VERIFICATION UNDER OATH

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Kahm Clinic IOP-PHP
Eating Disorder Treatment Program
GMCB-009-21con

Verification Under Oath

Nicholas Kahm, being duly sworn, states on oath as follows:

1. I am the Chief Executive Officer of Kahm Clinic IOP-PHP, LLC. I have reviewed the Certificate of Need Application (Application) to begin an IOP-PHP eating disorder treatment program.

2. Based on my personal knowledge, and after diligent inquiry, I attest that the information contained in the Answers to First Set of Questions is true, accurate and complete and does not contain any untrue statement of a material fact, and does not omit to state a material fact.

3. My personal knowledge of the truth, accuracy and completeness of the information contained in the Application is based on my actual knowledge of the subject information or upon information reasonably believed to be true and reliable to me (for example information in published articles).

4. In the event that the information contained in the Application becomes untrue, in accurate or incomplete in any material respect, I acknowledge my obligation to notify the Green Mountain Care Board as soon as I know that the information or document has become untrue, inaccurate or incomplete in any material respect.

Nicholas Kahm

On March 24, 2022 Nicholas Kahm appeared before me and swore to the truth, accuracy and completeness of the foregoing.

Mary A. Mead
Notary Public

My Commission expires 1-31-2023
Comm# 157.0000283

1. **Please review the document titled, *Kahm Clinic IOP/PHP, LLC, Expense Detail* submitted in response to Questions submitted on January 18, 2022,**
    a. **This document must include all annual operating expenses incurred to make theIOP and PHP programs fully operational.**
        i. **Confirm that all annual operating expenses for year 1, 2, and 3 ofoperation are included in this document.**

        We confirm that they are.

        ii. **In proposed year 1, 2 and 3, confirm the amount and the line item wherethe operating lease costs of the Metabolic Testing Device and the Body Composition Device are included.**

        There is no line item because we expect the equipment lease and space lease between the Kahm Clinic and the IOP-PHP programs to be roughly equal, or at least close to it. There may be a small but negligible expense or income concerning this as we monitor the arrangement to ensure that it remains an arms-length exchange of fair market value. For more details on this arrangement see the answer to the 5th question in the 1st round of questions.

        iii. **If there will be no payments to the owner, then the line item titled, OwnerDistributions/Owner Draws, should be deleted and totals should be corrected.**

            1. **Note: In Response to Questions submitted on February 16, 2022, your response to question 15 states that, "The owner does not expect to take back capital investment or withdraw equity in any ofthe years shown."**

        Owner distributions will be made annually to cover the taxes associated with the passthrough income from the entity.

        iv. **If the questions above prompt changes to the Expense Detail document, please revise and resubmit. If, after reviewing the issues raised above, you are not changing the Expense Detail document, please confirm that theseare the final numbers.**

        The numbers there are final.

2. **Response to Questions submitted on February 16, 2022, Question 1: In your response, you identify what the Metabolic Test Device and the Body Composition Analysis Device measure. Using specific examples, explain how the information measured by each deviceis then used in the treatment of patients in the proposed IOP and PHP programs.**

Using the metabolic testing and body composition analysis in nutritional assessment of eating disorder patients shows how malnourished a patient is. This information helps us treat the patient more effectively and efficiently for full recovery and it also helps avoid later relapse, so commonly seen in eating disorder patients. The information from this testing is used to customize treatment for the patient's individual disease state and to involve the patient in evaluating their body's data as part of treatment, as described below.

When a body becomes malnourished, it loses skeletal muscle mass which pre-ages the body: the body composition analysis measures this muscle loss. With less muscle mass there is also less healthy cell mass, there are less mitochondria, and the metabolism drops. The metabolic drop makes the body "slow down" in order to survive – this slowed metabolism is called hypometabolism. The severity of the hypometabolic situation is measured via metabolic testing.

A hypometabolic and malnourished body has lost its normal hunger signals needed to heal and fuel itself, i.e. the body is less hungry, it has lost its appetite. This is why telling an eating disorder patient to eat when hungry (intuitive eating) is ineffective, they don't have appropriate hunger signals. Often a patient will eat less and less as the metabolism slows, making the situation worse. The testing provides individualized data on how many calories the patient needs and the amount of lean mass their body needs to be healthy.

Metabolic testing and body composition analysis will show not only the clinician but also the patient the damage they have caused their body by dieting/restricting. It gives the patient an understanding of how it has affected not only their body but also their brain (which consumes a very large quantity of calories). Facing the test results gives patients motivation to recover, learning that recovery is possible when the body is fully restored when the test numbers are within normal levels. It gives them hope that life without an eating disorder is possible, and we can show them with the help of the empirical data, what it takes to not have an eating disorder, to not obsess about food, weight, and body.

Our book – "Measuring Health From The Inside" – has multiple cases and testimonials and we refer you to that, but here are some additional cases to explain why theses tests are invaluable compared to just using weight/height charts and blood-work. Please let us know if any of you would like a copy of the book and we will be happy to provide you with one.

As there is no IOP or PHP, there are no specific examples of how the information is used in that treatment. In an effort to be responsive, we have created hypothetical patients that represent the Kahm Clinic's outpatient experience and describe how the testing would be used if the hypothetical patients were seen in IOP or PHP. We strongly believe that using these two tests greatly increases the

quality and accuracy of care which ultimately shortens the length of treatment and the probability of relapse.

Hypothetical 1

Jane a female college student, 5'4", diagnosed with Anorexia Nervosa with multiple out of state residential and PHP treatments. On discharge from the last program, her food plan recommended 2000 kcal/day and a goal to maintain her weight at or above 115 lbs. Jane loves to run, but has been unable to run for the last two years because of a series of stress fractures.

Projected PHP Course – Use of Testing

Initial testing in PHP program showed that she was hypo-metabolic, burning 1277 kcal instead of >1600 kcal predicted/day. She was also catabolic, using her muscle and organs for fuel, due to her pre-treatment, under-eating and over-exercising. The results were confirmed by her low skeletal muscle mass, 4 lbs. below minimum expected for her age, height and sex. These results lead to the conclusion that she needed to keep re-feeding her body and also explained the damage she had done to her body, even her bones had been affected, as the stress fractures had shown. The testing results would be used to adjust the incorrect goal weight from the prior treating providers.

What is important here is that the residential treatment facilities got her goal weight wrong. We see this far too often in our current patients who come to us from higher levels of care. In most cases they use height/weight charts and BMI to determine ideal weight. At 115 lbs. she would fit into being at "low-normal" according to weight/height charts, but by using these tests we could prove that her metabolism was far too low, as was her muscle mass and as a result she didn't have clear hunger signals to guide her to eat enough. This is one of the big reasons why relapses are so common in eating disorders.

Without the metabolic test and body composition analysis we wouldn't have known how hard to push her: we increased her calories from 2000 → 2600 – 2800 kcal/day. The testing results would be used to adjust the incorrect caloric goal from the prior treating providers. With this caloric increase and without exercise, her muscle mass increased 5 lbs. in two months in the PHP program. Despite the success, or perhaps because of it, in week 8 she panicked about the weight that she had gained. At the end of the week and through the weekend she began cutting corners on her meal plan when she was not at the PHP because she thought it was too much food. However, early in the following week we saw on her Body Composition Analysis that she had lost .5lbs of skeletal muscle mass. The testing results would be used to evaluate adherence to the caloric goals. This solidified that her meal plan was, in fact, not too much. This helped her to understand that she truly needed to fuel her body well and that even small, sneaky restrictions would result in her body starting to compensate by breaking down muscle. She and her treatment team worked closely both in group and in individual therapy, reassuring her that the weight she had gained was, in fact, good for her and necessary for her permanent recovery. The testing results would be used to objectively show the patient the body damage and results of not following the caloric intake goals, quickly and with support to overcome barriers to meeting the goals.

In the following week she regained what she had lost during that small relapse. The test

results would be used to prevent a larger relapse. In the big picture, though, her energy increased, she slept better, her menses became regular, and she noticed better focus, concentration, and memory. Her parents and friends noticed that she was back to behaving like her good old self and she was able to return to school.

One of the biggest improvements was with respect to her hunger signals that had increased and her obsession with weight and body had decreased compared with when she was discharged from the residential treatment centers. With a higher metabolic rate (1277 → 1725 kcal/24 hrs.) she now had clear, strong and appropriate hunger signals, guiding her to eat >2500 kcal/day, accepting and maintaining a higher weight (120 – 125 lbs.). With strong hunger signals and coming to accept her higher weight, she is far less likely to end up relapsing which so commonly happens with female athletes who only partially recover from an eating disorder. She made great therapeutic progress, gaining effective coping skills to deal with uncomfortable feelings and rigid thought patters instead of turning to eating disorder behaviors. After 6 weeks in the IOP program she graduated to outpatient treatment.

Hypothetical Case 2

John is a 41 year old male patient, 6'1" and 270 lbs., who had complained to his medical doctor about his failure to lose weight and he wondered if there was a possible thyroid problem. He was constantly fatigued, frequently constipated and had a low sex drive. Since all of his lab work came back normal, his doctor thought that there was nothing medically wrong. He finally opened up to a therapist who he saw for depression and admitted that for over 7 years he had been purging (by vomiting) 5 x week on days when he had binged at night, eating 1500 to 3000 kcal. He abused laxatives in order to control his weight and when he wanted to eat something "good" and only taste it without having the calories, he would chew and then spit out the food. He was also abusing Metamucil (a fiber supplement) to feel full and be able to skip a meal. He was married and felt terribly guilty when his wife confronted him because she found wrappers of processed food, left over from binges, hidden in his home office.

He had been seeing a dietitian weekly and was trying to follow a balanced weight loss plan on 1800 kcal/day. Occasionally he lost a little weight and was praised, but he couldn't stop the eating disorder behaviors. What the dietitian suggested wasn't sustainable: he had been trying to follow it for over a year and if anything had gained more weight and become more depressed. He felt like a failure and was worried because his hunger signals were off and he couldn't stop the urge to binge. His therapist diagnosed him with Bulimia Nervosa and granting the severity and length of his disorder, referred him to the Kahm Clinic's IOP for treatment.

Projected Course of Treatment IOP – Using Testing

The metabolic test showed that he was hypometabolic. He was very surprised when he learned that he needed to increase his calories from 1800 kcal to 2700 kcal and 150 grams protein/day. The testing results would be used to correct his daily caloric goals. He was advised to eat 1/3 of the recommended intake before lunch, i.e. 900 kcal with 50 gram protein before lunch, the same amount for lunch and afternoon and again, the same amount for dinner/evening.

At first this was extremely difficult because he had no hunger in the morning and only started craving carbohydrates by the end of the day. He was initially nauseated having to eat breakfast but after just a few weeks his hunger increased, and he found himself hungry for breakfast. This was a breakthrough for him and meant that his metabolic rate was correcting. This is also when he started to feel better and felt a surge of energy. He became much more productive at work. After some time when his body trusted that it was continuously getting the calories it needed, he was slowly but surely able to stop vomiting. Seeing that the numbers improved and that he could eat more convinced him to continue fueling his body. The testing results would be used to objectively show the patient the body response to increased caloric intake quickly and allow the patient insight into his own treatment.

After 2-3 months in the program his eating disorder behaviors had decreased significantly. His metabolism had increased from 1463 to 2114 and he could now eat 500 -600 kcal more/day. His depression slowly lifted and through the group and individual therapeutic work his obsessive thoughts about food and weight decreased. He had come to accept reality and surrendered to what his body needed and that finally gave him some inner peace. He no longer needed his eating disorder behaviors to control his weight, his energy and libido improved, as did his bowel movements, and he now also functioned better both mentally and socially.

Note: you may wonder why the amount of protein is mentioned in this case. A balanced intake means supplying the body with food every 3 – 4 hours to keep our blood sugar at normal levels. The amount of protein needed is based on a patient's fat-free mass, a number that we get from the body composition analysis, in this case it was 150 grams/day. When the right amount of protein is provided throughout the day, the body doesn't crave carbohydrates and the physical reason behind the binge can be dealt with.

3. **Response to Questions submitted on March 7, 2022, question 8, p. 4: Confirm whether the daily charges reflected in the table include or exclude the $100 per week charged for the Metabolic Test Device and the Body Composition Analysis Device for patients in theproposed IOP and PHP programs.**

   Those daily charges exclude the $100 weekly testing charge. There are no other charges than the daily charges and weekly testing charge. This $100 weekly charge may not exist for all. It depends on whether insurance companies cover the testing. We cannot know that until we negotiate with the insurance companies and the insurance companies will not negotiate with us unless we have a CON.

4. **In response to question 2 in your March 7, 2022 submission, it is stated that, "In Vermont, but not in other states, the testing is generally not covered by insurance. Identify other states in New England where commercial and/or Medicaid do providereimbursement for the Metabolic Testing device and the Body Composition device.**

My apologies, but the person who helps us with our billing reminded me that I forgot to include some of the insurance companies that do cover metabolic testing here in VT. Not only does VT Medicaid cover it, but also Cigna, Aetna, MVP, and United Healthcare generally pay for metabolic testing in New England. There is some reason to be hopeful that we can negotiate coverage with them. I just spoke to Carolyn Hodges Chaffee, owner of the Upstate New York Eating Disorder Service, who runs multiple IOP and PHP programs in upstate NY that use metabolic testing and body composition analysis. She told me that **all** of their local insurance companies pay for metabolic testing with a medical director on staff, and some of them will pay for the body composition analysis. That being said, as we said in our response to that second question, the IOP/PHP and current Kahm Clinic is not an apples to apples comparison, and there is reason to be hopeful that it the costs will be significantly less than $100/week.

