property and equipment are as follows:

Buildings and improvements	2-30 years
Leasehold improvements	5-15 years
Equipment and vehicles	3-10 years
Furniture and fixtures	5-10 years
Software	3 years

The Company capitalizes interest costs as a component of construction in progress, based on the rates paid for long-term borrowing. The following table summarizes capitalized interest for the Successor and Predecessor Periods including the amortization of deferred financing fees, which is included in interest expense.

	Successor	Predecessor	
	Period From May 10, 2021 Through June 30, 2021	Period From July 1, 2020 Through May 9, 2021	Year Ended June 30, 2020
Total interest incurred	$ 1,654,714	$ 8,310,186	$ 10,904,333
Capitalized interest	-	-	(413,586)
Amortization of deferred financing fees	119,331	494,142	703,428
Interest expensed	$ 1,774,045	$ 8,804,328	$ 11,194,175

Goodwill

The Company elected the accounting alternative provided in ASU 2014-02, *Intangibles - Goodwill and Other (Topic 350): Accounting for Goodwill*. The alternative accounting provided for in ASU 2014-02 allows private companies to amortize goodwill and apply a simplified impairment test. The Company is using a 10-year useful life for calculation of amortization expense for goodwill.

Under this alternative, the Company tests goodwill for impairment when there is a triggering event indicating that the fair value of the entity may be below its carrying amount. In testing goodwill for impairment, the Company has the option first to perform a qualitative assessment to determine whether it is more likely than not that goodwill is impaired or the entity can bypass the qualitative assessment and proceed directly to the quantitative test by comparing the carrying amount, including goodwill, of the entity with its fair value. The goodwill impairment loss, if any, is measured as the amount by which the carrying amount of the reporting unit, including goodwill, exceeds its fair value. Subsequent increases in goodwill value are not recognized in the consolidated financial statements.

The Company also elected the private company accounting alternative provided for identifiable intangible assets in a business combination. Under this alternative, certain customer-related intangible assets and non-competition agreements are subsumed into goodwill and are no longer required to be recognized separately in the accounting for a business combination.

Other Intangible Assets

Successor

The Company has other intangible assets including trade names and certificate of need contracts. Amortization for these items is computed using the straight-line method with lives of 15 and 5 years, respectively. Such assets are periodically evaluated as to the recoverability of their carrying values.

Predecessor

The Company had other intangible assets including non-compete agreements, payer contracts, network patient referrals and other intangibles. Amortization for these items was computed using the straight-line method with lives ranging from 2 to 20 years. Such assets were periodically evaluated as to the recoverability of their carrying values.

Trade names and licenses associated with the Company and its subsidiaries previously had indefinite lives. These intangible assets were evaluated annually for impairment or more frequently if impairment indicators were present. A qualitative assessment was performed to determine whether the existence of events or circumstances leads to a determination that it was more likely than not the fair value of the indefinite-lived intangible asset was less than the carrying amount. If, based on the evaluation, it was determined to be more likely than not that the fair value was less than the carrying value, then the indefinite-lived intangible asset was tested further for impairment. If the implied fair value of the indefinite-lived intangible asset was lower than its carrying amount, an impairment loss was recognized for the difference. Subsequent increases in the indefinite-lived intangible asset values were not recognized in the consolidated financial statements.

Long-Lived Asset Impairment

The Company evaluates the recoverability of the carrying value of long-lived assets whenever events or circumstances indicate the carrying amount may not be recoverable. If a long-lived asset is tested for recoverability and the undiscounted estimated future cash flows expected to result from the use and eventual disposition of the asset is less than the carrying amount of the asset, the asset cost is adjusted to fair value and an impairment loss is recognized as the amount by which the carrying amount of a long-lived asset exceeds its fair value.

No material asset impairment was recognized during the Successor or Predecessor Periods.

Refund Liabilities

The consideration the Company has received from patients for which it does not expect to be entitled to is recorded as a refund liability and is included on the balance sheet in patient refunds payable and advanced payments.

Patient Service Revenue

Patient service revenue is recognized as the Company satisfies performance obligations under its contracts with patients. Patient service revenue is reported at the estimated transaction price or amount that reflects the consideration to which the Company expects to be entitled in exchange for providing services. The Company determines the transaction price based on standard charges for services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Company's policies, laws, regulations and implicit price concessions provided to uninsured patients.

The Company determines its estimates of explicit price concessions, which represent adjustments and discounts based on contractual agreements, its discount policies and historical experience by payor groups. The Company determines its estimate of implicit price concessions based on its historical collection experience by classes of patients. The estimated amounts also include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews and investigations by third-party payors.

Income Taxes and Uncertain Tax Positions

Successor

The Successor Entity, is subject to federal and state income taxes. Deferred tax assets and liabilities are recognized for the tax effects of differences between the financial statements and tax basis of assets and liabilities of the subsidiary. A valuation allowance is established to reduce deferred tax assets if it is more likely than not that a deferred tax asset will not be realized.

Predecessor

The Predecessor Entity is not directly subject to income taxes under the provisions of the Internal Revenue Code and applicable state laws. Taxable income or loss was allocated to its members in accordance with their respective percentage ownership for inclusion in their respective tax returns.

The Predecessor Entity's wholly owned subsidiary, Pyramid Healthcare, Inc., is subject to federal and state income taxes. Deferred tax assets and liabilities are recognized for the tax effects of differences between the financial statements and tax basis of assets and liabilities of the subsidiary. A valuation allowance is established to reduce deferred tax assets if it is more likely than not that a deferred tax asset will not be realized.

Uncertain Tax Positions

The Company recognizes the benefit or expense of an uncertain tax position in accordance with the Financial Accounting Standards Board Accounting Standards Codification (ASC) Topic 740, *Income Taxes*, after considering if it is more likely than not, based on the technical merits, that a tax position will be realized and sustained upon examination. For tax positions meeting a "more-likely-than-not" threshold, the amount recognized in the consolidated financial statements is the largest amount expected to be realized upon settlement with the tax authority. The Company's income tax returns filed subsequent to 2017 are still subject to federal and state examinations by tax authorities. As of June 30, 2021, the Company had no material uncertain tax positions.

Self-Insurance

The Company has elected to self-insure certain costs related to employee health benefit programs. Costs resulting from non-insured losses are charged to income when incurred, as the Company accrues for incurred but not reported claims. The Company has purchased insurance that limits its exposure for individual claims to $200,000 per occurrence, with no cap per person per plan year.

