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January 9, 2025

Moira Lawson  
Program Manager  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

Re: Foundations Inpatient LLC  
CON Application- Intermediate Care Facility

Dear Ms. Lawson:

On December 3, 2024, the applicant Foundations Inpatient LLC (“Foundations” or “Foundations Inpatient”) received a completeness inquiry from the Maryland Health Care Commission (“Commission”) in response to its application for a CON for Level III.7 beds for an Intermediate Care Facility in Baltimore County. We are submitting this response on behalf of Foundations Inpatient.

**PART I**

**1. Provide an organizational chart that shows/explains the relationships between MBM Ventures, Foundations Recovery Center, LLC, Foundations Inpatient LLC (i.e., the applicant), and Amatus Health.**

MBM Ventures is owned by Baruch Rabhan, and is the founder and controlling investor in several substance abuse/treatment facilities. MBM Ventures owns 61.5% of Amatus Health, which is a managed service organization providing finance and accounting, IT, revenue cycle management, HR and other administrative services to the affiliated substance abuse/treatment facilities that are owned by MBM Ventures. Amatus Health has no direct ownership of any of the facilities.

Foundations Recovery Center, LLC was founded in 2017 and operated as an outpatient substance abuse/treatment facility at a location separate from the Rutherford location. Through restructuring of the facilities, Foundations Recovery entered the lease for the Rutherford property with the intention of moving the Foundations Recovery inpatient/outpatient program to the



Foundations Inpatient opens. Services were established with Comcast under Foundations Recovery Center LLC, but were transferred to Foundations Inpatient as of January 2, 2025.

An account has been established with Northwest Refuse for trash pickup. The account was established under Foundations Recovery but was transferred to Foundations Inpatient as of January 2, 2025.

Water & sewer is under the landlord's name and is billed to Foundations Inpatient as part of the sublease cost. Please see below per the lease agreement

A. UTILITIES

Tenant shall apply for and pay all costs of electricity, gas, telephone and other utilities used or consumed on the Premises, together with all taxes, levies or other charges on such utilities.

Tenant agrees to pay Landlord, as Additional Rent, Tenant's Pro-Rata Share of the Water and Sewer Charges (as defined below). "Water and Sewer Charges" are those charges for consumption and use of water and sewer services chargeable to the building, together with all land, parking, improvements and other common areas adjacent thereto (collectively, "Property"). "Tenant's Pro-Rata Share of Water and Sewer Charges" shall mean the same percentage that the gross square foot area of the Premises bears to the gross square foot area of all leasable floor area within the Property that is occupied during the calendar year billing period. Landlord shall notify Tenant of any change in Tenant's Pro Rata Share of Water and Sewer Charges.

**PART II-**

**3. Provide a list of assumptions related to budget.**

The budget assumes a patient population of 90% Medicaid patients and 10% commercial payor patients.

The facility is able to fit 84 total beds, with a planned 75-bed mature utilization, only 50 beds of which will be licensed for Level III.7.

Once Foundation's Inpatient receives its Level III.5 program license, it will open the Rutherford facility for Level 3.5 and slowly ramp up to 40 beds at Level 3.5. Once Foundation's Inpatient receives CON approval and a license for its Level III.7 beds, it will add up to 35 beds at

Level III.7. While Foundations is seeking approval for 50 Level III.7 beds to provide flexibility to absorb fluctuating needs, Foundations Inpatient believes that currently it is realistic that 35 to 42 Level III.7 beds will be filled at any given time.

As Foundation's Inpatient frees up the Baltimore Detox Center from Level III.7 residential, more Level III.7 Detox clients will be able to be treated at BDC, which will lead to more step downs for Foundations Inpatient Level III.7 and III.5 beds. The Level III.5 is also supported by the Awakenings overflow.

An assignment of the financial obligation for the lease between Foundations Recovery Center, LLC and Foundations Inpatient LLC on January 1, 2025, which will include prior "moveable equipment" and leasehold improvements.

**4. Provide any contingencies for the budget.**

The budget is contingent on Foundations receiving approvals for Level III.5 and Level III.7 licensing, and CON First Use approval for 50 Level III.7 beds.

**5. Provide an explanation of the budgeted items, start-up costs (i.e., staff, rent and utilities, and food/supplies) vs. 'moveable equipment' on Table B.**

Cost for moveable equipment, which includes beds and dressers, is included in the lease cost and is not included on the budget as a separate line item. The lease already includes furnishings and fixtures so there is no additional line item for those items.

Start-up costs are limited to one month rent, utilities and a heavy ramp in staffing on the front end (primarily in administrative roles given the lower census in the first couple months). We have an internal recruiter who is an Amatus employee that has already begun recruiting heavily for all positions, so no additional cost due to this.

We have a prep kitchen and a caterer with the ability to slowly ramp up food/supplies, etc. but the budget includes average per census estimates.

There will be limited marketing and opening expenses because Foundations is driving most of its census from current facility referrals and step downs.

Preparation of this application (legal/contractual) or the processing of the application (See response to #6)

Capital Expenses, which will be incurred after license for Level III.5 beds is granted - \$170k

- Cabling, network and security - \$90k

- Other Leasehold Improvements - \$30k
- Commercial Washer and Dryer - \$20k
- Window Tinting - \$20k
- Other Misc- \$10k

**6. Include in the budget any expenses incurred for the preparation of this application (legal/contractual) or the processing of the application going forward.**

See updates to Table B. There are \$60k in costs incurred for the preparation of this application.

**PART IV/STATE HEALTH PLAN**

**7. Approval rules related to facility size - Foundations has not supplied any evidence for why the 50-bed standard for applicants establishing a new intermediate care facility (ICF) should not apply. Provide evidence of the health and financial need for (25) additional adult beds or revise your application to decrease the bed capacity to 50 Level 3.7 beds. Foundations' primary justification appears to be that it will increase its bed capacity post- implementation regardless of the number of beds approved. The Commission does not find this justification persuasive.**

Upon further reflection and following Foundation's conversation with MHCC staff at its site visit, Foundations believes that the best course of action is to proceed with applying for a CON for 50 Level 3.7 beds instead of the originally requested 75 beds.

As previously mentioned, Foundations applied for a license for 90 Level 3.5 beds. Given Foundations' commitment to only having four beds per room in the Rutherford facility, it will only operate a total of 84 beds at any time.

Foundations anticipates receiving approval for its Level 3.5 beds before this CON application is approved. As such, it plans to open its Level 3.5 beds at the Rutherford location to begin serving the community while this CON application is pending. At such time as this CON application and First Use are approved, Foundations plans to begin admitting patients requiring Level 3.7 residential care, filling up to the approved 50 beds with Level 3.7 patients. The remaining beds not filled with Level 3.7 patients will be available for patients receiving Level 3.5 care.

Foundations has attached updated Tables to reflect this change in planned operation as this impacts the staffing plan and projected revenue.

**8. Sliding Fee Scale – Provide the process used for the determination of charity care at Foundations, including which combination of five documents will be required before a determination of eligibility is made and how long the process will take.**

Foundations follows the provided sliding fee schedule. Foundations will ask the patients to provide a minimum of two of the listed documents, but understands that each patient's situation is different and they may not have access to some of the documents requested. Foundations makes best efforts to ensure that it is appropriately assessing the patient's financial situation and applying the appropriate discount according to the sliding fee schedule. A decision on eligibility for charity care or reduced payment is decided within 24 hours of Foundations receiving the requested documentation.

**9. Indigent and gray area patients – Explain how Foundations will track the number of bed days for indigent or gray area patients at the facility and how Foundations will admit more of these patients if bed days for indigent or gray area clients fall below 15%?**

Foundations will track indigent and gray area patients utilizing reporting from its electronic medical record (EMR) system which tracks census data by payor. This is reviewed by Amatus's financial analyst and reported via emails as part of the weekly dashboard. This information will also be part of the Foundation's quarterly Quality Assurance meeting.

**10. Information regarding charges- Provide a draft of the document that will inform patients of charges for patient services at Foundations. Will this information be available at the time of referral to the facility?**

Information regarding financial responsibility is relayed to commercially insured and self-pay patients during the admissions process verbally and by providing a written letter informing the patient of the anticipated charges which the patient signs and returns to Foundations. See Exhibit 1. This is kept on file in the patient's EMR. This is a good faith estimate based on information provided at the time of admission. If a facility or potential patient calls Foundations and asks for this information prior to admission, Foundations will make this information available in writing sent to the inquiring party via the communication method of their choice (fax, email, conventional mail).

**11. Quality assurance - Affirm each of the following:**

**a. Foundations will obtain accreditation by an appropriate entity before ICF operations begin. The Commission notes that the JCAHO letter, Exhibit 6, refers to "residential care services" (i.e., Level 3.5) and the survey period is due to expire December 2024.**

Foundations affirms that it will obtain accreditation by an appropriate entity before ICF Level 3.7 operations begin.

**b. Foundations will notify the Commission and the Behavioral Health Administration (BHA) within 15 days if its accreditation is revoked.**

Foundations affirms that it will notify the Commission and the BHA within 15 days if its accreditation is revoked.

**c. Foundations understands that if it loses its accreditation, it may be permitted to operate on a provisional basis with the approval of the Commission and pending remediation of any deficiency that caused the revocation.**

Foundations affirms its understanding that if it loses its accreditation, it may be permitted to operate on a provisional basis with the approval of the Commission and pending remediation of any deficiency that caused the revocation.

**d. Foundations must notify the Commission if it loses State certification and must cease operations until BHA notifies the Commission that the deficiencies have been corrected.**

Foundations affirms it will notify the Commission if it loses State certification and must cease operations until BHA notifies the Commission that the deficiencies have been corrected.

**e. Foundations understands that effective on the date that BHA revokes State certification, the regulations at COMAR 10.24.01.03D governing temporary delicensure of a health care facility will apply to its ICF bed capacity.**

Foundations affirms its understanding that effective on the date that BHA revokes State certification, the regulations at COMAR 10.24.01.03D governing temporary delicensure of a health care facility will apply to its ICF bed capacity.

**13. Utilization review and control programs – Revise the Transfer – Internal/External policy to state that each patient’s discharge plan will include 12 months of aftercare. Cite the specific language in Exhibit 7 which refers to the provision of 12-month aftercare.**

Please find updated policy at Exhibit 2.

Transfer – Internal / External- Policy

Contact Post Discharge

It is the policy of the organization to contact the client within 72 business hours of discharge (any discharge type) followed by 12 months of aftercare. The Case Manager assigned to the client or Alumni Coordinator is responsible for all post discharge contacts. The goal is to determine how the client is adapting to their elements and to ensure the client is safe. It is also

the policy to contact the agency where the client was referred to for continue care services (if applicable and appropriate). The goal is to determine if the agency has all the information and clinical documentation to appropriately treat the client.

**14. Provide the criteria that determines program ineligibility referred to in Exhibit 5 – Program Eligibility.**

Program Eligibility- Policy

Exclusionary criteria:

- Active suicidal or homicidal ideation. (Refer to Emergency room)
- Current Acute Medical issues (Refer to Emergency room)
- Covid Positive
- Arson Conviction
- Sexual offense conviction or charges
- Anyone younger than 18 including those who may turn 18 during treatment

**15. Transfer and referral agreements – The referral agreements provided all state “Incoming Referral Agreement”. Confirm that all agreements include both transfers to and referrals from the facility.**

The body of the agreements states that they include transfers and referrals and are reciprocal agreements:

The purpose of this document is to formalize the relationship between Foundations Inpatient and Truhealing Hagerstown Inpatient (3.5 residential). This cooperative and reciprocal arrangement will expedite referral, admission and discharge of clients, allowing both agencies to serve clients better.

In accordance with COMAR 10.24.14.05 (j) referral and transfer agreements will be made with providers in the Central Maryland Planning Region. Foundations Inpatient will provide 15% of its available bed space to gray area and indigent consumers under COMAR 10.24.14.05 (j,k). This agreement is intended to establish referrals for gray areas and indigent consumers.

**16. Provide the names, contact information, and facility type related to each of the referral agreements provided, including acute care hospitals; halfway houses; therapeutic communities; long term care facilities; local alcohol and drug abuse intensive and other outpatient programs; local community mental health centers; Baltimore**

**County's mental health and alcohol and drug abuse authorities; BHA; and Baltimore County's agencies that provide prevention, education, and other services.**

Anchor Recovery  
Travis Shields  
tshields@anchortreatment.com  
Sober Living/Halfway House

Pascal Crisis Stabilization  
Tiffany Sands  
443-404-9488  
Mental Health stabilization

TruHealing Outpatient  
Amber Vermillion  
304-279-7549  
PHP/OP

TruHealing Hagerstown  
Jason Swanger  
443-454-9066  
Inpatient Residential

Baltimore Detox  
Kathy Hill  
443-726-5679  
Detoxification/Intensive Inpatient Residential

**17. Provide the same for facilities for which referral agreements have not yet been signed but will be sought prior to first use approval.**

Foundations is actively working to identify outpatient programs that are closer to the Foundations location. Foundations received an additional agreement since submitting its initial application:

One Promise Counseling and DUI Education- (DUI education, MH, OP, Long term housing). Exhibit 3.

Additionally, Foundations is seeking agreements with the following facilities, which have agreements with BDC:

Elevate Recovery (IP, OP, IOP)- mparis@elevaterecoverycenters.com

Achieve Behavioral Health (IP, OP, IOP)

BHA- Ari Blum, LCSW-C, ablum@baltimorecountymd.gov

BHD (education, testing and follow up care for HIV, Hepatitis, STI, Narcan)- Monica Bordick, 410-303-4505

Westview Urgent Care Center (Urgent Care)- Sudhir Sidhu, Director

HUB City Sober Living (Sober Home)

Gratitude Foundation, Inc. (Sober Home)

Addiction Medication Clinic- (OP SUD and Mental Health Treatment) Sarah Davis

Recovery 180 (low intensity SUD residential treatment program) – Liz Markus

Turning Corners –(OP treatment services)

MISHA House (PHP, IOP, DUI/DWI Education, OP, MH Therapy, Sober homes)

Hope House, Treatment Center (SUD and MH treatment through short term residential, inpatient detox, IOP, OP, MAT, 12 step groups).

GBMC (Hospital)

Changing Turn Community Healthcare Services (OP MH and SUD treatment, DUI/DWI Education)

**18. Outpatient alcohol and drug abuse programs – The sole outpatient treatment center with which an agreement has been made is in Hagerstown. The driving distance between Windsor Mill (Baltimore County) and Hagerstown (Washington County) is over 60 miles. Explain how Foundations will coordinate or provide transportation to this outpatient facility in Hagerstown.**

Foundations is working to identify additional outpatient programs with which it may enter into agreements that are closer in distance to Foundations. Additionally, Foundations is part of a network of facilities services by a Transportation Team provided by Amatus Health, the management company of Foundations. The transportation services are available from 8am to

8pm, 7 days per week. Once the Foundation's patient is referred to an outpatient program, transportation needs are addressed by that outpatient program.

**19. Is Foundations in talks with other providers of outpatient services within the greater Baltimore area for clients post-discharge? List the names, locations, and level of services offered for these programs and the status of these discussions.**

Foundations is working to identify additional outpatient programs with which it may enter into agreements that are closer in distance to Foundations. Please refer to the list provided in response to Question 17 above.

**20. Best practices for patient discharge includes a warm handoff (i.e., a process of transferring a patient's care between two members of the healthcare team face-to-face and in front the patient) that can include transportation to the new program, involvement of families, and meeting social needs). How will Foundations conform to this best practice?**

When patients are stepped down within the same facility, the healthcare team meets face-to-face with the patient. This is not feasible to do when a patient is transferred to an external facility for continued care as the clinicians and case managers do not travel to external sources and it is not feasible for them to do so while treating other patients at the facility at which they are employed. Transfer meetings are done via telephone by the clinicians and case managers of both facilities, and appropriate discharge information is provided during that call.

**21. Program Reporting – Affirm that Foundations will agree to report data to BHA if requested and participate in any comparable collection program specified by the Department of Health.**

Foundations affirms that it will report data to BHA if requested and participate in any comparable collection program specified by the Department of Health.

**22. Need - Provide a response that includes a quantitative analysis of the primary and secondary service area, the population size and demographics, and the expected population growth. Provide a table of drug overdoses and deaths for jurisdictions in the primary and secondary service area and explain how this data supports the need for the proposed beds.**

In COMAR Section 10.24.14.05B(1)(a) - Identification of Intermediate Care Facility Alcohol and Drug Abuse Bed Need, the State Health Plan ("SHP") for Facilities and Services: Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services states that for applicants seeking CON approval to establish or expand an intermediate care facility for Track One substance abuse treatment services, 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. As such, the SHP requirement is to project Track One ICF bed need in a region. There is no requirement in the

SHP to define primary and secondary services areas. Unlike for hospitals and other facilities and service lines, the SHP does not provide a standard definition of or prescribe a method for how to define primary and secondary service areas. Furthermore, unlike hospital acute care services, there is no publicly available discharge database for ICF services to analyze current service levels in a jurisdiction and meaningfully project a service area bed need. While the SHP does not require the definition of primary and secondary service areas, nor prescribe a method for defining a service area, Foundations Inpatient expects to primarily serve residents of Baltimore County and Baltimore City (Central Region) and Washington County (Western Region), based on BDC’s experience. The Central Region also includes Harford, Howard and Anne Arundel Counties, and the Western Region includes Allegany, Garrett, Fredrick and Carroll Counties.