5. **Clarify whether both CBT and FBT therapy will be used in the IOP program foradolescents.**

   FBT will certainly be used; CBT can be used: it is evidence based and is appropriate for adolescents. Whether or not we use CBT with adolescents is a question of programmatic preference and will depend in part on the particular experience and expertise of the clinicians that we are able to hire.

6. **Revise and resubmit the Treatment Schedule submitted with the application so that it comports with seven-hour daily treatment program for the adult PHP noted on a table inyour responses to questions submitted on March 11, 2022.**

   My mistake. The PHP program is 6 hours/day rather than 7. The table submitted with the application in exhibit 4 is correct and does show a 6hr/day schedule.

7. **Provide a more detailed overview of external quality measures/programs you willparticipate in and whether they provide any benchmarking.**

   I have included the Joint Commission's standards for residential and outpatient eating disorder programs, which you will see are quite rigorous and comprehensive. For an overview of these standards please see the attached Joint Commission R^3 report. Unfortunately, there is no industry wide benchmarking for eating disorder IOPs and PHPs.

8. **The American Psychiatric Association Practice Guidelines for the Treatment of Eating Disorders is from 2006. Confirm whether there is a more recent update of this document.If so, provide a copy of the updated**

document.

The APA reformatted the chart in 2010, but the content is identical.

9. **The financial tables included in the PDF version of your submission dated on January 18,2022 are not the same as the excel version of those same tables submitted on the same date. Resubmit financial tables 1, 2, 3 B, C; 4 B, C; 5 B, C; 6 B, C; 7 B, C; 8 B, C and 9 B, C and the Annual Operating Expense Detail table as a PDF and the same Excel document.**

   Happy you found that! We accidentally included the wrong version of the excel document. The correct ones are included.

NOTE: When completing this table make entries in the shaded fields only.

Kahm Clinic IOP/PHP, LLC
PROJECT NAME
TABLE 1
PROJECT COSTS

Construction Costs		
1. New Construction	$	-
2. Renovation		347,220
3. Site Work		-
4. Fixed Equipment		-
5. Design/Bidding Contingency		-
6. Construction Contingency		-
7. Construction Manager Fee		-
8. Other (Software)		-
Subtotal	$	347,220
Related Project Costs		
1. Major Moveable Equipment	$	-
2. Furnishings, Fixtures & Other Equip.		85,879
3. Architectural/Engineering Fees		30,000
4. Land Acquisition		-
5. Purchase of Buildings		-
6. Administrative Expenses & Permits		-
7. Debt Financing Expenses (see below)		-
8. Debt Service Reserve Fund		-
9. Working Capital		411,901
10. Other (Software)		25,000
Subtotal	$	552,780
Total Project Costs	**$**	**900,000**

Debt Financing Expenses		
1. Capital Interest	$	-
2. Bond Discount or Placement Fee		-
3. Misc. Financing Fees & Exp. (issuance costs)		-
4. Other		-
Subtotal	$	-
Less Interest Earnings on Funds		
1. Debt Service Reserve Funds	$	-
2. Capitalized Interest Account		-
3. Construction Fund		-
4. Other		-
Subtotal	$	-
Total Debt Financing Expenses	**$**	**-**
feeds to line 7 above		

NOTE: When completing this table make entries in the shaded fields only.

Kahm Clinic IOP/PHP, LLC

PROJECT NAME

TABLE 2

DEBT FINANCING ARRANGEMENT, SOURCES & USES OF FUNDS

Sources of Funds

1. Financing Instrument	Bond			
a. Interest Rate	0.0%			
b. Loan Period		To:		
c. Amount Financed			$	-
2. Equity Contribution				900,000
3. Other Sources				
a. Working Capital				-
b. Fundraising				-
c. Grants				-
d. Other				-
Total Required Funds			**$**	**900,000**

Uses of Funds

Project Costs (feeds from Table 1)		
1. New Construction	$	-
2. Renovation		347,220
3. Site Work		-
4. Fixed Equipment		-
5. Design/Bidding Contingency		-
6. Construction Contingency		-
7. Construction Manager Fee		-
8. Major Moveable Equipment		-
9. Furnishings, Fixtures & Other Equip.		85,879
10. Architectural/Engineering Fees		30,000
11. Land Acquisition		-
12. Purchase of Buildings		-
13. Administrative Expenses & Permits		-
14. Debt Financing Expenses		-
15. Debt Service Reserve Fund		-
16. Working Capital		411,901
17. Other (Software)		25,000
Total Uses of Funds	**$**	**900,000**

Total sources should equal total uses of funds.

NOTE: When completing this table make entries in the shaded fields only.

Kahm Clinic IOP/PHP, LLC
PROJECT NAME
TABLE 3A
INCOME STATEMENT
THIS IS NEW ENTITY THIS TABLE IS NOT APPLICABLE

	Latest Actual 2020	Budget 2021	Proposed Year 1 2022	Proposed Year 2 2023	Proposed Year 3 2024
Revenues					
Inpatient Care Revenue	$ -	$ -	$ -	$ -	$ -
Outpatient Care Revenue	-	-	-	-	-
Chronic/Rehab Revenue	-	-	-	-	-
SNF/ECF Patient Care Revenue	-	-	-	-	-
Swing Beds Patient Care Revenue	-	-	-	-	-
Gross Patient Care Revenue	$ -	$ -	$ -	$ -	$ -
Disproportionate Share Payments	$ -	$ -	$ -	$ -	$ -
Free Care & Bad Debt	-	-	-	-	-
Deductions from Revenue	-	-	-	-	-
Net Patient Care Revenue	$ -	$ -	$ -	$ -	$ -
Other Operating Revenue					
Total Operating Revenue	$ -	$ -	$ -	$ -	$ -
Operating Expense					
Salaries (Non-MD)	$ -	$ -	$ -	$ -	$ -
Frings Benefits (Non-MD)	-	-	-	-	-
Physician Fees/Salaries/Contracts/Fringe	-	-	-	-	-
Health Care Provider Tax					
Depreciation/Amortization					
Interest					
Other Operating Expense					
Total Operating Expense	$ -	$ -	$ -	$ -	$ -
Net Operating Income (Loss)	$ -	$ -	$ -	$ -	$ -
Non-Operating Revenue					
Excess (Deficit) of Rev Over Exp	$ -	$ -	$ -	$ -	$ -

Latest actual numbers should tie to the hospital budget process.

NOTE: When completing this table make entries in the shaded fields only.

Kahm Clinic IOP/PHP, LLC
PROJECT NAME
TABLE 3B
INCOME STATEMENT
PROJECT ONLY

	Latest Actual 2020	Pre CO 2021	Proposed Year 1 2022	Proposed Year 2 2023	Proposed Year 3 2024
Revenues					
Inpatient Care Revenue	N/A	$ -	$ -	$ -	$ -
Outpatient Care Revenue	N/A	-	1,031,100	2,420,150	3,010,150
Chronic/Rehab Revenue	N/A	-	-	-	-
SNF/ECF Patient Care Revenue	N/A	-	-	-	-
Swing Beds Patient Care Revenue	N/A	-	-	-	-
Gross Patient Care Revenue		$ -	$ 1,031,100	$ 2,420,150	$ 3,010,150
Disproportionate Share Payments	N/A	$ -	$ -	$ -	$ -
Free Care & Bad Debt	N/A	-	(51,555)	(121,008)	(150,508)
Deductions from Revenue	N/A	-	-	-	-
Net Patient Care Revenue	N/A	$ -	$ 979,545	$ 2,299,142	$ 2,859,642
Other Operating Revenue	N/A	-	-	-	-
Total Operating Revenue	N/A	$ -	$ 979,545	$ 2,299,142	$ 2,859,642
Operating Expense					
Salaries (Non-MD)	N/A	$ 18,752	505,338	$ 697,412	$ 958,310
Frings Benefits (Non-MD)	N/A	3,686	112,954	146,473	209,545
Physician Fees/Salaries/Contracts/Fring	N/A	-	122,168	155,486	250,410
Health Care Provider Tax	N/A	-	-	-	-
Depreciation/Amortization	N/A	-	19,312	19,312	23,731
Interest	N/A	-	-	-	-
Other Operating Expense	N/A	77,895	446,796	535,624	673,511
Total Operating Expense	N/A	$ 100,333	$ 1,206,568	$ 1,554,307	$ 2,115,507
Net Operating Income (Loss)	N/A	$ (100,333)	$ (227,023)	$ 744,835	$ 744,135
Non-Operating Revenue	N/A	-	-	-	-
Excess (Deficit) of Rev Over Exp	N/A	$ (100,333)	$ (227,023)	$ 744,835	$ 744,135

Latest actual numbers should tie to the hospital budget process.

NOTE: This table requires no 'fill-in' as it is populated automatically from Tables 3A & 3B.

Kahm Clinic IOP/PHP, LLC
PROJECT NAME
TABLE 3C
INCOME STATEMENT
THIS IS NEW ENTITY THIS TABLE IS NOT APPLICABLE AS ITS SAME AS TABLE B

	Latest Actual 2020	Budget 2021	Proposed Year 1 2022	Proposed Year 2 2023	Proposed Year 3 2024
Revenues					
Inpatient Care Revenue	#VALUE!	$ -	$ -	$ -	$ -
Outpatient Care Revenue	#VALUE!	-	1,031,100	2,420,150	3,010,150
Chronic/Rehab Revenue	#VALUE!	-	-	-	-
SNF/ECF Patient Care Revenue	#VALUE!	-	-	-	-
Swing Beds Patient Care Revenue	#VALUE!	-	-	-	-
Gross Patient Care Revenue	#VALUE!	$ -	$ 1,031,100	$ 2,420,150	$ 3,010,150
Disproportionate Share Payments	#VALUE!	$ -	$ -	$ -	$ -
Free Care & Bad Debt	#VALUE!	-	(51,555)	(121,008)	(150,508)
Deductions from Revenue	#VALUE!	-	-	-	-
Net Patient Care Revenue	#VALUE!	$ -	$ 979,545	$ 2,299,142	$ 2,859,642
Other Operating Revenue	#VALUE!	-	-	-	-
Total Operating Revenue	#VALUE!	$ -	$ 979,545	$ 2,299,142	$ 2,859,642
Operating Expense					
Salaries (Non-MD)	#VALUE!	$ 18,752	$ 505,338	$ 697,412	$ 958,310
Frings Benefits (Non-MD)	#VALUE!	3,686	112,954	146,473	209,545
Physician Fees/Salaries/Contracts/Fring	#VALUE!	-	122,168	155,486	250,410
Health Care Provider Tax	#VALUE!	-	-	-	-
Depreciation/Amortization	#VALUE!	-	19,312	19,312	23,731
Interest	#VALUE!	-	-	-	-
Other Operating Expense	#VALUE!	77,895	446,796	535,624	673,511
Total Operating Expense	#VALUE!	$ 100,333	$ 1,206,568	$ 1,554,307	$ 2,115,507
Net Operating Income (Loss)	#VALUE!	$ (100,333)	$ (227,023)	$ 744,835	$ 744,135
Non-Operating Revenue	#VALUE!	-	-	-	-
Excess (Deficit) of Rev Over Exp	#VALUE!	$ (100,333)	$ (227,023)	$ 744,835	$ 744,135

Latest actual numbers should tie to the hospital budget process.

NOTE: When completing this table make entries in the shaded fields only.

Kahm Clinic IOP/PHP, LLC
PROJECT NAME
TABLE 4A
BALANCE SHEET - UNRESTRICTED FUNDS
THIS IS NEW ENTITY THIS TABLE IS NOT APPLICABLE

ASSETS	Latest Actual 2020	Budget 2021	Proposed Year 1 2022	Proposed Year 2 2023	Proposed Year 3 2024
Current Assets					
Cash & Investments	$ -	$ -	$ -	$ -	$ -
Patient Accounts Receivable, Gross					
Less: Allowance for Uncollectable Accts.					
Due from Third Parties					
Other Current Assets					
Total Current Assets	$ -	$ -	$ -	$ -	$ -
Board Designated Assets					
Funded Depreciation	$ -	$ -	$ -	$ -	$ -
Escrowed Bond Funds					
Other					
Total Board Designated Assets	$ -	$ -	$ -	$ -	$ -
Property, Plant & Equipment					
Land, Buildings & Improvements	$ -	$ -	$ -	$ -	$ -
Fixed Equipment					
Major Moveable Equipment					
Construction in Progress					
Total Property, Plant & Equipment	$ -	$ -	$ -	$ -	$ -
Less: Accumulated Depreciation					
Land, Buildings & Improvements	$ -	$ -	$ -	$ -	$ -
Fixed Equipment					
Major Moveable Equipment					
Total Accumulated Depreciation	$ -	$ -	$ -	$ -	$ -
Total Net Property, Plant & Equipment	$ -	$ -	$ -	$ -	$ -
Other Long-Term Assets	$ -	$ -	$ -	$ -	$ -
TOTAL ASSETS	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
LIABILITIES AND FUND BALANCE					
Current Liabilities					
Accounts Payable	$ -	$ -	$ -	$ -	$ -
Salaries, Wages & Payroll Taxes Payable					
Estimated Third-Party Settlements					
Other Current Liabilities					
Current Portion of Long-Term Debt					
Total Current Liabilities	$ -	$ -	$ -	$ -	$ -
Long-Term Debt					
Bonds & Mortgages Payable	$ -	$ -	$ -	$ -	$ -
Capital Lease Obligations	-	-	-	-	-
Other Long-Term Debt	-	-	-	-	-
Total Long-Term Debt	$ -	$ -	$ -	$ -	$ -
Total Other Non-Current Liabilities	$ -	$ -	$ -	$ -	$ -
Total Liabilities	$ -	$ -	$ -	$ -	$ -
Fund Balance	$ -	$ -	$ -	$ -	$ -
TOTAL LIABILITIES & FUND BALANCE	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

NOTE: When completing this table make entries in the shaded fields only.