Change in Accounting Principle

The Company adopted the FASB ASU 2014-09, *Revenue from Contracts with Customers* (Topic 606), using a modified-retrospective method of adoption to open contracts with customers (patients) at July 1, 2020. The core guidance in ASU 2014-09 is to recognize revenue to depict the transfer of promised goods or services to patients in an amount that reflects the consideration to which the Company expects to be entitled in exchange for those goods or services. The amount to which the Company expects to be entitled is calculated as the transaction price and recorded as revenue in exchange for providing patient care services to its patients. Adoption of Topic 606 resulted in changes in presentation of the consolidated financial statements and related disclosures in the notes to the consolidated financial statements. Prior to the adoption of Topic 606, the majority of the provision for doubtful accounts related to patients without insurance, as well as patient responsibility balances for co-pays, co-insurance and deductibles for patients with insurance. Under Topic 606, the estimated amounts due from patients for which the Company does not expect to be entitled or collect from the patients are considered implicit price concessions and excluded from the Company's estimation of the transaction price or revenue recorded.

The adoption had no impact on operating results or net cash used in operating activities.

Reclassifications

Certain reclassifications have been made to the 2020 consolidated financial statements to conform to the 2021 consolidated financial statement presentation. These reclassifications had no effect on net earnings.

Note 2: Business Combinations

Successor Acquisition

Effective May 10, 2021 (the "Closing Date"), the Pyramid Healthcare Acquisition Corp. (Successor Entity) acquired 100% of the outstanding equity of Pyramid Healthcare, Inc. (Pyramid), CV Twelve Oaks Holding, Inc. and CV Silvermist Holdings, Inc. (collectively, the Entities), for approximately $380,472,000 in consideration. As part of the acquisition, the Successor Entity's Parent, Pyramid Healthcare Holding Company, LLC (Parent) issued $12,230,000 of equity units to certain sellers in exchange for ownership of Pyramid, which was subsequently contributed to the Successor Entity. The valuation of the equity issued was determined equivalent to the cash purchase price for the equity on the transaction date. The Successor Entity purchased the Entities as part of the overall investment strategy of its investor group, which considered several factors including industry growth and market presence.

The purchase agreement provides for certain proceeds to be held in escrow accounts to indemnify the Successor Entity including an escrow for COVID relief funds totaling approximately $10,415,000. This escrow represents the estimated maximum amount of COVID relief funds received by the Company prior to the Closing Date that had yet to be reconciled with the payers as of the Closing Date and therefore may be subject to repayment. Such COVID relief funds were received by the Company prior to the Closing Date under government grants or insurance payor gap and prepayment programs. The Company had additional information and has reduced the estimated amount to be applied to services subsequent to the closing or repaid and has recorded these amounts as an assumed liability as of the Closing Date. The Company has also deferred certain governmental grant amounts as it was unable to conclude whether and to what extent it had met the terms and conditions to retain such funds. As a result, the Company has recorded an escrow indemnification receivable of $7,386,402, which equals the corresponding estimated liability which was assumed as of the closing date.

The results of operations for the Successor Period ended June 30, 2021 include the operations of the acquired entities from the date of acquisition. The gross amount of patient receivables net of price concessions and contractual discounts was approximately the fair value at the acquisition date.

The following table summarizes the consideration paid for and the amounts of the assets acquired and liabilities assumed at the acquisition date:

Fair Value of Consideration	
Cash paid to sellers	$ 373,014,557
Consideration payable - purchase price adjustment	2,613,718
Equity issued to sellers	12,230,000
	387,858,275
Recognized Amounts of Identifiable Assets Acquired	
Assets Acquired	
Cash	3,742,608
Patient accounts receivable	13,354,761
Other receivables	526,339
Indemnification receivable - escrow	7,386,402
Prepaids and other current assets	1,537,883
Property and equipment	77,682,030
Other intangible assets, excluding goodwill	78,280,000
Other long-term assets	874,882
Total assets	183,384,905
Liabilities Assumed	
Accounts payable	5,486,877
Accrued expenses	18,239,545
Patient refunds payable and advance payments	1,822,744
Other estimated third-party settlements	813,122
Deferred revenue, grants and other supplemental funding	7,386,402
Deferred tax liability	7,584,000
Notes payable	1,984,322
Deferred employer payroll expenses	2,139,095
Total liabilities	45,456,107
Net Assets Acquired	137,928,798
Goodwill	$ 249,929,477

In connection with the acquisitions, the Successor Entity incurred transaction costs of approximately $2,543,000, which were expensed during the Successor Period ended June 30, 2021. The weighted-average useful life of acquired intangible assets, excluding goodwill, was 14.3 years. Approximately $5,002,000 of the debt financing transaction costs were paid to the Company's lenders who are also equity investors and therefore deemed related parties. The consideration paid for the goodwill was primarily attributable to the expected future cash flows and growth of the businesses. Approximately $51,000,000 of the total goodwill from the business combination is expected to be deductible for income tax purposes by the Successor Entity.

The Successor Entity has not completed the tax allocation related to the business combinations, as a result, the tax deductible goodwill and any other temporary differences have been provisionally estimated as of the acquisition date.

Predecessor Acquisition

The Predecessor Entity acquired 100% of the outstanding equity units of Aspen Investment Group, LLC (d/b/a Freedom Detox) and certain real estate assets held by Bluebrooke, LLC, a majority owned subsidiary of Freedom (collectively "Freedom" or "Sellers" or "the business"), effective October 4, 2019. The Predecessor Entity paid $7,300,000 in cash consideration for the business. The Predecessor Entity executed the acquisition as part of the overall investment strategy of the Predecessor Entity and its investor group, which considered several factors including industry growth and market presence. Under the terms of the purchase agreement, the Sellers were entitled to all closing date accounts receivable balances collected for 150 days after the closing and the Sellers were also responsible for the payment of most liabilities incurred as of the closing date.

In connection with the purchase, the Predecessor Entity incurred purchase transaction costs of approximately $170,000, which were expensed and included in other operating expenses during the year ended June 30, 2020. Approximately $126,000 of the transaction expense were paid to related parties. The operations of Freedom have been included in the 2020 consolidated financial statements from the acquisition date.

The consideration paid for the goodwill was primarily attributable to the expected future cash flows and growth of the business. Goodwill is deductible for income tax purposes.