<i>County</i>	<i>Estimated Population Size- 2025<sup>1</sup></i>	<i>Demographics<sup>2</sup></i>	<i>Expected Population Growth<sup>3</sup></i>	<i>Drug Overdoses<sup>4</sup></i>	<i>Overdose Deaths<sup>5</sup></i>
<i>Baltimore County</i>	<i>868,120</i>	<i>Age 18-64 – 59.6%  White- 51.6%</i>	<i>-0.15%</i>	<i>1276</i>	<i>196</i>

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<sup>1</sup> This information came from Preliminary Historical and Projected Total Population for Maryland's Jurisdictions (December 2022)

<sup>2</sup> This information came from the US Census Bureau website:

<sup>3</sup> This information came from World Population Review website and based on US Census data. The estimated population growth is based on past year growth. <https://worldpopulationreview.com/us-counties/maryland>

<sup>4</sup> This information came from the Maryland Department of Health Overdose Data Portal and reflects data for Emergency Department Visits between December 2023 and November 2024. It does not include EMS Naloxone administrations because it is not clear whether some of those who received naloxone from EMS were also counted as Emergency Department Visits. Therefore, the numbers shown are likely less than the actual instances of drug overdoses in the county: <https://health.maryland.gov/dataoffice/Pages/mdh-dashboards.aspx>

<sup>5</sup> This information came from the Maryland Department of Health Overdose Data Portal and reflects data overdose deaths between December 2023 and November 2024: <https://health.maryland.gov/dataoffice/Pages/mdh-dashboards.aspx>

		<p><i>Black- 32.2%</i></p> <p><i>Hispanic/Latino- 8%</i></p> <p><i>Asian- 6.5%</i></p> <p><i>American Indian and Alaska Native- .6%</i></p> <p><i>Native Hawaiian and other Pacific Islander- .1%</i></p> <p><i>Median Household Income- \$90,904</i></p>			
<i>Baltimore City</i>	<i>594,530</i>	<p><i>Age 18-64 – 64.2%</i></p> <p><i>White- 27.4%</i></p> <p><i>Black- 60%</i></p> <p><i>Hispanic/Latino- 7.9%</i></p> <p><i>Asian- 2.5%</i></p> <p><i>American Indian and Alaska Native- .4%</i></p> <p><i>Native Hawaiian and other Pacific Islander- 0%</i></p>	<i>-1.06%</i>	<i>3,473</i>	<i>740</i>

		<i>Median Household Income- \$59,623</i>			
<i>Anne Arundel</i>	<i>621,690</i>	<i>Age 18-64 – 61%</i>  <i>White- 70.7%</i>  <i>Black- 20.2%</i>  <i>Hispanic/Latino- 10.7%</i>  <i>Asian- 4.7%</i>  <i>American Indian and Alaska Native- .6%</i>  <i>Native Hawaiian and other Pacific Islander- .1%</i>  <i>Median Household Income- \$120,324</i>	<i>0.21%</i>	<i>637</i>	<i>115</i>
<i>Harford</i>	<i>270,060</i>	<i>Age 18-64 – 59.9%</i>  <i>White- 76.7%</i>  <i>Black- 16.3%</i>  <i>Hispanic/Latino- 5.98%</i>  <i>Asian- 3.3%</i>	<i>0.31%</i>	<i>230</i>	<i>39</i>

		<p><i>American Indian and Alaska Native- .4%</i></p> <p><i>Native Hawaiian and other Pacific Islander-.1%</i></p> <p><i>Median Household Income-\$111,317</i></p>			
<i>Howard</i>	<i>349,700</i>	<p><i>Age 18-64 – 60.6%</i></p> <p><i>White- 53.2%</i></p> <p><i>Black- 21.7%</i></p> <p><i>Hispanic/Latino- 8.9%</i></p> <p><i>Asian- 20.5%</i></p> <p><i>American Indian and Alaska Native- .5%</i></p> <p><i>Native Hawaiian and other Pacific Islander-.1%</i></p> <p><i>Median Household Income-\$146,982</i></p>	<i>0.19%</i>	<i>85</i>	<i>37</i>

<i>Washington County</i>	160,450	<i>Age 18-64 – 60%</i>  <i>White- 79.5%</i>  <i>Black- 14.1%</i>  <i>Hispanic/Latino- 8.4%</i>  <i>Asian- 2,2%</i>  <i>American Indian and Alaska Native- .5%</i>  <i>Native Hawaiian and other Pacific Islander- .1%</i>  <i>Median Household Income- \$90,904</i>	0.36%	111	48
<i>Allegany</i>	68,460	<i>Age 18-64 – 60.7%</i>  <i>White- 88%</i>  <i>Black- 7.9%</i>  <i>Hispanic/Latino- 2.1%</i>  <i>Asian- 1.2%</i>  <i>American Indian and Alaska Native- .3%</i>  <i>Native Hawaiian and other</i>	0.01%	91	26

		<i>Pacific Islander- .1%</i>			
		<i>Median Household Income- \$57,393</i>			
<i>Garrett</i>	<i>28,806</i>	<i>Age 18-64 – 57.4%</i>  <i>White- 96.8%</i>  <i>Black- 1.2%</i>  <i>Hispanic/Latino- 1.5%</i>  <i>Asian- 0.5%</i>  <i>American Indian and Alaska Native- .3%</i>  <i>Native Hawaiian and other Pacific Islander- 0%</i>  <i>Median Household Income- \$69,031</i>	<i>-0.58%</i>	<i>13</i>	<i>None reported</i>
<i>Frederick</i>	<i>293,170</i>	<i>Age 18-64 – 61%</i>  <i>White- 76.6%</i>  <i>Black- 12.5%</i>  <i>Hispanic/Latino- 13.2%</i>  <i>Asian- 6.7%</i>	<i>1.99%</i>	<i>75</i>	<i>34</i>

		<p><i>American Indian and Alaska Native- .6%</i></p> <p><i>Native Hawaiian and other Pacific Islander- .1%</i></p> <p><i>Median Household Income- \$120,458</i></p>			
<i>Carroll</i>	<i>176,400</i>	<p><i>Age 18-64 – 59.5%</i></p> <p><i>White- 89.8%</i></p> <p><i>Black- 4.6%</i></p> <p><i>Hispanic/Latino- 5.38%</i></p> <p><i>Asian- 2.7%</i></p> <p><i>American Indian and Alaska Native- .4%</i></p> <p><i>Native Hawaiian and other Pacific Islander- .1%</i></p> <p><i>Median Household Income- \$115,876</i></p>	<i>.66%</i>	<i>209</i>	<i>19</i>

According to the MHCC Bed Report provided in Spring of 2024, the only approved ICF beds in Baltimore County are the 24 beds provided by BDC. However, Foundations is aware that MHCC approved 50 Level III.7 beds for Hygea Detox located at 1210 Middle River Rd., Middle River, MD 21220, which were not included in the Bed Report. Docket No. 21-03-2450. However, Hygea Detox at Middle River is 25.3 miles away from BDC and serves Central and Southern Maryland.

BDC could fill its 24 Level III.7 beds as detox only, which is a shorter stay of 5-7 days, after which the patients are moved to a lower level of care such as Level III.7 residential treatment, which lasts approximately 8 days and Level III.5 which lasts approximately 20 days. Below is a table showing capacity over the last two years. BDC is limited in the number of detox patients it can accommodate because it needs to have a Level III.7 residential bed to transfer the patient into once they have completed detox and those longer stay beds do not open up as quickly as the detox beds. By opening an additional 50 Level III.7 beds nearby at Foundations, BDC can accommodate many more detox patients and have the ability to transition their care to Foundations after detox.

BDC	2023												2024											
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2023 Avg	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2024 Avg		
<b>Admits</b>	26	20	71	99	63	70	74	85	64	126	121	143	126	138	123	121	133	131	123	114	127			
DTX	1	1	52	75	50	48	59	54	43	84	76	98	78	85	75	69	78	80	62	70	78			
RTC	25	19	19	24	13	22	15	31	21	42	45	45	48	53	48	52	55	51	61	44	49			
<b>Discharges</b>	13	22	66	90	71	66	69	90	61	122	116	151	124	132	115	125	138	128	129	106	118			
DTX	1	1	47	67	56	48	54	61	42	76	73	104	78	79	72	73	87	73	69	64	72			
RTC	12	21	19	23	15	18	15	29	19	46	43	47	46	53	43	52	51	55	60	42	46			
<b>(+/-)</b>	13	(2)	5	9	(8)	4	5	(5)	21	4	5	(8)	2	6	8	(4)	(5)	3	(6)	8	13			
DTX	-	-	5	8	(6)	-	5	(7)	5	8	3	(6)	-	6	3	(4)	(9)	7	(7)	6	7			
RTC	13	(2)	-	1	(2)	4	-	2	16	(4)	2	(2)	2	-	5	-	4	(4)	1	2	6			
<b>Average Daily Census</b>	11	14	17	24	23	23	21	27	13	30	30	37	32	30	34	36	35	34	31	34	33			
DTX	0	0	7	13	11	9	11	12	5	16	16	22	15	14	15	14	17	15	12	14	15			
RTC 3.7	-	-	-	-	-	-	-	7	1	12	12	10	11	8	8	9	10	8	8	6	9			
RTC 3.5	11	14	10	10	12	14	10	9	8	2	2	5	6	8	12	12	8	11	11	14	8			
<b>Bed Utilization % (39 Max)</b>	28%	37%	44%	61%	59%	60%	54%	70%	34%	77%	77%	95%	82%	78%	88%	91%	90%	86%	80%	86%	85%			

In addition to the viability of the inpatient program at BDC, Awakenings, which provides Level III.5 care in Hagerstown, has operated over the past many years at a census in the mid-50's and overall facility utilization in the upper 80th percentile.

ARC	2023												2024												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2023 Avg	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
<b>Admits</b>	87	78	85	74	78	80	63	74	78	78	81	87	79	84	82	86	89	68	74	83	96	81	72	78	81
DTX	87	78	85	74	78	80	63	74	78	78	81	87	79	84	82	86	89	68	74	83	96	81	72	78	81
RTC	28	86	78	73	92	73	72	68	69	79	85	91	75	81	83	82	83	81	66	91	88	85	72	74	77
<b>Discharges</b>	28	86	78	73	92	73	72	68	69	79	85	91	75	81	83	82	83	81	66	91	88	85	72	74	77
DTX	28	86	78	73	92	73	72	68	69	79	85	91	75	81	83	82	83	81	66	91	88	85	72	74	77
RTC	59	(8)	7	1	(14)	7	(9)	6	9	(1)	(4)	(4)	49	3	(1)	4	6	(13)	8	(8)	8	(4)	-	4	7
<b>(+/-)</b>	59	(8)	7	1	(14)	7	(9)	6	9	(1)	(4)	(4)	49	3	(1)	4	6	(13)	8	(8)	8	(4)	-	4	7
DTX	59	(8)	7	1	(14)	7	(9)	6	9	(1)	(4)	(4)	49	3	(1)	4	6	(13)	8	(8)	8	(4)	-	4	7
RTC	59	(8)	7	1	(14)	7	(9)	6	9	(1)	(4)	(4)	49	3	(1)	4	6	(13)	8	(8)	8	(4)	-	4	7
<b>Average Daily Census</b>	59	52	60	59	53	50	45	47	57	58	58	56	55	54	56	59	57	51	55	53	57	54	59	54	55
DTX	59	52	60	59	53	50	45	47	57	58	58	56	55	54	56	59	57	51	55	53	57	54	59	54	55
RTC	59	52	60	59	53	50	45	47	57	58	58	56	55	54	56	59	57	51	55	53	57	54	59	54	55
<b>Bed Utilization % (64 Max)</b>	92%	81%	94%	92%	83%	78%	70%	73%	89%	91%	91%	88%	85%	84%	88%	92%	89%	80%	86%	83%	89%	84%	92%	84%	87%

Foundations anticipates that it will have a similar patient mix to BDC, largely because BDC will be a primary referral source to Foundations given the close proximity between the facilities. The majority of BDC’s patients currently come from Baltimore County, followed by Washington County and then Baltimore City. A small number of patients come the Eastern Shore. Washington County does not have any approved ICF beds.

Although Baltimore City has 223 approved ICF beds, which have their own access and availability issues, therapeutically, it is often appropriate for a patient who lives in Baltimore City to seek treatment in Baltimore County where the patient will be removed from their social circumstances which can contribute significantly to continued drug abuse patterns. Furthermore, it is typically easier to obtain placement in a Baltimore County half-way house or lower level of care after an ICF stay in Baltimore County, which will continue to keep the patient away from social influences which may cause the patient to fall back into old patterns.

Foundations also considered the bed need analysis provided by Hygea Detox in its application in 2023, Docket No. 23-02-2468, which followed the SHP need analysis through 2025 for Central Maryland (Baltimore City, Baltimore County, Harford County, Howard County, and Anne Arundel County) and found that the SHP analysis projects a need for 49 Track One ICF beds in Central Maryland. At the time that Hygea Detox was applying for 16 Level III.7 beds in Anne Arundel County, the number of Track One ICF beds approved by the Commission in Central Maryland was 195 (though it is not clear that all of those beds are being used for Level III.7), which already exceeded the projected 49 Track One ICF bed need supported by the SHP need analysis, indicating that the Commission understands that the need analysis methodology provided in the SHP is outdated and does not accurately represent the need for Level III.7 beds in Maryland. Additionally, although Foundations is applying for Track One beds, it anticipates that the vast majority of its beds will be filled by patients who are covered by Medicaid, which additionally changes the need analysis provided in the SHP, which excludes consideration of the Medicaid population’s needs from the Track One need analysis. Finally, Foundations will be serving Western Maryland in addition to Central Maryland. Washington County and Allegheny County are large referral sources to BDC, and are anticipated to be large referral sources to Foundations. According to the MHCC’s Bed Report, Allegheny County only has 45 beds (10 of which are at a hospital) inclusive of Level III.5 and III.7. Washington County and Garrett County have no Level III.7 beds.

Hygea Detox- Central Maryland Data- <i>Docket No. 23-02-2468</i>	Base Year 2020	Target Year 2025
(a) Projected Adult Population (18 years and older) – Estimated 2020	2,053,814	2,123,573
(b) Indigent Adult Population (18 years and older) - Central Maryland	458,027	529,189
(c) Non-Indigent Population (a-b)	1,595,787	1,594,384
(d) Estimated Number of Substance Abusers (c*8.64%)	137,876	137,755
(e) Estimated Annual Target Population (d*25%)	34,469	34,439

(f) Estimated Number Requiring Treatment (e*95%)	32,746	32,717
(g) Estimated Population requiring ICF/CD (12.5%-15%)		
(g1) Minimum (f*0.125)	4,093	4,090
(g2) Maximum (f*0.15)	4,912	4,908
(h) Estimated Range requiring Readmission (10%)		
(h1) Minimum (g1*0.1)	409	409
(h2) Maximum (g2*0.1)	491	491
(i) Total Discharges from out of state (this information is not available)	-	-
(j) Range of Adults Requiring ICF/CD Care		
(j1) Minimum (g1+h1+i)	4,502	4,499
(j2) Maximum (g2+h2+i)	5,403	5,399
(k) Gross Number of Adult ICF Track One Beds Needed		
(k1) Minimum = ((f*14 ALOS)/365)/0.85	203	203
(k2) Maximum = ((f*14 ALOS)/365)/0.85	244	244
(l) Existing Track One Inventory ICF/CD beds	144	145
(m) Net Private ICF/CD Bed Need		
(m1) Minimum (k1-l)	59	8
(m2) Maximum (k2-l)	100	49

**23. Provide the following information:**

**a. A projection of the percentage of patients that will come from Baltimore Detox Center (BDC)? Since it is expected that this population will represent the majority of patients, show the breakdown of admissions/discharges by gender and jurisdiction.**

See Step Down Excel Data- Exhibit 4. Foundations Inpatient expects that around 90% of BDC's patients who step down to Level 3.7 or 3.5 will transfer to Foundations Inpatient because of the proximity and availability of beds.

**b. The number of BDC patients released to Level 3.7 inpatient programs each month over the last 12 months. To which Level 3.7 facility are these clients currently transferred?**

See Step Down Excel Data- Exhibit 4. The facility to which all BDC 3.7 detox patients are released is BDC 3.7 Residential. This is because BDC was the only 3.7 Residential in the area until recently (Hygea Detox).

**c. The number of BDC patients that were waitlisted for Level 3.7 care after detox due to a lack of available beds.**

No BDC patients who are admitted for detox are waitlisted for 3.7 residential because these patients are already in a bed that is licensed for both levels of care. However, the lack of available 3.7 Residential beds to move detox patients to limits the number of patients that BDC can admit for detox.

**d. How was an Average Length of Stay (ALOS) of 30 days calculated? Provide the current ALOS for Level 3.7 programs in Maryland and the source for your data.**

Upon further reflection, the ALOS of 30 days for Level 3.7 is not accurate. The correct ALOS is 8 days. Foundations calculated this based on the Baltimore Detox Center’s experience which, for the last 12 months, demonstrated an average of an 8 day stay at Level 3.7. This is also supported by the Hygea Detox CON application information.

Location	BDC																
Average of LOS	Column Labels																
Row Labels	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total				
SUD Residential 3.7	11	10	9	8	6	6	9	6	5	4	4	8	8				
<b>Grand Total</b>	<b>11</b>	<b>10</b>	<b>9</b>	<b>8</b>	<b>6</b>	<b>6</b>	<b>9</b>	<b>6</b>	<b>5</b>	<b>4</b>	<b>4</b>	<b>8</b>	<b>8</b>				

**24. Will patients completing the BDC program have a choice of inpatient Level 3.7 programs to which they can be transferred or will they automatically be transferred to the proposed facility? From which other providers could patients be referred besides BDC?**

Patients will be provided a written disclosure of common ownership between BDC and Foundations Inpatient, be informed that the patient has the right to receive treatment at any program of their choosing, and be informed that there are other programs available in the area. The only other program in Baltimore County is Hygea Detox.

