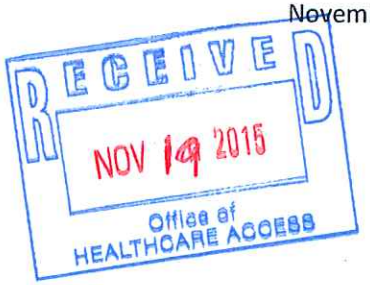
CENTER FOR DISCOVERY™
Transforming Lives

November 13, 2015



Steven W. Lazarus
Associate Health Care Analyst
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Dear Steve,

I am pleased to submit Discovery Practice Management's application for a Certificate of Need for our second Mental Health Residential Living Center to provide residential treatment for women with eating disorders at 1320 Mill Hill Road, Southport, CT 06890. The house will provide therapeutic support 24 hours a day, 7 days a week, to no more than 6 individuals at one time. Discovery Practice Management, aka Center for Discovery, is one of the nation's leading providers in residential treatment for eating disorders.

Enclosed you will find our application for a Certificate of Need. I have also included the edits, questions, and additional information provided in response to our first CON, in order to help expedite the process. This application is to provide the exact same services as with our first CON, just at a new location. Our existing facility in Fairfield is running at capacity and we have a waitlist that is several months long. Our hope is that we can open this second facility and help alleviate the wait time of the clients who desperately need help.

Please feel free to contact me at any time for responses to questions or concerns with the application. Thank you for your help and we look forward to working with your department again.

Best regards,

Tim Davis, CFA
Director of Business Development
Center for Discovery
4281 Katella Avenue, Suite 111
Los Alamitos, CA 90720
714-947-7357 (OFFICE)
806-438-3505 (CELL)
714-828-1868 (FAX)
tim.davis@centerfordiscovery.com
www.centerfordiscovery.com

AFFIDAVIT

Applicant: __Discovery Practice Management, Inc. dba "Center for Discovery Eating Disorder Program, Southport_____

Project Title: ____Center for Discovery Eating Disorder Program, Southport
_____

I, _Dr. Craig M. Brown_____, ____CEO_____
(Individual's Name) (Position Title – CEO or CFO)

of Discovery Practice Management, Inc. being duly sworn, depose and state that
(Hospital or Facility Name)

Discovery Practice Management, Inc's information submitted in this Certificate of
(Hospital or Facility Name)

Need Application is accurate and correct to the best of my knowledge.

_____ 11-13-2015
Signature Date

Subscribed and sworn to before me on Paola Grijalva Dominguez

November 13, 2015
_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

PAOLA GRIJALVA DOMINGUEZ
Commission # 2097330
Notary Public - California
Orange County
My Comm. Expires Jan 16, 2019

Application Checklist

Instructions:

1. **Please check each box below, as appropriate; and**
2. **The completed checklist *must* be submitted as the first page of the CON application.**

☒ **Attached is the CON application filing fee in the form of a certified, cashier or business check made out to the "Treasurer State of Connecticut" in the amount of $500.**

For OHCA Use Only:

Docket No.: 15-32042 CON **Check No.:** 36633
OHCA Verified by: SO **Date:** 11/19/15

☒ **Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication)***

☒ **Attached is a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.**

☒ **Attached are completed Financial Attachments I and II.**

☒ **Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders.**

Note: **A CON application may be filed with OHCA electronically through email, if the total number of pages submitted is 50 pages or less. In this case, the CON Application must be emailed to ohca@ct.gov.**

Important: **For CON applications(less than 50 pages) filed electronically through email, the singed affidavit and the check in the amount of $500 must be delivered to OHCA in hardcopy.**

☒ **The following have been submitted on a CD**

1. **A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.**
2. **An electronic copy of the documents in MS Word and MS Excel as appropriate.**

Order Confirmation

Ad Order Number	Customer	Payor Customer
0002110567	CTR FOR DISCOVERY	CTR FOR DISCOVERY
Sales Rep. dsettani	**Customer Account** 223721	**Payor Account** 223721
Order Taker dsettani	**Customer Address** 4281 KATELLA AVENUE,SUITE 111 LOS ALAMITOS CA 90720 USA	**Payor Address** 4281 KATELLA AVENUE,SUITE 111 LOS ALAMITOS CA 90720 USA
Ordered By tim davis	**Customer Phone** 714-947-7357 806-438-3505	**Payor Phone** 714-947-7357 806-438-3505
Order Source E-mail		
PO Number	**Customer Fax** 714-828-1868	**Customer EMail** tim.davis@centerfordiscovery.com

Ad Content Proof

Discovery Practice Management is applying for a Certificate of Need pursuant to section 19a-638 of the general statues to provide residential treatment for no more than 6 adult women with eating disorders at one time. Proposed location is 1320 Mill Hill Rd. Southport, CT 06890. No capital expenditures required. The Certificate of Need will be filed with the Connecticut Department of Public Health Division of Office of Health Care Access (OHCA), interested parties should contact OHCA.

Tear Sheets	Proofs	Affidavits	Special Pricing	Promo Type
3	0	0	None	

Order Notes: C/C/CONF#015559- 9/15/15

Invoice Text: APPROVED

Blind Box	Materials	Payment Method
		Credit Card

Net Amount	Tax Amount	Total Amount	Payment Amt	Amount Due
$291.40	$0.00	$291.40	$291.40	$0.00

Ad Number	Ad Type	Ad Size	Pick Up Number
0002110567-01	Legal Liners	1.0 X 17 Li	

External Ad #	Ad Released	Ad Attributes
	No	

Color	Production Method	Production Notes
<NONE>	AdBooker	

Product / Run Dates / Sort Text / Run Schedule Invoice Text	Placement/Class	# Inserts	Cost
Connecticut Post:: 9/22/2015, 9/23/2015, 9/24/2015 DISCOVERYPRACTICEMANAGEMENTISAPPLYINGFORACERTIFICATEOFNEEDPUR: Discovery Practice Management is applying for a Certificate of N	Public Notices	3	$275.40
Connpost.com:: 9/22/2015, 9/23/2015, 9/24/2015 DISCOVERYPRACTICEMANAGEMENTISAPPLYINGFORACERTIFICATEOFNEEDPUR: Discovery Practice Management is applying for a Certificate of N	Public Notices	3	$10.00

CONNECTICUT media GROUP

Payment Receipt

Tuesday, September 15, 2015

Transaction Type:	Payment
Ad Number:	0002110567
Apply to Current Order:	No
Payment Method:	Credit Card
Bad Debt:	-
Credit Card Number:	xxxxxxxxxxx2772 - Visa
Credit Card Expire Date:	March 2018
Payment Amount:	$291.40
Amount Due:	$0.00
Reference Number:	015559
Charge to Company:	Connecticut Post
Category:	Classified
Credit to Transaction Number:	
Invoice Text:	
Invoice Notes:	

Customer Type:	Legal
Customer Category:	7005 Legals
Customer Status:	Active
Customer Group:	Classified
Customer Trade:	
Account Number:	223721
Phone Number:	7149477357
Company / Individual:	Company
Customer Name:	CTR FOR DISCOVERY
Customer Address:	4281 KATELLA AVENUE SUITE 111 LOS ALAMITOS, CA 90720 USA
Check Number:	
Routing Number:	

State of Connecticut
Office of Health Care Access
Certificate of Need Application

Instructions: Please complete all sections of the Certificate of Need ("CON") application. If any section or question is not relevant to your project, a response of "Not Applicable" may be deemed an acceptable answer. If there is more than one applicant, identify the name and all contact information for each applicant. OHCA will assign a Docket Number to the CON application once the application is received by OHCA.

Docket Number:

Applicant: Discovery Practice Management, Inc. dba "Center for Discovery"

Contact Person:	Tim Davis
Contact Person's Title:	Director of Business Development
Contact Person's Address:	4281 Katella Ave. Suite 111, Los Alamitos, CA 90720
Contact Person's Phone Number:	714-947-7357
Contact Person's Fax Number:	714-828-1868
Contact Person's Email Address:	tim.davis@centerfordiscovery.com
Project Town:	Fairfield
Project Name:	Center for Discovery, Southport
Statute Reference:	Section 19a-638, C.G.S.
Estimated Total Capital Expenditure:	$0

1. **Project Description: New Service (Behavioral Health/Substance Abuse)**

   a. Please provide a narrative detailing the proposal.

Center for Discovery proposes the opening of a 6 bed Mental Health Residential Living Center for adult women (ages 18+) who suffer from eating disorders such as anorexia, bulimia and binge-eating disorder. Center for Discovery has a proprietary program operating throughout the country that specializes in the treatment of eating disorders. While at the Center, residents undergo one-on-one therapeutic treatment 3-4 times per week and they participate in over 30 therapeutic groups per week. A physician and psychiatrist check on every client once a week to ensure medical stability is maintained and improving and to make any adjustments to medications that are needed. The Center also provides an intensive dietary program that involves weekly one-on-one meetings with a dietitian, meal prep, food logs, restaurant outings to deal with high anxiety behaviors, etc. Center for Discovery is contracted with private pay insurers nationwide.

Mission Statement

Discovery is the process of uncovering and revealing that which had been previously unknown. We at Discovery choose as our Mission to provide an intensive therapeutic experience aimed at profoundly and creatively facilitating behavioral, emotional, and spiritual growth for individuals and their families. In addition, Discovery combines the finest traditional inpatient approaches with creative, innovative and individualized interventions at a substantially reduced, cost efficient fee, and positions our therapeutic experience at the forefront of eating disorder treatment.

Population to be served

Center for Discovery Residential Eating Disorder Program, Southport will be designed to treat adult women afflicted with eating disorders. Our clients have an eating disorder (anorexia, bulimia, binge-eating) as their primary diagnosis. Often, our clients have secondary or co-occurring diagnosis including depression, anxiety, etc.

Program Description

The eating disorder program is designed to treat female women who suffer from anorexia, bulimia and binge eating disorders. The program is accredited by the Joint Commission. Clients must be medically stable as determined by our medical physician in order to be cleared for admission into the treatment program. While our clients are admitted based on a primary diagnosis of an eating disorder, many of these clients do have various secondary mental health diagnosis. Our therapeutic environment is designed to treat the client as a whole and our therapists are trained to deal with multi-level problems and family systems. However, we do not admit clients with psychotic disorders or a history of aggressive behavior.

The average length of stay is 40 days. A client is deemed appropriate for discharge when the treatment team determines the client able to sustain treatment gains and maintain current stability and recovery with an outpatient team consisting of a physician, psychiatrist, dietitian and psychotherapist.

The program is designed to provide an intermediate level of care between acute inpatient care and outpatient care. The National Task Force on Eating Disorders has identified residential treatment of eating disorders as an effective and necessary level of intervention in the treatment of more severe and treatment resistant disorders. It has been established that eating disorders that remain untreated result in the premature termination of life and are one of the leading causes of death for adolescent females.

The team at Center for Discovery consists of a physician, psychiatrist, dietitian, psychotherapist, registered nurses, and counselors. Each resident receives three to four psychotherapy sessions each week with a minimum of one being a family psychotherapy session. They will receive a minimum of one weekly consult with the psychiatrist, physician, and dietitian. Additional treatment components include psycho-educational group therapy, discharge planning, exercise therapy and recreational activities, exposure response prevention, and a variety of activities including art and music therapy.

Residents work through a treatment "phase system" and follow an individualized treatment plan that monitors their progress on a weekly basis. The program is designed to promote improved family interactions, social supports along with personal age appropriate independence including self-responsibility for their recovery. Funding for treatment generally comes from private insurance or through family resources for a private pay agreement.

2. Clear Public Need

a. Provide the following regarding the proposal's location:

i. The rationale for choosing the proposed service location;

The Connecticut population is underserved by eating disorder specialist centers. Currently, there is only one residential center for adults in the greater Connecticut area. We, Discovery, operate this other center and our waitlist is several months long. We have a facility in Southport we would like to utilize as a second treatment home for the many women that are on our waiting list and needing this life-saving treatment.

ii. The service area towns and the basis for their selection;

The service will occur in Fairfield/Southport, CT. Center for Discovery has a great relationship with local officials in Fairfield. Currently, the Center operates two adolescent facilities and one adult facility in the Fairfield jurisdiction and is confident about the local support and need in this area. The site under consideration currently operates as a residential treatment center with approval from the city.

iii. The population to be served, including specific evidence such as incidence, prevalence, or other demographic data that demonstrates need;

The population served will be adult women (ages 18+) who suffer from eating disorders such as anorexia, bulimia, and binge-eating disorder that require a residential treatment level of care.