Kahm Clinic IOP/PHP, LLC
PROJECT NAME
TABLE 4B
BALANCE SHEET - UNRESTRICTED FUNDS
PROJECT ONLY

ASSETS	Latest Actual 2020	Pre CO 2021	Proposed Year 1 2022	Proposed Year 2 2023	Proposed Year 3 2024
Current Assets					
Cash & Investments	N/A	$ 430,148	$ 45,974	$ 467,347	$ 750,284
Patient Accounts Receivable, Gross	N/A	-	185,750	232,950	291,950
Less: Allowance for Uncollectable Accts.	N/A	-	(9,288)	(11,647)	(14,598)
Due from Third Parties	N/A	-			
Other Current Assets	N/A			-	-
Total Current Assets	N/A	$ 430,148	$ 222,436	$ 688,650	$ 1,027,636
Board Designated Assets					
Funded Depreciation	N/A	$ -	$ -	$ -	$ -
Escrowed Bond Funds	N/A	-			
Other	N/A	9,246	9,246	9,246	12,645
Total Board Designated Assets	N/A	$ 9,246	$ 9,246	$ 9,246	$ 12,645
Property, Plant & Equipment					
Land, Buildings & Improvements	N/A	$ 277,220	$ 277,220	$ 277,220	$ 377,220
Fixed Equipment	N/A	-	-		
Major Moveable Equipment	N/A	83,053	83,053	83,053	110,879
Construction in Progress	N/A	-			
Total Property, Plant & Equipment	N/A	$ 360,273	$ 360,273	$ 360,273	$ 488,099
Less: Accumulated Depreciation					
Land, Buildings & Improvements	N/A	$ -	$ (7,108)	$ (14,216)	$ (23,798)
Fixed Equipment	N/A	-			
Major Moveable Equipment	N/A	-	(12,204)	(24,407)	(38,556)
Total Accumulated Depreciation	N/A	$ -	$ (19,312)	$ (38,623)	$ (62,354)
Total Net Property, Plant & Equipment	N/A	$ 360,273	$ 340,961	$ 321,650	$ 425,745
Other Long-Term Assets	N/A	$ -	$ -	$ -	$ -
TOTAL ASSETS	N/A	**$ 799,667**	**$ 572,643**	**$ 1,019,546**	**$ 1,466,026**
LIABILITIES AND FUND BALANCE					
Current Liabilities					
Accounts Payable	N/A	$ -	$ -	$ -	$ -
Salaries, Wages & Payroll Taxes Payable	N/A	-	-	-	-
Estimated Third-Party Settlements	N/A	-	-	-	-
Other Current Liabilities	N/A	-	-	-	-
Current Portion of Long-Term Debt	N/A	-	-	-	-
Total Current Liabilities	N/A	$ -	$ -	$ -	$ -
Long-Term Debt					
Bonds & Mortgages Payable	N/A	$ -	$ -	$ -	$ -
Capital Lease Obligations	N/A	-	-	-	-
Other Long-Term Debt	N/A	-	-	-	-
Total Long-Term Debt	N/A	$ -	$ -	$ -	$ -
Total Other Non-Current Liabilities	N/A	$ -	$ -	$ -	$ -
Total Liabilities	N/A	$ -	$ -	$ -	$ -
Fund Balance	N/A	$ 799,667	$ 572,644	$ 1,019,545	$ 1,466,026
TOTAL LIABILITIES & FUND BALANCE	N/A	**$ 799,667**	**$ 572,644**	**$ 1,019,545**	**$ 1,466,026**

NOTE: This table requires no 'fill-in' as it is populated automatically from Tables 4A & 4B.

Kahm Clinic IOP/PHP, LLC
PROJECT NAME
TABLE 4C
BALANCE SHEET - UNRESTRICTED FUNDS
THIS IS NEW ENTITY THIS TABLE IS NOT APPLICABLE AS ITS SAME AS TABLE B

ASSETS	Latest Actual 2020	Budget 2021	Proposed Year 1 2022	Proposed Year 2 2023	Proposed Year 3 2024
Current Assets					
Cash & Investments	#VALUE!	$ 430,148	$ 45,974	$ 467,347	$ 750,284
Patient Accounts Receivable, Gross	#VALUE!	-	185,750	232,950	291,950
Less: Allowance for Uncollectable Accts.	#VALUE!	-	(9,288)	(11,647)	(14,598)
Due from Third Parties	#VALUE!	-	-	-	-
Other Current Assets	#VALUE!	-	-	-	-
Total Current Assets	#VALUE!	$ 430,148	$ 222,436	$ 688,650	$ 1,027,636
Board Designated Assets					
Funded Depreciation	#VALUE!	$ -	$ -	$ -	$ -
Escrowed Bond Funds	#VALUE!	-	-	-	-
Other	#VALUE!	9,246	9,246	9,246	12,645
Total Board Designated Assets	#VALUE!	$ 9,246	$ 9,246	$ 9,246	$ 12,645
Property, Plant & Equipment					
Land, Buildings & Improvements	#VALUE!	$ 277,220	$ 277,220	$ 277,220	$ 377,220
Fixed Equipment	#VALUE!	-	-	-	-
Major Moveable Equipment	#VALUE!	83,053	83,053	83,053	110,879
Construction in Progress	#VALUE!	-	-	-	-
Total Property, Plant & Equipment	#VALUE!	$ 360,273	$ 360,273	$ 360,273	$ 488,099
Less: Accumulated Depreciation					
Land, Buildings & Improvements	#VALUE!	$ -	$ (7,108)	$ (14,216)	$ (23,798)
Fixed Equipment	#VALUE!	-	-	-	-
Major Moveable Equipment	#VALUE!	-	(12,204)	(24,407)	(38,556)
Total Accumulated Depreciation	#VALUE!	$ -	$ (19,312)	$ (38,623)	$ (62,354)
Total Net Property, Plant & Equipment	#VALUE!	$ 360,273	$ 340,961	$ 321,650	$ 425,745
Other Long-Term Assets	#VALUE!	$ -	$ -	$ -	$ -
TOTAL ASSETS	**#VALUE!**	**$ 799,667**	**$ 572,643**	**$ 1,019,546**	**$ 1,466,026**
LIABILITIES AND FUND BALANCE					
Current Liabilities					
Accounts Payable	#VALUE!	$ -	$ -	$ -	$ -
Salaries, Wages & Payroll Taxes Payable	#VALUE!	-	-	-	-
Estimated Third-Party Settlements	#VALUE!	-	-	-	-
Other Current Liabilities	#VALUE!	-	-	-	-
Current Portion of Long-Term Debt	#VALUE!	-	-	-	-
Total Current Liabilities	#VALUE!	$ -	$ -	$ -	$ -
Long-Term Debt					
Bonds & Mortgages Payable	#VALUE!	$ -	$ -	$ -	$ -
Capital Lease Obligations	#VALUE!	-	-	-	-
Other Long-Term Debt	#VALUE!	-	-	-	-
Total Long-Term Debt	#VALUE!	$ -	$ -	$ -	$ -
Total Other Non-Current Liabilities	#VALUE!	$ -	$ -	$ -	$ -
Total Liabilities	#VALUE!	$ -	$ -	$ -	$ -
Fund Balance	#VALUE!	$ 799,667	$ 572,644	$ 1,019,545	$ 1,466,026
TOTAL LIABILITIES & FUND BALANCE	**#VALUE!**	**$ 799,667**	**$ 572,644**	**$ 1,019,545**	**$ 1,466,026**

NOTE: When completing this table make entries in the shaded fields only.

Kahm Clinic IOP/PHP, LLC
PROJECT NAME
TABLE 5A
STATEMENT OF CASH FLOWS

THIS IS NEW ENTITY THIS TABLE IS NOT APPLICABLE

	Latest Actual 2020	Budget 2021	Proposed Year 1 2022	Proposed Year 2 2023	Proposed Year 3 2024
Beginning Cash	$ -	$ -	$ -	$ -	$ -
Operations					
Excess revenues over expenses	-	-	-	-	-
Depreciation / Amortization	-	-	-	-	-
(Increase)/Decrease Patient A/R	-	-	-	-	-
(Increase)/Decrease Other Changes	-	-	-	-	-
Subtotal Cash from Operations	$ -	$ -	$ -	$ -	$ -
Investing Activity					
Capital Spending					
Capital					
Capitalized Interest					
Change in accum depr less depreciation	-	-	-	-	-
(Increase) Decrease in capital assets	-	-	-	-	-
Subtotal Capital Spending	$ -	$ -	$ -	$ -	$ -
(Increase) / Decrease					
Funded Depreciation		-	-	-	-
Other LT assets & escrowed bonds & other		-	-	-	-
Subtotal (Increase) / Decrease	$ -	$ -	$ -	$ -	$ -
Subtotal Cash from Investing Activity	$ -	$ -	$ -	$ -	$ -
Financing Activity					
Debt (increase) decrease					
Bonds & mortgages		-	-	-	-
Repayment					
Capital lease & other long term debt	-	-	-	-	-
Subtotal Cash from Financing Activity	$ -	$ -	$ -	$ -	$ -
Other Changes (please describe)					
Manual adjustment					
Other					
Change in fund balance less net income		-	-	-	-
Other					
Subtotal Other Changes	$ -	$ -	$ -	$ -	$ -
Net Increase (Decrease) in Cash	$ -	$ -	$ -	$ -	$ -
Ending Cash	$ -	$ -	$ -	$ -	$ -

NOTE: This table requires no 'fill-in' as it automatically populates from Tables 4B, 5A and 5B.

Kahm Clinic IOP/PHP, LLC
PROJECT NAME
TABLE 5B
STATEMENT OF CASH FLOWS
PROJECT ONLY

	Latest Actual 2020	Pre CO 2021	Proposed Year 1 2022	Proposed Year 2 2023	Proposed Year 3 2024
Beginning Cash	N/A	N/A	$ 430,648	$ 45,974	$ 467,347
Operations					
Excess revenues over expenses	N/A	(100,333)	(227,023)	744,835	744,135
Depreciation / Amortization	N/A	-	19,312	19,313	23,730
(Increase)/Decrease Patient A/R	N/A		(176,462)	(44,841)	(56,049)
(Increase)/Decrease Other Changes	N/A		-	-	-
Subtotal Cash from Operations	N/A	$ (100,333)	$ (384,173)	$ 719,307	$ 711,816
Investing Activity					
Capital Spending					
Capital	N/A	900,000			
Capitalized Interest	N/A				
Change in accum depr less depreciation	N/A		-	-	-
(Increase) Decrease in capital assets	N/A	(360,273)	-	-	(127,826)
Subtotal Capital Spending	N/A	$ 539,727	$ -	$ -	$ (127,826)
(Increase) / Decrease					
Funded Depreciation	N/A		-	-	-
Other LT assets & escrowed bonds & other	N/A		-	-	(3,399)
Subtotal (Increase) / Decrease	N/A	$ -	$ -	$ -	$ (3,399)
Subtotal Cash from Investing Activity	N/A	$ 539,727	$ -	$ -	$ (131,225)
Financing Activity					
Debt (increase) decrease					
Bonds & mortgages	N/A		-	-	-
Repayment	N/A				
Capital lease & other long term debt	N/A		-	-	-
Subtotal Cash from Financing Activity	N/A	$ -	$ -	$ -	$ -
Other Changes (please describe)					
Manual adjustment	N/A				
Other	N/A				
Change in fund balance less net income	N/A		-	(297,934)	(297,654)
Other	N/A				
Subtotal Other Changes	N/A	$ -	$ -	$ (297,934)	$ (297,654)
Net Increase (Decrease) in Cash	N/A	$ 439,394	$ (384,173)	$ 421,373	$ 282,937
Ending Cash	N/A	$ 430,148	$ 45,974	$ 467,347	$ 750,284

NOTE: This table requires no 'fill-in' as it is populated automatically from Tables 5A & 5B.