**25. Cost effective alternatives - The response provided was insufficient. Provide a response that includes alternatives to the current plan. Describe the planning process used to determine the current proposed project.**

The proposed project is the most cost-effective and efficient means to make available an additional 50 Level III.7 beds in Baltimore County through Foundations Inpatient. The total start up cost of this project is \$562,817 with \$230,000 in capital costs, \$332,817 in operating deficit for the first couple of months during ramp up, and an expected timeline to open to patients of three months from CON and licensing approval to complete minor finishing renovations and hire staff. Alternative options, which include either the expansion of other existing facilities or

construction of an entirely new facility would likely be more expensive and would take longer to accomplish than the proposed project. In addition, other facilities managed by Amatus Health and owned, in part, by MBM Ventures, do not have the capacity, even through expansion, to meet the needs of the community.

**26. Viability - Affirm that there have been no audited financial statements for the past two years for the entities and parent companies.**

There have not been any audited financial statements for the past two years for Foundations Inpatient or MBM Ventures.

**27. The CPA letter provided as Exhibit 13 does not state the total funds available to support the project. Provide a CPA letter with exact availability of funds in dollars that matches or exceeds the requirement of \$286K stated in the application. As the facility does not plan to have a positive net income through 2026, the letter should include the availability of funds to cover the net loss.**

Please see the updated CPA Letter attached as Exhibit 5. The Tables and financial projections, including positive net income, have also been updated. Exhibit 8.

**28. Will Foundations fill empty Level 3.7 beds with Level 3.5 patients if it is unable to meet full occupancy with Level 3.7 patients? How will this affect the financial viability of the facility?**

Yes, Foundations will fill empty Level III.7 beds with Level III.5 patients if it is unable to meet full occupancy with Level III.7 patients. The impact would be \$140 per day per bed. If Level III.5 patients made up the majority of patients for an extended period of time, Foundations would adjust staffing accordingly in the direct care category.

**29. Compliance with terms and conditions of previous CONs – Affirm that BDC has met all the conditions from the November 16, 2023 project change. Demonstrate how BDC is complying with Condition 1 of the project change in meeting the 15% gray area and indigent patients for 2023 and YTD 2024.**

Below is a table showing the patient mix for BDC for 2023 and 2024. The patient mix is primarily made up of Medicaid patients, which meets the Condition 1 of the project change in meeting 15% gray area and indigent patients for 2023 and 2024.

BDC Census by Payor	2023									2024									2024 AVG	Total Avg			
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2023 AVG	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep			Oct	Nov	Dec
Maryland Medicaid	9.42	13.50	15.65	25.90	27.33	28.48	29.43	34.65	23.04	26.00	27.79	33.19	28.67	27.00	30.53	31.35	31.84	31.03	27.13	30.67	17.35	29.56	26.82
BCBS	-	-	0.32	0.71	1.43	0.55	-	-	0.38	0.94	1.07	0.71	0.63	0.39	0.50	0.52	0.52	0.07	0.23	0.83	-	0.58	0.50
UHC	-	-	-	0.23	-	-	-	-	0.03	-	-	-	0.23	-	1.07	0.48	0.13	0.10	-	0.27	0.61	0.21	0.13
Aetna	-	-	-	-	-	0.23	-	-	0.03	-	-	-	-	0.23	-	1.00	0.19	-	-	0.03	0.06	0.13	0.09
UMR	0.10	-	-	-	-	0.97	0.23	-	0.16	-	-	-	-	-	-	-	-	-	-	-	-	-	0.07
Cigna	-	0.07	0.23	-	-	-	-	-	0.04	-	-	-	-	0.10	0.13	0.13	-	0.17	-	-	-	0.05	0.04
Anthem	-	-	-	-	-	-	-	-	-	-	0.25	-	0.10	0.26	-	-	-	-	-	-	-	0.06	0.03
Private Pay	-	-	-	-	-	-	-	-	-	-	-	-	0.03	0.19	-	-	-	-	-	-	-	0.02	0.01
Tricare East	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.10	-	-	-	-	-	-	0.01	0.01
<b>Total</b>	<b>9.52</b>	<b>13.57</b>	<b>16.19</b>	<b>26.61</b>	<b>29.00</b>	<b>30.23</b>	<b>29.67</b>	<b>34.65</b>	<b>23.67</b>	<b>26.94</b>	<b>29.11</b>	<b>33.90</b>	<b>29.67</b>	<b>28.16</b>	<b>32.33</b>	<b>33.48</b>	<b>32.68</b>	<b>31.37</b>	<b>27.35</b>	<b>31.80</b>	<b>18.03</b>	<b>30.62</b>	<b>27.70</b>

**30. Affirm that the problems encountered with the BDC CON will not be repeated for the Foundations CON. Specifically, any changes in the program prior to first use will be reported to the facility in a timely manner, and that Foundations will submit a project change request for changes in the project cost or floor plan.**

Foundations affirms that the problems encountered with the BDC CON will not be repeated for the Foundations CON. Foundations affirms that any changes in the program prior to first use will be reported to the facility in a timely manner, and that Foundations will submit a project change request for changes in the project cost or floor plan.

**31. Impact – The response provided was insufficient. Address elements a-d of this criteria. Specifically, provide data on where patients are currently receiving care, the payor mix of these individuals, how many of those patients will be seen at Foundations instead, and why this won't impact the operations of those facilities. Discuss the impact on the cost to the health care delivery system.**

As addressed above, the Commission's bed need methodology demonstrates a net bed need in the range of 8 to 49 beds in the Central Maryland region for the target year 2025, though the existing inventory of beds may be overstated and out-of-state discharges understated. The Commission's defined methodology likely understates bed need in the state. The additional 50 Level III.7 beds by Foundations Inpatient will help to meet this need. Because this project is designed to meet unmet needs in Central Maryland, Foundations expects that there should be no material negative impact on the volumes of any other existing Maryland ICF providers of these services.

Table 2 below displays the location of each Track One provider in the State of Maryland and its proximity to the proposed Foundations location. Based upon ICF bed inventory provided by the Commission in Spring 2024, there are currently 145 Track One beds in Central Maryland. These 145 beds are comprised of 24 beds at BDC in Baltimore, Maryland and 121 beds at Ashley Treatment Center in Havre de Grace, Maryland. Additionally, though not included in the Commission's Bed Need table, Foundations is aware that Hygea Detox was granted approval for an additional 50 ICF Track One beds to be opened in 2024 in Middle River, Docket No. 21-03-2450.

**Table 2**

**Maryland ICF Track One ASAM Level 3.7 Providers**

<b>Provider</b>	<b>County</b>	<b>Region</b>	<b>Track One ICF Beds</b>	<b>Driving Distance from Foundation's Proposed Site</b>
Baltimore Detox Center	Baltimore	Central MD	24	1.2
Hygea Detox- Middle River	Baltimore	Central MD	50	23.5
Hygea Detox- Camp Meade	Baltimore City	Central MD	16	12.5
Ashley Addiction Treatment	Harford	Central MD	121	50
Recovery Centers of America, Waldorf	Charles	Southern MD	64	68
Avenues Recovery Center of Maryland	Calvert	Southern MD	20	63
Avenues Recovery Center of Chesapeake Bay	Dorchester	Eastern Shore	104	89.1
Recovery Centers of America,	Cecil	Eastern Shore	123	87
Hudson Health Services	Wicomico	Eastern Shore	51	121

Foundations does not believe its proposed 75 additional ICF beds will have a significant impact on other providers such as Hygea Detox at Camp Meade, Middle River or Ashley Addiction Treatment given the geographic distance between the facilities. In addition to serving Central Maryland, Foundations is the western most Track 1 ICF facility noted, which means that it is serving Western Maryland as well as Central Maryland, further reducing the impact to the existing Track 1 ICF facilities in Central Maryland.

This project will improve Track One ICF services for residents of the Central Maryland region. These beds only partially meet the needs of Central Maryland residents. BDC's experience supports the lack of sufficient Level III.7 capacity based on wait time for those seeking care. See also, for example, In re: House Bill 384 (2018 Reg. Sess.), House Committee Hearing before the Health and Government Operations Committee, Feb 13, 2018 (presenting testimony regarding a survey of 17 ICF providers in Maryland indicating that 12 of 17 ICF provider survey respondents had a wait time of two or more weeks) ; Final Report of the Lieutenant Governor's Heroin & Opioid Emergency Task Force, December 1, 2015 ("Families consistently reported experiencing multiple and repeated barriers, such as excessively long waiting periods...") ; In re Ashley, Inc., Docket No. 13-12-2340, Commission Decision, Sept. 19, 2013, p. 13 (reporting mean wait times of 4.96 days for monitored intensive inpatient (ASAM level 3.7) care, and 3.55 days for detoxification (ASAM level 3.7-D) care).

Based on the continued rise in substance use disorder deaths in Maryland, the unmet need for Track One Level 3.7 beds identified by the Commission's methodology and as supported by anecdotal evidence discussed in this application, and the proposed project's location and distance from other providers, Foundations expects that other providers will not experience any significant volume shift as a result of Foundation's proposed project.

BDC has not experienced any significant staffing challenges post-pandemic. As such, Foundations does not anticipate experiencing staffing challenges for its ICF programs. Amatus Health engages a staffing agency to assist the programs it manages in obtaining required staff and plans to do the same for Foundations.

Foundations notes that like other Track One providers who have applied for and received Certificates of Need in recent years, it has committed to providing at least 15% of its annual patient bed days to indigent and/or gray area patients, and expects that its payer mix will be similar to that of BDC and other Track One providers. Based on this commitment, the need for these services, and its distance from other providers, Foundations does not expect to affect the payer mix of existing providers.

Foundations Inpatient notes that ICF providers do not publicly report their volume of patient mix. Thus, even if it would have an impact on the volume or payer mix of existing providers, Foundations would not have access to data that would permit it to meaningfully project the impact.

### **Impact on Health Care Delivery System**

Foundations Inpatient's proposed project will provide needed ICF services comparably with other approved Track One facilities. Foundations Inpatient projects a Gross Patient Revenue per Patient Day of approximately \$389. This is far less than Hygea Detox at Camp Meade, whose proposed Patient Revenue per Patient Day was \$1,244.50. This is because Foundations Inpatient anticipates that 90% of its patient population will be made up of Medicaid patients, and Medicaid reimburses less than commercial payors for these services. Foundations Inpatient pricing should create pricing competition, which the Commission has acknowledged as causing positive charges to the market price for these services. See In rel. Hygea Detox, Inc., Docket No. 21-03-2450, Staff Report Recommendation, p. 26.

Reimbursement rates at Foundations Inpatient will be set by Medicaid and commercial payers. These rates are generally standardized across providers, therefore, the approval of this application will not impact reimbursement rates for these services in Maryland and, therefore, have not impact on cost or charges to the health care system.

**32. Health Equity - Provide the demographic breakdown of the entirety of the population to be served (both private and public pay patients), especially for the primary and secondary service area, and how the proposed health equity plan will benefit these**

**populations. Explain how Foundations will address substance use health disparities that exist. How will the facility address the needs of dual diagnosis patients?**

Demographic breakdown by county:

<i>County</i>	<i>Population Size- 2025<sup>6</sup></i>	<i>Demographics<sup>7</sup></i>
<i>Baltimore County</i>	<i>868,120</i>	<i>Age 18-64 – 59.6%</i> <i>White- 51.6%</i> <i>Black- 32.2%</i> <i>Hispanic/Latino- 8%</i> <i>Asian- 6.5%</i> <i>American Indian and Alaska Native- .6%</i> <i>Native Hawaiian and other Pacific Islander- .1%</i> <i>Median Household Income- \$90,904</i>
<i>Baltimore City</i>	<i>594,530</i>	<i>Age 18-64 – 64.2%</i> <i>White- 27.4%</i> <i>Black- 60%</i> <i>Hispanic/Latino- 7.9%</i> <i>Asian- 2.5%</i> <i>American Indian and Alaska Native- .4%</i> <i>Native Hawaiian and other Pacific Islander- 0%</i> <i>Median Household Income- \$59,623</i>

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<sup>6</sup> This information came from Preliminary Historical and Projected Total Population for Maryland's Jurisdictions (December 2022)

<sup>7</sup> This information came from the US Census Bureau website:

<i>Anne Arundel</i>	621,690	<p><i>Age 18-64 – 61%</i></p> <p><i>White- 70.7%</i></p> <p><i>Black- 20.2%</i></p> <p><i>Hispanic/Latino-10.7%</i></p> <p><i>Asian- 4.7%</i></p> <p><i>American Indian and Alaska Native- .6%</i></p> <p><i>Native Hawaiian and other Pacific Islander- .1%</i></p> <p><i>Median Household Income- \$120,324</i></p>
<i>Harford</i>	270,060	<p><i>Age 18-64 – 59.9%</i></p> <p><i>White- 76.7%</i></p> <p><i>Black- 16.3%</i></p> <p><i>Hispanic/Latino-5.98%</i></p> <p><i>Asian- 3.3%</i></p> <p><i>American Indian and Alaska Native- .4%</i></p> <p><i>Native Hawaiian and other Pacific Islander- .1%</i></p> <p><i>Median Household Income- \$111,317</i></p>
<i>Howard</i>	349,700	<p><i>Age 18-64 – 60.6%</i></p> <p><i>White- 53.2%</i></p> <p><i>Black- 21.7%</i></p> <p><i>Hispanic/Latino- 8.9%</i></p> <p><i>Asian- 20.5%</i></p> <p><i>American Indian and Alaska Native- .5%</i></p> <p><i>Native Hawaiian and other Pacific Islander- .1%</i></p> <p><i>Median Household Income- \$146,982</i></p>

<i>Washington County</i>	<i>160,450</i>	<p><i>Age 18-64 – 60%</i></p> <p><i>White- 79.5%</i></p> <p><i>Black- 14.1%</i></p> <p><i>Hispanic/Latino- 8.4%</i></p> <p><i>Asian- 2,2%</i></p> <p><i>American Indian and Alaska Native- .5%</i></p> <p><i>Native Hawaiian and other Pacific Islander- .1%</i></p> <p><i>Median Household Income- \$90,904</i></p>
<i>Allegheny</i>	<i>68,460</i>	<p><i>Age 18-64 – 60.7%</i></p> <p><i>White- 88%</i></p> <p><i>Black- 7.9%</i></p> <p><i>Hispanic/Latino- 2.1%</i></p> <p><i>Asian- 1.2%</i></p> <p><i>American Indian and Alaska Native- .3%</i></p> <p><i>Native Hawaiian and other Pacific Islander- .1%</i></p> <p><i>Median Household Income- \$57,393</i></p>
<i>Garrett</i>	<i>28,806</i>	<p><i>Age 18-64 – 57.4%</i></p> <p><i>White- 96.8%</i></p> <p><i>Black- 1.2%</i></p> <p><i>Hispanic/Latino- 1.5%</i></p> <p><i>Asian- 0.5%</i></p> <p><i>American Indian and Alaska Native- .3%</i></p> <p><i>Native Hawaiian and other Pacific Islander- 0%</i></p> <p><i>Median Household Income- \$69,031</i></p>

<i>Frederick</i>	<i>293,170</i>	<i>Age 18-64 – 61%</i> <i>White- 76.6%</i> <i>Black- 12.5%</i> <i>Hispanic/Latino- 13.2%</i> <i>Asian- 6.7%</i> <i>American Indian and Alaska Native- .6%</i> <i>Native Hawaiian and other Pacific Islander- .1%</i> <i>Median Household Income- \$120,458</i>
<i>Carroll</i>	<i>176,400</i>	<i>Age 18-64 – 59.5%</i> <i>White- 89.8%</i> <i>Black- 4.6%</i> <i>Hispanic/Latino-5.38%</i> <i>Asian- 2.7%</i> <i>American Indian and Alaska Native- .4%</i> <i>Native Hawaiian and other Pacific Islander- .1%</i> <i>Median Household Income- \$115,876</i>

The areas to be served by Foundations Inpatient include medically underserved populations, as that term is defined by HRSA. Many are eligible for Medicaid, and are historically disadvantaged populations of color. Black and Hispanic individuals are far less likely to receive treatment for SUD than other populations. The cause of this is multifactor, but increasing culturally competent staff can assist with encouraging these populations to seek and stay in treatment.

Foundations Inpatient hires staff based on EEO guidelines. Many of the staff have personal experience with SUD which make them more effective when working with patients. Foundations trains staff on cultural competencies and multi-cultural diversity in the workplace by providing the following training third-party Relias:

Cultural Awareness and Humility

Supporting the Behavioral Health Goals of LGBTQ+ Clients

A Multicultural Approach to Recovery-Oriented Practice

Discrimination in the Workplace for Supervisors

Foundations additionally provides staff with access to language line services when needed to best serve patients.

Foundations' admission policy does not discriminate based on race, culture, or gender. This is the same admission policy used by BDC, which has the following patient mix:

<b>Race</b>	<b>Percent</b>
White	29%
Black	17%
Asian	1%
Hispanic	3%
American Indian	2%
Alaskan Native	0%
Unknown/Unreported	48%

### **Dual Diagnosis**

SAMHSA statistics from 2022 show that 21.5 million people (or 1 in 3) suffer from a combination of SUD and co-occurring mental health disorders. Foundations Inpatients' services are provided by a team of psychiatric nurse practitioners who provide assessment and medication management for clients suffering with dual diagnoses. Our team of qualified therapists are able to provide integrated behavioral and mental health strategies targeting dual diagnosis clients. All clients have individual therapy as part of their treatment plan.

Additionally, as indicated in response to Question 17 above, Foundations has entered into and plans to enter into referral and transfer agreements with various programs that provide mental health treatment, half-way housing and other services that will benefit the diverse population that Foundations plans to serve.