Our current program in Fairfield opened in April of this year. It quickly ramped up to capacity census and we have a 3 month waitlist of clients waiting to get in.

Eating Disorders occur in approximately 10% of the female population with that number going as high as 30% during college years (age 18-24). (See attached articles). 4% of individuals suffering from Anorexia will die from complications related to the disease while approximately 3.9% of bulimics will die. Based off these statistics and the attached Fairfield County Metrics, 1% of the adult women between the ages of 18-65 will require our level of treatment, this projects approximately 2700 women in the Fairfield county area and 10,600 women in Connecticut overall. If we adjust the numbers downward and assume only 33% of those clients in need actually seek and receive treatment, we are still left with 891 women in Fairfield County and 3,512 women in Connecticut who require treatment for an eating disorder at the residential level. Our existing program has a maximum capacity of about 50 patients a year.

iv. How and where the proposed patient population is currently being served;

Currently, the proposed population has only one residential treatment site in the state of Connecticut. That is our Center for Discovery, Fairfield facility. The other nearest residential providers for adults are in Boston, New York, and Philadelphia.

v. All existing providers (name, address, services provided) of the proposed service in the towns listed above and in nearby towns; and

Closest providers of adult residential treatment:
Center for Discovery Fairfield – 4536 Congress St. Fairfield, CT 06824
Renfrew Treatment Center – 475 Spring Lane, Philadelphia, PA 19128
Cambridge Eating Disorder Program – 3 Bow Street, Cambridge, MA 02138

vi. The effect of the proposal on existing providers, explaining how current referral patterns will be affected by the proposal.

Existing providers will be provided the opportunity to refer their clients to a highly specialized level of care that does not exist for the community. This offers a great step-down platform for In-Patient Psych units to refer to as patients are discharged and offers a higher level of care for out-patient practictioners outside of the hospital.

3. Projected Volume

a. Complete the following table for the first three fiscal years ("FY") of the proposed service.

Table 1: Projected Volume

	Projected Volume (First 3 Full Operational FYs)**			
	FY2014	FY2015	FY2016	FY2017
Residential Treatment for Eating Disorders				
Total Clients per Year	N/A	35	42	49
Total		**35**	**42**	**49**

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.
*** Identify each service/procedure type and add lines as necessary.
**** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

b. Provide a detailed description of all assumptions used in the derivation/calculation of the projected volumes.

Projections are conservative estimates based off historical company data. Average lengths of stay for adult women with eating disorders are just over 40 days. In the state of Connecticut, our adolescent facilities run over 90% occupancy rates throughout the year and our existing adult facility has been running at 100% occupancy for several months. For a 6 bed facility with 90% occupancy and 40 day stays, this makes an average census of 49 which should be achieved after enough time has elapsed for marketing efforts and outreach to take full effect. The projected numbers are actually a conservative estimate of operation volumes.

c. Provide historical volumes for three full years and the current year to date for any of the Applicant's existing services that support the need to implement the proposed service.

Our adult facility in Fairfield that opened in April, 2015 took only 3 months to reach capacity census, and since then has run at occupancy levels between 90-100%.

d. Provide a copy of any articles, studies, or reports that support the statements made in this application justifying need for the proposal, along with a brief explanation regarding the relevance of the selected articles.

See Attached "Articles" Section

Center for Discovery's outcome data shows the results of our proprietary treatment method over our 18 years of treating eating disorders.

Eating Disorder Statistics & Research – This article discusses the prevalence of eating disorders within the general community. It goes into detail of the percentage of the population that struggles with each of the different diagnoses of eating disorders

The Prevalence and Correlates of Eating Disorders in the National Comorbidity Survey Replication – Discusses both the reported frequency of severe eating disorder cases and also the comorbidity issues that are often related to the eating disorder.

4. Quality Measures

a. Submit a list of all key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.

See "Resumes" attachment

Also, below is an outline of the different job roles associated with a treatment home.

Staffing Plan

- *The program is overseen by a Program Director, who works full-time on-site at the facility location. The Program Director reports to the Director of Operations and communes on a daily basis.*
- *The Program Director leads a multi-disciplinary treatment team for the facility. The team is composed of a Physician, Psychiatrist, Primary Therapist, Dietitian, and Facility Administrator. The team convenes on a weekly basis to assess each client and modify and design unique treatment plans for each individual client.*
- *In addition to the treatment team, each facility has Registered Nurses, 2-3 diet techs, and 12-15 counselors on staff.*
- *The facility is monitored 24 hours through rotating shifts of counselors. During nighttime hours, a counselor is always awake and performing bed checks throughout the night.*
- ***Staff Descriptions and credentials***
    - *The Program Director is responsible for the supervision of the treatment program and facility. He/She consults with the Operations Director and the Chief of Operations on an as needed basis to ensure the best, most efficient utilization of program and company resources. The Program Director closely supervises all services to assure they are delivered in keeping with the Discovery Mission statement. Masters Degree required. Two years experience in residential or hospital setting.*
    - *The Physician is responsible to ensure appropriate medical interventions. The Physician sees each resident and completes a history and physical assessment. If indicated, medications are prescribed, and monitored by the Physician at least once weekly. The Physician consults with the treatment team and may attend the treatment planning meetings if indicated. Must be a graduate of an approved medical school and licensed in the state of Connecticut. Eligible for membership in the local branch of the State Medical Society.*
    - *The Psychiatrist is responsible to consult with the DD, DOO, and COO to ensure appropriate psychiatric/pharmacological interventions. The Psychiatrist sees each resident and completes a psychiatric assessment. If indicated, medications are prescribed, and monitored by the Psychiatrist at least once weekly. In addition, the Psychiatrist consults with the treatment team and attends the weekly treatment planning meetings. Must be a graduate of an approved medical school and licensed in the state. Must be eligible for membership in the local branch of the State Medical Society. Must be experienced in adolescent psychiatry and treatment.*
    - *The Primary Therapist provides and oversees treatment services as defined in the daily schedule and assists with supervision and facility management. The*

combined responsibilities of clinical and administrative supervision/management are key to the success of the treatment facility. The Primary Therapist must possess a Masters Degree or Doctorate in an appropriate field with Licensure. The Center for Discovery utilizes MFT and LCSW interns and psychological assistants under the supervision of an appropriate Licensed Independent Practitioner. The Primary Therapist must have at least one year in acute care or residential treatment or closely related experience.

- *The Registered Dietitian is responsible to consult in a collaborative fashion with treatment team to ensure the best standard of nutrition and dietary services. The Registered Dietitian is responsible for all the dietary services in addition to overseeing the Dietary component within the program. Responsibilities include training new RD's, dietary support and supervision, grocery budget allocation, nutrition component design, creation of original class protocols and working in collaboration with the Program Director to provide dietary employee reviews and support. The Registered Dietitian must have a Master's Degree with appropriate emphasis, state registration, American Dietetic Association certification and Servsafe certification. The Registered Dietitian must have five years experience in dietary education and management.*
- *The Counselor is responsible for assisting and supporting residents through the entire treatment experience from admission through discharge. The Counselor monitors the course of treatment for each resident in a pro-active manner to ensure that no problem or trouble may compromise the resident's or treatment staff's effort. The Counselor is responsible for contributing insightful, practical, and meaningful information to the treatment planning process. The Counselor introduces each new resident to his/her fellow residents and the treatment staff, orientates each resident to the Discovery Treatment Program, orients the resident with the rules, expectations, intent, and routine of the daily treatment schedule. The Counselor must have a Bachelor's degree or sufficient experience in an appropriate field and must be willing to attend all training, education, and staff enrichment activities.*
- *The Registered Nurse consults with the Physician and Psychiatrist to ensure appropriate medical interventions. The RN meets with each resident and completes a daily nursing progress note and develops a Nursing Care Plan specific to the identified needs of each resident. The RN is responsible to carry out any orders received from the Physician and Psychiatrist and attends treatment team as indicated. Education: As required for Licensure. Experience: Must be experienced in psychiatric nursing.*
- *The Diet Technician is responsible to consult with the registered Dietitian and the Treatment Team relative to clients menu planning and challenges and obstacles. The Diet Tech plans each client's daily menu planning and menu correcting. The Diet Tech follows dietary instructions from the Registered Dietitian in preparing meals to meet each client's dietary needs and preferences. The Diet Tech acts as an assistant to the Registered Dietitian and assists the weekly dietary group.*

Current student in a dietary or Diet Technician training program, DTR preferred. Prior experience not required.

b. Explain how the proposal contributes to the quality of health care delivery in the region.

Residential treatment helps to bridge the gap between patients coming off fedding tubes or medical weight restoration and continue the appropriate weight gain while still providing the 24 hour supervision that an Out-Patient center cannot provide. Clients are more likely to succeed in treatment if they move through all phases of the levels of care. The initiation of residential care in the area should help lower the number of in-patient stays and help prevent clients from cycling back and forth between In-Patient and Out-Patient levels.

5. Organizational and Financial Information

a. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).

Corporation

b. Does the Applicant have non-profit status?
☐ Yes (Provide documentation) ☒ No

c. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant and indicate any additional licensure categories being sought in relation to the proposal.

See attached

d. Financial Statements

i. <u>If the Applicant is a Connecticut hospital:</u> Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.

ii. <u>If the Applicant is not a Connecticut hospital (other health care facilities):</u> Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)

e. Submit a final version of all capital expenditures/costs as follows:

Capital Expenditures are N/A because the facility is already owned and operated by Center for Discovery. Center for Discovery is looking to move the current business (adolescent care) to a new location and all equipment and capital needs have already been purchased for the facility.

Table 2: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	$N/A
Imaging Equipment Purchase	
Non-Medical Equipment Purchase	
Land/Building Purchase *	
Construction/Renovation **	
Other Non-Construction (Specify)	
Total Capital Expenditure (TCE)	**$N/A**
Medical Equipment Lease (Fair Market Value) ***	$N/A
Imaging Equipment Lease (Fair Market Value) ***	
Non-Medical Equipment Lease (Fair Market Value) ***	
Fair Market Value of Space ***	
Total Capital Cost (TCC)	**$N/A**
Total Project Cost (TCE + TCC)	**$N/A**
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	$0

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.
** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.
*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

f. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges and funds received to date; letter of interest or approval from a lending institution.

Center for Discovery Residential Eating Disorder Program, Southport will be funded by internal operations of Center for Discovery if the need arises. Discovery operates over 20 residential facilities across that country that provide the cash flow if needed. Appropriate financial documentation is attached.

6. Patient Population Mix: Current and Projected

a. Provide the current and projected patient population mix (based on the number of patients, not based on revenue) with the CON proposal for the proposed program.

Table 3: Patient Population Mix

	Current**	Year 1	Year 2	Year 3

	FY 2015	FY 2016	FY 2017	FY 2018
Medicare*				
Medicaid*				
CHAMPUS & TriCare				
Total Government				
Commercial Insurers*		98%	98%	98%
Uninsured		2%	2%	2%
Workers Compensation				
Total Non-Government		**100%**	**100%**	**100%**
Total Payer Mix				

* Includes managed care activity.
** New programs may leave the "current" column blank.
*** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

b. Provide the basis for/assumptions used to project the patient population mix.

Assumptions are based off the current payer mix at our existing Connecticut adult and adolescent facilities. Most of our business is done through private pay commercial insurers with a few patients coming to us without insurance. These ratios are expected to stay relatively consistent for the new adult house.

7. Financial Attachments I & II

a. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Complete Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.

Actual results for fiscal year and numerical results for project without the CON are N/A as the proposed program does not exist and will not be able to operate with a CON.

b. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three full fiscal years of the project.

See attached

c. Provide the assumptions utilized in developing **both Financial Attachments I and II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

Assumptions:

10 FTE's: The house employs two full-time therapists, 1 full-time Facility Administrator and 3-4 full-time counselors. The other counselors, diet techs and staff only work 5-15 hours per week and constitute the other 3-4 FTE's.

Professional Contracted Services: This includes independent contractor agreements with Physicians, Nurses, and outside practitioners if needed. Professional services such as Physicians are only needed for 1-5 hours per week.