The following table summarizes the consideration paid in addition to the assets acquired and liabilities assumed at the acquisition date.

Fair Value of Consideration	
Cash paid to sellers	$ 7,300,000
Recognized Amounts of Identifiable Assets Acquired	
Assets Acquired	
Cash	100,000
Property and equipment	2,260,000
Other assets	3,028
Total assets	2,363,028
Liabilities Assumed - accrued expenses	14,760
Net Assets Acquired	2,348,268
Goodwill	$ 4,951,732

Note 3: Patient Service Revenue

Patient service revenue is reported at the amount that reflects the consideration to which the Company expects to be entitled in exchange for providing services. These amounts are due from patients, third-party payors (including health insurers and government programs) and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews and investigations. Generally, the Company bills the patients and third-party payors several days after the services are performed or the patient is discharged from the facility. Revenue is recognized as performance obligations are satisfied.

Performance Obligations

Performance obligations are determined based on the nature of the services provided by the Company. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected or actual charges. The Company believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients receiving inpatient or outpatient services in Company facilities and other settings. The Company measures the performance obligation from admission to its facilities or the commencement of an outpatient service, to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge or completion of the outpatient services.

Transaction Price

The Company determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Company's policy and implicit price concessions provided to uninsured patients. The Company determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies and historical experience. The Company determines its estimate of implicit price concessions based on its historical collection experience with this class of patients.

Third-Party Payors

Agreements with third-party payors typically provide for payments at amounts less than established charges. A summary of the payment arrangements with major third-party payors follows:

Medicaid

Services rendered to Medicaid program beneficiaries are reimbursed at established rates based on the type of service provided.

County and Other Government Funding

The Company is contracted through certain counties and state-sponsored government agencies to provide services to eligible individuals. The Company is reimbursed by the various agencies at contracted rates.

Other Third-Party Payors

The Company has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations and preferred provider organizations. The basis for payment to the Company under these agreements includes contractually determined rates per discharge, discounts from established charges and contractually determined daily rates. The Company is out-of-network with various commercial insurance carriers who reimburse the Company at prospectively determined amounts.

Laws and regulations concerning government programs, including Medicaid and other county and government funding, are complex and subject to varying interpretation. Compliance with such laws and regulations may be subject to future government review and interpretation, as well as significant regulatory action. There can be no assurance that regulatory authorities will not challenge the Company's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the Company. In addition, the contracts the Company has with commercial payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the Company's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known based on newly available information or as years are settled or are no longer subject to such audits, reviews and investigations.

As a result of the COVID-19 pandemic, beginning in 2020 and continuing through 2021, certain third-party payors moved to supplemental and alternative payment models to accelerate payments to providers and compensate organizations for declines in volumes. The extent of these models range from temporary rate increases to gap payments measured to compensate providers against pre-COVID baselines from previous periods. Amounts recognized as patient revenues associated with these programs approximated $2,490,000 during the Successor Period ended June 30, 2021, and $10,995,000 during the Predecessor Period ended May 9, 2021. No amounts were recognized as revenue during the Predecessor year-ended June 30, 2020 as there was not sufficient information to reasonably determine final settlement as of that time. At June 30, 2021 (Successor Period) and June 30, 2020 (Predecessor Period), the Company has recognized $4,329,127 and $4,063,858, respectively, of such amounts received from such third-party payors within deferred revenue, grants and other supplemental funding in the current liability section of the consolidated balance sheets. These amounts are either expected to be repaid, applied to periods after June 30, 2021 or sufficient information is not yet available to reasonably determine a settlement amount. Amounts received under these supplemental and alternative payment models at the acquisition date of May 10, 2021 are included in deferred revenue, grants and other supplemental funding. Any amounts recognized at the acquisition date that are retained and not refunded to third-party payors or applied to balances outstanding for services provided prior to the acquisition date will reduce the liability account and the estimated COVID escrow claim, which is recorded in the Escrow Claim Receivable asset account established at closing and reflected on the June 30, 2021 balance sheet.

The Company continues to evaluate these supplemental and alternative payments against known payment terms and reconcile payment amounts with payors where payment terms are unknown. To the extent that information becomes available where the Company can reasonably estimate that Successor period amounts will not be subject to repayment, these accelerated and advanced payments will be recognized as patient service revenues in the period known. Given the complexities and uncertainties of these programs, it is reasonably possible that recorded estimates will change materially in the near term.

Patient and Uninsured Payors

The Company has determined it has provided implicit price concessions to uninsured patients and patients with other uninsured balances, such as copays and deductibles. The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the Company expects to collect based on its collection history with those patients.

Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Company also provides services to uninsured patients and offers those uninsured patients a discount, either by policy or law, from standard charges. The Company estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts and implicit price concessions based on historical collection experience. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay are recorded as bad debt expense.

Revenue Composition

The Company has determined that the nature, amount, timing and uncertainty of revenue and cash flows are affected by payors and service lines. Tables providing details of these factors are presented below.

The composition of patient service revenue by primary payor for the Successor Period ended June 30, 2021, the Predecessor Period ended May 9, 2021 and the Predecessor year ended June 30, 2020 is as follows:

	Successor	Predecessor	
	Period From May 10, 2021 Through June 30, 2021	Period From July 1, 2020 Through May 9, 2021	Year Ended June 30, 2020
Medicaid	$ 15,948,844	$ 90,039,147	$ 90,356,740
County and other government funding	1,145,301	5,973,001	11,252,424
Other third-party payors	13,773,323	75,835,625	78,966,711
Self-pay and other	2,044,611	12,309,818	10,382,471
	$ 32,912,079	$ 184,157,591	$ 190,958,346

Revenue from patients' deductibles and coinsurance are included in the categories presented above based on the primary payor.

The composition of patient service revenue based on lines of business for the Successor Period ended June 30, 2021, the Predecessor Period ended May 9, 2021 is as follows:

	Successor Period From May 10, 2021 Through June 30, 2021	Predecessor Period From July 1, 2020 Through May 9, 2021
Inpatient and residential	$ [illegible],774,285	$ 96,914,779
Outpatient	14,549,536	72,640,184
School	1,432,[illegible]28	9,107,703
Methadone	1,15[illegible],230	5,494,925
	$ [illegible]2,712,079	$ 184,157,591

All of the Company's revenues represent services that transfer to the patient over time.