**32. Character and Competence - Indicate the percent ownership interest of each owner of the real property, bed rights, and operations (including MBM Ventures, LLC, Lyon Group I Joint Ventures, LLC, Amatus Health, LLC, Baruch Raban, and Aharon Kibel). Include the following information for any person with 5% or more ownership interest in the real property, bed rights, or operations of the facility.**

Aharon Kibel is an employee of Amatus Health but is not an owner of any of the entities.

Amatus Health, LLC is the management company for Foundations but does not own any part of the real property, bed rights, or operations of the facility.

Foundations Inpatient, LLC owns 100% of the bed rights. MBM Ventures, LLC, owns Foundations Inpatient, LLC. MBM Ventures, LLC is solely owned by Baruch Raban (100%).

Lyon Group I Joint Ventures, LLC owns 100% of the interest in the real property.

• **for each individual/entity identified, disclose any involvement in the ownership, development, or management of another health care facility.**

Responding to the footnote, Part III asks about other “health care facilities” which are defined as those needing a CON under the Maryland regulations. The facilities listed in the CPA letter but not included in this application response are not “health care facilities” under that definition as they either (1) do not require a CON, or (2) are not within Maryland. The only entity that is responsive to this question is Baltimore Detox Center.

• **for each individual/entity and facility identified, disclose if any license has been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years.**

Baruch Rabhan- No health care facility license of any entity owned by MBM Ventures has been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years.

MBM Ventures, LLC- No health care facility license of any entity owned by MBM Ventures has been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years.

Foundations Inpatient, LLC- No health care facility license has been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years as Foundations Inpatient does not currently hold any health care facility licenses.

Lyon Group I Joint Ventures, LLC- No health care facility license has been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years as Lyon Group does not hold any health care facility licenses.

- **for each individual/entity and facility identified, disclose inquiries in the last 10 years from any federal (Centers for Medicare and Medicaid Services or CMS) or state authority, or other regulatory body regarding possible non-compliance with any state, or federal 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.**

Baruch Rabhan- Baruch Rabhan has not received any inquiries in the last 10 years from any federal (Centers for Medicare and Medicaid Services or CMS) or state authority, or other regulatory body regarding possible non-compliance with any state, or federal 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 sanction.

MBM Ventures, LLC- MBM Ventures has not received any inquiries in the last 10 years from any federal (Centers for Medicare and Medicaid Services or CMS) or state authority, or other regulatory body regarding possible non-compliance with any state, or federal 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 sanction.

Foundations Inpatient, LLC- Foundations Inpatient has not received any inquiries in the last 10 years from any federal (Centers for Medicare and Medicaid Services or CMS) or state authority, or other regulatory body regarding possible non-compliance with any state, or federal 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 sanction.

Lyon Group I Joint Ventures, LLC- Lyon Group has not received any inquiries in the last 10 years from any federal (Centers for Medicare and Medicaid Services or CMS) or state authority, or other regulatory body regarding possible non-compliance with any state, or federal 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 sanction.

• **for each individual/entity and facility identified, disclose any prior experience in owning and/or operating chemical dependency and substance abuse services. List the name and location for these programs.**

Foundations Inpatient, LLC- No prior experience in owning and/or operating chemical dependency and substance abuse services.

MBM Ventures, LLC:

- Amatus Recovery Centers LLC- Owings Mills, MD
- Awakenings Recovery Center LLC- Hagerstown, MD
- Awakenings Recovery Center LLC DBA Awakenings at Funkstown LLC- Funkstown, MD
- Bonfire Behavioral Health- Rochester NH
- Bonfire Behavioral Health, LLC DBA New Hampshire Detox- Bethlehem, NH
- Midwest Detox Center LLC- Maumee, OH
- Midwest Recovery Center LLC- Toledo, OH
- Ohio Detox- Maumee, OH
- Ohio Treatment Center- Maumee, OH
- Pax Riverbend LLC- Jeffersonville, IN
- Valor Recovery Center of Youngstown LLC- Youngstown, OH

Lyon Group I Joint Ventures, LLC- No prior experience in owning and/or operating chemical dependency and substance abuse services.

## **TABLES**

Foundations updated the Tables A-G, attached as Exhibit 8.

**33. Table A shows that there will be 25 beds for female patients and 50 for male patients. Where in the facility will be the female wing and where will be the male wing. How will male and female patients be separated for patient safety?**

Female beds are located on the left side of the building and Male beds are on the right side of the building. Please see notation on Exhibit 6, Floor Plans. These two sections are

separated by a keyless entry fob system. Entry between the two areas will be limited to staff movement.

**34. Provide a larger scale floor plan of the facility including the dimensions for each of the bedrooms. Show the location of each of the beds that will house patients in the facility. How much space (square footage) will be provided for each patient?**

Foundations has provided all of the floor plans that it has for this project. Exhibit 6. The floor plans show square footage. All rooms will only have four beds. If the Commission requires floor plans that show location of each bed, dimensions of each room, and square footage of each room, Foundations will have to re-engage the architecture firm to obtain these floor plans.

<i>Square Footage of Room</i>	<i>Number of Residents</i>	<i>Sq Footage per Resident</i>	<i>Number of Rooms with these dimensions</i>
343	4	85.75	1
252	4	63	1
275	4	68.75	1
246	4	61.5	2
387	4	96.75	1
321	4	80.25	1
298	4	73.75	2
408	4	102	1
346	4	86.5	1
300	4	75	1
327	4	81.75	1
407	4	101.75	2
243	4	60.75	1
307	4	76.75	1
293	4	73.25	1

292	4	73	1
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**35. How many toilets and showers will be available for patients?**

There is a total of 5 toilets and 8 showers in the female wing and 5 toilets, 2 urinals and 8 showers in the male wing.

**36. Table B shows total Project Budget adding up to \$849,946 (\$238,630 + \$611,316) in building lease costs, which does not match the stated requirement of \$286,256.00 on Page 6 of the application. Explain the discrepancy and amend the document so that these figures are the same.**

The figures have been updated and the new total is \$982,130 (\$230,000 + \$752,130).

**37. Table B shows the Annual Lease Cost for Building at \$611K; however, the Facility Expenses, rent, taxes, utilities (2d) under Table F are \$581K. Explain the discrepancy.**

Foundations has made changes to all of the Tables. Table B now shows lease costs (which includes movable equipment and water) of \$752,130. Table F now reflects \$921,945 for 2025 for Facility Expenses, rent, taxes and utilities. This accounts for the additional utilities that are not included in the lease cost. This number increases each year to account for increases in cost of taxes and utilities.

**38. Table E shows revenues of \$4.1 million from Level 3.7 patients in 2024. Explain how this revenue will be generated since the CON will not be approved before 2025. Correct the revenue and expense tables to include only Level 3.7 services after the CON is approved.**

Foundations has updated the tables to start in 2025, and additional, has added Level III.5 services to the tables.

**39. Table E shows that the facility will have 2,250 discharges annually, while the Executive Summary of the Project states that the project will serve 900 patients annually. Explain the discrepancy.**

Foundations estimates total discharges of 1,463 in 2025, and 2,293 in each following years. Foundations plans to serve 1,463 patients in the first year of operation.

**40. Table E/F- The revenue and expense table are based on 100% occupancy year-round. Explain how this is possible, taking into consideration the changeover of rooms**

**after discharge, possible patients dropping out of care unexpectedly, open beds available for emergency admissions, etc.**

Foundations has updated the tables to reflect occupancy in 2025 of 56%, increasing to 89% in 2026 and 2027 when Foundations is fully operational. Foundations believes this is more realistic for anticipated occupancy.

**41. Table F - Will food be prepared on site or will it be brought in by outside suppliers? Show the cost of food service on the revenue and expense table (including a projected inflation allowance for food costs over the entire projection period).**

Foundations has an agreement with a catering company that currently provides meals to BDC. The catering company will provide three meals a day. No food will be prepared on site. Table F includes the cost of food service in the line item “client/clinical expenses.” It is broken out further in Exhibit 7, Statement of Assumptions.

**42. Table F - In CY 2024, management fees are \$581K and increase by 103% to \$1.1 M in CY 2025. Explain the reason behind the increase.**

Amatus Health, which is a managed service organization providing finance and accounting, IT, revenue cycle management, HR and other administrative services to the affiliated substance abuse/treatment facilities. Billing is based on a percentage of collections, in line with industry standard. As Foundations serves more patients and uses more resources from Amatus, the management fees increase.

**43. Table F - Foundations is paying Amatus Health a yearly management fee of around \$510K for CY 2024 that is supposed to increase to \$1M in CY 2025; however, per Exhibit 13 CPA letter, Amatus Health is going to be financing the new project. Explain how this financing arrangement is expected to work with an exact plan of the funding.**

MBM Ventures is financing the project. Amatus Health, which is a managed service organization providing finance and accounting, IT, revenue cycle management, HR and other administrative services to the affiliated substance abuse/treatment facilities. Amatus Health is not financing the project.

**44. The revenue and expense table does not show a positive net income in the first years of operation. When does Foundations project to see a net income? Provide projections in Table E and F for at least four years or until the net income is positive for two full years of operation after the proposed project breaks even.**

Foundations has updated the tables. Month 5 of the first year of operation should have positive net income for the month, Month 9 should have positive accumulated net income.

**45. Other than facility rent/taxes/utilities and Amatus contracting, the expenses for the facility do not increase year over year from 2025 through 2026. Explain how this is possible, given the costs of salaries, benefits, and supplies may rise over this period.**

Foundations has updated the tables. There are increases in the current model of approximately 3% year over year.

**46. Submit the statement of assumptions to support Tables E and F . Include the assumptions used in the charity care figures as the facility plans to provide 80% of its bed days to Medicaid patients.**

Please find attached as Exhibit 7.

**47. Table G - Provide information on any projected salary changes or staffing changes through the final year of the project.**

Direct support labor will increase to the capacity and utilization requested in the document. Foundations has built in an annual increase in salary and benefits of 3%.

**48. Table G - There is no provision for facility maintenance in the staffing plan. Explain how Foundations will address janitorial services, facility maintenance, and facility security.**

Housekeeping and maintenance are listed in the labor force. Facility security is addressed in the capital expense costs for start-up. Foundations will be installing cameras, alarms and keypass/code security systems for doors.

**49. Table G - Provide the cost of benefits for facility employees.**

Foundations will incur a cost of 15% of salary amount to cover the burden for benefits for employees. This amounts to approximately \$335k in Year One. The amount is built into the column "Total Cost" in Table G.

**50. Table G - Will the food plan for clients be overseen by a nutritionist? If so, show the cost of the nutritionist on the staffing plan and the revenue and expense table.**

The catering company contract includes the cost of meal plan development.

**51. Table G – The discharge planning policy calls for an Alumni Coordinator to follow up on discharged patients. Include this staff member in the staffing plan.**

This staff member has been added to the amended tables.

**52. Table G - Calculate the total of the line items such as Administration, Direct Care, Support as well as Regular Employees grand total.**

This total has been calculated in the amended tables.

Foundations appreciates the opportunity to provide this clarifying information to the Commission. Please do not hesitate to contact me at the above noted contact information if you have any questions.

Sincerely,

*Darci Smith*

Darci Smith

CC: Della Leister, RN, Deputy Health Officer, Baltimore County Health Department

Wynee Hawk, RN, JD, Director, Center for Health Care Facilities Planning and Development, MHCC

Lucy Wilson, M.D, Health Officer, Baltimore County

“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.”

DocuSigned by:  
*Baruch Rabhan*  
B90E00EDCDAA0401...

Baruch Rabhan

1/9/2025

Date

Exhibit Table of Contents- Completeness Response 1.9.25	
Exhibit 1	Letter to Patient- Financial Responsibility
Exhibit 2	Updated Transfer- Internal/External Policy
Exhibit 3	One Promise Counseling- Agreement
Exhibit 4	Step Down Excel Data
Exhibit 5	Updated CPA Letter
Exhibit 6	Floor Plans
Exhibit 7	Statement of Assumptions
Exhibit 8	Updated Tables

# EXHIBIT 1

**Foundations Inpatient**

**FINANCIAL AGREEMENT**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Financially Responsible Party (If different from patient): \_\_\_\_\_

Address of Responsible Party:

Street: \_\_\_\_\_

Town/City and Zip: \_\_\_\_\_

Email for Responsible Party: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Facility Name: \_\_\_\_\_

\*\*\*\*\*

1. "Self-Pay Patient" is a patient who either:
  - a. Does not presently have insurance coverage for the services provided by **Foundations Inpatient** (the "Facility"); or
  - b. Has health insurance coverage for the services provided by Facility but chooses NOT to use their insurance benefits and waives the right to bill insurance for services received by Facility.
  - c. Has Insurance and has a deductible due for services
2. I, the undersigned Self-Pay Patient or Financially Responsible Party on their behalf, agree to be responsible for payment of services provided to the Self-Pay Patient by the Facility as follows:
  - Self-Pay Patients or the Financially Responsible Party are responsible for payment for all services provided by the Facility to Self-Pay Patients.
  - Prior to rendering any services by the Facility, Self-Pay Patients are required to provide up-front payments for all services rendered or based on the terms of the agreement.
  - Payment for services to Self-Pay Patients under this agreement is non-refundable, including in cases where a Self-Pay Patient prematurely leaves the Facility's care before completion of services.
  - Failure to comply with this agreement or any rules established by the Facility will result in the Self-Pay Patient's discharge and the termination of all treatment, **with no refund** given for sums already paid.

- The agreed upon rate for services as outlined below \$ \_\_\_\_\_.

**Services to be covered under this agreement:**

**Additional payment term(s):**

3. The Facility shall not be responsible and shall incur no liability for injuries of any kind which the Patient may suffer, except where the injury is caused by gross negligence of the Facility employees. If the Patient leaves the Facility either temporarily or permanently, any responsibility on the part of the Facility shall terminate. It shall be understood that we provide a treatment service aimed at educating those suffering from addictions. We make absolutely no guarantees, either expressly or implied, that a Patient will remain sober during the course of treatment. The decision to use or not to use drugs and/or alcohol shall at all times be borne by the Patient and shall be handled as such.
4. Ancillary Fees: The Patient will be responsible for payment for all outside services, including but not limited to medical fees incurred onsite or offsite, hospital services, dental and hygiene services, and prescription medications.

THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ THE FOREGOING AND HAS RECEIVED A COPY THEREOF AND IS THE SELF-PAY PATIENT OR THE FINANCIALLY RESPONSIBLE PARTY WHO IS AUTHORIZED TO ACT AS THE PATIENT' S GENERAL AGENT TO EXECUTE THIS AGREEMENT AND ACCEPT ITS TERMS. EITHER THE SELF-PAY PATIENT OR FINANCIALLY RESPONSIBLE PARTY AGREES TO PAY FOR THE SERVICES PROVIDED WITHOUT UTILIZING INSURANCE BENEFITS OF ANY KIND. THE FULL RESPONSIBILITY OF PAYMENT SHALL BE UNDERTAKEN BY THE SELF-PAY PATIENT AND/OR FINANCIALLY RESPONSIBLE PARTY.

\_\_\_\_\_  
Signature of Patient and/or Financially Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient and/or Financially Responsible Party

\_\_\_\_\_  
Relationship to Patient

# EXHIBIT 2

Care, Treatment, and Services			
Reference/Standard	CTS 01.01.01 / CTS 02.03.13		
Description	Program Eligibility		
Creation Date	05/2024	Approval Date	6/2024
Creator	Foundations Inpatient	Most Recent Review	6/2024

Policy

It is the policy of the organization to screen all clients to ensure our facility is an appropriate setting for their needs.

The organization provides services for adults who are 18 years of age or older. Individuals must be deemed capable of self-preservation, medically and psychiatrically stable enough to be able to engage in treatment.

The Medical Director, Clinical Director and Executive Director may decline any admission based on the criteria collected.

Procedure

Individuals may call the contact center between 7:00a and 8:00p EST to speak with a representative. The representative will explain all programs, including locations, hours of operations, services, and protocols. Through various screenings, the representative will have the ability to explain the potential services. The representative has full access to clinical and medical professionals for clearance or recommendations. Individuals also have the option to walk into the facility to be assessed.

When the representative speaks with the individual, the representative will explain the process from start to finish. In the case it is determined that the individual does not meet the criteria based on the initial screening, the individual will be given a minimum of two external resources that may be able to assist the individual.

If the individual does meet eligibility and appropriateness of our program(s), the individual and representative will discuss an intake date and time. At that time, the individual will go through the intake process (see additional policy). For Detox programs, the Medical Director or designee, will accept the client into the program. For all other levels of care, the Clinical Director will accept the client into the level of care. The Executive Director is the only employee allowed to override the decision of the Clinical or Medical Director. Exclusionary criteria:

- Active suicidal or homicidal ideation. (Refer to Emergency room)
- Current Acute Medical issues (Refer to Emergency room)
- Covid Positive
- Arson Conviction
- Sexual offense conviction or charges
- Anyone younger than 18 including those who may turn 18 during treatment

The information collected to determine the level of care is the following:

- Potential Client Information:
  - a. Name
  - b. SSN
  - c. Address
  - d. DOB
  - e. Phone
  - f. Age
  - g. Presenting factors for the call now
  - h. Substance abuse usage and history
  - i. Description of what physically happens when the individual stops using substances.
  - j. Has the individual recently completed detox?
  - k. Prior substance abuse treatment: if so, when, what type (OP vs. Inpatient) where and response to the previous treatment episode.
  - l. Type of discharge from previous treatment.
  - m. Current physical issues which may interfere with treatment services.
  - n. Any current and history of mental health issues including context and descriptions.
  - o. Current legal issues.
  - p. Financial ability to pay for services, Cash payment, or insurance.
    - The person who is responsible for payment.
    - Insurance information.
      - Type of insurance
        - Policy number
        - Verification phone number
      - Primary policyholder:
        - Name
        - Address
        - Phone
        - Relationship to potential client

All information collected will be housed in the organization's secure CRM and EMR.