Volume Statistics: These are conservative estimates based on similar 6 bed homes we operate throughout the country including two adolescent homes and one adult home in Connecticut. Typical clients per year numbers range from 30-50 based on need in the area. As Connecticut has a high need and only one other residential home, we anticipate these numbers being higher than our projections.

Other Expenses: These are composed of projections for groceries/food supplies, auto, gas, maintenance, lawn care, cleaning services and general maintenance and repair.

Project Commencement Date: Projected opening is March 1, 2016

Revenue: Based off our existing home numbers.

d. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).

We are contracted with most of the major insurance providers in the area, unfortunately, these contracts are confidential in nature.

e. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

We would only need to see one additional client per year for an average length of stay in order to show incremental operational gains.

f. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

N/A

g. Describe how this proposal is cost effective.

Center for Discovery already has control of the subject property and has a full staff in place ready to operate. Therefore, the costs to open and run an adult program are minimal. Residential treatment is meant to fill the gap between In-Patient and Out-Patient care. Unfortunately, eating disorder patients require a very high level of supervision and monitoring to truly alter their self-harming behaviors such as starvation or purging. Individuals that

discharge directly to an out-patient program from the hospital typically have very high levels of relapse and the medical bills are a never-ending cycle of in-patient and out-patient visits. Residential care provides the long-term supervision and support that hospitals are unable to offer and provides a structured learning environment where clients can learn and practice the healing behaviors they will need to successful in an out-patient and at home setting. The cost benefit comes in long-term when these clients are able to stop the endless cycle of in-patient and out-patient and have success at lower levels of care.

Financial Attachments I & II

Audited Financial Statements

12.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description Residential Eating Disorder Treatment for Women
Type of Unit Description: Client Days
# of Months in Operation 12

FY _____ **FY Projected Incremental** Total Incremental Expenses: **$854,750**	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Total Facility by Payer Category:										
Medicare			0	$0				$0	$0	$0
Medicaid		$0	0	$0				$0	$0	$0
CHAMPUS/TriCare		$0	0	$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$1,000	1,328	$1,328,000				$1,328,000	$792,673	$535,327
Uninsured		$1,300	80	$104,000				$104,000	$62,077	$41,923
Total NonGovernment		$0	1,408	$1,432,000	$0	$0	$0	$1,432,000	$854,750	$577,250
Total All Payers		$0	1,408	$1,432,000	$0	$0	$0	$1,432,000	$854,750	$577,250

13. B i. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
NET PATIENT REVENUE										
Non-Government		$0	$1,432,000	$1,432,000	$0	$1,646,800	$1,646,800	$0	$1,893,820	$1,893,820
Medicare		$0	$0	$0	$0	$0	$0	$0	$0	$0
Medicaid and Other Medical Assistance		$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Government		$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Net Patient Patient Revenue	$0	$0	$1,432,000	$1,432,000	$0	$1,646,800	$1,646,800	$0	$1,893,820	$1,893,820
Other Operating Revenue		$0	$0	$0	$0	$0	$0			
Revenue from Operations	$0	$0	$1,432,000	$1,432,000	$0	$1,646,800	$1,646,800	$0	$1,893,820	$1,893,820
OPERATING EXPENSES										
Salaries and Fringe Benefits		$0	$504,000	$504,000	$0	$524,160	$524,160	$0	$545,126	$545,126
Professional / Contracted Services		$0	$123,750	$123,750	$0	$128,700	$128,700	$0	$133,848	$133,848
Supplies and Drugs		$0	$40,800	$40,800	$0	$42,432	$42,432	$0	$44,129	$44,129
Bad Debts		$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Expense		$0	$61,200	$61,200	$0	$63,648	$63,648	$0	$66,194	$66,194
Subtotal	$0	$0	$729,750	$729,750	$0	$758,940	$758,940	$0	$789,298	$789,298
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense		$0	$125,000	$125,000		$125,000	$125,000		$125,000	$125,000
Total Operating Expenses	$0	$0	$854,750	$854,750	$0	$883,940	$883,940	$0	$914,298	$914,298
Income (Loss) from Operations	$0	$0	$577,250	$577,250	$0	$762,860	$762,860	$0	$979,522	$979,522
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$577,250	$577,250	$0	$762,860	$762,860	$0	$979,522	$979,522
Provision for income taxes			$202,038	$202,038		$267,001	$267,001		$342,833	$342,833
Net Income	$0	$0	$375,213	$375,213	$0	$495,859	$495,859	$0	$636,690	$636,690
Retained earnings, beginning of year		$0	$0	$0	$0	$375,213	$375,213	$0	$871,072	$871,072
Retained earnings, end of year	$0	$0	$375,213	$375,213	$0	$871,072	$871,072	$0	$1,507,761	$1,507,761
FTEs				10			10			10

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

HCVT CERTIFIED PUBLIC ACCOUNTANTS

HOLTHOUSE CARLIN & VAN TRIGT LLP

BEHAVIORAL HEALTH HOLDINGS II, INC. AND SUBSIDIARY

CONSOLIDATED FINANCIAL STATEMENTS,
INDEPENDENT AUDITOR'S REPORT
AND
SUPPLEMENTAL INFORMATION
DECEMBER 31, 2014

BEHAVIORAL HEALTH HOLDINGS II, INC. AND SUBSIDIARY

CONSOLIDATED FINANCIAL STATEMENTS
DECEMBER 31, 2014

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HCVT CERTIFIED PUBLIC ACCOUNTANTS HOLTHOUSE CARLIN & VAN TRIGT LLP

Independent Auditor's Report

To the Shareholder of
Behavioral Health Holdings II, Inc.:

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Behavioral Health Holdings II, Inc. and subsidiary (collectively, the "Company"), which comprise the consolidated balance sheet as of December 31, 2014, and the related consolidated statements of income, changes in shareholder's equity and cash flows for the year then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of the consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2014, and the results of their operations and their cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Report on the Supplemental Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying consolidating balance sheet as of December 31, 2014, consolidating statement of income and schedule of management adjusted earnings before interest, taxes, depreciation and amortization ("Management Adjusted EBITDA") for the year ended December 31, 2014 are presented for purposes of additional analysis and not required as part of the consolidated financial statements. This information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements.

This information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Holthouse Carlin & Van Trigt LLP

Long Beach, California
April 1, 2015

BEHAVIORAL HEALTH HOLDINGS II, INC. AND SUBSIDIARY

CONSOLIDATED BALANCE SHEET

DECEMBER 31, 2014

ASSETS

Current assets:		
Cash and cash equivalents	$	402,102
Accounts receivable, net		6,635,688
Prepaid expenses and other current assets		1,102,444
Deferred income taxes		262,364
Total current assets		8,402,598
Property and equipment, net		1,900,994
Deferred financing costs, net		247,068
Goodwill		6,922,000
Intangible assets, net		12,130,742
Other assets		565,425
Total assets	$	30,168,827

LIABILITIES AND SHAREHOLDER'S EQUITY

Current liabilities:		
Revolving line of credit	$	500,000
Accounts payable		751,666
Accrued expenses and other current liabilities		887,986
Current portion of long-term debt		1,419,683
Total current liabilities		3,559,335
Long-term debt, net of current portion		25,116,386
Deferred income taxes		996,961
Total liabilities		29,672,682
Commitments and contingencies		
Shareholder's equity:		
Common stock, $0.0001 par value, 1,000 shares authorized, 101 shares issued and outstanding		1
Retained earnings		496,144
Total shareholder's equity		496,145
Total liabilities and shareholder's equity	$	30,168,827

See accompanying notes to consolidated financial statements.

CENTER FOR DISCOVERY®
OUTCOME DATA

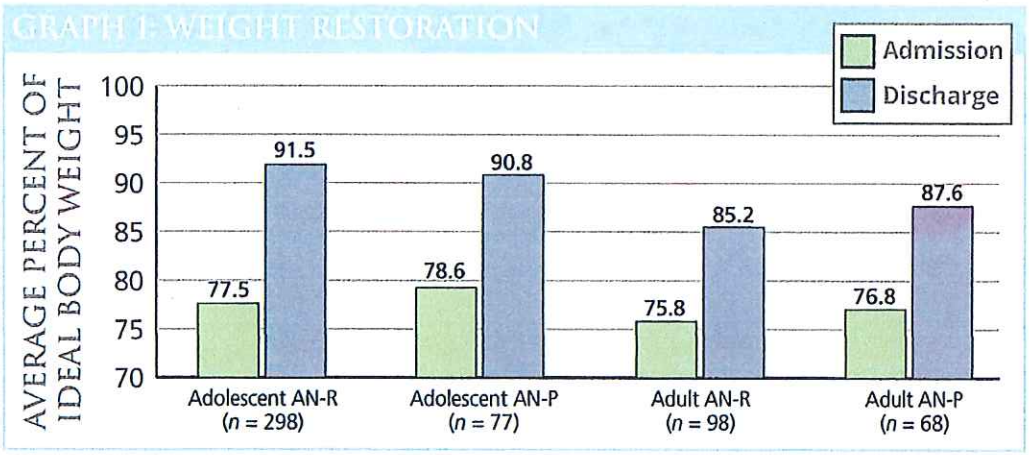
Treating eating disorders since 1999, Center for Discovery has a strong commitment to evidence-based practice. To this end, Discovery has been collecting data on our clients and, in several separate research endeavors, has begun to be able to answer pertinent questions related to 1) ***the process of treatment,*** *2)* ***the post-discharge experience****, and 3)* ***the need for readmission.***

The process of treatment:

Center for Discovery collects admission and discharge data on clients with eating disorders and has teamed with North Shore LIJ and The Feinstein Institute for Biomedical Research to analyze this de-identified data. We are especially interested in the outcome of residential treatment for eating disorders and factors that may correlate with need for residential treatment, with treatment success, and with need for readmission. Preliminary findings from the external data analyses have been presented at both the 2015 Academy for Eating Disorders (AED) International Conference and the 2015 Society for Adolescent Health and Medicine (SAHM) Annual Meeting. In the interim of the full analyses, we present the following results from data collected from clients who received residential eating disorder treatment at Center for Discovery between January 2006 and January 2015 (N = 1,915).

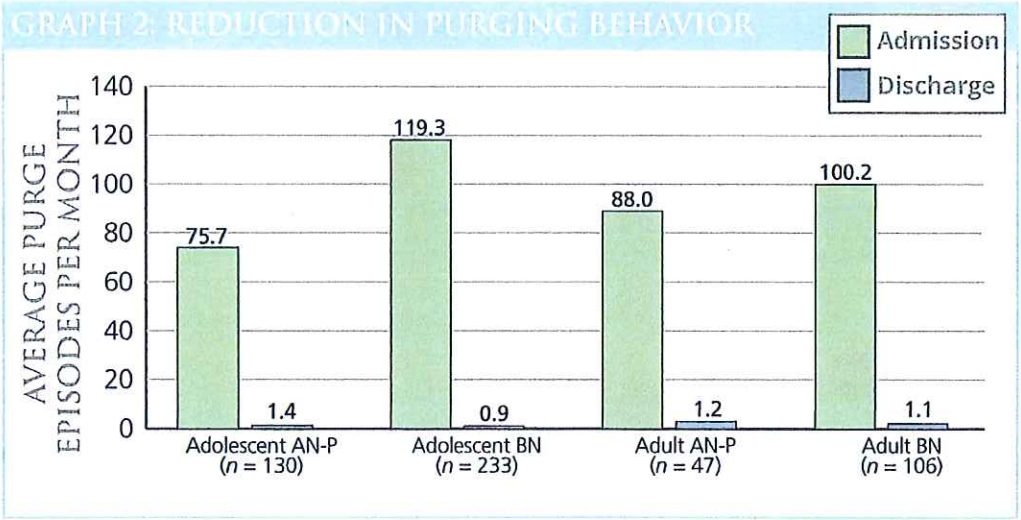
GRAPH 1: Adult clients with active[1] anorexia (AN), who entered residential treatment[2] extremely malnourished, with an average percent of ideal body weight (IBW) in the mid-70s, had significant increases of 10.0 percentage points on average. For adolescent clients with active AN-Restricting Type (AN-R), the mean percent of IBW increased by 14.0; for adolescent clients with active AN-Purging Type (AN-P), mean percent of IBW increased by 12.2. These increases represent an improvement from medically compromising averages of between 77.5% and 78.6% of IBW at admission to above 90% at discharge. Reaching the benchmark of 90% of IBW for developing adolescents is important for a number of reasons including a marked reduction of symptoms of malnutrition[3] and the evidence that psychopathological symptoms can persist for years when weight restoration is incomplete[4]. Furthermore, leading eating disorder researchers[4,5] cite slow and low weight restoration as dangerous, as it results in not just the eventual risk of bone disease and relapse but also a decline in motivation for recovery.