Kahm Clinic IOP/PHP, LLC
PROJECT NAME
TABLE 5C
STATEMENT OF CASH FLOWS

THIS IS NEW ENTITY THIS TABLE IS NOT APPLICABLE AS ITS SAME AS TABLE B

	Latest Actual 2020	Budget 2021	Proposed Year 1 2022	Proposed Year 2 2023	Proposed Year 3 2024
Beginning Cash	**#VALUE!**	**#VALUE!**	**$ 430,648**	**$ 45,974**	**$ 467,347**
Operations					
Excess revenues over expenses	#VALUE!	(100,333)	(227,023)	744,835	744,135
Depreciation / Amortization	#VALUE!	-	19,312	19,313	23,730
(Increase)/Decrease Patient A/R	#VALUE!	-	(176,462)	(44,841)	(56,049)
(Increase)/Decrease Other Changes	#VALUE!	-	-	-	-
Subtotal Cash from Operations	**#VALUE!**	**$ (100,333)**	**$ (384,173)**	**$ 719,307**	**$ 711,816**
Investing Activity					
Capital Spending					
Capital	#VALUE!	900,000	-	-	-
Capitalized Interest	#VALUE!	-	-	-	-
Change in accum depr less depreciation	#VALUE!	-	-	-	-
(Increase) Decrease in capital assets	#VALUE!	(360,273)	-	-	(127,826)
Subtotal Capital Spending	#VALUE!	$ 539,727	$ -	$ -	$ (127,826)
(Increase) / Decrease					
Funded Depreciation	#VALUE!	-	-	-	-
Other LT assets & escrowed bonds & other	#VALUE!	-	-	-	(3,399)
Subtotal (Increase) / Decrease	#VALUE!	$ -	$ -	$ -	$ (3,399)
Subtotal Cash from Investing Activity	**#VALUE!**	**$ 539,727**	**$ -**	**$ -**	**$ (131,225)**
Financing Activity					
Debt (increase) decrease					
Bonds & mortgages	#VALUE!	-	-	-	-
Repayment	#VALUE!	-	-	-	-
Capital lease & other long term debt	#VALUE!	-	-	-	-
Subtotal Cash from Financing Activity	**#VALUE!**	**$ -**	**$ -**	**$ -**	**$ -**
Other Changes (please describe)					
Manual adjustment	#VALUE!	-	-	-	-
Other	#VALUE!	-	-	-	-
Change in fund balance less net income	#VALUE!	-	-	(297,934)	(297,654)
Other	#VALUE!	-	-	-	-
Subtotal Other Changes	**#VALUE!**	**$ -**	**$ -**	**$ (297,934)**	**$ (297,654)**
Net Increase (Decrease) in Cash	**#VALUE!**	**$ 439,394**	**$ (384,173)**	**$ 421,373**	**$ 282,937**
Ending Cash	**#VALUE!**	**#VALUE!**	**$ 46,475**	**$ 467,347**	**$ 750,284**

NOTE: When completing this table make entries in the shaded fields only.

Kahm Clinic IOP/PHP, LLC
PROJECT NAME
TABLE 6A
REVENUE SOURCE PROJECTIONS
THIS IS NEW ENTITY THIS TABLE IS NOT APPLICABLE

	Latest Actual 2020	% of Total	Budget 2021	% of Total	Proposed Year 1 2022	% of Total	Proposed Year 2 2023	% of Total	Proposed Year 3 2024	% of Total
Gross Inpatient Revenue										
Medicare	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Medicaid		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Commercial		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Self Pay		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Free Care / Bad Debt		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Other		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Gross Outpatient Revenue										
Medicare	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Medicaid	-	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Commercial	-	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Self Pay	-	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Free Care / Bad Debt	-	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Other	-	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Gross Other Revenue										
Medicare	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Medicaid	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Commercial	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Self Pay	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Free Care / Bad Debt	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Other	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Gross Patient Revenue										
Medicare	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Medicaid	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Commercial	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Self Pay	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Free Care / Bad Debt	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Other	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Deductions from Revenue										
Medicare	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Medicaid	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Commercial	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Self Pay	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Free Care / Bad Debt	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Other	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Net Patient Revenue										
Medicare	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Medicaid	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Commercial	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Self Pay	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Free Care / Bad Debt	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Other	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
DSP*	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!

Latest actual numbers should tie to the hospital budget process.
* Disproportionate share payments

NOTE: When completing this table make entries in the shaded fields only.

Kahm Clinic IOP/PHP, LLC
PROJECT NAME
TABLE 6B
REVENUE SOURCE PROJECTIONS
PROJECT ONLY

	Latest Actual 2020	% of Total	Budget 2021	% of Total	Proposed Year 1 2022	% of Total	Proposed Year 2 2023	% of Total	Proposed Year 3 2024	% of Total
Gross Inpatient Revenue										
Medicare	N/A		$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Medicaid	N/A		-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Commercial	N/A		-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Self Pay	N/A		-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Free Care / Bad Debt	N/A		-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Other	N/A		-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
	N/A		$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Gross Outpatient Revenue										
Medicare	N/A		$ -	#DIV/0!	$ -	0.0%	$ -	0.0%	$ -	0.0%
Medicaid	N/A		-	#DIV/0!	-	0.0%	-	0.0%	-	0.0%
Commercial	N/A		-	#DIV/0!	876,435	85.0%	2,057,128	85.0%	2,558,628	85.0%
Self Pay	N/A		-	#DIV/0!	154,665	15.0%	363,023	15.0%	451,523	15.0%
Free Care / Bad Debt	N/A		-	#DIV/0!	-	0.0%	-	0.0%	-	0.0%
Other	N/A		-	#DIV/0!	-	0.0%	-	0.0%	-	0.0%
	N/A		$ -	#DIV/0!	$ 1,031,100	100.0%	$ 2,420,150	100.0%	$ 3,010,150	100.0%
Gross Other Revenue										
Medicare	N/A		$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Medicaid	N/A		-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Commercial	N/A		-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Self Pay	N/A		-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Free Care / Bad Debt	N/A		-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Other	N/A		-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
	N/A		$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Gross Patient Revenue										
Medicare	N/A		$ -	#DIV/0!	$ -	0.0%	$ -	0.0%	$ -	0.0%
Medicaid	N/A		-	#DIV/0!	-	0.0%	-	0.0%	-	0.0%
Commercial	N/A		-	#DIV/0!	876,435	85.0%	2,057,128	85.0%	2,558,628	85.0%
Self Pay	N/A		-	#DIV/0!	154,665	15.0%	363,023	15.0%	451,523	15.0%
Free Care / Bad Debt	N/A		-	#DIV/0!	-	0.0%	-	0.0%	-	0.0%
Other	N/A		-	#DIV/0!	-	0.0%	-	0.0%	-	0.0%
	N/A		$ -	#DIV/0!	$ 1,031,100	100.0%	$ 2,420,150	100.0%	$ 3,010,150	100.0%
Deductions from Revenue										
Medicare	N/A		$ -	#DIV/0!	$ -	0.0%	$ -	0.0%	$ -	0.0%
Medicaid	N/A		-	#DIV/0!	-	0.0%	-	0.0%	-	0.0%
Commercial	N/A		-	#DIV/0!	-	0.0%	-	0.0%	-	0.0%
Self Pay	N/A		-	#DIV/0!	-	0.0%	-	0.0%	-	0.0%
Free Care / Bad Debt	N/A		-	#DIV/0!	51,555	100.0%	121,008	100.0%	150,508	100.0%
Other	N/A		-	#DIV/0!	-	0.0%	-	0.0%	-	0.0%
	N/A		$ -	#DIV/0!	$ 51,555	100.0%	$ 121,008	100.0%	$ 150,508	100.0%
Net Patient Revenue										
Medicare	N/A		$ -	#DIV/0!	$ -	0.0%	$ -	0.0%	$ -	0.0%
Medicaid	N/A		-	#DIV/0!	-	0.0%	-	0.0%	-	0.0%
Commercial	N/A		-	#DIV/0!	876,435	89.5%	2,057,128	89.5%	2,558,628	89.5%
Self Pay	N/A		-	#DIV/0!	154,665	15.8%	363,023	15.8%	451,523	15.8%
Free Care / Bad Debt	N/A		-	#DIV/0!	(51,555)	-5.3%	(121,008)	-5.3%	(150,508)	-5.3%
Other	N/A		-	#DIV/0!	-	0.0%	-	0.0%	-	0.0%
DSP*	N/A		N/A		N/A		N/A		N/A	
			$ -	#DIV/0!	$ 979,545	100.0%	$ 2,299,142	100.0%	$ 2,859,642	100.0%

Latest actual numbers should tie to the hospital budget process.

* Disproportionate share payments

NOTE: This table requires no 'fill-in' as it will automatically populate from Tables 6A & 6B.

Kahm Clinic IOP/PHP, LLC
PROJECT NAME
TABLE 6C
REVENUE SOURCE PROJECTIONS
THIS IS NEW ENTITY THIS TABLE IS NOT APPLICABLE AS ITS SAME AS TABLE B

	Latest Actual 2020	% of Total	Budget 2021	% of Total	Proposed Year 1 2022	% of Total	Proposed Year 2 2023	% of Total	Proposed Year 3 2024	% of Total
Gross Inpatient Revenue										
Medicare	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Medicaid	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Commercial	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Self Pay	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Free Care / Bad Debt	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Other	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Gross Outpatient Revenue										
Medicare	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Medicaid	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Commercial	-	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Self Pay	-	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Free Care / Bad Debt	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Other	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Gross Other Revenue										
Medicare	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Medicaid	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Commercial	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Self Pay	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Free Care / Bad Debt	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Other	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Gross Patient Revenue										
Medicare	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Medicaid	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Commercial	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Self Pay	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Free Care / Bad Debt	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Other	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Deductions from Revenue										
Medicare	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Medicaid	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Commercial	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Self Pay	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Free Care / Bad Debt	-	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Other	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Net Patient Revenue										
Medicare	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Medicaid	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Commercial	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Self Pay	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Free Care / Bad Debt	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Other	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
DSP*	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!

Latest actual numbers should tie to the hospital budget process.

* Disproportionate share payments

NOTE: When completing this table make entries in the shaded fields only.

Kahm Clinic IOP/PHP, LLC
PROJECT NAME
TABLE 7
UTILIZATION PROJECTIONS
TOTALS

A: WITHOUT PROJECT	New Entity N/A		Proposed	Proposed	Proposed
	Latest Actual	Pre CO	Year 1	Year 2	Year 3
		1	2	3	4
Inpatient Utilization					
Staffed Beds					
Admissions					
Patient Days					
Average Length of Stay					
Outpatient Utilization					
All Outpatient Visits					
OR Procedures					
Observation Units					
Physician Office Visits					
Ancillary					
All OR Procedures					
Emergency Room Visits					
Adjusted Statistics					
Adjusted Admissions					
Adjusted Patient Days					

B: PROJECT ONLY			Proposed	Proposed	Proposed
	Latest Actual	Pre CO	Year 1	Year 2	Year 3
	0	1	2	3	4
Inpatient Utilization					
Staffed Beds	N/A	-	-	-	-
Admissions	N/A	-	-	-	-
Patient Days	N/A	-	-	-	-
Average Length of Stay	N/A	-	-	-	-
Outpatient Utilization	N/A				
All Outpatient Visits	N/A	-	2,282	5,303	**6,903**
OR Procedures	N/A	-	-	-	-
Observation Units	N/A	-	-	-	-
Physician Office Visits	N/A	-	-	-	-
Ancillary	N/A				
All OR Procedures	N/A	-	-	-	-
Emergency Room Visits	N/A	-	-	-	-
Adjusted Statistics	N/A		-	-	-
Adjusted Admissions	N/A	-	-	-	-
Adjusted Patient Days	N/A	-	-	-	-

C: WITH PROJECT	N/A, same as B		Proposed	Proposed	Proposed
	Latest Actual	Pre CO	Year 1	Year 2	Year 3
	0	1	2	3	4
Inpatient Utilization					
Staffed Beds	-				
Admissions	-	-	-	-	-
Patient Days	-	-	-	-	-
Average Length of Stay	-				
Outpatient Utilization					
All Outpatient Visits	-	-	2,282	5,303	6,903
OR Procedures	-	-	-	-	-
Observation Units	-	-	-	-	-
Physician Office Visits	-	-	-	-	-
Ancillary					
All OR Procedures	-	-	-	-	-
Emergency Room Visits	-	-	-	-	-
Adjusted Statistics					
Adjusted Admissions	-				
Adjusted Patient Days	-				

NOTE: When completing this table make entries in the shaded fields only.

Kahm Clinic IOP/PHP, LLC
PROJECT NAME
TABLE 8
UTILIZATION PROJECTIONS
PROJECT SPECIFIC

A: WITHOUT PROJECT	New Entity N/A		Proposed	Proposed	Proposed
You may wish to enter your own categories below:	Latest Actual	Pre CO	Year 1	Year 2	Year 3
		1	2	3	4
Acute					
Acute Care Admissions					
Acute Patient Days					
Acute Staffed Beds					
Imaging					
Radiology - Diagnostic Procedures					
Nuclear Medicine Procedures					
Cat Scan Procedures					
Magnetic Resonance Imaging					
Other					
Laboratory Tests					

Division staff can assist in determining the amount of detail required to support your proposal.

B: PROJECT ONLY	Latest Actual	Pre CO	Proposed Year 1	Proposed Year 2	Proposed Year 3
	0	1	2	3	4
PHP	N/A	-	970	2,375	2,375
IOP (Day)	N/A	-	-	1,152	1,152
IOP (Evening)	N/A	-	1,312	1,776	1,776
IOP (Adolescents)	N/A	-	-	-	1,600
	N/A	-	-	-	-
	N/A	-	-	-	-
	N/A	-	-	-	-
	N/A	-	-	-	-
	N/A				
	N/A				
	N/A				
	N/A				
	N/A				

C: WITH PROJECT	N/A, Same as B		Proposed	Proposed	Proposed
	Latest Actual	Pre CO	Year 1	Year 2	Year 3
	0	1	2	3	4
PHP	-	-	970	2,375	2,375
IOP (Day)	-	-	-	1,152	1,152
IOP (Evening)	-	-	1,312	1,776	1,776
IOP (Adolescents)					1,600
	-	-	-	-	
	-	-	-	-	-
	-	-	-	-	-
	-	-	-	-	-
	-	-	-	-	-
	-	-	-	-	-
	-	-	-	-	-
	-	-	-	-	-
	-	-	-	-	-
	-	-	-	-	-

NOTE: When completing this table make entries in the shaded fields only.