For specific level of care criteria and program descriptions, please see the separate level of care policies below.

Care, Treatment, and Services			
Reference/Standard			
Description	LOC – Detox – WM (ASAM 3.7)		
Creation Date	05/2024	Approval Date	6/2024
Creator	Foundations Inpatient	Most Recent Review	6/2024

Policy:

It is the policy of this organization to provide medically managed services and clinical programming to assure that clients have a 24-hour monitored and safe treatment setting. It is policy that all clients will be offered the following services while in 3.7 WM level of care: planning for aftercare services/ discharge planning, withdrawal symptom assessment, withdrawal symptom medication management, medication assisted treatment, medical provider appointments as needed, group therapy, case management, and individual therapy.

Procedure:

Clients will complete their initial biopsychosocial assessment at Centralized Intake to determine an appropriate level of care. Clients completing detoxification services will be assessed by a clinician prior to discharge to determine the next appropriate level of care. Clients will submit to a UA test upon admission to detoxification and will be asked to randomly partake in drug testing while in the detox level of care.

Clients will be housed in a 24-hour medically monitored facility and will receive as needed medical care including: History and Physicals, withdrawal symptom assessments, medication management, and Buprenorphine/Naloxone Maintenance (if applicable). Medical staff such as psychiatrists, nurse practitioners, and licensed nurses will be available to clients 24 –hours a day.

Clients will be provided with 3 nutritious meals per day and 1 snack in the evening. Clients will be provided with a clean, safe, and therapeutic environment and will be given the opportunity to sleep for 8 hours each night.

Clinical staff will provide group programming based on client needs during the detoxification process. Groups may focus on illness education and the next level of care in the recovery process. Will provide 20 hours of group programming, which will include a minimum of 10 hours of evidence-based curriculum. Evidence-based programming will be facilitated by CDCAs/Clinicians and will include topics such as: relapse prevention, coping skills to combat triggers, problem-solving, building a recovery environment, etc.

Clients will be offered unstructured activities and personal time.

Each client will be assigned an individual therapist, case manager, and discharge planner throughout their time in detoxification services.

The discharge planner will meet with the client at least 2 times during their stay to initiate a discharge plan and facilitate aftercare services.

An individual therapist is on site to meet clients as they present. The therapist will work with the client to develop a treatment plan, complete an ASAM, and provide therapeutic resources to promote long-term sobriety. Therapists will also assist with crisis intervention as needed.

Clients will have access to a case manager to assist with any needs beyond their detox stay.

Clients will meet with a provider within 24 hours of arrival for a history and physical examination and medication management, at that time providers discuss medication assisted treatment options. Clients may request to see a provider at any time during their stay for any medical or mental health issues.

Licensed nursing staff are available on site 24 hours a day to assess and treat any medical needs that may arise related to the substance use diagnosis or any comorbid conditions. Severity of withdrawal symptoms are assessed and medications are given as ordered, per the medical provider.

Care, Treatment, and Services			
Reference/Standard			
Description	LOC – Residential (ASAM 3.7)		
Creation Date	05/2024	Approval Date	6/2024
Creator	Foundations Inpatient	Most Recent Review	6/2024

Policy:

It is the policy of this organization to provide medically managed services and clinical programming to assure that clients have a 24-hour monitored and safe treatment setting. It is policy that all clients will be offered the following services while in 3.7 residential level of care: planning for aftercare services/discharge planning, medication assisted treatment, group therapy, case management, and individual therapy.

Procedure:

Clients will complete their initial biopsychosocial assessment at Centralized Intake to determine an appropriate level of care. Clients completing detoxification services will be assessed by a clinician prior to discharge to determine if residential is an appropriate level of care. Upon arrival to the residential program; staff will provide the client with a tour of the facility along with a welcome packet to explain the rules and regulations of the facility and expectations of treatment. Clients will submit to a UA test upon admission and will be asked to randomly partake in drug testing while in the residential level of care.

Clients will be housed in a 24-hour medically monitored facility and will receive as needed medical care including: History and Physicals, medication management, and Suboxone/Naloxone Maintenance (if applicable.) Medical staff such as psychiatrists, nurse practitioners, and licensed nurses will be available to clients 24 –hours a day.

Clients will be provided with 3 nutritious meals per day and 1 snack in the evening. Clients will be provided with a clean, safe, and therapeutic environment and will be given the opportunity to sleep for 8 hours each night. Clients will be required to perform housekeeping tasks to maintain a safe, healthy living space.

Clinical staff will provide interpersonal and group living skills groups including: resources for education, job training, job interviews, employment stabilization, and obtaining alternative living arrangements for a minimum of 20 hours per week. Clients will be in an evidence-based curriculum group for a minimum of 10 hours per week. Evidence-based programming will be facilitated by CDCAs/Clinicians and will include topics such as: relapse prevention, coping skills to combat triggers, problem-solving, building a recovery environment, etc.

Clients will be offered unstructured activities, personal time, and self-help groups such as AA and NA. In this level of care, clients will be offered a medical/nursing group 1x per week to obtain education on SUBMAT, psychotropic medications, and mental health resources.

Each client will be assigned an individual therapist, case manager, and discharge planner throughout their time in residential services.

The discharge planner will meet with the client at least 3 times during their stay to initiate a discharge plan and facilitate aftercare services.

Clients will be offered individual therapy at least once per week to build skills to address ongoing mental health concerns through treatment planning. During the initial therapy session, the client will work with their therapist to develop a treatment plan, complete an ASAM, and provide therapeutic resources to promote long-term sobriety. Therapists will also assist with crisis intervention as needed.

Clients will meet with a case manager at least once per week to develop an Ohio Case Management Assessment to determine needs. During ongoing appointments, clients will meet with case management for legal concerns, offering resources to outside medical providers, transportation for medically necessary appointments, and address any questions related to government assistance.

Care, Treatment, and Services			
Reference/Standard	CTS 06.02.01 / CTS 06.02.05		
Description	Transfer – Internal / External		
Creation Date	05/2024	Approval Date	06/2024
Creator	Foundations Inpatient	Most Recent Review	06/2024

Policy

It is policy of the organization to ensure when an individual receiving services is transferred or discharged the continuity of care, treatment, or services is maintained. The organization has established protocols address the continuity of care, treatment of services after discharge or transfer that includes the following:

- The transfer of responsibility for care, treatment, or services for the individual served from one staff, organization, organizational program, or service to another.
- The reason for transfer or discharge when moving from one staff, organization, organizational program, or service to another.
- Mechanisms for internal and external transfer.
- Identification of the person who has accountability and responsibility for the safety of the individual served during an external transfer.

See Specific Procedure

Procedures

- Transfer Internal

Care Coordination Team - If it determined that a client must be transferred to a different therapist or Case Manager, the Clinical Director must first approve the transfer. From there, the Clinical Director or designee is responsible for entering a clinical note justifying the transfer.

Level of Care – When a client is transferred to a level of care within our system of care, the Therapist is responsible for completing a clinical note justifying the step up or down. All transfers within a substance use level of care must meet ASAM criteria. If the client receives a new therapist due to the transfer, the client must meet with the new Therapist within 48 hours to update the treatment plan.

- Transfer External

There are several reasons why a client may be transferred to an external organization including, administratively discharged, completed successfully, medical reasons, or it is determined our facility is not a good fit for the client.

For non-emergency transfers, it is the responsibility of the Case Manager and Primary Therapist to ensure the client’s discharge summary and aftercare plan is completed. The Case Manager or designee will ensure the client has all their belongings, discharge paperwork, referrals/orders, and medications. In the case that the client leaves any of these items at the facility, they will be held for 5 business days before shipping to the address on file. If we are unable to ship the items due to regulations, the items that cannot be shipped will be destroyed or donated.

For emergency transfers, it is the responsibility of the staff on duty to ensure the receiving facility has the clients facesheet, medication logs, limited medical records (upon request) insurance information, our organizations contact information, and a no-narcotic form. If the client is transferred by EMS, the above items will be given to the paramedic. The staff on duty must collect the information, EMS company, paramedics' name, and receiving facility. This information will be added to the incident report that must be filled out and submitted. The staff is also responsible for contacting the emergency contact on file.

The Director of Nursing or leadership designee is responsible for contacting the receiving facility to check the status of the client. If it is determined that the client is stable to return to our facility, it must be cleared by the Executive Director for all behavioral issues, Clinical Director for all clinical issues, and Medical Director or Medical designee for all medical issues.

- All Discharges and Transfers

The organization utilizes several discharge dispositions, including, completed, AMA/ACA, administratively discharged, and transferred. Regardless of the discharge type, the Primary Therapist is responsible for completing the discharge summary, closing the treatment plans, and completing the aftercare plan (with the Case Manager). The documentation should state the discharge type, where the client discharged to, the date and time of the discharge, narrative regarding the discharge, the resources/referrals provided to the client, and the status for the client's progress.

The discharge summary should be completed within 5 days of discharge. If the client left AMA from a residential or detox level of care, the discharge summary should be completed within 24 hours. The discharge summary should state what education was provided, the risks that were discussed if leaving AMA, where the client reported they were going, and what resources were provided to the client to minimize the risk of leaving AMA. All AMAs are asked to sign an acknowledgement of the above. If a client does not sign an acknowledgement, the Primary Therapist will document that the above has been discussed.

If a client is in outpatient and does not attend sessions, it is the responsibility of the Care Team to contact the client daily. Upon the third consecutive missed session (Group, individual, or family session), the Primary Therapist will enter the client in Suspended Care. When in Suspended Care, the Case Manager or designee is responsible to attempt contact with the client three times over 10 days. Every attempt to contact the client will be documented in a clinical note. If the organization does not make contact within the 10 days, the client will be dispositioned as administratively discharged or AMA, based on the Clinical Director or Executive Director's decision. The Alumni Coordinator will then take over all communication and follow up.

#### Contact Post Discharge

It is the policy of the organization to contact the client within 72 business hours of discharge (any discharge type) followed by 12 month of aftercare. The Case Manager assigned to the client or Alumni Coordinator is responsible for all post discharge contacts. The goal is to determine how the client is adapting to their elements and to ensure the client is safe. It is also the policy to contact the agency where the client was referred to for continue care services (if applicable and appropriate). The goal is to determine if the agency has all the information and clinical documentation to appropriately treat the client.

\*\* Our organization may contract with a third party agency to complete all post discharge calls and surveys.

# EXHIBIT 3

Foundations Inpatient LLC

7131 Rutherford Rd.

Windsor Mill, MD 21244

RE: Incoming/Outgoing Referral Agreement

To whom it may concern,

The purpose of this document is to formalize the relationship between Foundations Inpatient and One Promise. This cooperative and reciprocal arrangement will expedite referral, admission and discharge of clients, allowing both agencies to serve clients better.

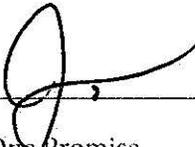
In accordance with COMAR 10.24.14.05 (j) referral and transfer agreements will be made with providers in the Central Maryland Planning Region. Foundations Inpatient will provide 15% of its available bed space to gray area and indigent consumers under COMAR 10.24.14.05 (j,k). This agreement is intended to establish referrals for gray areas and indigent consumers.

Both parties to this agreement shall provide all services in accordance with all applicable Federal and Maryland laws and applicable accreditation standards including confidentiality of client information requirements. Both parties agree that all services will be provided without regard to race, color, religion (creed), gender, expression, age, national origin (ancestry), disability, mental status, sexual orientation or any other impermissible basis.

Each party will be responsible for its own acts and omissions with respect to the care and services provided to clients.

Services will be provided under each party's usual arrangements for payment and/or funding and this agreement is not a guarantee that each party's services, treatment, slots or shelter eds will be available.

This agreement will become effective on the date both parties sign this agreement. Either party may terminate this agreement upon 20 days' written notice to the other party.

  
\_\_\_\_\_  
One Promise

12/18/24  
\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Foundations Inpatient LLC

12.10.24  
\_\_\_\_\_  
Date

# EXHIBIT 4

Stepdowns By Gender			
Row Labels	Step Down	Total Clients	% Stepped Down
Female	106	258	41%
Male	182	475	38%
<b>Grand Total</b>	<b>288</b>	<b>733</b>	<b>39%</b>

Stepdowns by County			
Row Labels	Step Down	Total Clients	% Stepped Down
Adams County	0	1	0%
Allegany County	14	31	45%
Anne Arundel	1	3	33%
Anne Arundel County	16	47	34%
Augusta County	0	1	0%
Baltimore City	61	155	39%
Baltimore County	48	145	33%
Berkeley County	2	5	40%
Calvert County	2	5	40%
Carroll County	19	38	50%
Cecil County	8	16	50%
Charles County	2	8	25%
Fairfax County	1	2	50%
Franklin County	1	1	100%
Frederick County	14	33	42%
Garrett County	1	5	20%
Grayson County	0	1	0%
Hampshire County	0	1	0%
Harford	1	5	20%
Harford County	9	24	38%
Howard County	9	21	43%
Jefferson County	0	1	0%
Lycoming County	0	2	0%
Marion County	1	1	100%
Montgomery County	13	34	38%
Nassau County	1	1	100%
Prince Georges	0	1	0%
Prince George's County	11	27	41%
Queen Anne's County	1	3	33%
Shanandoah County	1	1	100%
St. Mary's County	3	4	75%
Talbot County	0	1	0%
Unknown	3	7	43%
Washington County	45	100	45%
Wicomico County	0	1	0%
Tablot County	0	1	0%
<b>Grand Total</b>	<b>288</b>	<b>733</b>	<b>39%</b>

Stepdowns by Month	
Month	Stepdowns
Jan	29
Feb	30
Mar	27
Apr	24
May	27
Jun	32
Jul	23
Aug	32
Sep	25
Oct	25
Nov	21

3.7 Admissions by County	
Program	SUD Residential 3.7
Row Labels	Count of Full Name
Baltimore County	5
Carroll County	2
Montgomery County	1
Washington County	3
<b>Grand Total</b>	<b>11</b>

# EXHIBIT 5

January 8<sup>th</sup>, 2025

Foundations Inpatient  
Att: Baruch Rabhan  
7131 Rutherford Road  
Windsor Mill, MD 21244

Re: Viability of Proposal for Maryland Health Care Commission

Dear Mr. Rabhan,

I have been engaged to review and update the status of Foundations Inpatient, LLC and MBM Ventures financial viability.

I am independent, with respect to Foundations, MBM and any of their officers and directors and have no financial interest in the determination by the Commission as it relates to the proposal. During my engagement, I have reviewed and analyzed the Balance Sheets, Profit and Loss Statements, and Statement of Cash Flows provided by you for the following entities, which you are owner and managing member:

- Amatus Health LLC
- Amatus Recovery Centers LLC
- Awakenings Recovery Center LLC
- Awakenings Recovery Center LLC DBA Awakenings at Funkstown LLC
- Bonfire Behavioral Health
- Bonfire Behavioral Health, LLC DBA New Hampshire Detox
- Foundations Recovery Center LLC
- Midwest Detox Center LLC
- Midwest Recovery Center LLC
- Ohio Detox
- Ohio Treatment Center
- Pax Riverbend LLC
- Valor Recovery Center of Youngstown LLC

I have reviewed and analyzed the following information provided by you:

- 3-year projections for Foundations Inpatient
- Projected revenue and expenses, including statement of assumptions included within Foundations Inpatient application.
- Review of the construction expenses
- Information pertaining to Foundations Inpatient current credit facility and capacity.
- Availability of funds

In addition to analyzing the above documents, I have also conferred with management as to their assumptions and believe that the assumptions included within the Application are achievable. I also confirm that there are available funds to cover the \$562,817, which consists of \$230,000 in start-up and capital expenditures, along with \$332,817 in operating deficit for the first couple of months during ramp up.

It is my conclusion based upon the information made available to me, that (a) Foundations and MBM generate sufficient free cash flow from continuing operations to fund the necessary working capital & renovation costs identified throughout their proposal and (b) MBM currently has enough liquidity to fund the working capital independent of the cash flow from operations.