Note 4: Concentration of Credit Risk

The Company grants credit without collateral to its patients, of which many are insured under third-party payor agreements. The mix of net receivables from patients and third-party payors at June 30, 2021 (Successor Period) and June 30, 2020 (Predecessor Period) is:

	Successor 2021	Predecessor 2020
Medicaid	26%	30%
County and other government funding	12%	15%
Other third-party payors	48%	46%
Self-pay and patient co-pays and deductibles	14%	9%
	100%	100%

Pyramid Healthcare Acquisition Corp.

Notes to Consolidated Financial Statements
June 30, 2021 (Successor) and June 30, 2020 (Predecessor)

Note 5: Property and Equipment

Property and equipment consist of the following at June 30, 2021 (Successor Period) and June 30, 2020 (Predecessor Period):

	Successor 2021	Predecessor 2020
Land	$ 9,490,000	$ 3,219,450
Buildings and leasehold improvements	48,105,819	63,264,009
Equipment, vehicles and software	4,061,275	19,863,498
Furniture and fixtures	831,303	1,098,200
Construction in progress	17,995,590	2,876,051
Total cost	80,485,987	90,321,208
Accumulated depreciation	(632,713)	(23,323,236)
Total	$ 79,853,274	$ 66,997,972

Note 6: Goodwill and Other Intangible Assets

The carrying basis and accumulated amortization of recognized goodwill and other intangible assets at June 30, 2021 (Successor Period) and June 30, 2020 (Predecessor Period) were:

	2021 (Successor)			
	Amortization Period (Years)	Gross Carrying Amount	Accumulated Amortization	Net Carrying Value
Amortized intangible assets:				
Trade names	15	$ 72,800,000	$ (691,470)	$ 72,108,530
Certificates of need	5	5,480,000	(156,150)	5,323,850
Goodwill	10	249,929,477	(3,559,142)	246,370,335
		$ 328,209,477	$ (4,406,762)	$ 323,802,715

Pyramid Healthcare Acquisition Corp.

Notes to Consolidated Financial Statements
June 30, 2021 (Successor) and June 30, 2020 (Predecessor)

	2020 (Predecessor)			
	Amortization Period (Years)	Gross Carrying Amount	Accumulated Amortization	Net Carrying Value
Amortized intangible assets				
Network patient referrals	10 - 20	$ 25,090,000	$ (10,592,745)	14,497,255
Payer contracts	4 - 5	13,160,000	(13,160,000)	-
Noncompete agreement	3 - 5	930,000	(930,000)	-
Licenses and certifications	2 - 3	354,000	(354,000)	-
Goodwill	10	47,909,455	(23,523,538)	24,475,917
		$ 87,533,455	$ (48,560,283)	$ 38,973,172
Unamortized intangible assets				
Trade names		$ 5,955,000	$ -	$ 5,955,000
Licenses and providers numbers		3,546,000	-	3,546,000
		$ 9,501,000	$ -	$ 9,501,000

For the Successor Period ended June 30, 2021, amortization expense related to goodwill and intangible assets was $4,406,762. For the Predecessor Period ended May 9, 2021 and June 30, 2020, amortization expense related to goodwill and intangible assets were $5,296,902 and $6,092,388, respectively. Estimated amortization expense for each of the following five years is $30,942,000 annually.

Changes in goodwill for the Successor Period ended June 30, 2021 and Predecessor Period ended May 9, 2021 and year ended June 30, 2020 were as follows:

Balance as of July 1, 2019 (Predecessor)	$ 24,245,077
Acquired goodwill in business combination	4,951,732
Amortization expense	(4,720,892)
Balance as of June 30, 2020 (Predecessor)	24,475,917
Amortization expense	(4,110,050)
Balance as of May 9, 2021 (Predecessor)	$ 20,365,867
Balance, May 10, 2021 (Successor)	$ -
Acquired goodwill in business combination	249,929,477
Amortization expense	(3,559,142)
Balance, June 30, 2021 (Successor)	$ 246,370,335

Note 7: Long-Term Debt and Line of Credit

Effective May 10, 2021, the Company entered into a credit agreement with a group of lenders. The agreement provides an initial term loan totaling $175,000,000, a revolving credit commitment of $20,000,000 and delayed draw term loan (DDTL) commitments of $60,000,000. The administrative agent and primary lenders are also equity investors in the Company. The agreement expires on May 10, 2027 and has certain restrictive covenants including maintenance of consolidated leverage ratio as defined in the agreement. The facility is collateralized by substantially all assets of the Company.

Interest is charged under the term loan, revolving line of credit or DDTL at a Base Rate or a Eurocurrency rate, plus an applicable margin. The Base Rate is the highest of i) the higher of prime or the federal funds rate plus 50 basis points, ii) the 1-month Eurocurrency rate plus 1.00%, or iii) 2.00%. The applicable margin is based on a consolidated leverage ratio and ranges from 3.75% to 5.25%. Interest is payable based on the interest period applicable to the interest tranche amount, generally monthly or quarterly. Quarterly principal payments of $437,500 are required under the term loan commencing September 30, 2021 with the balance due at maturity. Additional annual principal payments are due based on the Company's excess cash flow as defined in the credit agreement. The Company can prepay the term loan subject to certain prepayment premiums of 1% through May 10, 2023.

At June 30, 2021 (Successor Period), the interest rates in effect under the term loan was 5.75%. There were no amounts drawn under the revolving credit or DDTL commitments.

Unamortized debt issuance costs were $4,906,096 at June 30, 2021.

During the Predecessor Period, the Company had a credit facility which included an initial term loan commitment, revolving credit facility and various classes of DDTL commitments. No amounts were drawn on the revolving credit facility at June 30, 2020 (Predecessor Period). Interest was payable quarterly on the various commitments and varied with a LIBOR-based rate or the bank's prime rate, plus an applicable margin. The interest rates at June 30, 2020 ranged from 7.5% to 8.5%. Principal payments for the term note facility and DDTLs were made quarterly in equal aggregate installments of $325,791 with the balance due at maturity. The credit facility was subject to certain restrictive covenants and was collateralized by substantially all assets and was to mature on August 22, 2022.

The Company entered into an installment sales agreement for the acquisition of property and equipment for the operation of a single drug addiction recovery and rehabilitation center. The agreement calls for 240 monthly installment payments of $8,500 for the first 60 months and $4,087 for the remaining 180 months. The discount rate utilized for this sales agreement was 4.25%, which is reflected as imputed interest.