GRAPH 1: WEIGHT RESTORATION

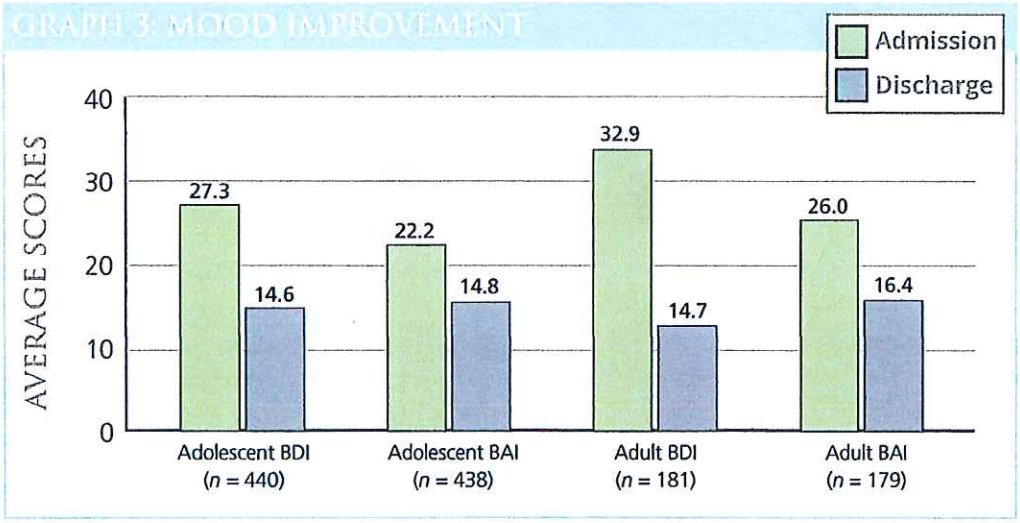


Turning to weight in pounds, during their length-of-stay[6] (adolescent AN-R, *m* = 59.3 days; adolescent AN-P, *m* = 56.9 days; adult AN-R, *m* = 44.1 days; adult AN-P, *m* = 44.4 days), Center for Discovery clients with active AN gained 2.1 pounds per week on average – a rate of restoration that is hard to achieve at lower levels of care and increases the likelihood of lasting recovery.[7] Because persistence of low body weight predicts poorer long-term outcome[5] and approximately 20-25% of individuals with AN will become chronically ill[5,8], Center for Discovery is committed to timely weight restoration.

GRAPH 2: Center for Discovery provides the necessary structure for a swift cessation of purging behavior, a symptom that can be difficult to extinguish in lower levels-of-care. On average, adolescents and adults with either AN-P or BN[9], who were exhibiting purge behavior upon admission, were able to reduce these behaviors by 99.0%. Furthermore, during an average length of stay[6] (adolescent AN-P, *m* = 58.5 days; adolescent BN, *m* = 50.0 days; adult AN-P, *m* = 51.2 days; adult BN, *m* = 45.8 days), the vast majority of clients (89.1%) were able to stop purging completely.



GRAPH 3: Because Center for Discovery takes a holistic approach, symptoms of depression and anxiety are important targets for treatment. Graph 3 presents average scores on the Beck Depression Inventory (BDI) and the Beck Anxiety Inventory (BAI) at the time of admission and discharge for adolescent and adult clients with a diagnosis of either AN or BN. On average, our adolescent clients entered residential treatment[2] at Center for Discovery within the **moderate** range of depression and anxiety, whereas adult clients began treatment within the **severe** range for depression and anxiety.[10] However, both adolescent and adult clients scored within or on the cusp of the **mild** range of depression and anxiety at the time of discharge, a vast improvement in mood and related functioning, and an improvement that can strengthen lasting recovery.[11]



Center for Discovery is dedicated to restoring weight, greatly reducing purge behavior, and improving mood, and we make great strides in these areas during clients' treatment with us. However, symptom improvement in treatment, no matter how great, is just the first step. Lasting recovery, although built upon the foundation of the work clients do in treatment, is forged once clients leave the structure of Center for Discovery. Thus, Discovery researchers knew following up with families after discharge would be imperative and initiated a research project to study clients' post-discharge experience.

The post-discharge experience:

The following information was collected from parents of our adolescent clients (n = 68) who were 6 months to 1 year post-discharge from Center for Discovery's residential eating disorder program.

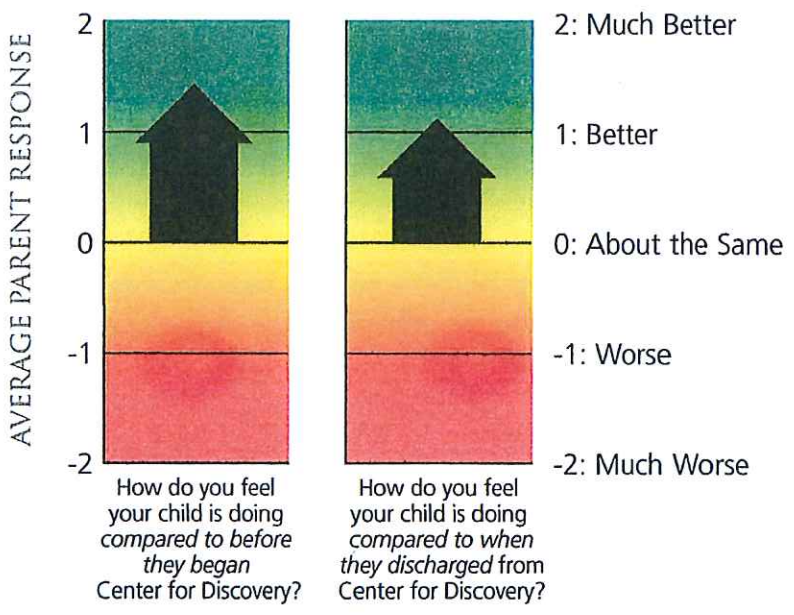
- 95.6 % of clients engaged in aftercare within 7 days of discharge (e.g., began PHP/IOP or attended outpatient treatment appointments)
- For clients who had been diagnosed with AN and were discharged at or above 90% of ideal body weight, 88.9% were reported to have maintained their weight
- For the clients with a history of purging, 78.6% were reported as being purge-free the month before contact
- 81.0% of clients who discharged to a lower level-of-care did not need to be stepped back up to a higher level of eating disorder treatment at Discovery ***or*** any other treatment setting
- Additionally, parents were asked to answer the following two questions using the below scale:

How do you feel like your child is doing compared to ***before they began*** *Center for Discovery?*
How do you feel like your child is doing compared to when they ***discharged from*** *Center for Discovery?*

Much better	Better	About the same	Worse	Much worse
2	1	0	-1	-2

GRAPH 4: Examining the first question, the vast majority (90.6%) of parents reported that their child was doing *better* or *much better* than before beginning treatment at Center for Discovery. The answer to the second question, which was designed to measure whether improvements achieved while in treatment were maintained after discharge, was a bit of a surprise to our researchers. Although we have routinely watched clients make great strides during their treatment, we could only hope that clients did not backslide after leaving the structure of Center for Discovery. However, the data suggests that not only are improvements maintained, but that Center for Discovery clients actually continue to get better following their discharge. In fact, 84.4% of parents reported their child was doing *better* or *much better* since discharging from Center for Discovery.

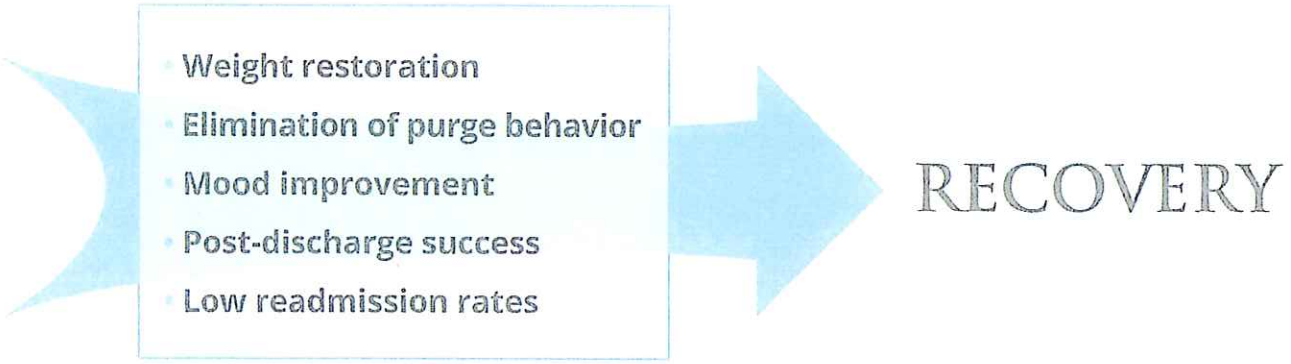
GRAPH 4: POST-DISCHARGE PROGRESS



In summary, 6 months to 1 year after discharge, clients who had received residential eating disorder treatment from Center for Discovery were not only maintaining the improvements they had made in treatment, but had actually continued to improve, with over ¾ of clients with a history of purging having ceased this behavior and approximately 90% of clients with AN having maintained their weight within a healthy range.

The need for readmission:

Since Center for Discovery began treating eating disorders in 1999, we have treated over 2,600 clients at the residential level-of-care. Of those clients, only 14.7% have readmitted to Discovery's residential eating disorder program *anytime* in the past 16 years. Examining readmission rates for specific time frames, 11.6% of our clients readmitted within one year of discharge, 8.8% readmitted within 6 months, 6.2% readmitted within 90 days, and 2.7% readmitted within 30 days of discharge. Such readmission rates are significantly lower than those typically found for a higher level-of-care for eating disorders, which can be as high as 45.0% to 77.5%.[12,13]



At Center for Discovery, we are driven to provide the most effective, evidence-based treatment experience ...and our results speak for themselves. Through all of our research endeavors, our mission is to continuously enhance our program, give confidence to families and clients regarding the decision to enroll, work with insurance companies for adequate length of treatment, and lead the field in understanding treatment for eating disorders.

FOR MORE INFORMATION ABOUT CENTER FOR DISCOVERY'S EVIDENCED-BASED TREATMENT, PLEASE CALL 866-407-2876.

www.centerfordiscovery.com

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[1] *Active* AN indicates clients who were below 85% of IBW upon admission to Center for Discovery.

[2] For the purpose of the analysis for this graph, residential treatment was operationalized as having received at least 7 days of treatment at the residential level-of-care.

[3] Strober, M., Freeman, R., & Morrell, W., (1997). The long-term course of severe Anorexia Nervosa in adolescents: Survival analysis of recovery, relapse, and outcome predictors over 10-15 years in a prospective study. *International Journal of Eating Disorders, 22*(4), 339-360.

[4] Strober, M., & Johnson, C. (2012). The need for complex ideas in Anorexia Nervosa: Why biology, environment, and psyche all matter, why therapists make mistakes, and why clinical benchmarks are needed for managing weight correction. *International Journal of Eating Disorders, 45*(2), 155-178.

[5] Steinhausen, H.C. (2002). The outcome of Anorexia Nervosa in the 20th century. *American Journal of Psychiatry, 159*, 1284-1293.

[6] Here length-of-stay averages are only representative of those clients meeting criteria for this analysis.

[7] Lund, B. C., Hernandez, E. R., Yates, W. R., Mitchell, J. R., McKee, P. A. & Johnson, C. L. (2009). Rate of inpatient weight restoration predicts outcome in Anorexia Nervosa. *International Journal of Eating Disorders, 42*, 301–305.

[8] Viricel, J., Bossu, C., Galusca, B., Kadem, M., Germain, N., Nicolau, A., et al. (2005). Restrospective study of Anorexia Nervosa: Reduced mortality and stable recovery rates. *La Presse Médicale, 34*, 1505-1510.

[9] For the purpose of the analysis for Graph 2, only clients with a length-of-stay of 30 days or greater were included, as at least one month of treatment was needed to calculate average purge episodes per month on discharge.