Sincerely,



Jeff Cohen, CPA (License #CA039051L)

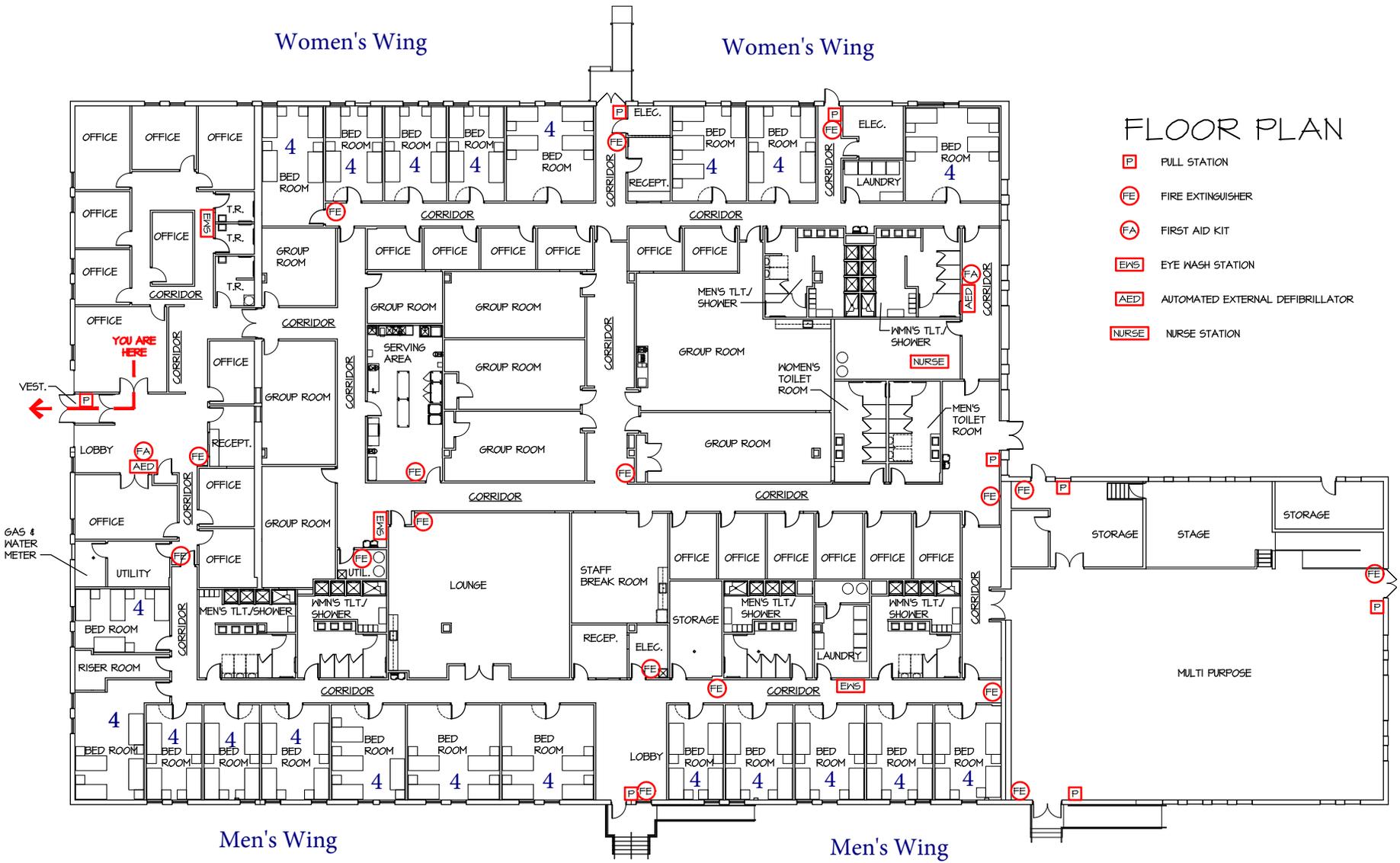
# EXHIBIT 6

Women's Wing

Women's Wing

# FLOOR PLAN

- P PULL STATION
- FE FIRE EXTINGUISHER
- FA FIRST AID KIT
- EWS EYE WASH STATION
- AED AUTOMATED EXTERNAL DEFIBRILLATOR
- NURSE NURSE STATION



7131 RUTHERFORD ROAD  
WINDSOR MILL, MARYLAND 21244

© DWIGHT GILLILAND, ARCHITECT 2024

**WALL CONSTRUCTION TYPES**

NOTE: NEW WALLS SHALL BE ALIGNED W/ EXISTING WALLS, COLUMNS, WINDOWS, ETC. UNLESS NOTED OTHERWISE.

EXISTING CONSTRUCTION TO REMAIN. PATCH AND REPAIR AS NECESSARY FOR NEW CONSTRUCTION. (PRIME & PAINT IN AREA OF ALTERATION).

5/8" GYPSUM WALLBOARD ON BOTH SIDES OF 3 5/8" METAL STUDS @ 16" C/C. PROVIDE 3 1/2" SOUND ATTENUATION INSULATION BATT BETWEEN STUDS. RUN PARTITION TO ABOVE CEILING. (MOISTURE RESISTANT GYPSUM BOARD AT SHAKERS AND MET WALLS)

LAUNDRY ROOM WALLS - (1) LAYER OF 5/8" MOISTURE RESISTANT GYPSUM BOARD ON EXPOSED SIDE OF 3 5/8" METAL STUDS @ 16" C/C. PRIME AND EPOXY PAINT

SHOWER LID - (1) LAYER OF 5/8" MOISTURE RESISTANT GYPSUM BOARD ON 3 5/8" METAL STUD CEILING FRAMING @ 16" C/C @ T-8" A.F.F.

SHOWER WING WALLS: (1) LAYER 5/8" MOISTURE RESISTANT GYPSUM BOARD ON EACH SIDE OF 3 5/8" METAL STUDS @ 16" C/C. RUN PARTITION TO ABOVE CEILING

WALLS WITHIN SHOWER COMPARTMENT NOT COVERED WITH SHOWER INSERT OR TILE SHALL BE PAINTED WITH HIGH PERFORMANCE EPOXY (HFC) PAINT

TILE INSTALLATION SHALL COMPLY W/ FINISH NOTES - SEE DRAWING A-7

**FIRE RATED ASSEMBLIES:**

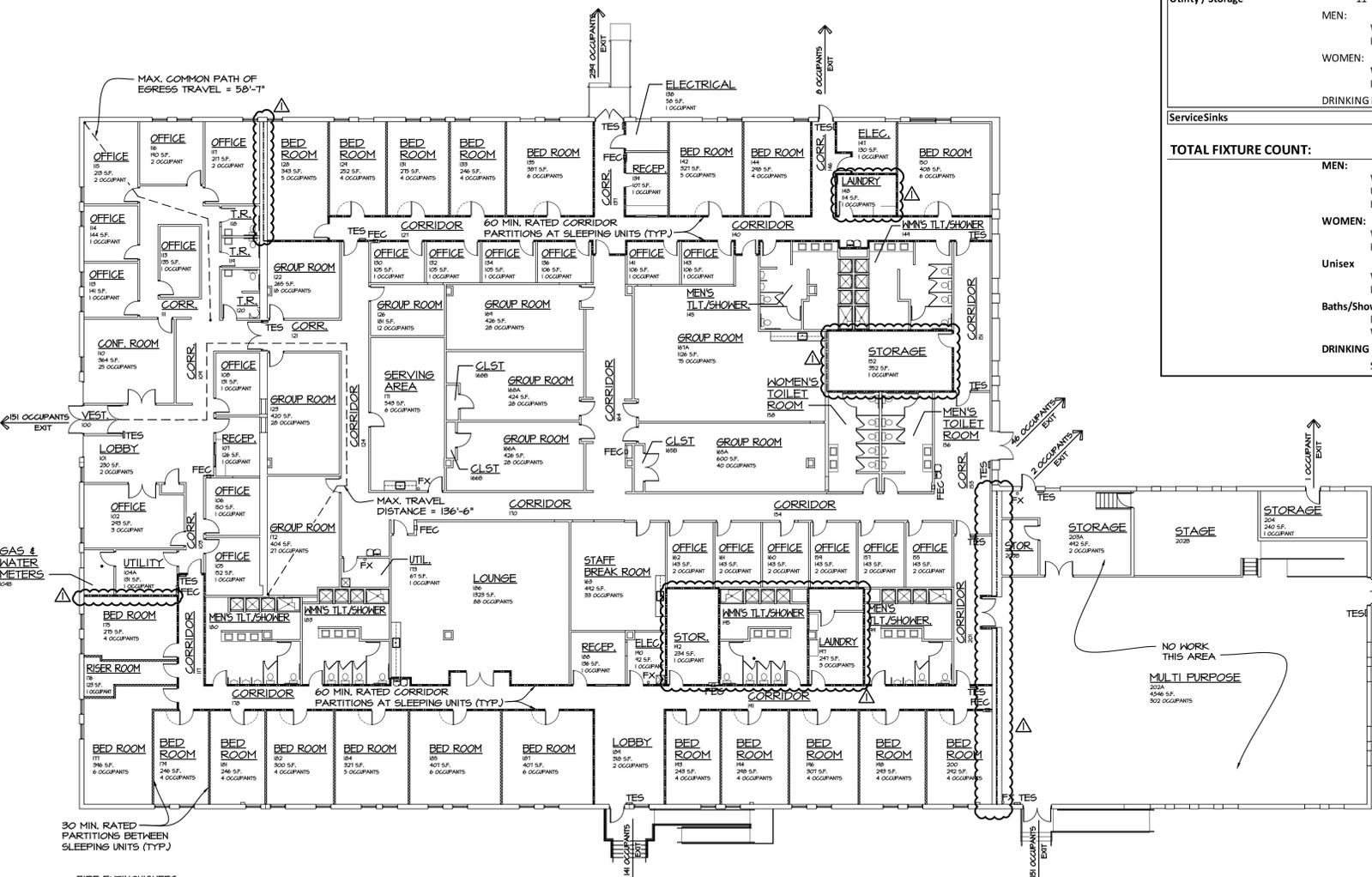
TYPE 2: 1/2 HOUR FIRE PARTITION BETWEEN SLEEPING UNITS. (SIMILAR UL 1407)  
(1) LAYER 5/8" GYPSUM BOARD ON EACH SIDE OF 3 5/8" METAL STUDS @ 16" C/C. WALLS TO HAVE 3 1/2" SOUND ATTENUATION BLANKETS BETWEEN STUDS. SEAL W/ CAULK @ TRANSITIONS (SEE DETAIL ON A-3.3)

TYPE 2B: SAME AS TYPE 2 - PROVIDE 3 5/8" METAL STUD INFILL ABOVE EXISTING METAL STUD WALL. EXTEND TO ROOF DECK ABOVE.

TYPE 3: 1 HOUR FIRE RATED CORRIDOR PARTITIONS (SIMILAR TO UL 1418)  
CONFIRM USE OF 5/8" FIRE RATED GYPSUM BOARD. IF NOT, REPLACE W/ 5/8" FIRE RATED GYPSUM BOARD AS NECESSARY. WALLS TO HAVE 3 1/2" SOUND ATTENUATION BLANKETS BETWEEN STUDS. (SEE DETAIL ON A-3.3) SEAL W/ CAULK AT TRANSITIONS.

TYPE 3B: SAME AS TYPE 3 - PROVIDE 3 5/8" METAL STUD INFILL ABOVE EXISTING METAL STUD WALL. EXTEND TO ROOF DECK ABOVE.

INFILL - 5/8" GYPSUM BOARD ON BOTH SIDES OF 3 5/8" METAL STUDS @ 16" C/C. PROVIDE MOISTURE RESISTANT GYPSUM BOARD ON MET WALLS. PROVIDE SOUND ATTENUATION BATT INSULATION BETWEEN STUDS. FIELD VERIFY EXISTING WALL DIMENSIONS



**EGRESS PLAN**  
SCALE: 1/16" = 1'-0"

**Project Occupancy & Fixture Count**

	Occupants	S.F.	S.F. / Person
I-1 Institutional - Residential Care Business (Office)	97	4956	51 @ 120sf ea
Assembly A-3 (Classrooms / Groups)	732	10966	15 @ 15sf ea
Assembly (Net)	0	3021	0 @ 0sf ea
Utility / Storage	11 (Actual)	2040	186 @ 300sf ea
<b>TOTAL BUILDING OCCUPANTS</b>	<b>890</b>		

**REQUIRED FIXTURE COUNT WORKSHEET:**

Category	Required	Provided
<b>I-1 Institutional - Residential Care</b>	97 TOTAL USERS / 2	48.5
MEN:	Waterclosets/Urinals (1/10)	48.5
	Lavatories (1/10)	48.5
WOMEN:	Waterclosets (1/10)	48.5
	Lavatories (1/10)	48.5
Baths/Showers:	Men (1/8)	6.06
	Women (1/8)	6.06
DRINKING FOUNTAINS (1/100)	0.97	
<b>B (Office Space)</b>	50 TOTAL USERS / 2	25
MEN:	Waterclosets/Urinals (1/25)	1.00
	Lavatories (1/40)	0.63
WOMEN:	Waterclosets (1/25)	1.00
	Lavatories (1/40)	0.63
DRINKING FOUNTAINS (1/100)	0.50	
<b>A-3 (Classrooms/Group)</b>	732 TOTAL USERS / 2	366
MEN:	Waterclosets/Urinals (1/125)	2.93
	Lavatories (1/200)	1.83
WOMEN:	Waterclosets (1/65)	3.66
	Lavatories (1/200)	1.83
DRINKING FOUNTAINS (1/500)	1.46	
<b>Utility / Storage</b>	11 TOTAL USERS / 2	5.5
MEN:	Waterclosets/Urinals (1/100)	0.06
	Lavatories (1/100)	0.06
WOMEN:	Waterclosets (1/100)	0.06
	Lavatories (1/100)	0.06
DRINKING FOUNTAINS (1/1000)	-	
<b>Service Sinks</b>		1

**TOTAL FIXTURE COUNT:**

	REQUIRED	PROVIDED
<b>MEN:</b>		
Waterclosets	8.83	9
Urinals		9
Lavatories	7.36	11
<b>WOMEN:</b>		
Waterclosets	11.54	17
Lavatories	7.31	11
<b>Unisex</b>		
Waterclosets		3
Lavatories		3
<b>Baths/Showers</b>		
Men	6.06	12
Women	6.06	12
<b>DRINKING FOUNTAINS:</b>		
Service Sinks	2.93	8
	1	2

**CODE INFORMATION**

**BUILDING CODE:** 2015 BALTIMORE COUNTY BUILDING CODE (2015 INTERNATIONAL BUILDING CODE WITH AMENDMENTS, 2015 INTERNATIONAL MECHANICAL CODE WITH AMENDMENTS, ELECTRICAL, 2021 NEC ENERGY, 2015 IECC FIRE PREVENTION CODE, 2018 NFPA 101 AND 2018 NFPA 1 ACCESSIBILITY, 2020 ADAAG REHABILITATION, 2015 IEBC

**TYPE OF PROJECT:** INTERIOR ALTERATIONS - REHABILITATION FACILITY. OCCUPANTS ARE CAPABLE OF SELF-PRESERVATION

**EXISTING USE GROUP:** E, B, A-3

**PROPOSED USE GROUP:** I-1, B, A-3 (B.C.), RESIDENTIAL BOARD AND CARE BUSINESS (NFPA 101)

**MIXED USE GROUPS:** I-1/B/A-3 NON SEPARATED

**EXISTING CONSTRUCTION CLASSIFICATION:** 2B

**PROPOSED CONSTRUCTION CLASSIFICATION:** 2B (IBC) (1000) (NFPA 101)

**BUILDING HEIGHT & AREA:**

**ALLOWABLE HEIGHTS (SPRINKLED):**

FEET	STORIES
A-3	3
B	4
I-3	4

**ALLOWABLE AREAS:**

FEET	SQ. FT.
A-3	30,000
B	40,000
I-3	40,000

**EXISTING HEIGHT:** 15 FT. - 1 STORIES

**PROPOSED HEIGHT (NO CHANGE):** 15 FT. - 1 STORIES

**ALLOWABLE HEIGHT (INCL. FINISHES):** 15 FT. - 3 STORIES

**TOTAL ALLOWABLE HEIGHT:** 15 FT. - 3 STORIES

**EXISTING AREA:** 36,421 SF

**ALLOWABLE AREA (A):** 30,000 SF

**PERIMETER INCREASE:** 4,560 SF

**TOTAL ALLOWABLE AREA:** 42,560 SF

**PROPOSED AREA:** 36,421 SF

**TOTAL BUILDING AREA:** 36,421 SF

**FIRE RESISTANCE RATINGS:**

**STRUCTURAL FRAME - INCLUDING COLUMNS, BEAMS, TRUSSES:** 0 - HOUR

**BEARING WALLS - EXTERIOR:** 0 - HOUR

**NON BEARING WALLS & PARTITIONS - EXTERIOR:** 0 - HOUR

**INTERIOR:** 0 - HOUR

**ROOF CONSTRUCTION - INCLUDING SUPPORTING BEAMS & JOISTS:** 0 - HOUR

**FIRE PARTITIONS:**

**DWELLING UNIT CORRIDORS:** 1 HOUR

**OPENING PROTECTIVES:** 1/3 - HOUR

**EXIT ACCESS CORRIDORS (NON-DWELLING UNITS):** 0 - HOUR

**STORAGE ROOMS > 100 SQ FT (NFPA 101):** 1 - HOUR

**LAUNDRY ROOMS (NFPA 101):** 1 - HOUR

**INTERIOR HALL & CEILING FINISH REQUIREMENTS:**

OCCUPANCY GROUP	FULLY SPRINKLED	EXIT ENCLOSURE & EXIT PASSAGEWAY	CORRIDORS	ROOMS & ENCLOSED SPACE	FLOOR COVERINGS
A-3	Y	B	B	C	CLASS II
B	Y	B	C	C	CLASS II
I-1	Y	A	B	B	CLASS II

**OCCUPANT LOAD:**

**FIRST FLOOR:** 890 OCCUPANTS

**TOTAL:** 890 OCCUPANTS

**NUMBER OF EXITS REQUIRED:** 4

**NUMBER OF EXITS PROVIDED:** 4

**EXIT ACCESS TRAVEL DISTANCE:** 250' MAX. ALLOWABLE TRAVEL DISTANCE - 150'-6" PROVIDED

**DEAD ENDS:** A-3: 20'-0" MAX. (SUPPRESSED); B: 30'-0" MAX. (SUPPRESSED); I-3: 50'-0" MAX. (SUPPRESSED)

**EGRESS WIDTHS:** DOORS, RAMPS, CORRIDORS (INCHES PER OCCUPANT): REQUIRED: 15" x 135.5"; PROVIDED: 50"

**FIRE SPRINKLER SYSTEM:** STANDPISPS: REQUIRED BY USER GROUP - NFPA 13

**FIRE ALARM SYSTEM:** REQUIRED BY USER GROUP

**FIRE DEPARTMENT CONNECTION:** EXISTING (NO CHANGE)

**GENERAL NOTES:**

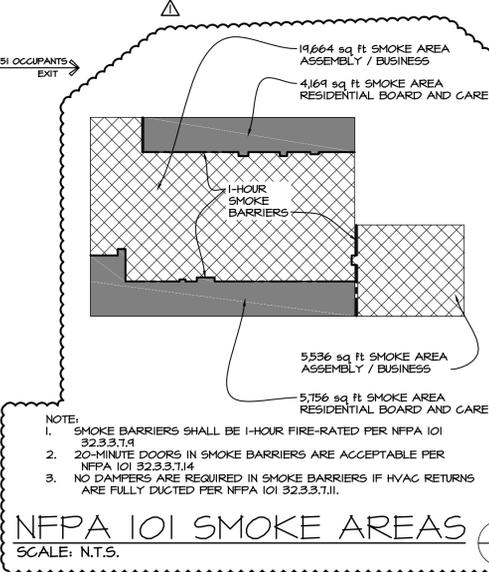
- ALL CONSTRUCTION SHALL CONFORM TO ALL FEDERAL, STATE, AND LOCAL CODES, ORDINANCES, AND REGULATIONS HAVING JURISDICTION.
- CONTRACTOR SHALL VERIFY ALL EXISTING CONDITIONS PRIOR TO BEGINNING WORK. CONTRACTOR SHALL NOTIFY ARCHITECT OF ANY AND ALL DISCREPANCIES AND FOR INTERPRETATIONS PRIOR TO INSTALLATION, FABRICATION, AND/OR ORDERING MATERIAL AND/OR WORK.
- PLACEMENT OF ADDRESS NUMBERS SHALL BE COORDINATED W/ OWNER. NUMBERS SHALL BE 4" HIGH W/ A STROKE WIDTH OF 0.5" MIN.