The Company leases various vehicles through capital lease arrangements. The leases expire at various times through 2026 and include interest ranging from 5.6% to 16.0%. The Company is obligated for the residual value of the vehicle, which is included within the present value of lease payments. Should the prevailing market value exceed the residual value at the term of the lease, the Company will receive credit or be refunded the difference.

Refer to Note 16 for information regarding the Company's PPP loans payable.

Long-term debt consists of the following at June 30, 2021 (Successor Period) and June 30, 2020 (Predecessor Period):

	Successor 2021	Predecessor 2020
Senior term note payable, bank	$ 175,000,000	$ 86,428,875
Delayed draw term note payable, bank	-	4,500,000
Delayed draw term note payable - 1, bank	-	14,561,500
Delayed draw term note payable - 2, bank	-	9,805,591
Delayed draw term note payable - 3, bank	-	7,401,250
Delayed draw term note payable - 4, bank	-	2,481,250
Capital lease payable	1,655,594	2,444,790
Installment sale note payable	496,206	523,527
	177,151,800	128,146,783
Less unamortized debt issuance costs	(4,906,096)	(2,915)
Less current maturities	(2,838,385)	(2,774,195)
	$ 169,407,319	$ 125,369,673

Aggregate annual maturities of long-term debt and capital leases at June 30, 2021 are:

	Long-Term Debt (Excl. Capital Leases)	Capital Lease Obligations
2022	$ 1,797,834	$ 1,064,142
2023	1,779,740	400,436
2024	1,781,829	230,649
2025	1,783,327	35,181
2026	1,783,776	10,717
Thereafter	165,571,454	-
	175,496,206	1,741,125
Less amount representing interest		(85,531)
Present value of future minimum lease payments		$ 1,655,594

Property and equipment include the following property under capital leases:

	Successor 2021	Predecessor 2020
Equipment and vehicles	$ 1,642,541	$ 6,465,981
Less accumulated depreciation	(6,816)	(4,000,842)
	$ 1,635,725	$ 2,465,139

Note 8: Operating Leases

The Company leases various treatment facilities and certain other equipment under operating leases. The leases expire in various periods through 2028. The terms of the facility leases generally allow for extension of the lease terms and require the Company to pay insurance, utilities, maintenance and property taxes in addition to monthly rental amounts.

Minimum annual rental payments required under facility operating leases, which have remaining terms in excess of one year as of June 30, 2021, are as follows:

2022	$ 6,462,481
2023	4,605,058
2024	2,217,683
2025	1,138,437
2026	927,433
Thereafter	620,682
	$ 15,971,774

Total rental expense, including short-term rentals excluded from the table above for the Successor Period ended June 30, 2021 was $1,177,831. Total rent expense for the Predecessor Period ended May 9, 2021 and June 30, 2020 was $6,407,689 and $7,947,968, respectively. See Note 12 for rental expense paid to related parties.

Note 9: Employee Benefits

The Company offers a 401(k) plan covering all eligible employees. The Company provides a matching contribution of 100% of employee contributions up to 1% of eligible employee compensation under the 401(k) plan, plus 50% of salary deferrals for the next 5% of eligible employee compensation. Contributions totaled $1,819,865 for the Predecessor Period ended June 30, 2020. The Company suspended its match temporarily effective June 17, 2020 and reinstated it July 2, 2021 for the pay period ending June 26, 2021 with contributions totaling $112,225 accrued at June 30, 2021.

Note 10: Income Taxes

The income tax expense includes these components for the years ended June 30, 2021 (Successor Period) and June 30, 2020 (Predecessor Period):

	Successor	Predecessor	
	2021	Period From July 1, 2020 Through May 9, 2021	Year Ended June 30, 2020
Deferred income taxes	$ 873,174	$ -	$ -
Taxes currently payable	275,243	1,105,329	205,301
Income tax expense	$ 1,148,417	$ 1,105,329	$ 205,301

Pyramid Healthcare Acquisition Corp.

Notes to Consolidated Financial Statements
June 30, 2021 (Successor) and June 30, 2020 (Predecessor)

A reconciliation of income tax expense at the statutory rate to the Company's actual income tax expense is shown below for the periods from May 10, 2021 through June 30, 2021 (Successor Period), July 1, 2020 through May 9, 2021 (Predecessor Period) as well as the year ended June 30, 2020 (Predecessor Period):

	Successor	Predecessor	
	Period From May 10, 2021 Through June 30, 2021	Period From July 1, 2020 Through May 9, 2021	Year Ended June 30, 2020
Computed at the statutory rate of 21% for 2021 and 2020	$ (453,474)	$ 2,856,392	$ (1,994,903)
Increase (decrease) resulting from			
Nontaxable income	-	-	90,914
Nondeductible expenses and acquisition cost	10,114	33,728	40,005
Nondeductible goodwill amortization	738,430	314,520	367,948
State income taxes	353,348	1,105,329	(389,134)
Changes in the deferred tax asset valuation allowance	-	(3,304,240)	2,049,408
Other	-	-	41,063
Actual tax expense	$ 648,418	$ 1,005,329	$ 205,301

The tax effects of temporary differences related to deferred taxes shown on the consolidated balance sheets at June 30, 2021 (Successor Period) and 2020 (Predecessor Period) were:

	Successor June 30, 2021	Predecessor June 30, 2020
Deferred tax assets		
Allowance for doubtful accounts	$ 960,211	$ 830,313
Accrued expenses	2,944,475	1,725,706
Net operating loss carryforward	1,371,207	8,249,645
Interest expense limitation - carryforward	-	3,019,426
Effect of state taxes and other	544,581	-
	5,820,474	13,825,090
Deferred tax liabilities		
Property and equipment	(2,135,137)	(904,898)
Intangible assets	(12,142,511)	(1,488,661)
Other	-	(170,032)
	(14,277,648)	(2,563,591)
Net deferred tax asset (liability) before valuation	(8,457,174)	11,261,499
Valuation allowance - state operating loss carryforward		
Beginning balance	-	(9,212,091)
Increase during the period	-	(2,049,408)
Ending balance	-	(11,261,499)
Net deferred tax asset (liability)	$ (8,457,174)	$ -

At June 30, 2021, the Company has approximately $6,500,000 of Federal net operating loss carryforwards expiring through 2040.