Kahm Clinic IOP/PHP, LLC
PROJECT NAME
TABLE 9
STAFFING PROJECTIONS
TOTALS

A: WITHOUT PROJECT	New Entity N/A		Proposed	Proposed	Proposed
	Latest Actual	Pre CO	Year 1	Year 2	Year 3
		1	2	3	4
Non-MD FTEs					
Total General Services					
Total Inpatient Routine Services					
Total Outpatient Routine Services					
Total Ancillary Services					
Total Other Services					
Total Non-MD FTEs	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Physician FTEs					
Direct Service Nurse FTEs					

B: PROJECT ONLY			Proposed	Proposed	Proposed
	Latest Actual	Pre CO	Year 1	Year 2	Year 3
	0	1	2	3	4
Non-MD FTEs					
Total General Services	N/A				
Total Inpatient Routine Services	N/A				
Total Outpatient Routine Services	N/A		6.0	6.0	9.0
Total Ancillary Services	N/A				
Total Other Services	N/A		1.0	1.5	1.5
Total Non-MD FTEs	N/A	**0.0**	**7.0**	**7.5**	**10.5**
Physician Services	N/A		**0.5**	**0.5**	**0.8**
Direct Service Nurse FTEs	N/A				

C: WITH PROJECT	N/A, same as B		Proposed	Proposed	Proposed
	Latest Actual	Pre CO	Year 1	Year 2	Year 3
	0	1	2	3	4
Non-MD FTEs					
Total General Services	#VALUE!	0.0	0.0	0.0	0.0
Total Inpatient Routine Services	#VALUE!	0.0	0.0	0.0	0.0
Total Outpatient Routine Services	#VALUE!	0.0	6.0	6.0	9.0
Total Ancillary Services	#VALUE!	0.0	0.0	0.0	0.0
Total Other Services	#VALUE!	0.0	1.0	1.5	1.5
Total Non-MD FTEs	**#VALUE!**	**0.0**	**7.0**	**7.5**	**10.5**
Physician Services	**#VALUE!**	**0.0**	**0.5**	**0.5**	**0.8**
Direct Service Nurse FTEs	**#VALUE!**	**0.0**	**0.0**	**0.0**	**0.0**

N.B. We are incrementally adding staff through the first year. Month 0, we are staffed at 30%, month 1 at 40%, month 2 at 50%, etc., until we reach 100% and are fully stafffed at month 7. We increase staff as well in the third year to accommodate taking adolescents.

R³ Report I Requirement, Rationale, Reference

A complimentary publication of The Joint Commission Issue 7, August 15, 2016

Published for Joint Commission accredited organizations and interested health care professionals, *R³ Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also provide a rationale, the rationale provided in *R³ Report* goes into more depth. The references provide the evidence that supports the requirement. *R³ Report* may be reproduced only in its entirety and credited to The Joint Commission.

Eating disorders standards for Behavioral Health Care

Requirements

In January 2016, The Joint Commission released a set of new Behavioral Health Care (BHC) standards for residential and outpatient eating disorders programs. These standards are designed to improve the quality and safety of care, treatment, or services provided by eating disorders programs. The standards accomplish this by covering the following critical aspects of care:

- **Assessments** (CTS.02.03.11) include certain laboratory and diagnostic tests, information from other providers, fall risk assessment, and refeeding assessment. This information must be obtained in order to effectively treat an individual with an eating disorder.
- **Plan for Care, Treatment, or Services** (CTS.03.01.03) for individuals with an eating disorder require some additional information, including a specific diagnosis and a plan for sufficient nutritional rehabilitation.
- **Assessing Outcomes** (CTS.03.01.09) of care, which are based on data collected at admission. The data collected are determined by the organization and are in accordance with the level of care provided. These assessments help the organization to monitor itself with regard to the effectiveness of the care, treatment, or services being provided.
- **Coordination of Care** (CTS.04.01.01) addresses, for example, if the individual served is transferred to a hospital during the course of care, treatment, or services. The organization would establish and maintain communication with the hospital regarding the individual's eating disorder. Some hospitals may not have protocols in place for treating individuals with eating disorders, and the information provided could be critical to the individual's well-being.
- **Additional Services** (CTS.04.02.16) cover specific core care, treatment, or service components that are provided by the organization to individuals with eating disorders, including psychosocial, medical, nutritional, and psychiatric components. Organizations also need to be knowledgeable about evidence-based guidelines regarding treatment for eating disorders.
- **Supervision** (CTS.04.02.18) ensures that, as needed, staff supervise individuals served to make sure they do not engage in behavior that could be detrimental to their health. It is important that staff members – not other individuals served – perform these duties.
- **Multidisciplinary Care Team(s)** (CTS.04.02.29) is employed by the organization to support and coordinate care, treatment, or services. These teams consist of a core group of professionals who will provide the care, treatment, or services required by the individuals served. Having the team helps to make certain that the care, treatment, or services are coordinated among the team members.
- **Discharge** (CTS.06.02.03 and CTS.06.02.05) plans contain specific information, and, with the consent of the individual, are shared with after-care providers within certain timeframes. This supports efficient and effective transitions of care.
- **Business Practices** (LD.04.02.03) include supplying individuals and their families with certain information regarding insurance and financial assistance. Program materials should contain specific information regarding the organization's eating disorders program. It is important for individuals and their families to be well informed about the program and what their financial commitment will be before deciding to commit to the program; it is the organization's responsibility to supply this information.

- **Performance Monitoring** (PI.01.01.01) is accomplished by the organization collecting data on outcomes of care, treatment, or services. By collecting and analyzing such data, the organization can determine whether it is meeting the needs of individuals served.
- **Individuals' Rights** (RI.01.01.01) ensures that residential facilities have specific policies regarding the individual's ability to leave the facility, have visitors, and access the internet. Having such policies in place can help the organization to keep the individual safe while he or she is under the care of the organization.

Rationale

Individuals who are served by residential and outpatient eating disorders programs require both behavioral *and* physical health care, treatment, or services; they can be very fragile.

Prior to the development of the eating disorders standards, The Joint Commission had two standards in the BHC accreditation manual that specifically addressed care, treatment, or services related to eating disorders. While many other standards in the manual applied to eating disorders programs, these were the only two that applied specifically to organizations providing care to individuals with eating disorders.

The field had asked The Joint Commission to consider writing additional standards for eating disorders programs. Concern had been expressed by the field that not all eating disorders programs were adhering to the level of rigor that is needed to effectively provide these services. Eating disorders have the highest mortality rate of any behavioral health disorder, making it very important that these programs provide the safest, highest quality care possible. Based on this information, The Joint Commission decided to develop additional requirements addressing eating disorders programs.

References

Engagement with stakeholders, customers, and experts

In addition to the required vetting of the proposed requirements with The Joint Commission's expert technical advisory and approval committees, research undertaken included the following:

- The Eating Disorders Technical Advisory Panel and the Eating Disorders Advisory Council, representing leading experts in the field of behavioral health and eating disorders, provided guidance regarding current principles and practice. These groups included consumers, clinicians, administrators, and educators.
- Conference calls with key external experts.
- Learning visits at accredited behavioral health care organizations with eating disorders programs.
- Formal field review of the proposed standards.
- Pilot testing at an accredited eating disorders program.

Level of Evidence

The following sources were used as references in the development of the eating disorders standards:

- Practice Guideline for the Treatment of Patients with Eating Disorders, Third Edition. Arlington, Virginia: American Psychiatric Association, 2010 (graded level of evidence). (Accessed June 14, 2016)
- Lock J, et al. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Eating Disorders, *Journal of the American Academy of Child and Adolescent Psychiatry*, 2015 May;54(5):412-25 (graded level of evidence). (Accessed June 14, 2016)
- Eating Disorders: Critical Points for Early Recognition and Medical Risk Management in the Care of Individuals with Eating Disorders, Second Edition. Deerfield, Illinois: Academy for Eating Disorders, 2012. (Accessed June 14, 2016)

Effective Date: January 1, 2022

Program: Behavioral Health and Human Services : Behavioral Health Care Services : Eating Disorders Treatment

Standard Label	EP	Elements of Performance Description
APR.09.04.01	1	The organization provides care, treatment, services, and an environment that pose no risk of an "Immediate Threat to Health or Safety."
CTS.01.01.01	1	The organization follows a written process for determining eligibility of individuals that includes the following: - The criteria to determine eligibility for care, treatment, or services - The information to be collected to determine eligibility for care, treatment, or services - The populations of individuals accepted or not accepted by the organization (for example, programs designed to treat adults that do not treat young children) - The procedures for accepting referrals
CTS.01.01.01	2	For organizations that elect The Joint Commission Behavioral Health Home option: The organization defines in writing the population(s) served by the behavioral health home; the population(s) served by the behavioral health home can be a defined subset(s) of the population served by the organization as a whole.
CTS.02.01.05	2	For organizations that elect The Joint Commission Behavioral Health Home option: If the screening triggers indicate the need for a medical history and physical examination, the behavioral health home arranges for the history and physical to occur in a time frame that meets the physical health care needs of the individual served.
CTS.02.01.06	1	For organizations providing residential care: The organization follows a written screening process to determine whether an individual served is in need of a medical history and physical examination that is based on the population(s) served and, at a minimum, includes the following: - Data to be collected - Time frame for completion of the screening - Screening triggers that indicate the need for a medical history and physical examination
CTS.02.01.06	2	For organizations providing residential care: A practitioner qualified by the scope of the license approves the organization's screening process.
CTS.02.01.06	3	For organizations providing residential care: Individuals who need a physical examination by a practitioner qualified by the scope of their license are either examined in the organization or referred to an outside source. The examination is conducted within 30 calendar days after admission, or sooner if warranted by the individual's physical health needs, and in accordance with law and regulation.
CTS.02.01.06	4	For organizations providing residential care: When the organization accepts a physical examination completed by a qualified practitioner within the 12 months prior to the individual's admission, the organization notes any changes to the individual's physical health condition and documents it in the individual's clinical/case record. If any changes(s) to the individual's physical health condition prompts any of the screening process triggers, a new medical history and physical examination is conducted.
CTS.02.01.06	5	For organizations providing residential care: If the date of the individual's most recent physical examination exceeds one year, a medical history and physical examination is performed.
CTS.02.02.01	7	For organizations that elect The Joint Commission Behavioral Health Home option: The assessment data collected include the individual's short- and long-term physical health care goals.

Standard Label	EP	Elements of Performance Description
CTS.02.02.01	8	For organizations that elect The Joint Commission Behavioral Health Home option: The assessment data collected include screening and/or assessment results for, at a minimum, the following chronic physical health conditions: - Diabetes - Hypertension - Heart disease - Asthma - Chronic obstructive pulmonary disease (COPD) - Hepatitis C - HIV/AIDS - Obesity - Any additional chronic physical health condition(s) the behavioral health home may regularly find in the population(s) it serves - Metabolic syndrome Note: Refer to https://www.heart.org/en/health-topics/metabolic-syndrome for more information on metabolic syndrome.
CTS.02.02.01	9	For organizations that elect The Joint Commission Behavioral Health Home option: The assessment data collected include the individual's ability to self-manage chronic behavioral and physical health conditions.
CTS.02.03.09	1	For organizations providing care, treatment, or services to individuals with eating disorders: The organization assesses the individual's beliefs, perceptions, attitudes, and behavior regarding food. (For more information, refer to Standard CTS.02.01.11)
CTS.02.03.09	2	For organizations providing care, treatment, or services to individuals with eating disorders: The organization includes family observations regarding the individual's food-related behavior in the assessment, when available.
CTS.02.03.11	1	For organizations that provide eating disorders care, treatment, or services: After admitting an individual to its program, the organization performs or makes a documented referral for the following tests, screenings, and procedures based on the needs of the individual served and in a time frame that meets the needs of the individual and is consistent with organization policy: - Complete blood count - Comprehensive serum metabolic profile, including phosphorus and magnesium - Thyroid function test - Electrocardiogram (ECG), if clinically indicated - Body mass index (BMI) - Heart rate - Screening for eating disorder behaviors - Any additional laboratory testing, as determined by the organization and in accordance with the level of care provided Note: For non-24-hour settings, the program may accept test results from other providers completed within two weeks prior to admission. (See also CTS.03.01.09, EP 4)
CTS.02.03.11	2	For organizations that provide eating disorders care, treatment, or services: The organization gathers clinical/case information from both inpatient and outpatient providers by whom the individual has been treated, and/or other eating disorders treatment programs in which the individual has participated, if available.
CTS.02.03.11	3	For organizations that provide eating disorders care, treatment, or services: The organization obtains or completes initial medical assessments, Diagnostic and Statistical Manual of Mental Disorders (DSM)-based diagnostic assessments, psychiatric evaluations, and nutritional assessments in accordance with the level of care provided, and within the time frame designated by the organization's policies and procedures. Note: Psychological testing is completed as clinically indicated.
CTS.02.03.11	4	For organizations that provide eating disorders care, treatment, or services: The organization conducts complete assessments in accordance with the level of care provided and within the time frame designated by the organization's policies and procedures.
CTS.02.03.11	5	For organizations that provide 24-hour eating disorders care, treatment, or services: The organization assesses the risk for falls for each individual served.