[10] For BDI, 0-9 is minimal, 10-18 is mild, 19-29 is moderate, and 30-63 is severe. For BAI, 0-7 is minimal, 8-15 is mild, 16-25 is moderate, and 26-63 is severe.

[11] Herpertz-Dahlmann, B., Wewetzer, C., & Remschmidt, H. (1995). The predictive value of depression in anorexia nervosa: Results of a seven-year follow-up study. *Acta Psychiatrica Scandinavica, 91*(2), 114-119.

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[13] Lay, B., Jennen-Steinmetz, C., Reinhard, I., & Schmidt, M. H. (2002). Characteristics of inpatient weight gain in adolescent anorexia nervosa: Relation to speed of relapse and re-admission. *European Eating Disorders Review, 10*(1), 22-40.

- Menu

Eating Disorder Statistics & Research

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Article Contents

- Anorexia Nervosa Statistics
- Bulimia Nervosa Statistics
- Binge Eating Disorder Statistics
- General Statistics on Eating Disorders
- Female Eating Disorder Prevalence Rates
- Male Eating Disorder Statistics
- Prevalence Rates of Eating Disorders in Adolescents
- Student Eating Disorder Statistics
- Prevalence of eating disorders among athletes
- Dieting Statistics and Prevalence

Eating disorders studies, statistics and research are surprisingly difficult to find. Occasionally you will find websites and articles that reference a few key studies, but they are few and far between outside of university or clinical journals and papers. We've put together some of the key statistics on eating disorders here for our readers.

Anorexia Nervosa Statistics

Anorexia Prevalence

- It is estimated that 1.0% to 4.2% of women have suffered from anorexia in their lifetime.[1]

Anorexia Mortality Rates

- Anorexia has the highest fatality rate of any mental illness.[2]
- It is estimated that 4% of anorexic individuals die from complications of the disease[3]

Access to Anorexia Treatment

- Only one third of individuals struggling with anorexia nervosa in the United States obtain treatment.[4]

Bulimia Nervosa Statistics

Bulimia Prevalence

- It is estimated that up to 4% of females in the United States will have bulimia during their lifetime[5].

Bulimia Mortality Rates

- 3.9% of these bulimic individuals will die.[6]

Access to Bulimia Treatment

- Of those practicing bulimia, only 6% obtain treatment[7].

Binge Eating Disorder Statistics

Binge Eating Prevalence

-

Advertisement

- 2.8 % of American adults will struggle with BED during their lifetime. Close to 43% of individuals suffering from Binge Eating Disorder will obtain treatment[8].

Binge Eating Disorder Mortality Rates

- 5.2% of individuals suffering from eating disorders not otherwise specified,[9] the former diagnosis that BED, among other forms of disordered eating) was included in under the DSM-IV) die from health complications.

Access to Binge Eating Treatment

- Close to 43% of individuals suffering from Binge Eating Disorder will obtain treatment.[10]

General Statistics on Eating Disorders

- Eating disorders are a daily struggle for 10 million females and 1 million males in the United States.[11]
- Four out of ten individuals have either personally experienced an eating disorder or know someone who has.[12]

Over a lifetime, the following percentages of women and men will experience an eating disorder:

Female Eating Disorder Prevalence Rates

- .9% of women will struggle with anorexia in their lifetime
- 1.5% of women will struggle with bulimia in their lifetime
- 3.5% of women will struggle with binge eating

Male Eating Disorder Statistics

- .3% of men will struggle with anorexia
- .5% of men will struggle with bulimia
- 2% of men will struggle with binge eating disorder [13]

Prevalence Rates of Eating Disorders in Adolescents

- The National Institute of Mental Health reports that 2.7% of teens, ages 13-18 years old, struggle with an eating disorder.[14]

Student Eating Disorder Statistics

- 50% of teenage girls and 30% of teenage boys use unhealthy weight control behaviors such as skipping meals, fasting, smoking cigarettes, vomiting, and taking laxatives to control their weight.[15]
- 25% of college-aged women engage in bingeing and purging as a method of managing their weight.[16]

Prevalence of eating disorders among athletes

- 13.5% of athletes have subclinical to clinical eating disorders[22]
- 42% of female athletes competing in aesthetic sports demonstrated eating disordered behaviors[16]

Dieting Statistics and Prevalence

- Over 50% of teenage girls and 33% of teenage boys are using restrictive measures to lose weight at any given time.[17]
- 46% of 9-11 year-olds are sometimes, or very often, on diets, and 82% of their families are sometimes, or very often, on diets).[18]
- 91% of women recently surveyed on a college campus had attempted to control their weight through dieting, 22% dieted often or always.[19]
- 95% of all dieters will regain their lost weight in 1-5 years.[20]
- 35% of normal dieters progress to pathological dieting. Of those, 20-25% progress to partial or full-syndrome eating disorders.
- 25% of American men and 45% of American women are on a diet on any given day.[21]

If you need treatment, find an eating disorder center and talk to a professional.

References

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3. Crow, S.J., Peterson, C.B., Swanson, S.A., Raymond, N.C., Specker, S., Eckert, E.D., Mitchell, J.E. (2009) Increased mortality in bulimia nervosa and other eating disorders. *American Journal of Psychiatry* 166, 1342-1346.
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5. The National Institute of Mental Health: Eating Disorders: Facts About Eating Disorders and the Search for Solutions. Pub No. 01-4901. Accessed Feb. 2002. http://www.nimh.nih.gov/publicat/nedspdisorder.cfm.)
6. Crow, S.J., Peterson, C.B., Swanson, S.A., Raymond, N.C., Specker, S., Eckert, E.D., Mitchell, J.E. (2009) Increased mortality in bulimia nervosa and other eating disorders. *American Journal of Psychiatry* 166, 1342-1346.
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8. Hudson JI, Hiripi E, Pope HG, Kessler RC. The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological Psychiatry.* 2007; 61:348-58.
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The Prevalence and Correlates of Eating Disorders in the National Comorbidity Survey Replication

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Abstract

Go to:

Background

Little population-based data exist on the prevalence or correlates of eating disorders.

Methods

Prevalence and correlates of eating disorders from the National Comorbidity Replication, a nationally representative face-to-face household survey (n _ 9282), conducted in 2001–2003, were assessed using the WHO Composite International Diagnostic Interview.

Results

Lifetime prevalence estimates of DSM-IV anorexia nervosa, bulimia nervosa, and binge eating disorder are .9%, 1.5%, and 3.5% among women, and .3% .5%, and 2.0% among men. Survival analysis based on retrospective age-of-onset reports suggests that risk of bulimia nervosa and binge eating disorder increased with successive birth cohorts. All 3 disorders are significantly comorbid with many other DSM-IV disorders. Lifetime anorexia nervosa is significantly associated with low current weight (body-mass index18.5), whereas lifetime binge eating disorder is associated with current severe obesity (body-mass index < _ 40). Although most respondents with 12-month bulimia nervosa and binge eating disorder report some role impairment (data unavailable for anorexia nervosa since no respondents met criteria for 12-month prevalence), only a minority of cases ever sought treatment.

Conclusions

Eating disorders, although relatively uncommon, represent a public health concern because they are frequently associated with other psychopathology and role impairment, and are frequently under-treated.

Keywords: Anorexia nervosa, binge eating disorder, bulimia nervosa, eating disorders, epidemiology, national comorbidity survey replication (NCS-R)

Two eating disorders—anorexia nervosa and bulimia nervosa—are recognized as diagnostic entities in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (American Psychiatric

Association 1994); a third category, binge eating disorder, is proposed in DSM-IV as a possible new diagnostic entity. However, data are incomplete on the prevalence of these 3 disorders in the general population. The prevalence of anorexia nervosa has been investigated mainly in samples of young women in Europe and North America, where the average point prevalence has been .3% (Hoek and van Hoeken 2003; Favaro et al 2004). The lifetime prevalence among adult women has been reported as .5%–.6% in 2 large population-based surveys in the United States (Walters and Kendler 1995) and Canada (Garfinkel et al 1996); the latter study found a prevalence of anorexia nervosa among adult men of .1%. The lifetime prevalence of bulimia nervosa in adult women has been estimated as 1.1%–2.8% in 3 large populationbased surveys in New Zealand (Bushnell et al 1990), the United States (Kendler et al 1991), and Canada (Garfinkel et al 1995). For men, the lifetime prevalence of bulimia nervosa was estimated at .1% in the Canadian study and .2% in the New Zealand study, but the point prevalence of bulimia nervosa in a study in Austria was reported as .5% (Kinzl et al 1999b). For the case of binge eating disorder, 2 population-based telephone interview surveys of adults in Austria estimated the point prevalence as 3.3% among women (Kinzl et al 1999a) and .8% among men (Kinzl et al 1999b). Other studies of binge eating disorder have been limited to specific populations (e.g., young women) or were based only on questionnaires, rather than personal interviews (Streigel-Moore and Franko 2003; Favaro et al 2004).

Population-based interview data are needed to ascertain the prevalence of the 3 eating disorders as well as to provide data on age-of-onset distributions, duration, and association with sociodemographics and body-mass index (BMI). Population data could also address the question of cohort effects—whether the incidence of eating disorders has changed in recent decades. Also of interest is the association of eating disorders with other mental disorders, with measures of disability, and with history of mental health treatment. Finally, population-based data may be useful in examining alternative definitions of eating disorder syndromes in order to determine which definitions are most meaningful as markers of psychopathology. To address these questions, we analyzed data from the recently completed National Comorbidity Survey Replication (NCS-R).

Methods and Materials

Go to:

Sample

The NCS-R is a nationally representative survey of the US household population that was administered face-to-face to a sample of 9282 English-speaking adults ages 18 and older between February 2001 and December 2003 (Kessler and Merikangas 2004). The response rate was 70.9%. The sample was based on a multi-stage clustered area probability design. Recruitment featured an advance letter and Study Fact Brochure followed by in-person interviewer visits to obtain informed consent. Consent was verbal rather than written in order to parallel the consent procedures in the baseline NCS (Kessler et al 1994). Respondents were given a $50 financial incentive for participation. The Human Subjects Committees of both Harvard Medical School and the University of Michigan approved these recruitment and consent procedures.

The survey was administered in 2 parts. Part I included the core diagnostic assessment and was administered to all respondents. Part II assessed additional disorders and correlates of disorders. Part II was administered to a subset of 5692 respondents consisting of all those who met lifetime criteria for a Part I disorder plus a probability sample of other respondents. Disorders of secondary interest were administered to probability sub-samples of the Part II sample. Eating disorders were among the latter disorders.

The analyses reported here were carried out in a sub-sample of 2980 Part II respondents who were randomly assigned to have an assessment of eating disorders. Data records in this subsample were weighted to adjust for the over-sampling of Part I respondents with a mental disorder, differential probabilities of selection within households, systematic non-response, and residual socio-demographic-geographic differences between the sample and the 2000 Census. NCS-R sampling and weighting are discussed in more detail elsewhere (Kessler et al 2004b).

Diagnostic Assessment

NCS-R diagnoses were based on Version 3.0 of the World Health Organization Composite International Diagnostic Interview (CIDI) (Kessler and Ustun 2004), a fully structured layadministered diagnostic interview that generates diagnoses according to both ICD-10 and DSM-IV criteria. DSM-IV criteria were used in the current report. Core disorders included the three broad classes of disorder assessed in previous CIDI surveys (anxiety disorders, mood disorders, and substance disorders) plus a group of disorders that share a common feature of difficulties with impulse control (e.g., intermittent explosive disorder, attention-deficit/hyperactivity disorder, retrospectively reported childhood oppositional-defiant disorder, and conduct disorder). Diagnostic hierarchy rules and organic exclusion rules were used in making all diagnoses. As detailed elsewhere (Kessler et al 2004a, 2005), good concordance was found between these core CIDI diagnoses and diagnoses based on the Structured Clinical Interview for DSM-IV (SCID) (First et al 2002) in a probability sub-sample of NCS-R respondents who were administered clinical reappraisal interviews. The area under the receiver operator characteristic curve was in the range of .65–.81 for anxiety disorders, .75 for major depressive episode, .62–.88 for substance disorders, and .76 for any anxiety, mood, or substance disorder. No clinical reappraisal interviews were carried out for the impulse-control disorders, as these were not core NCS-R disorders.