Note 11: Equity-Based Compensation

Effective May 10, 2021, Pyramid Healthcare Holding Company, LLC, the parent entity of the Company, issued a total of 24,044,165 of incentive units to certain employees of the Company. The units issued were comprised of 7,317,544 of class B-1, 5,241,418 of class B-2, 5,565,031 of class B-3, and 5,919,172 of class B-4 units. The operating agreement allows for the grant of up to 32,561,429 of total B units. The Company believes that such incentive unit awards align the interests of its employees with those of its equity holders. The Parent has pushed down the accounting for the equity-based compensation to the Company's financial statements to align with the reporting of the employee compensation.

Incentive unit awards are granted with an exercise price equal to or greater than the market price of the Company's membership units at the grant date. The class B-1 incentive units vest over a period of five years. Class B-2, B-3, and B-4 units vest only upon certain distribution thresholds being paid to the Class A unitholders. The operating agreement provides for accelerated vesting of B-1 units if there is a change in control (as defined). The grant date fair value of the units issued approximated $2,761,000 for Class B-1 and $1,203,000 for all remaining units. Approximately $69,000 of non-cash equity compensation expense was recognized within the financial statements of the Company for the Successor period ended June 30, 2021 and all units are unvested. The remaining unrecognized compensation expense of $2,692,000 for the Class B-1 units will be recognized over the remaining vesting period of 4.9 years as of June 30, 2021. The unrecognized compensation expenses associated with the B-2, B-3 and B-4 units will be recognized once the performance condition is met.

The fair value of each award was estimated on the grant date using a Black-Scholes option valuation model that used the assumptions noted below and other valuation techniques. Expected volatility was based on historical volatility for guideline public companies that operate in the Company's industry. The expected term of awards granted represents management's estimate for the number of years until a liquidity event as of the grant date. The risk-free rate for the period of the expected term was based on the U.S. Treasury yield curve in effect at the time of grant. In addition, management considered the distribution priority schedule or "waterfall calculation" for the Company in its estimation process.

	Successor 2021
Expected dividend yield	0%
Expected volatility	42.40%
Risk-free interest rate	0.80%
Expected life (years)	5.00

During the Predecessor Period, the Company's 2011 Profits Interest Plan (Plan) permitted the grant of Class B units of the Company to its employees. The Company had granted 180,000 Class B membership units as of June 30, 2020. The Class B units vested over a four-year term and were subject to certain restrictions and minimum capital components that are withheld from future distributions based on the Company's operating agreement. The grant date fair value of the Class B units was not material. The Plan provided for accelerated vesting if there is a change in control (as defined in the Plan). As of June 30 2020, 143,750 units were vested under the Plan.

Note 12: Related Party Transactions

The Company pays management fees and acquisition transaction fees to Nautic Partners, LLC., a company related through equity ownership. During the period ended June 30, 2021 (Successor Period), management fee expense approximated $142,000 and is included with professional fees in the consolidated statements of operations.

The Company's interest expense and accrued interest payable to the lender who is an equity investor totaled approximately $1,625,000 and $1,518,000, respectively during the Successor Period ended June 30, 2021.

The Company rents various facilities from related parties. Rental expense paid to related parties for the Successor Period ended June 30, 2021 approximated $95,000. Rental expense paid to related parties for the Predecessor Period ended May 9, 2021 and year June 30, 2020 approximated $476,000 and $572,000, respectively.

During the Predecessor Period, the Company paid management fees and acquisition transaction fees to Clearview Capital, L.P., a company related through common ownership. During the Predecessor Period ended May 9, 2021 and year ended June 30, 2020, management fee expense was $500,000 for each of the periods, and is included with professional fees in the consolidated statements of operations. Acquisition transaction fees paid to Clearview Capital, L.P. totaled $80,000 for the year ended June 30, 2020.

The Company had accounts payable to related parties in the amount of $142,000 and $170,036 as of June 30, 2021 (Successor Period) and June 30, 2020 (Predecessor Period), respectively.

Note 13: Contingencies and Commitments

In the normal course of business, the Company is, from time to time, subject to allegations that may or do result in claims and litigation. Some of these allegations may be in areas not covered by the Company's commercial insurance policies. The Company evaluates such allegations by conducting investigations to determine the validity of each potential claim. Based upon the advice of counsel, management records an estimate of the amount of ultimate expected loss, if any, for each of these matters. Management is of the opinion that the ultimate resolution of any known claims, either individually or in the aggregate, will not have a material adverse impact on the Company's consolidated financial position or results of operations or cash flows. Events could occur that would cause the estimate of ultimate loss to differ materially in the near term.

Note 14: Professional Liability Claims

The Company purchases medical malpractice insurance under a claims-made policy. Under such a policy, only claims made and reported to the insurer during the policy term, regardless of when the incidents giving rise to the claims occurred, are covered. Based upon the Company's claims experience, no accrual has been made for the Company's estimated medical malpractice costs as of June 30, 2021 (Successor Period) and 2020 (Predecessor Period).

Note 15: Self-Insured and Liability Retention Plans

Substantially all of the Company's employees and their dependents are eligible to participate in the Company's employee health insurance plan, subject to the eligibility requirements and waiting periods. Costs resulting from non-insured losses are charged to income when incurred including both claims reported and claims incurred but not yet reported.

At June 30, 2021 (Successor Period) and 2020 (Predecessor Period), the Company's accrual for incurred but not recorded medical expenses was $1,145,[illegible] and $1,[illegible], respectively, which was net of any refunds expected from the reinsurance provider. The Company has purchased insurance that limits its exposure for individual claims to $200,000 per occurrence, with no cap per person per plan year.

The Company has certain liability retention arrangements for workers' compensation, general liability and automobile, cyber and directors and officers liability insurance coverage. Under the terms of the agreements, the Company pays a fixed premium for insurance coverage and participates in actual claims cost up to certain maximum deductible levels. The workers' compensation per occurrence deductible is $250,000, the auto liability per occurrence deductibles is $100,000 and the general liability per occurrence deductible is $100,000. The Company accrues based on calculations from its insurance broker management consultant's projected retention amounts. The maximum aggregate deductible cost for workers' compensation and automobile liability insurance is approximately $2,100,000. As of June 30, 2021 (Successor Period) and 2020 (Predecessor Period), the Company has accrued approximately $990,000 and $393,000, respectively, in connection with claims incurred in connection with the retention portion of the insurance policies for automobile and workers' compensation.