**FIRE SUPPRESSION NOTE:**

- FIRE SUPPRESSION CONTRACTOR SHALL FIELD VERIFY EXISTING SYSTEM & PROVIDE MARYLAND CERTIFIED DRAWINGS FOR PLAN REVIEW & APPROVAL.
- FIRE SUPPRESSION CONTRACTOR SHALL PROVIDE & INSTALL COMPLETE SYSTEM AS REQUIRED BY 2015 BALTIMORE COUNTY BUILDING CODE.
- WORK SHALL BE COORDINATED WITH CEILING PATTERN, SO HEADS ARE LOCATED WITHIN THE CENTER OF THE PATTERN.

**FIRE ALARM NOTE:**

- FIRE ALARM CONTRACTOR SHALL PROVIDE DRAWINGS BY FIRE ALARM DESIGNER CERTIFIED IN THE STATE OF MARYLAND AND SUBMITTED UNDER SEPARATE PERMIT.
- FIRE ALARM CONTRACTOR SHALL PROVIDE AND INSTALL COMPLETE SYSTEM AS REQUIRED BY 2015 BALTIMORE COUNTY BUILDING CODE AND NFPA 72.



Dwight Gilliland  
Architect  
(410) 824-3311  
5622 Mayberry Square  
Sylva, Oh. 43560

CODE INFORMATION, EGRESS PLAN, AND NOTES

INTERIOR ALTERATIONS FOR:  
**FOUNDATIONS RECOVERY CENTER**  
7131 RUTHERFORD ROAD  
WINDSOR MILL, MARYLAND 21244

PROJECT NO:	21160	DATE:	05/02/2021
DRAWN BY:	A.S.H.	CHECKED BY:	D.N.G.
DATE/REVISION:	02/14/2022 CORRECTION LETTER	DATE/REVISION:	12/9/2021 PERMIT
	11/6/2021 OWNER REVIEW		
			2021
			© Dwight Gilliland, AIA
			A-1
			1 OF 12 DRAWINGS



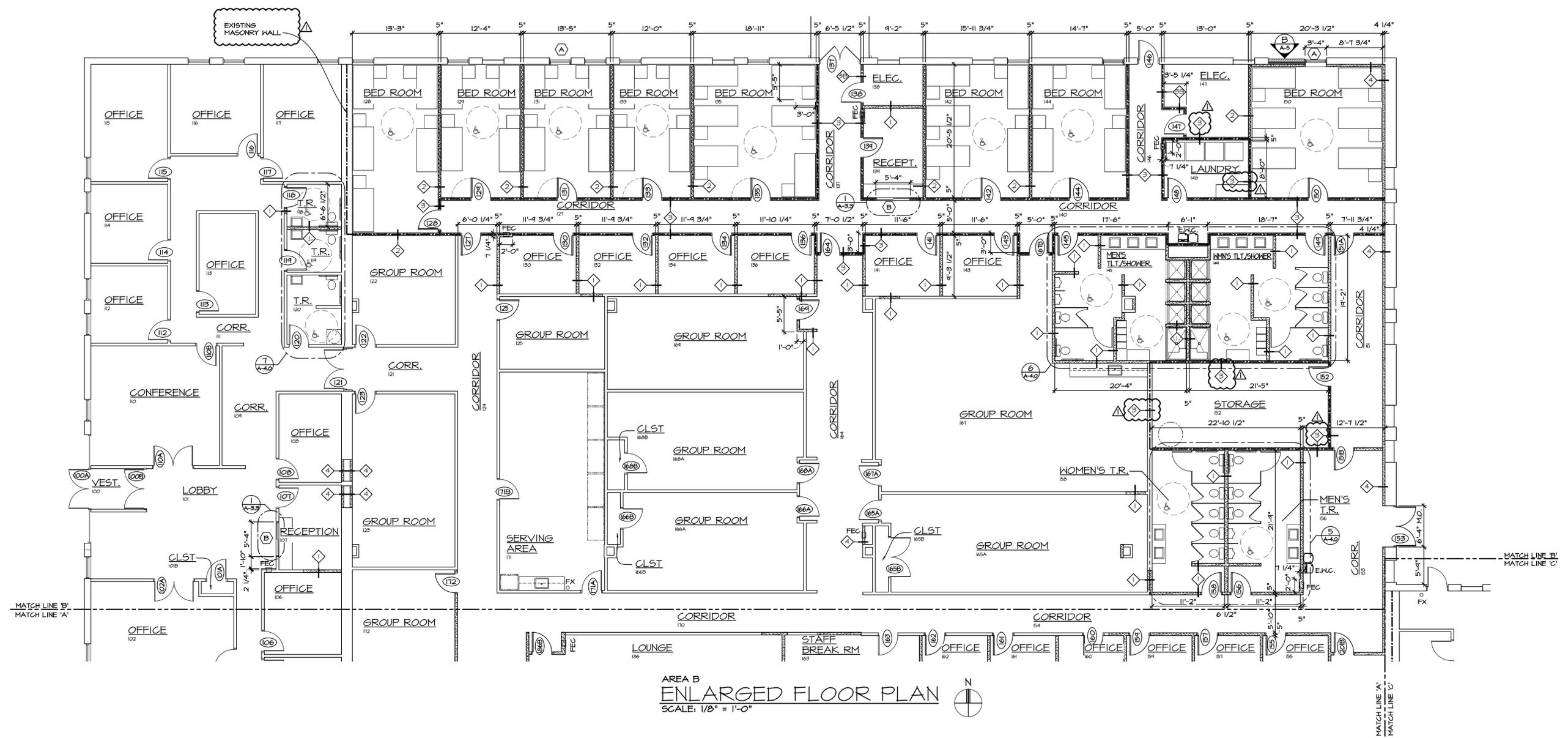


(414) 824-3311  
5622 Mayberry Square  
Sylvania, Oh. 43560

Dwight Gilliland  
Architect

ENLARGED FLOOR PLAN - AREA "B"  
INTERIOR ALTERATIONS FOR:  
**FOUNDATIONS RECOVERY CENTER**  
7131 RUTHERFORD ROAD  
WINDSOR MILL, MARYLAND 21244

PROJECT NO: 2160	DATE: 02/14/2022	CORRECTION LETTER: A-3.2
DRAWN BY: A.S.H.	PER-MIT: 12/9/2021	OWNER REVIEW: 1/16/2021
DATE/REVISION:	© Dwight Gilliland, AIA 2021	



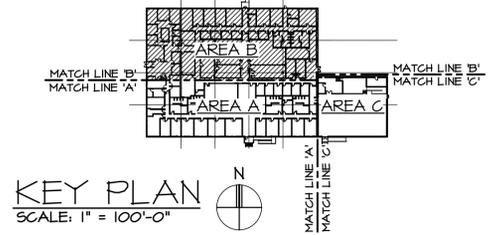
AREA B  
**ENLARGED FLOOR PLAN**  
SCALE: 1/8" = 1'-0"

**WALL CONSTRUCTION TYPES**

NOTE: NEW WALLS SHALL BE ALIGNED W/ EXISTING WALLS, COLUMNS, WINDOWS, ETC. UNLESS NOTED OTHERWISE.

- EXISTING CONSTRUCTION TO REMAIN. PATCH AND REPAIR AS NECESSARY FOR NEW CONSTRUCTION. (PRIME & PAINT IN AREA OF ALTERATION).
- 5/8" GYPSUM WALLBOARD ON BOTH SIDES OF 3 5/8" METAL STUDS @ 16" c/c. PROVIDE 3 1/2" SOUND ATTENUATION INSULATION BATT BETWEEN STUDS. RUN PARTITION TO ABOVE CEILING (MOISTURE RESISTANT GYPSUM BOARD AT SHOWERS AND NET WALLS).
- LAUNDRY ROOM WALLS - (1) LAYER OF 5/8" MOISTURE RESISTANT GYPSUM BOARD ON EXPOSED SIDE OF 3 5/8" METAL STUDS @ 16" c/c. PRIME AND EPOXY PAINT.
- SHOWER LID - (1) LAYER OF 5/8" MOISTURE RESISTANT GYPSUM BOARD ON 3 5/8" METAL STUD CEILING FRAMING @ 16" c/c @ 1'-8" A.F.F.
- SHOWER WING WALLS: (1) LAYER OF 5/8" MOISTURE RESISTANT GYPSUM BOARD ON EACH SIDE OF 3 5/8" METAL STUDS @ 16" c/c. RUN PARTITION TO ABOVE CEILING.
- WALLS WITHIN SHOWER COMPARTMENT NOT COVERED WITH SHOWER INSERT OR TILE SHALL BE PAINTED WITH HIGH PERFORMANCE EPOXY (HPC) PAINT.
- TILE INSTALLATION SHALL COMPLY W/ FINISH NOTES - SEE DRAWING A-1.

- FIRE RATED ASSEMBLIES:**
- TYPE 2:  
1/2 HOUR FIRE PARTITION BETWEEN SLEEPING UNITS; (SIMILAR U.L. U407)  
(1) LAYER 5/8" GYPSUM BOARD ON EACH SIDE OF 3 5/8" METAL STUDS @ 16" c/c. WALLS TO HAVE 3 1/2" SOUND ATTENUATION BLANKETS BETWEEN STUDS. SEAL W/ CAULK @ TRANSITIONS (SEE DETAIL ON A-3.3).
  - TYPE 2B:  
SAME AS TYPE 2 - PROVIDE 3 5/8" METAL STUD INFILL ABOVE EXISTING METAL STUD WALL. EXTEND TO ROOF DECK ABOVE.
  - TYPE 3:  
1 HOUR FIRE RATED CORRIDOR PARTITIONS (SIMILAR TO U.L. U419)  
CONFIRM USE OF 5/8" FIRE RATED GYPSUM BOARD; IF NOT, REPLACE W/ 5/8" FIRE RATED GYPSUM BOARD AS NECESSARY. WALLS TO HAVE 3 1/2" SOUND ATTENUATION BLANKETS BETWEEN STUDS. (SEE DETAIL ON A-3.3) SEAL W/ CAULK AT TRANSITIONS.
  - TYPE 3B:  
SAME AS TYPE 3 - PROVIDE 3 5/8" METAL STUD INFILL ABOVE EXISTING METAL STUD WALL. EXTEND TO ROOF DECK ABOVE.
  - INFILL -  
5/8" GYPSUM BOARD ON BOTH SIDES OF 3 5/8" METAL STUDS @ 16" c/c. PROVIDE MOISTURE RESISTANT GYPSUM BOARD ON NET WALLS. PROVIDE SOUND ATTENUATION BATT INSULATION BETWEEN STUDS. FIELD VERIFY EXISTING WALL DIMENSIONS.
  - 5/8" GYPSUM WALLBOARD ON (1) SIDE OF 3 5/8" METAL STUDS @ 16" c/c. PROVIDE 3 1/2" SOUND ATTENUATION INSULATION BATT BETWEEN STUDS. RUN PARTITION TO ABOVE CEILING.



**KEY PLAN**  
SCALE: 1" = 100'-0"

# EXHIBIT 7

TABLE F. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

Statement of Assumptions

Other Expenses for the facility can be divided into four distinct categories:

- Property-related expenses, comprising about 34% of the Other Expenses;
- Client-related expenses, comprising about 21% of the Other Expenses; and
- Facility operations expenses, comprising about 45% of the Other Expenses.

Property-related expenses include rent, property taxes and insurance, utilities, repairs and maintenance, and property management.

Client-related expenses include food, medical expenses for clients, transportation, and client incidentals.

Facility operations includes business insurance, workers' compensation insurance, payroll/HR expenses, office-related expenses, billing expenses, marketing expenses, hiring and training costs. The itemized costs for each of these categories appears in the exhibit below.

<b>Detail of Other Expenses Reported on Table F, Line 2</b>			
	<u>CY 2025</u>	<u>CY 2026</u>	<u>CY 2027</u>
<b>Property Expenses</b>	\$ 921,945	\$ 1,051,824	\$ 1,099,058
Rent	638,848	658,014	681,708
Cam and Property Taxes	113,282	116,680	120,882
Utilities (phone, internet, power, water, waste management, etc)	57,725	110,675	124,019
Repairs & Maintenance	16,000	24,660	25,548
Landscaping/Pest Control	16,000	24,660	25,548
Copier/Printer Leases	20,000	30,825	31,935
Office Cleaning	16,000	24,660	25,548
Other	44,090	61,650	63,870
<b>Client and Clinical Expenses</b>	\$ 591,096	\$ 935,415	\$ 944,011
Food	428,330	684,375	688,156
Medical Supplies	28,133	45,000	45,373
Transportation	28,133	45,000	45,373
Other Client-Related Expenses and Clinical expenses	106,500	161,040	165,109
<b>Facility Operations and Support</b>	\$ 1,225,255	\$ 1,763,431	\$ 1,822,149
Administrative Support Services	761,989	1,289,257	1,308,236
Marketing	58,000	18,495	19,161
Insurance	70,560	102,675	111,617
Payroll Fees	17,497	27,867	28,352
Recruiting	49,320	50,800	52,629
Other Facility Operations Support Expenses	267,889	274,338	302,154
<b>Total Other Expenses</b>	<b>\$ 2,738,296</b>	<b>\$ 3,750,670</b>	<b>\$ 3,865,218</b>

# EXHIBIT 8

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

**TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT**

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

Before the Project						After Project Completion					
Service Location (Floor/Wing)	Current Licensed Beds	Based on Physical Capacity				Service Location (Floor/Wing)		Based on Physical Capacity			
		Room Count			Bed Count			Room Count			Bed Count
		Private	Semi-Private	Total Rooms	Physical Capacity			4 Bed	4 plus	Total Rooms	Physical Capacity
<b>III.7 AND III.7D</b>						<b>III.7 AND III.7D</b>					
				0	0	Female Wing		4	0	4	16
				0	0	Male Wing		6	0	6	24
				0	0					0	0
				0	0					0	0
				0	0					0	0
<b>Subtotal III.7 AND III.7D</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>Subtotal III.7 and III.7 D</b>		<b>10</b>	<b>0</b>	<b>10</b>	<b>40</b>
<b>RESIDENTIAL</b>						<b>RESIDENTIAL</b>					
				0	0	Female Wing		4	0	4	16
				0	0	Male Wing		7	0	7	28
<b>Subtotal Residential</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>Subtotal Residential</b>		<b>11</b>	<b>0</b>	<b>11</b>	<b>44</b>
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>TOTAL</b>		<b>21</b>	<b>0</b>	<b>21</b>	<b>84</b>
<i>Other (Specify/add rows as needed)</i>				0	0	<i>Other (Specify/add rows as needed)</i>				0	0
<b>TOTAL OTHER</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>TOTAL NON-ACUTE</b>		<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>FACILITY TOTAL</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>FACILITY TOTAL</b>		<b>21</b>	<b>0</b>	<b>21</b>	<b>84</b>

**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
<b>A. USE OF FUNDS</b>			
<b>1. CAPITAL COSTS</b>			
<b>a. New Construction</b>			
(1) Building			\$0
(2) Fixed Equipment			\$0
(3) Site and Infrastructure			\$0
(4) Architect/Engineering Fees			\$0
(5) Permits (Building, Utilities, Etc.)			\$0
<b>SUBTOTAL</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>b. Renovations</b>			
(1) Building			\$0
(2) Fixed Equipment (not included in construction)			\$0
(3) Architect/Engineering Fees			\$0
(4) Permits (Building, Utilities, Etc.)			\$0
<b>SUBTOTAL</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>c. Other Capital Costs</b>			
(1) Movable Equipment	\$0		\$0
(2) Contingency Allowance			\$0
(3) Gross interest during construction period			\$0
(4) Other (Specify/add rows if needed)	\$170,000		\$170,000
oCabling, network and security - \$90k			
oOther Leasehold Improvements - \$30k			
oCommercial Washer and Dryer - \$20k			
oWindow Tinting - \$20k			
oOther Misc- \$10k			
<b>SUBTOTAL</b>	<b>\$170,000</b>	<b>\$0</b>	<b>\$170,000</b>
<b>TOTAL CURRENT CAPITAL COSTS</b>	<b>\$170,000</b>	<b>\$0</b>	<b>\$170,000</b>
<b>d. Land Purchase</b>			
<b>e. Inflation Allowance</b>			\$0
<b>TOTAL CAPITAL COSTS</b>	<b>\$170,000</b>	<b>\$0</b>	<b>\$170,000</b>
<b>2. Financing Cost and Other Cash Requirements</b>			
a. Loan Placement Fees			\$0
b. Bond Discount			\$0
c. CON Application Assistance			
c1. Legal Fees	\$20,000		\$20,000
c2. Other (Specify/add rows if needed)- Consultant	\$40,000		
d. Non-CON Consulting Fees			
d1. Legal Fees			\$0
d2. Other (Specify/add rows if needed)			\$0
e. Debt Service Reserve Fund			\$0
i. Other (Specify/add rows if needed)			\$0
<b>SUBTOTAL</b>	<b>\$60,000</b>	<b>\$0</b>	<b>\$60,000</b>
<b>3. Working Capital Startup Costs</b>			\$0
<b>TOTAL USES OF FUNDS</b>	<b>\$230,000</b>	<b>\$0</b>	<b>\$230,000</b>
<b>B. Sources of Funds</b>			
<b>1. Cash</b>			\$0
<b>2. Philanthropy (to date and expected)</b>			\$0
<b>3. Authorized Bonds</b>			\$0
<b>4. Interest Income from bond proceeds listed in #3</b>			\$0
<b>5. Mortgage</b>			\$0
<b>6. Working Capital Loans</b>			\$0
<b>7. Grants or Appropriations</b>			
a. Federal			\$0
b. State			\$0
c. Local			\$0
<b>8. Other (Specify/add rows if needed)</b>			\$0
<b>TOTAL SOURCES OF FUNDS</b>			<b>\$0</b>
	III.7 and III.7D	RESIDENTIAL	TOTAL
<b>Annual Lease Costs (if applicable)</b>			
<b>1. Land</b>			\$0
<b>2. Building</b>	\$752,130		\$752,130
<b>3. Major Movable Equipment</b>			\$0
<b>4. Minor Movable Equipment</b>			\$0

<b>5. Other (Specify/add rows if needed)</b>			<b>\$0</b>
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\* Describe the terms of the lease(s) below, including information on the fair market value of the item(s), and the number of years, annual cost, and the interest rate for the lease.