For the present study, questions from the CIDI were used to assign diagnoses of anorexia nervosa, bulimia nervosa, and binge eating disorder based on DSM-IV criteria. The full diagnostic algorithms for all 3 disorders, together with a sensitivity analysis using alternative, narrower definitions of bulimia nervosa and binge eating disorder, are presented as supplemental material available online with the electronic version of this article and at www.hcp.med.harvard.edu/ncs//eating.php; the corresponding CIDI questions used to operationalize the criteria are available at www.hcp.med.harvard.edu/ncs.

Most of the CIDI questions closely paralleled the DSM-IV criteria, but to meet criteria for binge eating disorder, DSM-IV requires a minimum of 6 months of regular eating binges, whereas the CIDI asked only whether the individual experienced 3 months of symptoms. Thus, individuals displaying more than 3 months, but less than 6 months, of regular binge eating would be classified as having binge eating disorder in our algorithm, but not in DSM-IV. Also of note is that for binge eating episodes in bulimia nervosa and binge eating disorder, DSM-IV requires assessment of loss of control, and for binge eating disorder requires marked distress regarding binge eating; these items were assessed in the CIDI by a series of questions about attitudes and behaviors that are indicators of loss of control and of distress, rather than by direct questions.

In addition to the 3 eating disorders, we also defined 2 provisional entities. The first was "subthreshold binge eating disorder," defined as a) binge eating episodes, b) occurring at least twice a week for at least 3 months, and c) not occurring solely during the course of anorexia nervosa, bulimia nervosa, or binge eating disorder. Thus, subthreshold binge eating disorder did not require DSM-IV criterion B (3 of 5 features associated with binge eating) or C (marked distress regarding binge eating for binge eating disorder). The second was "any binge eating," also defined as a) binge eating episodes (again, not requiring DSM-IV criteria B and C), b) occurring at least twice a week for at least 3 months, but c) lacking the hierarchical exclusion criterion if the individual simultaneously exhibited another eating disorder. In other words, any binge eating was diagnosed regardless of whether or not the individual simultaneously met criteria for any of the other 3 eating disorders or for subthreshold binge eating disorder. This entity thus included all cases of bulimia nervosa, binge eating disorder, and subthreshold binge eating disorder, as well as cases of anorexia nervosa with binge eating. Full diagnostic algorithms for these 2 provisional entities, together with a sensitivity analysis parallel to that above, are presented as supplemental material available with the online version of this article and at www.hcp.med.harvard.edu/ncs//eating.php.

In summary, we examined a total of 5 conditions—2 official DSM-IV disorders (anorexia nervosa and bulimia nervosa), 1 proposed DSM-IV disorder (binge eating disorder), and 2 provisional entities that partially overlapped with 1 or more of the previous 3 disorders. Although in the following text we refer to these 5 conditions collectively as "disorders" for simplicity, the reader should bear in mind that they vary in terms of their level of general acceptance.

As indicated above, our criteria allowed that individuals could display more than one lifetime diagnosis of an eating disorder. We used data from the CIDI regarding time of onset and recency (i.e., the time when the disorder was last present) to apply diagnostic hierarchies, so that bulimia nervosa, binge eating disorder, and subthreshold binge eating disorder were not diagnosed in the presence of anorexia nervosa; and so that binge eating disorder and subthreshold binge eating disorder were not diagnosed in the presence of bulimia nervosa. Because the CIDI provides information only about onset and recency of a disorder, individuals with an episode of a given eating disorder occurring only in between two or more discrete episodes of a hierarchically exclusionary disorder (e.g., anorexia nervosa) would not have been diagnosed with that disorder.

For individuals meeting criteria for any of the 5 five disorders, the CIDI assessed age of onset, recency, years with the disorder, and professional help-seeking. Respondents with 12-month prevalence (that is, individuals who met criteria for the eating disorder at any time within the 12 months before interview) were additionally administered the Sheehan Disability Scales (Leon et al 1997) to assess the severity of recent episodes and were asked about treatment in the past 12 months.

Statistical Analyses

Cross-tabulations were used to estimate prevalence, disability, and treatment. The actuarial method (Wolter 1985) was used to estimate age-of-onset curves. Discrete-time survival analysis with the person-year as the unit of analysis (Willett and Singer 1993) using logistic regression (Hosmer and Lemeshow 2000) was used to estimate cohort effects. Logistic regression was also used to study socio-demographic correlates and comorbidity. Logits and their 95% confidence intervals were converted into odd ratios by exponentiation for ease of interpretation. Standard errors and significance tests were estimated using the Taylor series linearization method (Wolter 1985) implemented in the SUDAAN software system (Research Triangle Institute 2002) to adjust for the weighting and clustering of the NCS-R data. Multivariate significance of predictor sets was evaluated using Wald _ 2 tests based on design-corrected coefficient variance-covariance matrices. Statistical significance was evaluated using 2-tailed .05-level tests; it should be noted that this level, which was pre-specified for all NCS-R analyses, does not correct for multiple comparisons and thus underestimates the overall type I error rate.

Results Prevalence

Lifetime prevalence estimates of anorexia nervosa, bulimia nervosa, binge eating disorder, subthreshold binge eating disorder, and any binge eating were .6%, 1.0%, 2.8%, 1.2%, and 4.5% (Table 1). Lifetime prevalence was consistently 1¾ to 3 times as high among women as men for the 3 eating disorders (z _ 2.2–2.8, P_ .029–.005), 3 times as high among men as women for subthreshold binge eating disorder (z _ 3.3, P _ .001), and approximately equal among women and men for any binge eating (z _ 1.2., P _ .219). No 12-month cases of anorexia nervosa were found in the sample. The 12-month prevalence estimates of the other 4 disorders were considerably lower than the lifetime estimates, although with similar sex ratios. Estimates of cumulative lifetime risk by age 80, based on retrospective age-of-onset reports (Figure 1), were 0.6% for anorexia nervosa, 1.1% for bulimia nervosa, 3.9% for binge eating disorder, 1.4% for subthreshold binge eating disorder, and 5.7% for any binge eating.

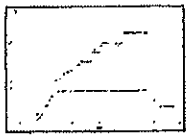


Figure 1
Age-of-onset distributions for DSM-IV eating disorders

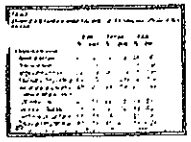


Table 1
Lifetime and 12-month prevalence estimates of DSM-IV eating disorders and related behavior

Age of Onset and Persistence

Median age of onset of the five disorders ranged from 18–21 years (Table 2). The period of onset risk was shorter for anorexia nervosa than for the other disorders, with the earliest cases of the other disorders beginning about 5 years earlier than those of anorexia nervosa (ages 10 vs. 15), and no cases of anorexia nervosa beginning after the mid-20s—whereas some cases of the other disorders began at a much older age (Figures 1 and 2).

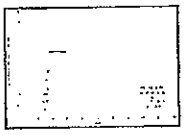


Figure 2
Cohort-specific age-of-onset distributions for DSM-IV Anorexia Nervosa

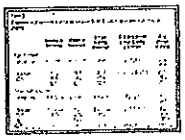


Table 2
Estimated age of onset and persistence of *DSM-IV* eating disorders and related entities

The mean number of years with anorexia nervosa (1.7 years) was significantly lower than for either bulimia nervosa (8.3; t _ 4.1, P _ .001), binge eating disorder (8.1; t _ 2.9, P _.006), subthreshold binge eating disorder (7.2; t _ 2.6, P _ .013), or any binge eating (8.7; t _ 2.9, P _ .005) (Table 2). Consistent with these differences in duration, 12-month persistence, defined as 12-month prevalence among lifetime cases, was lowest for anorexia nervosa (.0%) and higher for bulimia nervosa (30.6%), binge eating disorder (44.2%), subthreshold binge eating (47.2%), and any binge eating (46.9%).

Cohort Effects

Consistent inverse associations between cohort (age at interview) and lifetime risk were found in survival analyses of all 5 disorders (Table 3). However, the odds ratios in younger (ages 18–29, 30–44) versus older (60_) cohorts were significantly higher for all comparisons only for bulimia nervosa, binge eating disorder, and any binge eating.

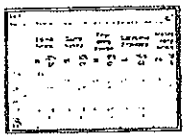


Table 3
Inter-cohort differences in lifetime risk of DSM-IV eating disorders and related behavior

Association with Body-Mass Index

Individuals with a lifetime diagnosis of anorexia nervosa displayed a significantly lower current BMI—with a greater prevalence of a current BMI of _ 18.5, and a lower prevalence of a current BMI _ 40—than respondents without any eating disorder (Table 4). The reverse pattern was found for binge eating disorder, with a significantly higher prevalence of BMI of _ 40 among individuals with binge eating disorder than respondents without any eating disorder. Any binge eating was also associated with severe obesity, but this finding was attributable entirely to cases of binge eating disorder.

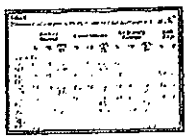


Table 4
Difference in BMI categories at the time of interview in lifetime prevalence of DSM-IV disorders and related behavior

Twelve-Month Role Impairment

Role impairment was assessed only for 12-month cases; since there were no 12-month cases of anorexia nervosa, our analysis was limited to the other 4 disorders. The majority of respondents with bulimia nervosa,

binge eating disorder, or any binge eating reported at least some role impairment (mild, moderate, or severe) in at least 1 role domain (53.1%–78.0%), but only 21.8% of respondents with subthreshold binge eating disorder reported this degree of impairment (Table 5). Severe role impairment was much less common, and ranged from 3.4% in subthreshold binge eating to 16.3% in bulimia nervosa, with no significant differences in prevalence among groups.

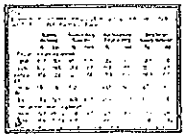


Table 5
Impairment in role functioning (Sheehan Disability Scales) associated with 12-month DSM-IV eating disorders and related behavior

Comorbidity

More than half (56.2%) of respondents with anorexia nervosa, 94.5% with bulimia nervosa, 78.9% with binge eating disorder, 63.6% with subthreshold binge eating disorder, and 76.5% with any binge eating met criteria for at least 1 of the core DSM-IV disorders assessed in the NCS-R (Table 6). Eating disorders were positively related to almost all of the core DSM-IV mood, anxiety, impulse-control, and substance use disorders after controlling for age, sex, and race-ethnicity, with 89% of the odds ratios for the association between individual eating disorders and individual comorbid conditions greater than 1.0 and 67% significant at the .05 level. The odds ratios were consistently largest, though, for bulimia nervosa, with a median (and inter-quartile range in parentheses) odds ratio of 4.7 (4.3–7.5), next highest for binge eating disorder (3.2 [2.6–3.7]) and any binge eating (3.2 [2.4–3.8]), and smaller for anorexia nervosa (2.1 [1.2–2.9]) and subthreshold binge eating disorder (2.2 [1.1–2.9]). No single class of disorders stood out as showing consistently or markedly higher comorbidity with eating disorders.

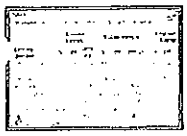


Table 6
Lifetime co-morbidity (OR) of DSM-IV Eating Disorders with other core NCS-R/DSM-IV disorders and related behaviors[1]

Treatment

A majority of respondents with anorexia nervosa, bulimia nervosa, and binge eating disorder (50.0%–63.2%) received treatment for emotional problems at some time in their lives, with the most common site of treatment being the general medical sector for anorexia nervosa (45.3%) and binge eating disorder (36.3%), and the mental health specialty sector for bulimia nervosa (48.2% for psychiatrist and 48.3% for other mental health) (Table 7). However, smaller proportions sought treatment specifically for their bulimia nervosa (43.2%) or binge eating disorder (43.6%). Only 15.6% of respondents with 12-month bulimia nervosa and 28.5% with 12-month binge eating disorder received treatment for emotional problems in the 12 months before interview, with the most common site of treatment being the general medical sector, and similar proportions received 12-month treatment specifically for their bulimia nervosa or binge eating disorder.

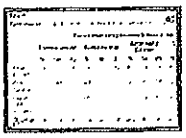


Table 7
Age-of-onset priority of DSM-IV eating disorders and related behavior with comorbid DSM-IV disorders

Supplemental data are available with the electronic version of this article and online at www.hcp.med.harvard.edu/ncs/eating.php.