The Company is subject to claims and lawsuits that arise primarily in the ordinary course of business. It is the opinion of management that the disposition or ultimate resolution of such claims and lawsuits will not have a material adverse effect on the consolidated financial position, results of operations and cash flows of the Company. The Company coordinates its legal response to such claims and lawsuits with its insurance carrier and internal and external legal counsel. As of June 30, 2021 (Successor Period) and June 30, 2020 (Predecessor Period), the Company has accrued approximately $257,000 and $291,000, respectively, related to the estimated liability.

Note 16: COVID-19 Uncertainty and CARES Act Funding

The United States and global economies have been impacted at various levels during 2020 and 2021 as a result of the COVID-19 pandemic. Businesses may experience disruptions including inflationary changes, which could negatively affect financial positions, results of operations and cash flows of entities. The future financial and operating impact, if any, to the Company cannot be estimated at this time.

Payroll Tax Credits

The CARES Act provides for a deferral of payments of the employer portion of payroll tax incurred during the pandemic, allowing half of such payroll taxes to be deferred until December 31, 2021 and the remaining half until December 31, 2022. At June 30, 2021 (Successor Period) and June 30, 2020 (Predecessor Period), the Company had deferred $4,278,190 and $1,847,482, respectively, of payroll taxes in the accompanying consolidated balance sheets, with $2,139,095 included in accrued expenses as a current liability at June 30, 2021 and the remaining amounts classified as long-term.

Paycheck Protection Program (PPP) Loan

During the Predecessor Period, the Company's subsidiaries qualified and applied for Paycheck Protection Program (PPP) loans and received seven term loans totaling $15,915,900 under the Paycheck Protection Program (PPP), which was established under the CARES Act. While the Company believed they would qualify for forgiveness of these loans, the Company repaid all loans in full during the Predecessor Period ending May 9, 2021 prior to the acquisition described in Note 2.

Provider Relief Funds

During the Predecessor Period ended May 9, 2021, the Company received $3,110,993 from the phase two general distribution of the CARES Act Provider Relief Fund (collectively, the Provider Relief Fund). This distribution from the Provider Relief Fund is not subject to repayment to the United States Department of Health and Human Services (HHS), provided the Company is able to attest to and comply with the terms and conditions of the funding, including demonstrating that the distributions received have been used for healthcare-related expenses or lost revenue attributable to COVID-19, as defined by HHS.

The Company accounts for such payments as conditional contributions in accordance with ASC Topic 958-605 – *Revenue Recognition*. Payments are recognized as contribution revenue once the applicable terms and conditions required to retain the funds have been substantially met. Based on an analysis of the compliance and reporting requirements of the Provider Relief Fund ("PRF") and the effect of the pandemic on the Company's revenues and expenses, the Company deferred the entire amount received as it was unable to conclude as of the date of the financials that it had met the terms and conditions required to retain such PRF funds. The determination of the amount of such PRF funds that the Company will retain may be impacted by the amounts to be repaid or retained from other third-party payors. The uncertainty surrounding the application of payor specific accelerated and advanced payment programs established to compensate the Company for similar pandemic-related expenses and lost revenues has impacted the Company's ability to make the required determinations to retain such PRF funds as of June 30, 2021. The unrecognized amount of distributions from the Provider Relief Fund are recorded as deferred revenue, grants and other supplemental funding in the accompanying consolidated balance sheets. All amounts have been reflected as a liability on the Company's consolidated balance sheet as of June 30, 2021 and corresponding receivable from the COVID escrow claim receivable account as discussed in Note 2. Any amounts retained by the Successor Company will reduce the amounts receivable from the COVID escrow claim receivable and the corresponding liability account.

Third-Party Payor Supplemental and Alternative Payment Programs

Supplemental and alternative payment models employed by certain third-party payors during 2020 and throughout 2021 are described in Note 3.

Note 17: Significant Estimates

Accounting principles generally accepted in the United States of America require disclosure of certain significant estimates and current vulnerabilities due to certain concentrations. Those matters include the following:

Variable Consideration

Estimates of variable consideration in determining the transaction price for patient service revenue as described in Notes 1 and 3

Third-Party Payor Supplemental and Alternative Payment Programs

Refer to Note 3 for estimates related to payer supplemental and alternative payment programs.

General Litigation

The Company is subject to claims and lawsuits that arose primarily in the ordinary course of its activities. Some of these allegations are in areas not covered by the Company's insurance programs (discussed elsewhere in these notes). The Company evaluates such allegations by conducting investigations to determine the validity of each potential claim. It is the opinion of management the disposition or ultimate resolution of such claims and lawsuits will not have a material adverse effect on the consolidated balance sheets, results of operations and cash flows of the Company. Events could occur that would change this estimate materially in the near term.

Note 18: Future Changes in Accounting Principles

Leases

The Financial Accounting Standards Board (FASB) amended its standard related to the accounting for leases. Under the new standard, lessees will now be required to recognize substantially all leases on the balance sheet as both a right-of-use asset and a liability. The standard has two types of leases for income statement recognition purposes, operating leases and finance leases. Operating leases will result in the recognition of a single lease expense on a straight-line basis over the lease term similar to the treatment for operating leases under existing standards. Finance leases will result in an accelerated expense similar to the accounting for capital leases under existing standards. The determination of lease classification as operating or finance will be done in a manner similar to existing standards. The new standard also contains amended guidance regarding the identification of embedded leases in service contracts and the identification of lease and non-lease components in an arrangement. The new standard is effective for annual periods beginning after December 15, 2021. The Company is evaluating the impact the standard will have on the consolidated financial statements; however, the standard is expected to have a material impact on the consolidated financial statements due to the recognition of additional assets and liabilities for operating leases.

Note 19: Subsequent Events

Subsequent events have been evaluated through November 5, 2021, which is the date the consolidated financial statements were available to be issued.