Standard Label	EP	Elements of Performance Description
CTS.02.03.11	6	For organizations that provide 24-hour eating disorders care, treatment, or services: The organization implements interventions to reduce falls based on the individual's assessed risk.
CTS.02.03.11	7	For organizations that provide 24-hour eating disorders care, treatment, or services: Individuals served are assessed and reassessed for refeeding syndrome based on the individual's physiological status.
CTS.03.01.01	13	For organizations that elect The Joint Commission Behavioral Health Home option: The physical health goals of the individual served are identified based on the screening and assessment and used in the plan for care, treatment, or services.
CTS.03.01.01	14	For organizations that elect The Joint Commission Behavioral Health Home option: All physical and behavioral health care, treatment, or service decisions are collaborative and integrated when more than one discipline is involved in the care, treatment, or services provided to the individual served.
CTS.03.01.03	20	For organizations that elect The Joint Commission Behavioral Health Home option: The plan for care, treatment, or services includes the following: - The physical health care needs of the individual - The physical health care goals of the individual - How the organization will meet those needs - How the organization will help the individual to work toward achieving the individual's goals
CTS.03.01.03	21	For organizations that elect The Joint Commission Behavioral Health Home option: The organization identifies the verbal and written communication needs of the individual served, including the individual's preferred language for discussing health care. Note: Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials.
CTS.03.01.03	22	For organizations that elect The Joint Commission Behavioral Health Home option: The organization communicates with the individual served during the provision of care, treatment, or services in a manner that meets the individual's verbal and written communication needs.
CTS.03.01.03	23	For organizations that elect The Joint Commission Behavioral Health Home option: The organization works in partnership with the individual served to achieve planned integrated care outcomes.
CTS.03.01.03	24	For organizations that elect The Joint Commission Behavioral Health Home option: The individual's self-management goals related to behavioral and physical health conditions are identified and incorporated into the individual's plan of care, treatment, or services. (For more information, refer to RI.01.02.01, EP 1)
CTS.03.01.03	25	For organizations that elect The Joint Commission Behavioral Health Home option: The organization involves the individual served in the development of the individual's plan of care, treatment, or services.
CTS.03.01.03	26	For organizations that provide eating disorders care, treatment, or services: The plan of care, treatment, or services specifies a diagnosis based on the current Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the current edition of the International Classification of Diseases (ICD).
CTS.03.01.03	27	For organizations that provide eating disorders care, treatment, or services: The plan of care, treatment, or services provides for sufficient nutritional rehabilitation to support regular and consistent weight when indicated (including expected rates of controlled weight gain of at least one pound per week), and/or measurable improvement in eating disorders behavior (for example, restricting, binge eating, purging).
CTS.03.01.09	2	The organization gathers and analyzes the data generated through standardized monitoring, and the results are used to inform the goals and objectives of the individual's plan for care, treatment, or services as needed.
CTS.03.01.09	4	For organizations that provide eating disorders care, treatment, or services: The organization assesses outcomes of care, treatment, or services based on data collected at admission. Examples of such data include complete history and physical including height, weight, frequency of binge eating and purging (when applicable), eating disorder diagnosis, body mass index (BMI), heart rate, date of last period, and other appropriate lab tests such as potassium, phosphorus, thyroid, hemoglobin, glucose, as determined by the organization and in accordance with the level of care provided. (See also CTS.02.03.11, EP 1)
CTS.04.01.01	7	For organizations that provide eating disorders care, treatment, or services: If during the course of care, treatment, or services the individual served is transferred to a hospital, the organization provides the hospital with a clinical contact person who can provide information relevant to the individual's eating disorder in support of the individual's care, treatment, or services.

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CTS.04.01.01	9	For organizations that elect The Joint Commission Behavioral Health Home option: The activities detailed in the plan of care, treatment, or services are designed to occur in a time frame that meets the physical health care needs of the individual served.
CTS.04.01.01	19	For organizations that elect The Joint Commission Behavioral Health Home option: If an organization has multiple integrated care teams, each team provides care, treatment, or services for a designated panel of individuals.
CTS.04.01.01	20	For organizations that elect The Joint Commission Behavioral Health Home option: When an individual is referred to an external organization, the integrated care team does the following: - Assists the individual with making the referral appointment, when needed - Assists the individual in getting to the appointment, when needed - Tracks whether the individual kept the appointment - Reviews and tracks the care, treatment, or services provided to the individual
CTS.04.01.01	21	For organizations that provide 24-hour eating disorders care, treatment, or services: A registered nurse is either on duty or available 24 hours a day, 7 days a week.
CTS.04.01.03	25	For organizations that elect The Joint Commission Behavioral Health Home option: The organization identifies the health literacy needs of the individual served. Note: Typically, this is an interactive process. For example, individuals may be asked to demonstrate their understanding of information provided by explaining it in their own words.
CTS.04.01.03	26	For organizations that elect The Joint Commission Behavioral Health Home option: The organization incorporates the health literacy needs of the individual served into the individual's education.
CTS.04.01.03	27	For organizations that elect The Joint Commission Behavioral Health Home option: The organization educates the individual served on self-management support, based on the individual's needs.
CTS.04.01.03	28	For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides education to the individual served on the benefits of integrating behavioral and physical health care including, at a minimum, how improvements in either behavioral or physical health can positively affect the other.
CTS.04.01.07	1	For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides individuals served with the ability to do the following 24 hours a day, 7 days a week: - Contact the behavioral health home to request an appointment - Request prescription renewal - Request clinical advice for urgent health needs Note: This ability may be provided through a number of methods, including telephone, e-mail, flexible hours, websites, and portals.
CTS.04.01.07	2	For organizations that elect The Joint Commission Behavioral Health Home option: The organization offers flexible scheduling to accommodate the individual’s care, treatment, or service needs. Note: This may include open access scheduling, same-day or next available appointments, group visits, expanded hours, and arrangements with other organizations.
CTS.04.01.07	3	For organizations that elect The Joint Commission Behavioral Health Home option: The organization has a process to respond to an individual’s urgent care needs 24 hours a day, 7 days a week.
CTS.04.01.07	4	For organizations that elect The Joint Commission Behavioral Health Home option: The organization facilitates individuals’ online access to their health information within four business days after the information is available to the integrated care team. This information includes diagnostic test results, lab results, summary lists, and medication lists.
CTS.04.01.07	5	For organizations that elect The Joint Commission Behavioral Health Home option: The organization uses a certified electronic health record to provide appointment reminders to individuals.
CTS.04.01.07	6	For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides individuals with contact information for the team coordinator on their integrated care team.
CTS.04.02.16	1	For organizations that provide eating disorders care, treatment, or services: Each individual served receives core care, treatment, or service components (psychosocial, medical, nutritional, and psychiatric) according to his or her assessed needs. This includes, but is not limited to, individual therapy, group therapy, family therapy (as applicable), medical monitoring, medication monitoring (as applicable), and nutritional counseling.

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CTS.04.02.16	2	For organizations that provide eating disorders care, treatment, or services: The organization is knowledgeable about evidence-based guidelines for treatment of individuals with eating disorders, such as the American Psychiatric Association Eating Disorder Treatment Guidelines, the Guidelines of the British National Institute for Clinical Excellence (NICE Guidelines), or the American Academy of Child and Adolescent Psychiatry Practice Parameter for the Assessment and Treatment of Children and Adolescents With Eating Disorders.
CTS.04.02.16	3	For organizations that provide eating disorders care, treatment, or services: A registered dietitian is available to provide for individuals' nutritional needs, including assessing, educating, and counseling individuals, parents and/or guardians, and staff on food- and nutrition-related issues.
CTS.04.02.16	4	For organizations that provide eating disorders care, treatment, or services: A registered dietitian designs, implements, and manages safe and effective nutrition-related strategies that enhance growth and development; support recovery from disordered eating; and promote lifelong health.
CTS.04.02.16	5	For organizations that provide eating disorders care, treatment, or services: The organization attempts to engage family members who have not acknowledged the organization's efforts to involve them in the individual's care, treatment, or services, in accordance with the needs and preferences of the individual served. (See also CTS.03.01.05, EP 1)
CTS.04.02.17	1	For organizations providing care, treatment, or services to individuals with eating disorders: The organization monitors the individual's weight in accordance with organizational policy.
CTS.04.02.17	2	For organizations providing care, treatment, or services to individuals with eating disorders: The organization monitors the individual's food-related behaviors.
CTS.04.02.18	1	For organizations that provide 24-hour eating disorders care, treatment, or services: The organization supervises the daily activities of individuals served as needed to prevent them from engaging in behavior that could be detrimental to their health, such as excessive or inappropriate exercise, inappropriate use of laxatives, or self-induced vomiting.
CTS.04.02.18	2	For organizations that provide 24-hour eating disorders care, treatment, or services: Supervision is conducted by staff; the organization prohibits one individual served from supervising another.
CTS.04.02.23	1	For organizations that elect The Joint Commission Behavioral Health Home option: The organization makes available to the integrated care team all information needed to facilitate the delivery of integrated physical and behavioral health care, treatment, or services.
CTS.04.02.23	2	For organizations that elect The Joint Commission Behavioral Health Home option: The behavioral health home staff have access to a primary physical health care clinician for consultation purposes at all times.
CTS.04.02.23	3	For organizations that elect The Joint Commission Behavioral Health Home option: The behavioral health home staff have access to a behavioral health care clinician for consultation purposes at all times.
CTS.04.02.25	1	For organizations that elect The Joint Commission Behavioral Health Home option: The organization manages transitions in care and facilitates the individual's access to integrated care, treatment, or services including the following: - Acute care - Management of chronic care - Preventive services that are age- and gender-specific - Behavioral health care needs - Oral health care - Vision care - Urgent and emergent care Note: Some of these services may be obtained through the use of community resources as available, or in collaboration with other organizations.
CTS.04.02.25	2	For organizations that elect The Joint Commission Behavioral Health Home option: The integrated care, treatment, or services address various phases of the lifespan of the individuals it serves, including end-of-life care when relevant to the population(s) served. (See also RI.01.05.01, EP 10)
CTS.04.02.25	3	For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides disease and chronic care management services to the individuals it serves, as needed or as clinically indicated.

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CTS.04.02.25	4	For organizations that elect The Joint Commission Behavioral Health Home option: The organization communicates its role in supporting individuals who require specialty physical health assessment, care, treatment, or services to the individual and, as appropriate, the individual's family, with the permission of the individual and in accordance with law and regulation.
CTS.04.02.25	5	For organizations that elect The Joint Commission Behavioral Health Home option: The organization makes certain that the specialty physical health care, treatment, or services provider receives all the information about the individual’s behavioral and physical health that is needed to facilitate the specialty physical health assessment(s) and care, treatment, or services, with the permission of the individual and in accordance with law and regulation.
CTS.04.02.27	1	For organizations that elect The Joint Commission Behavioral Health Home option: The organization identifies the composition of the integrated care team.
CTS.04.02.27	2	For organizations that elect The Joint Commission Behavioral Health Home option: The members of the integrated care team provide comprehensive and coordinated care, treatment, or services and maintain the continuity of care, treatment, or services. Note: The provision of care, treatment, or services may include making internal and external referrals.
CTS.04.02.27	3	For organizations that elect The Joint Commission Behavioral Health Home option: The organization designates one member of the integrated care team to serve as team coordinator. This team member is accountable for coordinating the provision and continuity of the integrated care, treatment, or services and facilitating the individual's access to all needed care, treatment, or services, whether behavioral or physical. Note 1: Coordination of integrated care, treatment, or services may include coordinating internal and external referrals and coordinating the development and evaluation of plans of care, treatment, or services. Note 2: Portions of these activities may be delegated to other staff members by the team coordinator, with accountability remaining with the team coordinator.
CTS.04.02.27	4	For organizations that elect The Joint Commission Behavioral Health Home option: The integrated care team participates in the development of the individual’s plan of care, treatment, or services.
CTS.04.02.27	5	For organizations that elect The Joint Commission Behavioral Health Home option: The integrated care team assesses individuals for health risk behaviors.
CTS.04.02.29	1	For organizations that provide eating disorders care, treatment, or services: The organization has a multidisciplinary care, treatment, or services team that consists of at least the following: - A licensed clinician with experience and/or training in treating eating disorders - A doctor of medicine or osteopathy with experience and/or training in treating eating disorders, either on staff or available to the team during regular hours of operation. If individuals served are under the age of 13, the MD or DO is a pediatrician. If the MD or DO is not on staff, an advanced practice nurse with experience and/or training in treating eating disorders and licensed to prescribe medications is on staff. - A psychiatrist or clinical psychologist with experience and/or training in treating eating disorders, either on staff or available to the team 24 hours a day, 7 days a week - A registered dietitian - A registered nurse, unless there is an advanced practice nurse on staff Note: The MD or DO who is part of the team does not need to be employed by the organization or on the organization’s staff, but the organization does need to have an established relationship with an MD or DO who has experience or training in treating eating disorders to whom the organization can refer individuals when needed. The MD or DO could be the individual’s primary care physician, if the MD or DO has experience or training in treating eating disorders.
CTS.04.02.29	2	For organizations that provide eating disorders care, treatment, or services: If individuals served are less than 18 years of age, the organization has access to consultation from a child or adolescent psychiatrist. Note: The psychiatrist may be either on staff or otherwise available to the multidisciplinary team, such as via a teleconference link.
CTS.04.03.21	1	For organizations that use animal-assisted therapy: Each individual is assessed to determine whether they are a candidate for animal-assisted therapy and whether the individual has any contraindications to animal-assisted therapy.
CTS.04.03.21	2	For organizations that use animal-assisted therapy: The organization follows its procedures for maintaining the safety of the individuals served.