Discussion

Go to:

In a population-based survey of American households—the first nationally representative study of eating disorders in the United States—we found estimates of lifetime prevalence for eating disorders that are broadly[42]

consistent with earlier data. However, we found a surprisingly high proportion of men with anorexia nervosa and bulimia nervosa (representing approximately one-fourth of cases of each of these disorders). By contrast, clinical and case registry studies (Fairburn and Beglin 1990; Hoek and van Hoeken 2003) report that fewer than 10% men among cases of these disorders, and population-based studies report a 15% proportion of men for anorexia nervosa (Garfinkel et al 1996) and 8%–10% of men for bulimia nervosa (Bushnell et al 1990; Garfinkel et al 1995). Note, however, that estimates from population-based studies, including ours, are unstable because they involve small numbers of men with eating disorders (no more than 5 men with either disorder in any study).

Our findings provide unique data regarding the lifetime duration of eating disorders, and the onset and duration of binge eating disorder, together with extensive information on sociodemographic features of individuals with all 5 disorders. Also, our study provides support for the common impression that the incidence of bulimia nervosa has increased significantly in the second half of the twentieth century (Kendler et al 1991; Hoek and van Hoek 2003), and it provides the first data showing a similar trend for binge eating disorder. Nevertheless, there are some data suggesting that the incidence of bulimia nervosa may be leveling off in recent years (Currin et al 2005). Whether the incidence of anorexia nervosa has increased over time is unclear and subject to debate. We failed to find a significant increase, but had little power to detect such a trend; case registry study data have yielded conflicting findings and interpretations (Fombonne, 1995; Lucas et al 1999; Hoek and van Hoeken 2003; Currin et al 2005).

We found that lifetime anorexia nervosa is associated with a low current BMI, a finding consistent with follow-up studies of clinical samples of individuals with anorexia nervosa showing that low weight often persists after resolution of the disorder (Steinhausen 2002). By contrast, binge eating disorder was found to be strongly associated with current severe obesity (BMI _ 40)—a finding also consistent with earlier reports (de Zwaan 2001; Streigel-Moore and Franko 2003; Hudson et al 2006). Although the causal pathways responsible for this latter association are unclear, shared familial factors (such as shared genes or shared family environmental exposures) are likely at least partly responsible (Hudson et al 2006).

We also assessed role impairment in all disorders except anorexia nervosa, where analysis was precluded because no 12-month cases were identified. While the majority of respondents with bulimia nervosa, binge eating disorder, or any binge eating reported at least some role impairment in at least 1 role domain, only 21.8% of respondents with subthreshold binge eating disorder reported any role impairment. Severe role impairment was uncommon in all conditions. It is important to note, though, that participants may possibly have under-reported role impairment due to factors such as minimization, shame, secrecy, or lack of insight stemming from the ego-syntonicity of symptoms.

Less than half of individuals with bulimia nervosa or binge eating disorder had ever sought treatment for their eating disorder (a measure not assessed for anorexia nervosa), although the majority of individuals with all 3 disorders had received treatment at some point for some emotional problem. This finding, coupled with the observation that physicians infrequently assess patients for binge eating (Crow et al 2004) and often fail to recognize bulimia nervosa and binge eating disorder (Johnson et al 2001), highlights the importance of querying patients about eating problems even when they do not include such problems among their presenting complaints.

We found a high prevalence of lifetime comorbid psychiatric disorders in individuals with all disorders except subthreshold binge eating disorder, although this finding was less pronounced for anorexia nervosa. These results are again generally consistent with those reported in previous population-based studies for anorexia nervosa (Garfinkel et al 1996), bulimia nervosa (Kendler et al 1991; Bushnell et al 1994; Garfinkel et al 1995; Rowe et al 2002), binge eating behavior (Vollrath et al 1992; Angst 1988; Bulik et al 2002), and regular binge eating without compensatory behaviors (Reichborn-Kjennerud et al 2004b), as well as in previous studies of clinical populations for anorexia nervosa, bulimia nervosa, and binge eating disorder (Hudson et al 1987; Halmi et al 1991; Johnson et al 2001; Godart et al 2002; Kaye et al 2004; McElroy et al 2005). The cause for

the high levels of comorbidity is not known, although there is evidence that the co-occurrence of eating disorders with mood disorders may be caused in part by common familial (Mangweth et al 2003) or genetic factors (Walters et al 1992; Wade et al 2000).

Several findings in this study are particularly noteworthy. First, we found that anorexia nervosa displayed a significantly shorter lifetime duration and lower 12-month persistence, as well as lower overall levels of comorbidity, than either bulimia nervosa or binge eating disorder. These findings contrast with previous studies (Steinhausen 2002) that have conceptualized anorexia nervosa as a chronic and malignant condition. This discrepancy may be due to the fact that our population-based method identified individuals with milder cases of anorexia nervosa who might have been missed in previous follow-up studies, which were based largely on clinical samples. Alternatively, our population-based method might have missed more severe cases of anorexia nervosa, either because they were unavailable, unreachable, hospitalized, or unwilling to participate in an interview about emotional problems. Parenthetically, we would note that while we found no cases of current anorexia nervosa in our study, 15.6% of the individuals with a lifetime diagnosis of anorexia nervosa still had a current BMI of less than 18.5 at the time of interview. Indeed, these individuals (3 cases) were all below 85% of ideal body weight, thus meeting our operationalization for DSM-IV criterion A for anorexia nervosa. However, all of these individuals failed to meet at least one of the other criteria for anorexia nervosa currently—although our data did not permit an analysis of which specific criteria were lacking in individual cases. Nevertheless, these data suggest that a minority of individuals with past anorexia nervosa may continue to maintain an abnormally low body weight, even though they no longer meet full criteria for anorexia nervosa.

Our findings also provide further evidence for the clinical and public health importance of binge eating disorder. In contrast to some earlier studies suggesting that binge eating disorder might be a relatively transient condition (Cachelin et al 1999; Fairburn et al 2000), the present findings, together with those from another recent study (Pope et al. in press), suggest that this disorder is at least as chronic and stable as anorexia nervosa or bulimia nervosa. Binge eating disorder also appears more common than either of the other two eating disorders, exhibits substantial comorbidity with other psychiatric disorders, and is strongly associated with severe obesity. Collectively, these findings suggest that binge eating disorder represents a public health problem at least equal to that of the other 2 better-established eating disorders, adding support to the case for elevating binge eating disorder from a provisional entity to an official diagnosis in DSM-V.

Subthreshold binge eating disorder, by contrast, was found to be associated with such low impairment and comorbidity that it likely does not merit consideration for inclusion as a DSM disorder. It should be recalled, in this connection, that the main difference between subthreshold binge eating disorder and binge eating disorder is that the former lacks the criterion of distress (see Appendix Table 1 in Supplement 1). These findings suggest that the criterion of distress may be important for defining clinically meaningful forms of binge eating.

Appendix table 1
Lifetime prevalence estimates of DSM-IV eating disorders and related behavior by age and sex

Note that subthreshold binge eating disorder may be defined in different ways. For example, relaxing the frequency criteria to less than the average of 2 days per week for 6 months required by DSM-IV identifies groups with characteristics similar to the full disorder (Striegel-Moore et al 2000; Crow et al 2002). We were unable, however, to evaluate these definitions due the nature of the CIDI questions, and instead defined subthreshold binge eating disorder by relaxing criteria other than frequency of binges. Thus, while our definition of subthreshold binge eating disorder does not appear to identify a clinically meaningful entity, other definitions may well do so.

Unlike subthreshold binge eating disorder, the entity "any binge eating" is associated with severe obesity,

modest levels of impairment, and high levels of comorbidity with other mental disorders. These features appear to be accounted for cases of bulimia nervosa or binge eating disorder within the "any binge eating" group, given that such features are not shared by those with subthreshold binge eating disorder, and individuals with anorexia nervosa contribute only a small number of cases. The findings for any binge eating are interesting to consider in the light of findings from twin studies of binge eating. These studies have suggested that there are genetic influences on binge eating (Bulik et al 1998) and on binge eating without compensatory behaviors (Reichborn-Kjennerud et al 2004a). On the basis of our findings here, it is tempting to speculate that the heritability of binge eating behavior may be attributable primarily to cases of bulimia nervosa and binge eating disorder—both of which have been shown to be familial (Strober et al 2000; Hudson et al 2006)—rather than to cases of subthreshold binge eating disorder within the group.

Several limitations of the study should be considered. First, some CIDI questions did not precisely mirror the DSM-IV criteria for the various eating disorders, as illustrated by in the diagnostic algorithms discussed in our methods section. Perhaps the most important inconsistency is that, in order to have parallel duration requirements for bulimia nervosa and for binge eating disorder, we required only 3 months of illness for a diagnosis of binge eating disorder, in contrast to the 6 months required by DSM-IV. Thus, it is possible that we may have overestimated the prevalence of binge eating disorder by including some cases with a duration of only 3 to 5 months.

Second, diagnoses were based on unvalidated, fully structured lay interviews where lifetime information was assessed retrospectively. These may be important considerations, given that an earlier version of the CIDI was found to underdiagnose eating disorders (Thornton et al 1998), possibly because some individuals minimized or denied symptoms. Version 3.0 of the CIDI was designed to reduce this sort of under-reporting by using a number of techniques developed by survey methodologists to reduce embarrassment and other psychological barriers to reporting (Kessler and Ustun 2004)—but these changes necessitated indirect assessments of loss of control and distress, as noted above. In any event, pending validation studies, it would seem prudent to think of the NCS-R estimates as lower bounds on the true prevalence of eating disorders.

Third, in our analyses of the associations between eating disorders and body weight, we possessed only current BMI, rather than maximum or minimum adult BMI, or BMI at the time of the disorder. Thus, we likely underestimated the magnitude of these associations.

Fourth, because recall of earlier experiences may diminish with age, our retrospective assessments may have overestimated the magnitude of cohort effects (Giuffra and Risch 1994). Since cohort effects and age effects are confounded, and no prospective studies have been performed over the period under study, it is not possible to assess the magnitude of this potential bias. Prospective studies will be useful to track possible cohort effects in the future,

Fifth, our results are based on the assumption that any exiting from the population available for sampling was non-informative and that there was no selection bias (in the form of non-response bias) due to sampling from available subjects; these limitations are discussed elsewhere (Hudson et al 2005). For example, the validity of our results would be threatened if the development of eating disorders rendered individuals less likely to be available for sampling, which might occur if there were a high mortality due to eating disorders, or a significant proportion of cases hospitalized at the time of sampling. Although some clinical follow-up studies have suggested substantial mortality for anorexia nervosa (Sullivan 1995; Steinhausen 2002; Keel et al 2003), data from a community case registry study (Iacovino 2004) did not find excess mortality.

Another possible threat to validity would be bias in sampling of available individuals, in that individuals with eating disorders might be more or less likely to participate. However, we carried out a non-response survey to deal with this problem, which offered a larger financial incentive ($100) to main survey nonrespondents for a short (15-min) telephone interview that assessed diagnostic stem questions. Very little evidence was found that survey respondents and non-respondents differed on stem question endorsement for the NCS-R core anxiety, mood, impulsecontrol, or substance use disorders (Kessler et al 2004b). Thus, it is likely that non-

response bias for eating disorders was minimal.

Sixth, while we examined 2 provisional entities in addition to those for which criteria were provided in DSM-IV, we did not examine many other possible entities that lie within the category of Eating Disorder Not Otherwise Specified (Fairburn and Bohn, 2005)—such as subthreshold forms of anorexia nervosa and bulimia nervosa, alternative definitions for subthreshold binge eating disorder (discussed above), purging without either bulimia nervosa or anorexia nervosa (Keel et al 2005), and night eating syndrome (Stunkard et al 2005)— because the questions in the CIDI did not permit evaluation of these conditions.

In conclusion, the lifetime prevalence of the individual eating disorders ranged from 0.6–4.5%; these disorders displayed substantial comorbidity with other DSM-IV disorders and were frequently associated with role impairment. These patterns raise concerns that such a low proportion of individuals with these disorders obtain treatment for their eating problems. As it turns out, though, a high proportion of cases did receive treatment for comorbid conditions. Thus, detection and treatment of eating disorders might be increased substantially if treatment providers queried patients about possible eating problems, even if the patients did not include such problems among their presenting complaints.