**TABLE C. STATISTICAL PROJECTIONS - ENTIRE FACILITY**

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

Indicate CY or FY	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.						
			CY 2025	CY 2026	CY 2026					
<b>1. DISCHARGES</b>										
a. Residential			646	753	753					
b. III.7 and III.7D			817	1,540	1,540					
c. Other (Specify/add rows of needed)			0							
<b>TOTAL DISCHARGES</b>	<b>0</b>	<b>0</b>	<b>1,463</b>	<b>2,293</b>	<b>2,293</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>2. PATIENT DAYS</b>										
a. Residential			12,919	15,056	15,056					
b. III.7 and III.7D			6,539	12,319	12,319					
c. Other (Specify/add rows of needed)			0							
<b>TOTAL PATIENT DAYS</b>	<b>0</b>	<b>0</b>	<b>19,458</b>	<b>27,375</b>	<b>27,375</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>3. AVERAGE LENGTH OF STAY (patient days divided by discharges)</b>										
a. Residential			20.0	20.0	20.0					
b. III.7 and III.7D			8.0	8.0	8.0					
c. Other (Specify/add rows of needed)			0.0	0.0	0.0					
<b>TOTAL AVERAGE LENGTH OF STAY</b>			<b>13.3</b>	<b>11.9</b>	<b>11.9</b>					
<b>4. NUMBER OF LICENSED BEDS</b>										
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
<b>TOTAL LICENSED BEDS</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>5. OCCUPANCY PERCENTAGE *IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.</b>										
a. Residential			42.0%	94.0%	94.0%					
b. III.7 and III.7D			66.0%	86.0%	86.0%					
c. Other (Specify/add rows of needed)			0.0%	0.0%	0.0%					
<b>TOTAL OCCUPANCY %</b>			<b>56.0%</b>	<b>89.0%</b>	<b>89.0%</b>					
<b>6. OUTPATIENT VISITS</b>										
a. Residential										
b. III.7 and III.7D										
c. Other (Specify/add rows of needed)										
<b>TOTAL OUTPATIENT VISITS</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

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

**TABLE D. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY**

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.								
Indicate CY or FY												
<b>1. REVENUE</b>												
a. Inpatient Services												
b. Outpatient Services												
<b>Gross Patient Service Revenues</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
c. Allowance For Bad Debt												
d. Contractual Allowance												
e. Charity Care												
<b>Net Patient Services Revenue</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
f. Other Operating Revenues (Specify/add rows if needed)												
<b>NET OPERATING REVENUE</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>2. EXPENSES</b>												
a. Salaries & Wages (including benefits)												
b. Contractual Services												
c. Interest on Current Debt												
d. Interest on Project Debt												
e. Current Depreciation												
f. Project Depreciation												
g. Current Amortization												
h. Project Amortization												
i. Supplies												
j. Other Expenses (Specify/add rows if needed)												
<b>TOTAL OPERATING EXPENSES</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>3. INCOME</b>												
<b>a. Income From Operation</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
b. Non-Operating Income												
<b>SUBTOTAL</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
c. Income Taxes												
<b>NET INCOME (LOSS)</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

**TABLE D. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY**

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

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

**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			CY 2025	CY 2026	CY 2026					
<b>1. DISCHARGES</b>										
a. Residential			646	753	753					
b. III.7 and III.7D			817	1,540	1,540					
c. Other (Specify)			0							
<b>TOTAL DISCHARGES</b>	<b>0</b>	<b>0</b>	<b>1,463</b>	<b>2,293</b>	<b>2,293</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>2. PATIENT DAYS</b>										
a. Residential			12,919	15,056	15,056					
b. III.7 and III.7D			6,539	12,319	12,319					
c. Other (Specify)			0							
<b>TOTAL PATIENT DAYS</b>	<b>0</b>	<b>0</b>	<b>19,458</b>	<b>27,375</b>	<b>27,375</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>3. AVERAGE LENGTH OF STAY (patient days divided by discharges)</b>										
a. Residential			20.0	20.0	20.0					
b. III.7 and III.7D			8.0	8.0	8.0					
c. Other (Specify)			0.0	0.0	0.0					
<b>TOTAL AVERAGE LENGTH OF STAY</b>			<b>13.3</b>	<b>11.9</b>	<b>11.9</b>					
<b>4. NUMBER OF LICENSED BEDS</b>										
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify)										
<b>TOTAL LICENSED BEDS</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>5. OCCUPANCY PERCENTAGE *IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.</b>										
a. Residential			42.0%	94.0%	94.0%					
b. III.7 and III.7D			66.0%	86.0%	86.0%					
c. Other (Specify)			0.0%	0.0%	0.0%					
<b>TOTAL OCCUPANCY %</b>			<b>56.0%</b>	<b>89.0%</b>	<b>89.0%</b>					
<b>6. OUTPATIENT VISITS</b>										
a. Residential										
b. III.7 and III.7D										
c. Other (Specify)										
<b>TOTAL OUTPATIENT VISITS</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

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

**TABLE F. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE**

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

Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.							
Indicate CY or FY	CY 2025	CY 2026	CY 2026				
<b>1. REVENUE</b>							
a. Inpatient Services	\$ 6,349,912	\$ 10,743,808	\$ 10,901,964				
b. Outpatient Services							
<b>Gross Patient Service Revenues</b>	<b>\$ 6,349,912</b>	<b>\$ 10,743,808</b>	<b>\$ 10,901,964</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
c. Allowance For Bad Debt	\$ 194,796	\$291,790	\$299,698				
d. Contractual Allowance							
e. Charity Care	\$ 122,700	\$245,400	\$245,400				
<b>Net Patient Services Revenue</b>	<b>\$ 6,032,416</b>	<b>\$ 10,206,618</b>	<b>\$ 10,356,866</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
f. Other Operating Revenues (Specify)							
<b>NET OPERATING REVENUE</b>	<b>\$ 6,032,416</b>	<b>\$ 10,206,618</b>	<b>\$ 10,356,866</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>2. EXPENSES</b>							
a. Salaries & Wages (including benefits)	\$ 2,606,552	\$ 4,240,151	\$ 4,281,531				
b. Client/Clinical Expenses	\$ 863,802	\$ 1,276,089	\$ 1,314,372				
c. Administrative Expenses - Supplies	\$ 190,560	\$ 133,500	\$ 143,552				
d. Facility Expenses, rent, taxes, utilities	\$ 921,945	\$ 1,051,824	\$ 1,099,058				
e. Management Fees - Amatus	\$ 761,989	\$ 1,289,257	\$ 1,308,236				
e. Start-up Costs	\$ 90,000						
g.							
h.							
i.							
j.							
<b>TOTAL OPERATING EXPENSES</b>	<b>\$ 5,434,848</b>	<b>\$ 7,990,821</b>	<b>\$ 8,146,749</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>3. INCOME</b>							
a. Income From Operation	\$ 597,567.86	\$ 2,215,797.20	\$ 2,210,117.23	\$ -	\$ -	\$ -	\$ -
b. Non-Operating Income							
<b>SUBTOTAL</b>	<b>\$ 597,567.86</b>	<b>\$ 2,215,797.20</b>	<b>\$ 2,210,117.23</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
c. Income Taxes							
<b>NET INCOME (LOSS)</b>	<b>\$ 597,567.86</b>	<b>\$ 2,215,797.20</b>	<b>\$ 2,210,117.23</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>4. PATIENT MIX</b>							
<b>a. Percent of Total Revenue</b>							
1) Medicare							
2) Medicaid	90.0%	90.0%	90.0%				
3) Blue Cross	5.0%	5.0%	5.0%				
4) Commercial Insurance	5.0%	5.0%	5.0%				
5) Self-pay							

**TABLE F. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE**

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

Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.							
Indicate CY or FY	CY 2025	CY 2026	CY 2026				
6) Other							
<b>TOTAL</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>
<b>b. Percent of Equivalent Inpatient Days</b>							
<b>Total MSGA</b>							
1) Medicare							
2) Medicaid	80.0%	80.0%	80.0%				
3) Blue Cross	10.0%	10.0%	10.0%				
4) Commercial Insurance	10.0%	10.0%	10.0%				
5) Self-pay							
6) Other							
<b>TOTAL</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>

**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.

Job Category	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) *	
	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)
<b>1. Regular Employees</b>											
Administration (List general categories, add rows if needed)											
Office Manager	1.0	\$60,000	\$63,162						\$0	1.0	\$63,162
Director of Operations	1.0	\$90,000	\$94,742						\$0	1.0	\$94,742
Executive Director - PT	1.0	\$60,000	\$66,412						\$0	1.0	\$66,412
Director Referral Management	1.0	\$75,000	\$78,952						\$0	1.0	\$78,952
Alumni Coordinator	1.0	\$45,000	\$25,875						\$0	1.0	\$25,875
<b>Total Administration</b>	<b>5.0</b>	<b>\$ 330,000</b>	<b>\$ 329,143</b>			<b>\$0</b>			<b>\$0</b>	<b>5.0</b>	<b>\$329,143</b>
Direct Care Staff (List general categories, add rows if needed)											
Medical Director	1.0	\$125,000	\$96,202						\$0	1.0	\$96,202
Clinical Director	1.0	\$125,000	\$131,587						\$0	1.0	\$131,587
Clinical Supervisor	1.0	\$75,000	\$71,322						\$0	1.0	\$71,322
Director of Nursing	1.0	\$125,000	\$96,202						\$0	1.0	\$96,202
Supervising Nurse	1.0	\$85,000	\$97,750						\$0	1.0	\$97,750
Nuses - RN and LPN	15.0	\$80,000	\$580,842						\$0	15.0	\$580,842
MedTechs	3.0	\$52,000	\$139,150						\$0	3.0	\$139,150
Intake Coordinator	2.0	\$40,000	\$61,392						\$0	2.0	\$61,392
Behavioral Health Tech Supervisor	1.0	\$55,000	\$57,898						\$0	1.0	\$57,898
Behavioral Health Tech	16.0	\$35,360	\$409,768			\$0			\$0	16.0	\$409,768
Case Manager	3.0	\$40,000	\$92,177						\$0	3.0	\$92,177
Therapist	5.0	\$65,000	\$255,300			\$0			\$0	5.0	\$255,300
Group Facilitator	2.0	\$40,000	\$61,392			\$0			\$0	2.0	\$61,392
<b>Total Direct Care</b>	<b>52.0</b>	<b>\$ 942,360</b>	<b>\$ 2,150,982</b>			<b>\$0</b>			<b>\$0</b>	<b>52.0</b>	<b>\$2,150,982</b>
Support Staff (List general categories, add rows if needed)											
Housekeeping	2.0	\$35,360	\$54,170			\$0			\$0	2.0	\$54,170
Maintenance	1.0	\$35,360	\$35,034			\$0			\$0	1.0	\$35,034
Transportation	1.0	\$35,360	\$37,223			\$0			\$0	1.0	\$37,223
<b>Total Support</b>	<b>4.0</b>	<b>\$ 106,080</b>	<b>\$ 126,427</b>			<b>\$0</b>			<b>\$0</b>	<b>4.0</b>	<b>\$126,427</b>
<b>REGULAR EMPLOYEES TOTAL</b>	<b>61.0</b>	<b>\$ 1,378,440</b>	<b>\$ 2,606,552</b>			<b>\$0</b>			<b>\$0</b>	<b>61.0</b>	<b>\$2,606,552</b>
<b>2. Contractual Employees</b>											
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
<b>Total Administration</b>			<b>\$0</b>			<b>\$0</b>			<b>\$0</b>	<b>0.0</b>	<b>\$0</b>
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
<b>Total Direct Care Staff</b>			<b>\$0</b>			<b>\$0</b>			<b>\$0</b>	<b>0.0</b>	<b>\$0</b>
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
<b>Total Support Staff</b>			<b>\$0</b>			<b>\$0</b>			<b>\$0</b>	<b>0.0</b>	<b>\$0</b>
<b>CONTRACTUAL EMPLOYEES TOTAL</b>			<b>\$0</b>			<b>\$0</b>			<b>\$0</b>	<b>0.0</b>	<b>\$0</b>
Benefits (State method of calculating benefits below):											
Assume 15% for employer portion of gross wages for payroll taxes and unemployment insurance plus the cost of employersponsored health insurance to all full-time staff.											
<b>TOTAL COST</b>	<b>61.0</b>		<b>\$2,606,552</b>	<b>0.0</b>		<b>\$0</b>	<b>0.0</b>		<b>\$0</b>		<b>\$2,606,552</b>

**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
<b>A. USE OF FUNDS</b>			
<b>1. CAPITAL COSTS</b>			
<b>a. New Construction</b>			
(1) Building			\$0
(2) Fixed Equipment			\$0
(3) Site and Infrastructure			\$0
(4) Architect/Engineering Fees			\$0
(5) Permits (Building, Utilities, Etc.)			\$0
<b>SUBTOTAL</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>b. Renovations</b>			
(1) Building			\$0
(2) Fixed Equipment (not included in construction)			\$0
(3) Architect/Engineering Fees			\$0
(4) Permits (Building, Utilities, Etc.)			\$0
<b>SUBTOTAL</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>c. Other Capital Costs</b>			
(1) Movable Equipment	\$0		\$0
(2) Contingency Allowance			\$0
(3) Gross interest during construction period			\$0
(4) Other (Specify/add rows if needed)	\$170,000		\$170,000
oCabling, network and security - \$90k			
oOther Leasehold Improvements - \$30k			
oCommercial Washer and Dryer - \$20k			
oWindow Tinting - \$20k			
oOther Misc- \$10k			
<b>SUBTOTAL</b>	<b>\$170,000</b>	<b>\$0</b>	<b>\$170,000</b>
<b>TOTAL CURRENT CAPITAL COSTS</b>	<b>\$170,000</b>	<b>\$0</b>	<b>\$170,000</b>
<b>d. Land Purchase</b>			
<b>e. Inflation Allowance</b>			\$0
<b>TOTAL CAPITAL COSTS</b>	<b>\$170,000</b>	<b>\$0</b>	<b>\$170,000</b>
<b>2. Financing Cost and Other Cash Requirements</b>			
a. Loan Placement Fees			\$0
b. Bond Discount			\$0
<b>c. CON Application Assistance</b>			
c1. Legal Fees	\$20,000		\$20,000
c2. Other (Specify/add rows if needed)- Consultant	\$40,000		
<b>d. Non-CON Consulting Fees</b>			
d1. Legal Fees			\$0
d2. Other (Specify/add rows if needed)			\$0
e. Debt Service Reserve Fund			\$0
i. Other (Specify/add rows if needed)			\$0
<b>SUBTOTAL</b>	<b>\$60,000</b>	<b>\$0</b>	<b>\$60,000</b>
<b>3. Working Capital Startup Costs</b>			\$0
<b>TOTAL USES OF FUNDS</b>	<b>\$230,000</b>	<b>\$0</b>	<b>\$230,000</b>
<b>B. Sources of Funds</b>			
<b>1. Cash</b>			\$0
<b>2. Philanthropy (to date and expected)</b>			\$0
<b>3. Authorized Bonds</b>			\$0
<b>4. Interest Income from bond proceeds listed in #3</b>			\$0
<b>5. Mortgage</b>			\$0
<b>6. Working Capital Loans</b>			\$0
<b>7. Grants or Appropriations</b>			
a. Federal			\$0
b. State			\$0
c. Local			\$0
<b>8. Other (Specify/add rows if needed)</b>			\$0
<b>TOTAL SOURCES OF FUNDS</b>			<b>\$0</b>
	III.7 and III.7D	RESIDENTIAL	TOTAL
<b>Annual Lease Costs (if applicable)</b>			
<b>1. Land</b>			\$0
<b>2. Building</b>	\$752,130		\$752,130
<b>3. Major Movable Equipment</b>			\$0
<b>4. Minor Movable Equipment</b>			\$0
<b>5. Other (Specify/add rows if needed)</b>			\$0

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\* 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.