Exhibit 20

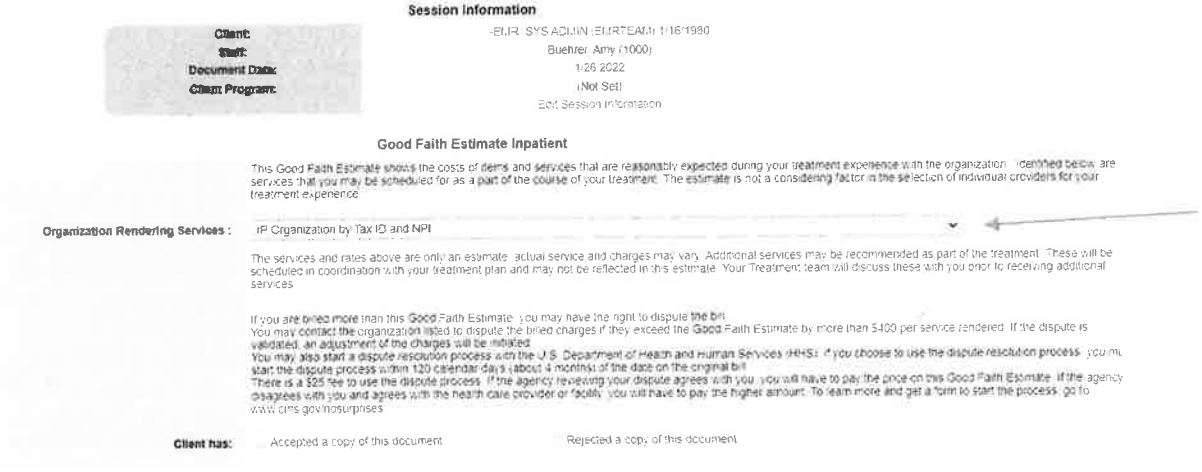
		SELF PAY RATES										
	Facility	TLP	Seeds of Hope	RAW	Life Counseling & POC	HFC	M&S	Walden	October Road	Pyramid/Quest/ Foundations / Hammonton	SILVERS (Includes Tapestry/GDRC/)	Tapestry/Lake Ariel
LOCA / Eval	LOCA/ Evaluation	$ 230.00	$ 230.00	$ 130.00	$ 150.00	$ 250.00	$ 150.00	$ 150.00	$ 180.00	$ 250.00	$ 250.00	$ 250.00
Outpatient	Individual	-	-	-	-	-	-	-	-	-	-	
	Individual 30 Min	$ 80.00	$ 80.00	$ 80.00	$ 50.00	$ 90.00	$ 80.00	$ 90.00	$ 80.00	$ 90.00	$ 100.00	$ 100.00
	Individual 45 Min	$ 110.00	$ 110.00	$ 110.00	$ 70.00	$ 140.00	$ 110.00	$ 140.00	$ 110.00	$ 140.00	$ 150.00	$ 150.00
	Individual 60 Min	$ 150.00	$ 150.00	$ 150.00	$ 90.00	$ 180.00	$ 150.00	$ 180.00	$ 150.00	$ 180.00	$ 200.00	$ 200.00
	Family Therapy	$ 150.00	$ 150.00	$ 150.00	$ 90.00	$ 180.00	$ 150.00	$ 180.00	$ 150.00	$ 180.00	$ 200.00	$ 200.00
	OP Group	$ 130.00	$ 130.00	$ 130.00	$ 60.00	$ 130.00	$ 130.00	$ 120.00	$ 110.00	$ 120.00	$ 150.00	$ 150.00
	Methadone Dosing	-	-	-	-	-	-	-	$ 16.60	$ 120 / week	-	
	Case Mgmt											
Intensive Outpatient	IOP - Daily	$ 280.00	$ 380.00	$ 280.00	-	$ 350.00	$ 320.00	$ 250.00	$ 200.00	$ 280.00	$ 350.00	$ 350.00
Partial Hospitalization Program	PHP - Daily	$ 520.00	$ 810.00	$ 350.00	-	$ 490.00	$ 540.00	$ 290.00	$ 260.00	$ 390.00	$ 550.00	$ 550.00
Inpatient / Residential	Residential Treatment		-	-	-			$ 600.00		$ 600.00	$ 1,000.00	$ 1,200.00
	Detox	-	-	-	-			$ 700.00		$ 700.00	$ 1,200.00	
	Nursing Assessment									$ 180.00		
	MAT Services / Induction	-	-	$ 130.00	-		$ 270.00	$ 170.00	$ 330.00	$ 250.00		
	Psych Eval	$ 200.00	-	-	$ 170.00		$ 260.00	$ 170.00		$ 250.00		
	Med Check / Psych 15 min (99213)	-	-	-	-				$ 80.00	$ 80.00		
	Med Check / Psych 25 min (99214)	$ 140.00	-	$ 130.00	$ 130.00		$ 130.00	$ 120.00	$ 120.00	$ 120.00		
	Med Check / Psych 30 min	-	-	-	-					$ 160.00		

Good Faith Estimate Form

The document is located under the financial tab in the client ECR

Choose the correct Good Faith Estimate depending on location: inpatient or outpatient

Choose the appropriate organization or location from the drop-down menu. Note: Because this form requires tax ID and NPI, some organizations are listed while others are the exact location. Staff should familiarize themselves with their location and corresponding Drop down.



Review the form with the client and ask if the client would like a copy of the document. Document accordingly.

Form should be signed by client, guardian if applicable, and staff completing the form.

Pyramid Healthcare

TO: CareLogic Users

FROM: Compliance, Rev Cycle, and EMR Departments

DATE: January 27, 2022

RE: Standardized Self Pay Rates and Federal Good Faith Estimate

Standardized Self Pay Rates for all Locations, effective February 1, 2022

On February 1, 2022, we will be moving to a new process for self-pay clients. Standardized self-pay rates have been added to CareLogic for all self-pay services. Prior to this addition, setting up a self-pay client involved manual entry of rates and numerous steps. The addition of standard rates eliminates the need to enter sliding scales. Clients who identify as self-pay will automatically be assigned the standard self-pay rate for all services rendered. A grid of all identified rates has been distributed to all appropriate departments and locations. In the event a client meets the requirements for a reduced rate due to hardship, facility staff should contact their biller directly for assistance.

Federal Good Faith Estimate effective January 31, 2022.

As of January 2022, all health care providers are now required to provide all self-pay clients with a Good Faith Estimate. This is a document that outlines the costs for all services being offered to an individual. In order to comply with the new requirement, forms have been created in Carelogic that must be completed upon admission for all self-pay clients. This requirement does not apply to individuals with insurance coverage or governmental funding.

Staff responsible for completing intake documentation should be educated on the use of the Good Faith Estimate form.

Instructions on completion of the form are attached with this memo.