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CTS.04.03.21	3	For organizations that use animal-assisted therapy: Training of the staff includes the following: - Safe handling of animals - Therapeutic goals of the animal-assisted therapy - Safety of individuals served - Supervision of the individuals served during animal-assisted therapy (Refer to Standard HRM.01.05.01 for more information on staff training.)
CTS.04.03.21	4	For organizations that use animal-assisted therapy: The organization establishes guidelines for selecting animals that include the following: - Population(s) of individuals served - Health of animals - Vaccination status - Temperament of the animals
CTS.06.01.05	1	For organizations that elect The Joint Commission Behavioral Health Home option: The individual served and, as appropriate, their family are partners with the integrated care team in care, treatment, or service planning.
CTS.06.01.05	2	For organizations that elect The Joint Commission Behavioral Health Home option: With the assistance of the integrated care team, the individual served and, as appropriate, the individual's family identify needs, preferences, and goals for the following: - Housing - Employment - Education - Transportation - Crisis support - Integrated health services - Illness self-management (for example, symptom management, medication management), including what to do in case of a health crisis or urgent health problem - Habilitation and rehabilitation services - Financial services and benefits - Assistance with housekeeping - Assistance with personal hygiene - Assistance with the retention and improvement of other skills related to activities of daily living - Social support and adaptive skills - Support of spirituality - Schools - Leisure and recreational activities - Parental support for children and youth - Interaction with the criminal or juvenile justice system, if applicable
CTS.06.01.05	3	For organizations that elect The Joint Commission Behavioral Health Home option: The integrated care team assists the individual served in identifying, using, and accessing family, neighborhood, and community supports and services.
CTS.06.01.05	4	For organizations that elect The Joint Commission Behavioral Health Home option: The integrated care team supports informed choice by individuals served.
CTS.06.01.05	5	For organizations that elect The Joint Commission Behavioral Health Home option: The integrated care team assists the individual served in achieving the individual's personal goals of independent living.
CTS.06.01.05	6	For organizations that elect The Joint Commission Behavioral Health Home option: The individual served and the integrated care team evaluate all services provided directly or through referral to the individual served on a periodic basis, as defined by the organization.
CTS.06.01.07	1	For organizations that elect The Joint Commission Behavioral Health Home option: Needs, preferences, and goals of the individual served guide the following: - The type of training and support provided - The intensity of training and support provided - The duration of training and support provided

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CTS.06.01.07	2	For organizations that elect The Joint Commission Behavioral Health Home option: Needs, preferences, and goals of the individual served and the organization's scope of services guide the provision of training and support opportunities regarding the following: - Personal grooming and hygiene - Housekeeping - Shopping for necessities - Meal preparation and healthy eating - Money management - Accessing public transportation - Use of community resources - Communication skills - Social skills - Leisure and recreational activities for children, youth, and adults - Volunteer activity - Illness self-management (for example, symptom management, medication management), including what to do in case of a health crisis or urgent health problem
CTS.06.02.03	10	For organizations that provide eating disorders care, treatment, or services: The discharge plan includes the following: - Level of care recommended, based on current assessment - Specific recommendations for follow-up treatment - Medication education, as needed - Contact information for follow-up appointments
CTS.06.02.05	3	For organizations that provide eating disorders care, treatment, or services: Upon written consent of the individual served, after-care providers will be given a copy of the discharge summary prior to discharge whenever possible but no later than within two weeks of discharge.
EC.02.04.03	3	The organization has a process for inspecting, testing as needed, and maintaining all medical equipment that it owns and operates, which is based on manufacturers' recommendations, risk levels, or current organization experience. These activities are documented. Note: This process does not encompass medical equipment owned by individuals served or other organizations.
EC.02.05.03	14	For organizations that operate a pharmacy: The organization implements a policy to provide emergency backup for essential medication dispensing equipment identified by the organization, such as automatic dispensing cabinets, medication carousels, and central medication robots. Note: Examples of emergency backup can include emergency power, battery-based indoor generators, or other actions describing how dispensing and administration of medications will continue when emergency backup is needed.
EC.02.05.03	15	The organization implements a policy to provide emergency backup for essential refrigeration for medications identified by the organization, such as designated refrigerators and freezers. Note: Examples of emergency backup can include emergency power, battery-based indoor generators, or other actions describing how refrigeration of medications will continue when emergency backup is needed.
HRM.01.03.01	16	For organizations that elect The Joint Commission Behavioral Health Home option: The organization orients staff on the following: - Behavioral health conditions most commonly found in the population(s) served - Chronic physical health conditions most commonly found in the population(s) served
HRM.01.03.01	17	For organizations that elect The Joint Commission Behavioral Health Home option: If the organization sponsors or offers peer support services, it orients staff providing peer support services to their roles and responsibilities as members of the integrated care team (for example, participating in activities that promote healthy choices and lifestyles).
HRM.01.05.01	10	For organizations that elect The Joint Commission Behavioral Health Home option: Staff providing direct care, treatment, or services participate in additional education and training that is specific to the following: - Behavioral health conditions most commonly found in the population(s) served - Chronic physical health conditions most commonly found in the population(s) served - Care, treatment, or services that are centered on the individual served - Strategies for engaging individuals served in participating in their care, treatment, or services - How equipment or technology related to the provision of primary physical health care is used

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IC.02.04.01	1	The organization establishes an annual influenza vaccination program that facilitates staff receiving the influenza vaccination.
IC.02.04.01	2	The organization educates staff about, at a minimum, the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza.
IC.02.04.01	3	The organization either offers the influenza vaccination to staff on site or facilitates staff obtaining influenza vaccination off site.
IC.02.04.01	4	The organization includes in its infection control plan the goal of improving influenza vaccination rates. (For more information, refer to Standard IC.01.04.01.)
IC.02.04.01	6	The organization has a written description of the methodology used to determine influenza vaccination rates. Note: The Centers for Disease Control and Prevention's National Healthcare Safety Network provides influenza vaccination reporting and protocol guidance at https://www.cdc.gov/nhsn/faqs/vaccination/faq-influenza-vaccination-summary-reporting.html and https://www.cdc.gov/nhsn/pdfs/hps-manual/vaccination/hps-flu-vaccine-protocol.pdf.
IC.02.04.01	7	The organization collects and reviews the reasons given by staff for declining the influenza vaccination. This collection and review occur at least annually.
IC.02.04.01	8	The organization improves its vaccination rates according to its established goals at least annually. (For more information, refer to Standards PI.02.01.01 and PI.03.01.01.) Note: Organizations with a small number of staff (10 or less) providing care, treatment, or services may present the data in a manner other than a percentage (for example, raw numbers).
IC.02.04.01	9	The organization provides influenza vaccination rate data to organization leaders at least annually.
IM.01.01.01	6	For organizations that elect The Joint Commission Behavioral Health Home option: The organization uses health information technology to do the following: - Support the continuity of care and the provision of integrated care, treatment, or services - Document and track care, treatment, or services - Support disease management, including educating the individual about disease management - Support preventive care, treatment, or services - Create reports for internal use and external reporting - Facilitate electronic exchange of information among providers - Support performance improvement
LD.03.07.01	21	For organizations that elect The Joint Commission Behavioral Health Home option: Leaders set priorities for physical health care performance improvement activities and outcomes. Note: As an example, activities and outcomes may be related to individuals with multiple chronic physical health conditions. (See also PI.01.01.01, EP 28)
LD.03.07.01	22	For organizations that elect The Joint Commission Behavioral Health Home option: Leaders involve individuals served in performance improvement activities related to integrated care. Note: This involvement may include activities such as participating on a quality committee or providing feedback on safety and quality issues.
LD.03.10.01	1	For organizations that elect The Joint Commission Behavioral Health Home option: The organization identifies clinical practice guidelines and/or evidence-based practices to evaluate and treat specific diagnoses, conditions, or symptoms for both physical and behavioral health care that are relevant to the population(s) served by the behavioral health home.
LD.03.10.01	2	For organizations that elect The Joint Commission Behavioral Health Home option: The organization uses clinical practice guidelines and/or evidence-based practices to evaluate and treat specific diagnoses, conditions, or symptoms for both physical and behavioral health care.
LD.03.10.01	3	For organizations that elect The Joint Commission Behavioral Health Home option: Leaders do the following related to the use of clinical practice guidelines and/or evidence-based practices: - Review and approve the clinical practice guidelines and/or evidence-based practices that have been selected - Manage and evaluate the implementation of the guidelines - Monitor and review clinical practice guidelines for their effectiveness and modify them as needed

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LD.04.02.03	8	For organizations that provide eating disorders care, treatment, or services: The organization's program materials indicate the following: - The program's setting(s), scope of services, and population(s) served - Availability of and/or the process for transfer to other settings of care, if necessary, such as acute hospital, psychiatric facility, or other setting - Pertinent information regarding availability of care, treatment, or services based on particular population characteristics (for example, only one half of available beds are open to adolescents; only females are served by the program; individuals must treat chemical dependency issues prior to entering program) - Description of the members of the multidisciplinary team providing care, treatment, or services
LD.04.02.03	9	For organizations that provide eating disorders care, treatment, or services: The organization is able to provide individuals served and their families, if applicable, with information on insurance coverage accepted by the organization, the availability of any financial assistance, and whether or not the facility is considered in-network for the individual's insurance company.
LS.02.01.30	5	Where residential or commercial cooking equipment is used to prepare meals for less than 31 people in a smoke compartment, one cooking facility is allowed to be open to the corridor provided all of the requirements at NFPA 101-2012: 18/19.3.2.5 are met.
LS.04.01.30	2	In existing buildings, vertical openings other than stairs are protected by fire-rated construction of 1/2 hour and limit the transfer of smoke. (For full text, refer to NFPA 101-2012: 33.2.3.1) Note: For stair enclosure requirements, see LS.04.01.20, EP 6.
LS.05.01.10	1	When building rehabilitation occurs, the organization incorporates NFPA 101-2012: Chapters 38, 39, and 43. (For full text, refer to NFPA 101-2012: 38/39.1.1.3; 4.6.7)
LS.05.01.10	2	Business occupancies are separated from parking structures by a 2-hour or greater fire barrier. (For full text, refer to NFPA 101-2012: 38/39.1.3.2.1)
LS.05.01.10	3	The fire protection rating for opening protectives in fire barriers, fire-rated smoke barriers, and fire-rated smoke partitions is as follows: - Three hours in 3-hour barriers and partitions - Ninety minutes in 2-hour barriers and partitions - Forty-five minutes in 1-hour barriers and partitions - Twenty minutes in ½-hour barriers and partitions Labels on fire door assemblies must be maintained in legible condition. (For full text, refer to NFPA 101-2012: 8.3.4.2; Table 8.3.4.2; 8.3.3.2.3; NFPA 80-2010: 5.2.13.3)
LS.05.01.10	4	Vertical openings must be protected in the following manner: - Enclosures serving four or more floors in new construction must have a 2-hour fire rating. - Enclosures serving three or less floors in new construction must have a 1-hour fire rating. - Enclosures in existing construction must have a ½-hour fire rating. - A vertical opening below the street level that contains storage or communicates with a different occupancy must be protected. (For full text, refer to NFPA 101-2012: 38/39.3)
LS.05.01.10	5	The space around pipes, conduits, bus ducts, cables, wire, air ducts, or pneumatic tubes penetrating the walls or floors are protected with an approved fire-rated material. Note: Non-approved polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text, refer to NFPA 101-2012: 8.3.5)
LS.05.01.10	6	Doors requiring a fire rating of 3/4 of an hour or longer are free of coverings, decorations, or other objects applied to the door face, with the exception of informational signs, which are applied with adhesive only. (For full text, refer to NFPA 80-2010: 4.1.4)
LS.05.01.10	7	The organization meets all other Life Safety Code requirements related to NFPA 101-2012: 38/39.1.
LS.05.01.20	1	Interior open stairways and ramps are permitted to serve as part of the egress system if not more than one level below the street floor. (For full text, refer to NFPA 101-2012 38/39.2.1.3.2)
LS.05.01.20	2	In occupancies that serve 50 or more persons, the corridors or passageways must be a minimum of 44 inches of clear width. (For full text, refer to NFPA 101-2012: 38/39.2.3.2)

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LS.05.01.20	3	Dead-end corridors cannot exceed 50 feet in existing facilities. In new facilities, dead-end corridors cannot exceed 50 feet unless fully sprinklered or cannot exceed 20 feet if they are not fully sprinklered. (For full text, refer to NFPA 101-2012: 38/39.2.5)
LS.05.01.20	4	Travel distance to an exit must not exceed 200 feet unless the facility is fully sprinklered, in which case the distance may be increased to 300 feet. (For full text, refer to NFPA 101-2012: 38/39.2.6)
LS.05.01.20	5	Means of egress must be continuously illuminated while occupied. (For full text, refer to NFPA 101-2012: 38/39.2.8)
LS.05.01.20	6	Emergency lighting for existing construction must be provided if the building is three or more stories in height, if the building has 100 occupants or more in the stories above or below the level of exit discharge, or the building has 1000 or more total occupants. (For full text, refer to NFPA 101-2012: 39.2.9)
LS.05.01.20	7	Emergency lighting for new construction must be provided if the building is three or more stories in height, if the occupancy has 50 occupants or more in the stories above or below the level of exit discharge, or the building has 300 or more total occupants. (For full text, refer to NFPA 101-2012: 38.2.9)
LS.05.01.20	8	Doors in a means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side unless a compliant locking configuration is used, such as a delayed-egress locking system or an access-controlled egress door assembly. (For full text, refer to NFPA 101-2012: 7.2.1.6.1, 7.2.1.6.2)
LS.05.01.20	9	The organization meets all other Life Safety Code means of egress requirements related to NFPA 101-2012: 38/39.2.
LS.05.01.30	1	Hazardous areas are protected from other areas by a 1-hour fire resistance–rated barrier (45-minute opening protectives) or a smoke resistive barrier and automatic sprinklers. Doors must be self-closing or automatic closing with latching hardware. (For full text, refer to NFPA 101-2012: 38/39. 3.2)
LS.05.01.30	2	Interior wall and ceiling finishes must be Class A or B for exits and exit access corridors. All other areas should be Class A, B, or C. (For full text, refer to NFPA 101-2012: 38/39.3.3)
LS.05.01.30	3	Alcohol-based hand rubs (ABHR) are stored and handled in accordance with NFPA 101-2012: 8.7.3.1 and as follows: - Corridor clear width of 44 inches is not compromised by dispenser. - ABHR does not exceed 95% alcohol. - Maximum individual dispenser capacity is 0.32 gallons of fluid (0.53 gallons in suites or rooms separated from corridors) or 18 ounces of NFPA Level 1–classified aerosols. - Dispensers have a minimum of 4 feet of horizontal spacing between them. - Dispensers are not installed within 1 inch of an ignition source. - If floor is carpeted, the building is fully sprinkler protected. - Operation of the dispensers must comply with the manufacturers' instructions for use. - ABHR is protected against inappropriate access. - Not more than an aggregate of 10 gallons of fluid or 1135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. - Storing more than 5 gallons of fluid in a single smoke compartment complies with NFPA 30.
LS.05.01.30	4	The organization meets all other Life Safety Code fire and smoke protection requirements related to NFPA 101-2012: 38/39.3.
LS.05.01.34	1	Fire alarm systems for existing construction are required if the building is three or more stories in height, there are 100 occupants or more below or above the level of exit discharge, or the building has 1000 or more occupants. The fire alarm system is initiated by manual means, a fire/smoke detection system, or a fire suppression system. The occupant notification system must activate a general alarm; however, in existing occupancies, notification can be made using voice communication or a public address system. A fail-safe process must be provided to notify emergency forces. (For full text, refer to NFPA 101-2012: 39.3.4)
LS.05.01.34	2	Fire alarm systems for new construction are required if the building is three or more stories in height, there are 50 occupants or more below or above the level of exit discharge, or the building has 300 or more occupants. The fire alarm system is initiated by manual means, a fire/smoke detection system, or a fire suppression system. The occupant notification system must activate a general alarm; however, in existing occupancies, notification can be made using voice communication or a public address system. A fail-safe process must be provided to notify emergency forces. (For full text, refer to 2012 NFPA 101-2012: 38.3.4)

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LS.05.01.34	3	The organization meets all other Life Safety Code fire alarm requirements related to NFPA 101-2012: 38/39.4.
LS.05.01.35	1	For new construction, a process for emergency response notification is provided and includes notifying both of the following: - Fire department in accordance with NFPA 101-2012: 9.6.4 - Local emergency organization, if provided (For full text, refer to NFPA 101-2012: 38.3.4.4)
LS.05.01.35	2	For existing construction, notification of emergency forces is accomplished in accordance with NFPA 101-2012: 9.6.4 when the existing fire alarm system is replaced. (For full text, refer to NFPA 101-2012: 39.3.4.4)
LS.05.01.35	3	The travel distance from any point to the nearest portable fire extinguisher is 75 feet or less. Portable fire extinguishers have appropriate signage, are installed in a cabinet or secured on a hanger made for the extinguisher, and are at least 4 inches off the floor. Those fire extinguishers that are 40 pounds or less are installed so the top is not more than 5 feet above the floor. (For full text, refer to NFPA 101-2012: 38/39.3.5; 9.7.4.1)
LS.05.01.35	4	Sprinklers are not damaged. They are also free from corrosion, foreign materials, and paint and have necessary escutcheon plates installed.
LS.05.01.35	5	There are 18 inches or more of open space maintained below the sprinkler to the top of storage. Note: Perimeter wall and stack shelving may extend up to the ceiling when not located directly below a sprinkler head.
LS.05.01.35	6	The organization meets all other Life Safety Code extinguishing requirements related to NFPA 101-2012: 38/39.3.5.
MM.01.01.03	1	The organization identifies, in writing, its high-alert and hazardous medications. * Note: This element of performance is also applicable to sample medications. Footnote *: For a list of high-alert medications, see https://www.ismp.org/recommendations. For a list of hazardous drugs, see https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf.
MM.01.01.03	2	The organization follows a process for managing high-alert and hazardous medications. Note: This element of performance is also applicable to sample medications. (See also EC.02.02.01, EP 2)
MM.03.01.01	4	For organizations that store medications: The organization follows a written policy addressing the control of medication between receipt by staff and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage. Note: This element of performance is also applicable to sample medications.
MM.04.01.01	1	For organizations that prescribe medications: The organization follows a written policy that identifies the specific types of medication orders that it deems acceptable for use. Note: There are several different types of medication orders. Medication orders commonly used include the following: - As needed (PRN) orders: Orders acted on based on the occurrence of a specific indication or symptom - Standing orders: A prewritten medication order and specific instructions from the prescriber to administer a medication to an individual in clearly defined circumstances as specified in the instructions - Automatic stop orders: Orders that include a date or time to discontinue a medication - Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval - Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or status of the individual served - Signed and held orders: New prewritten (held) medication orders and specific instructions from a licensed independent practitioner to administer medication(s) to an individual served or patient in clearly defined circumstances that become active upon the release of the orders on a specific date(s) and time(s) - Orders for medication-related devices (for example, inhalers, nebulizers, glucometers) - Orders for investigational medications - Orders for herbal products - Orders for medications at discharge or transfer
MM.08.01.01	16	When automatic dispensing cabinets (ADCs) are used, the organization has a policy that describes the types of medication overrides that will be reviewed for appropriateness and the frequency of the reviews. A 100% review of overrides is not required.

Standard Label	EP	Elements of Performance Description
PI.01.01.01	28	For organizations that elect The Joint Commission Behavioral Health Home option: The organization collects data on the following: Disease management outcomes. (See alsoLD.03.07.01, EP 21)
PI.01.01.01	29	For organizations that elect The Joint Commission Behavioral Health Home option: The organization collects data on the following: The individual's access to care within time frames established by the organization.
PI.01.01.01	30	For organizations that elect The Joint Commission Behavioral Health Home option: The organization collects data on the following: - The individual's experience and satisfaction related to access to care, treatment, or services and communication - The individual's perception of the comprehensiveness of care, treatment, or services - The individual's perception of the coordination of care, treatment, or services - The individual's perception of the continuity of care, treatment, or services
PI.01.01.01	31	For organizations that elect The Joint Commission Behavioral Health Home option: All staff who are part of the behavioral health home actively participate in performance improvement activities.
PI.01.01.01	36	For organizations that provide eating disorders care, treatment, or services: The organization collects data about care, treatment, or services outcomes. Examples of such data include the following: - If conducting follow-ups, confirmation of whether the individual is engaged in aftercare services and, if so, the type and frequency of those services. - Data collected from valid and reliable instruments used at admission and discharge that are self-administered by individuals served. Examples of such instruments include the Beck Depression Inventory (BDI), Eating Disorder Quality of Life (EDQOL), the SF-36, and Eating Disorder Inventory-3 (EDI-3). - Data collected from individuals' satisfaction questionnaires.
PI.02.01.01	1	Performance improvement priorities established by organization leaders are described in a written plan that includes the following: - The defined process(es) needing improvement, along with any stakeholder (for example, patient, staff, regulatory) requirements, project goals, and improvement activities - Method(s) for measuring performance of the process(es) identified for improvement - Analysis method(s) for identifying causes of variation and poor performance in the process(es) - Methods implemented to address process deficiencies and improve performance - Methods for monitoring and sustaining the improved process(es) (See also LD.03.07.01, EP 2)
PI.02.01.01	2	Leadership reviews the plan for addressing performance improvement priorities at least annually and updates it to reflect any changes in strategic priorities and in response to changes in the internal or external environment.
PI.03.01.01	9	For organizations that elect The Joint Commission Behavioral Health Home option: The organization uses patient registries, health information technology (HIT), and/or electronic health records (EHRs) to collect, analyze, and compare data in order to improve the outcomes of the individuals served.
PI.04.01.01	3	The organization uses improvement tools or methodologies to improve its performance.
PI.04.01.01	11	For organizations that elect The Joint Commission Behavioral Health Home option: The organization uses the data it collects on the individual's perception of the safety and quality of care, treatment, or services to improve its performance. This data includes the following: - The individual's experience and satisfaction related to access to care, treatment, or services and communication - The individual's perception of the comprehensiveness of care, treatment, or services - The individual's perception of the coordination of care, treatment, or services - The individual's perception of the continuity of care, treatment, or services

Standard Label	EP	Elements of Performance Description
RC.02.01.01	2	The clinical/case record of the individual served contains the following information: - The reason(s) for admission or initiation of care, treatment, or services - The initial diagnosis, diagnostic impression(s), condition(s), or circumstances requiring care or services - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the medical history and physical examination - Any diagnoses or conditions established during the course of care, treatment, or services - Any consultation reports - Any observations relevant to care, treatment, or services - The response to care, treatment, or services - Any emergency care, treatment, or services provided prior to arrival - Any progress notes - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration - Any access site for medication, administration devices used, and rate of administration (for intravenous therapy) - Any adverse drug reactions - Care, treatment, or service goals - Plan of care and revisions to the plan of care, treatment, or services - Orders for diagnostic and therapeutic tests and procedures and their results
RC.02.01.01	25	For organizations that elect The Joint Commission Behavioral Health Home option: The clinical/case record of the individual served contains the following information: - All behavioral and physical health diagnoses and conditions that have required care, treatment, or services - All hospital admissions - All hospital readmissions - All urgent care and emergency department visits
RC.02.01.01	26	For organizations that elect The Joint Commission Behavioral Health Home option: For the purpose of identifying disparities in care, treatment, or services, the clinical/case record contains the individual’s race and ethnicity.
RC.02.01.01	27	For organizations that elect The Joint Commission Behavioral Health Home option: The clinical/case record includes the individual’s self-management goals related to integrated care and the individual’s progress toward achieving those goals.
RI.01.01.01	30	For organizations that provide 24-hour eating disorders care, treatment, or services: The organization has a policy addressing those situations, if any, in which minors are permitted to leave the facility.
RI.01.01.01	31	For organizations that provide 24-hour eating disorders care, treatment, or services: The organization obtains consent from a minor’s parent or guardian for the minor to have visitors.
RI.01.01.01	32	For organizations that provide 24-hour eating disorders care, treatment, or services: The organization has a policy on Internet access for individuals served.
RI.01.02.01	31	For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides the individual served or surrogate decision-maker with the information about the outcomes of care, treatment, or services that the individual needs in order to participate in current and future physical health care decisions.
RI.01.02.01	32	For organizations that elect The Joint Commission Behavioral Health Home option: The organization respects the individual’s right to make decisions about the management of the individual's care, treatment, or services.
RI.01.02.01	33	For organizations that elect The Joint Commission Behavioral Health Home option: The organization respects the individual’s right and provides the individual with the opportunity to do the following: - Obtain care from other clinicians of the individual’s choosing within the behavioral health home - Seek a second opinion from a clinician of the individual’s choosing - Seek specialty care Note: This element of performance does not imply financial responsibility on the part of the organization for any activities associated with these rights.

Standard Label	EP	Elements of Performance Description
RI.01.04.01	6	For organizations that elect The Joint Commission Behavioral Health Home option: The organization informs the individual served of the scope of the license, certification, or registration of each behavioral health home staff member who possesses such a credential.
RI.01.04.03	1	For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides information to the individual served about the mission, vision, and goals of the behavioral health home. (Refer to LD.02.01.01, EP 3) Note: This may include how it provides for integrated care that is centered on the individual served, a systems-based approach to quality and safety, and enhanced access for individuals served.
RI.01.04.03	2	For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides information to the individual served about the scope of care, treatment, or services and types of services provided by the behavioral health home.
RI.01.04.03	3	For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides information to the individual served about how the behavioral health home functions, including the following: - The process for assigning or selecting clinicians - Involving the individual in their plan of care, treatment, or services - Obtaining and tracking referrals - Coordinating the individual's integrated care - Collaborating with clinicians who provide specialty care or second opinions
RI.01.04.03	4	For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides information to the individual served about how to access the behavioral health home for care or information both during and after regular hours of operation.
RI.01.04.03	5	For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides information to the individual served and, when needed, the individual's family or surrogate decision-maker about the individual's responsibilities, including providing their health history and current medications, and participating in self-management activities. (Refer to RI.01.01.03, EPs 1–3 and RI.02.01.01, EP 2) Note: Individuals' responsibilities will vary depending on their abilities and unique circumstances. In some cases, family members or surrogate decision-makers may be able to help individuals meet their responsibilities.
RI.01.04.03	6	For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides information to the individual served about the individual's right to obtain care from other clinicians within the behavioral health home, to seek a second opinion, and to seek specialty care. (Refer to RI.01.02.01, EPs 9 and 32)
RI.01.05.01	1	For organizations that elect The Joint Commission Behavioral Health Home option: The organization follows a written policy on physical health advance directives that address the following: - Whether the organization will honor physical health advance directives - Communicating its policy on physical health advance directives to the individuals it serves - For organizations that elect The Joint Commission Behavioral Health Home option: Informing all members of the integrated care team when an individual served has a physical health advance directive, and how to access it
RI.01.05.01	10	For organizations that elect The Joint Commission Behavioral Health Home option: Upon request, the organization shares with the individual possible sources of help in formulating physical health advance directives. (See also CTS.04.02.25, EP 2)