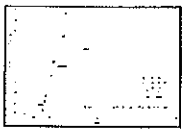


Figure 3
Cohort-specific age-of-onset distributions for DSM-IV Bulimia Nervosa

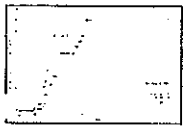
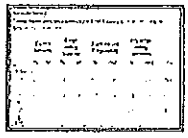
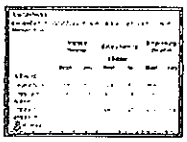


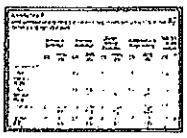
Figure 4
Cohort-specific age-of-onset distributions for DSM-IV Binge-Eating Disorder



Appendix table 2
Twelve-month prevalence estimates of DSM-IV eating disorders and related behavior by age and sex



Appendix table 3
Estimated age-of-onset and persistence of DSM-IV eating disorders by lifetime treatment status



Appendix table 4
Cross-sectional socio-demographic profile of respondents with lifetime DSM-IV eating disorders and related behavior[1]

Table 8a
Lifetime and 12-month treatment of DSM-IV eating disorders

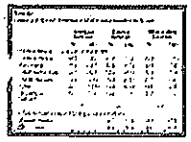


Table 8b
Lifetime and 12-month treatment of DSM-IV eating disorders for females

Table 8c

Acknowledgments

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Licenses

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0050

Mental Health Residential Living Center

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Discovery Practice Management, Inc. of Los Alamitos, CA, d/b/a Center for Discovery Residential Treatment for Adult Women with Eating Disorders is hereby licensed to maintain and operate a Mental Health Residential Living Center.

Center for Discovery Residential Treatment for Adult Women with Eating Disorders is located at 4536 Congress St, Fairfield, CT 06824 with:

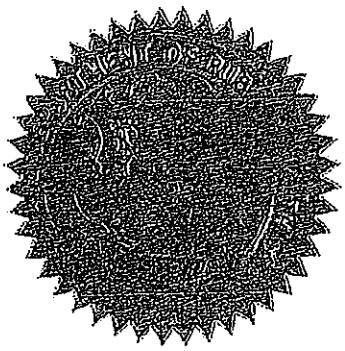
Perla Vilhjalmsdottir as Executive Director,
Samantha Bathija as Director.

The maximum number of beds shall not exceed at any time:

6 Mental Health Residential Living Center beds.

This license expires **March 31, 2017** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, April 17, 2015. **INITIAL**



Jewel Mullen, MD, MPH, MPA
Commissioner

Resumes

Round 1

RN

Janice Leibovitz

experienced registered nurse

West Haven, CT
jandeejen@live.com - (203) 645 7282

WORK EXPERIENCE

INSTRUCTOR for PATIENT CARE TECHNICIAN
CNA - 2011 to 2013

MEDICAL/BEHAVIORAL HEALTH SUPERVISOR
STONE ACADEMY - West Haven, CT - 2002 to 2011

STAFF AND CHARGE NURSING ON A DUAL DIAGNOSIS
VA MEDICAL CENTER - West Haven, CT - 1989 to 2003

HOMECARE PLUS MLFD., CT. (ASSISTED IN THE DEVELOPMENT, CASE MANAGEMENT, AND PATIENT CARE OF A NEW DEPT. IN A HOME HEALTH AGENCY, ACCORDING TO STATE AND MEDICARE REGULATIONS. MY WORK FOCUSED ON EDUCATING CLIENTS AND FAMILIES AS WELL AS OVERSEEING STAFF, PATIENT AND FAMILY PROGRESS.)

MEDICAL/PSYCHIATRIC NURSING 1989-2003
Inpatient and Outpatient settings
VA MEDICAL CENTER WEST HAVEN, CT. (STAFF AND CHARGE NURSING ON A DUAL DIAGNOSIS, SUBSTANCE ABUSE, AND PTSD UNITS: ASSISTED IN THE DEVELOPMENT AND MANAGED AN OUT-PATIENT UNIT. MY FOCUS WAS ON SUPERVISING AUXILARY STAFF, PATIENTS, AND EDUCATING BOTH IN DISEASE PROCESSES AND ASSUMING RESPONSIBILITY FOR WELLNESS.)

STAFF NURSE
PSYCHIATRIC CHARGE - 1985 to 1989

CT. MENTAL HEALTH CENTER NEW HAVEN, CT (CASE MANAGED, FACILITATED THERAPY GROUPS, TAUGHT DISEASE CONCEPT CLASSES, ASSISTED IN COURT MANDATED COMPETENCY MEETINGS)

CARDIAC REHAB INSTRUCTOR
YALE NEW HAVEN HOSPITAL - New Haven, CT - 1982 to 1985

PROVIDED PATIENT CARE, PRECEPTED NEW NURSES. ASSISTED IN THE DEVELOPMENT AND TAUGHT CARDIAC REHAB CLASSES TO RECOVERING PATIENTS AND FAMILIES)

STAFF AND CHARGE NURSE ON GENERAL PEDIATRIC UNIT; PROVIDED BACKUP NURSING TO NEWBORN ICU
ROOSEVELT HOSPITAL - New York, NY - 1980 to 1982

NYC, NY (STAFF AND CHARGE NURSE ON GENERAL PEDIATRIC UNIT; PROVIDED BACKUP NURSING TO NEWBORN ICU)

Cheri Kleiman

1 New Haven Avenue • Unit 2P• Milford, Connecticut 06460
Cheri.Kleiman@gmail.com • 203.823.0029

EDUCATION

Master of Science in Marriage and Family Therapy, 2008
Central Connecticut State University – New Britain, CT
Bachelor of Arts in Psychology, 2004 – Minor in Spanish
University of North Florida – Jacksonville, FL

EXPERIENCE

Marriage and Family Therapist, Collaborative Counseling Group, Fairfield, CT *05/2013-Current*
Private Practice

- Provide individual, family, and couples therapies within a group private practice setting
- Maintain positive relationships with other community providers in order to facilitate referral processes

Senior Supervising Clinician, Mid-Fairfield Child Guidance Center, Norwalk, CT *09/2012-Current*
Outpatient Clinic

- Responsible for providing clinical supervision to marriage and family therapy interns and therapists working toward licensure
- Provide individual and family therapies to clients served in an outpatient treatment setting
- Co-facilitate adolescent and multi-family Dialectical Behavior Therapy groups
- Provide Trauma-Focused Cognitive Behavioral Therapy to children and families with histories of trauma
- Manage client crises with use of on-call phone services
- Lead supervision groups focused on Trauma-Focused Cognitive Behavioral Therapy
- Participate in weekly DBT consultation team in compliance with the model

Clinical Therapist, The Children's Center of Hamden, Hamden, CT *04/2011- 08/2012*
Outpatient Substance Abuse Treatment Program

- Provided individual and family therapies to adolescents with substance abuse diagnoses
- Administered case management services in collaboration with the juvenile court system and the Department of Children and Families
- Completed all clinical documentation in compliance with Medicaid and agency standards
- Responsible for making referrals for aftercare services following discharge

Clinical Therapist, Youth Continuum Inc., North Haven, CT *10/2010- 08/2012*

- Provided individual and family therapies to adolescent males residing in a therapeutic group home
- Planned and conducted clinical and life skills groups that were formulated to engage residents with various complex mental health diagnoses
- Coordinated discharge plans to adult services or family reunification
- Collaborated with multidisciplinary treatment team to create individualized treatment plans

Clinical Therapist, The Children's Center of Hamden, Hamden, CT *10/2008-10/2010*
Outpatient Psychiatric Services and (CARE) Crisis Stabilization Program

- Responsible for providing individual and family therapies to clients in the Outpatient Mental Health Clinic and Crisis Stabilization Program
- Coordinated with outside agencies during assessment, treatment, and in planning for aftercare
- Developed crisis plans with families and provided them with information about community resources

Intake Coordinator, The Children's Center of Hamden, Hamden, CT *05/2008-10/2008*

Outpatient Psychiatric Services

- Conducted intake interviews and provided comprehensive clinical assessments of children and families referred to Extended Day Treatment Program and Outpatient Mental Health Clinic
- Evaluated referrals and determined necessity for admission to Crisis Stabilization Program
- Obtained authorization for services from insurance companies

Clinical Therapist Intern, The Children's Center of Hamden, Hamden, CT *08/2006-05/2008*
Extended Day Treatment Program

- Responsible for carrying a client caseload and providing individual, family, and group therapies
- Provided trauma based therapy working mostly with cases with histories of abuse and neglect
- Worked as part of a multidisciplinary treatment team providing information, strategies, and a clinical perspective on treatment of children
- Conducted multi-family therapy groups with clients in residential substance abuse treatment program

CERTIFICATIONS AND SPECIFIC TRAINING

- Licensed - Marriage and Family Therapist (LMFT) by the state of Connecticut. License number: 001386
- AAMFT Approved Supervisor candidate
- Intensively trained in Trauma-Focused Cognitive Behavioral Therapy model
- Completed training in adolescent Dialectical Behavior Therapy through Behavioral Tech, LLC
- Trained in the Risking Connections model for treating psychological trauma

Amber P. Tillman
14 Marie Dr. APT 12
Seymour CT, 06483
(203) 224-0957
ambertillman@yahoo.com

Education: *University of New Haven*, West Haven, CT Graduated in August 2011 with Masters in science degree for Criminal Justice with a concentration in Victimology

Bay Path College, Longmeadow, MA Graduated in May 2010 with Bachelor in science degree in Criminal Justice

Norwalk Community College , Norwalk, CT Graduated in December 2006 with Associates in science degree for Criminal Justice.

Work Experience:

The Center of Women and Families, Safe Advocate Fall 2012- Present

- Responsible for providing client intake and advocacy, Hotline coverage, provide support groups 2 – 3 per week. Advocating with outside system regarding client's needs, assisting client in developing safety planning which address client's particular situations
- Providing clients with information and referral and resources outside of the domestic violence program and provide victim compensation information and assisting in filing compensation forms.
- Providing crisis intervention for shelter clients as needed, providing transportation for shelter clients, medical needs, shopping, education program, cultural activities, etc.
- Updating shelter coordinator and/or on-call staff – phone when appropriate, Ensure positive and safe environment for shelter women and children and attend all scheduled per diem meetings and on-going trainings.
- Updating progress plan to assure that residents are actively working on goals. Meet with residents two times per week to monitor their progress, establish a calendar for planned activities for shelter residents and responsible for household and food inventory, weekly grocery shopping

Community Solutions, Inc. AIC Case Manager Fall 2012-Fall 2013

- Responsible for conducting client orientations, collecting intake data, performing client needs assessments and making recommendations to the supervisor regarding treatment needs.
- Developing and documenting program plan goals with clients. Monitoring treatment stipulations, job readiness preparation, community resource referrals. Developing and implementing a discharge plan for clients.
- Scheduling, conducting and documenting individual counseling sessions that address client personal issues and program performance. Making recommendations to supervisor for corrective action as required and monitoring on an ongoing basis.
- Maintaining client files and ensuring compliance with agency policy regarding confidential information.
- Completing all client-related documentation and making log entries on all shifts activities.

BHcare, Crisis Advocate Fall 2011- Fall 2012

- Responsible for delivering supportive services to domestic violence victims at shelter, such as domestic violence counseling, safety planning, shelter orientation to new clients, and transportation when appropriate.
- Coordinating sheltering with other domestic violence programs or other facilities in accordance with CT Coalition program standards, providing in person supportive services as needed at Griffin Hospital, catchment area police stations and safe houses, complete hotline intake for every hotline call received, complete hotline activity sheet for each shifted worked and establish an on call recourse file so that client concerns can be addressed effectively, performing danger assessment for clients, performing

LAP program(Lethality assessment program) with client and police officer.

State of Connecticut Judicial Branch, Probation Volunteer Fall 2011-Spring 2012

- Similar to my internship this position also involved communicating with clients to gather information to update their accounts, setting appointments for clients and documenting them , performing background checks on clients, completing probation forms and paperwork, faxing probation forms to other offices. Calling other probations offices and halfway houses for client's information and filing client's paperwork. Creating case notes for all client activities and inputting drug test results and status of treatment programs.
- Transferring probation clients from one officer to another; writing arrest warrants and police report summaries, mailing probation forms to clients, creating new restitution accounts for clients and preforming early probation termination process.

Computer Skills: Microsoft word, PowerPoint, Excel, Adobe Photoshop

KAREN M. SCHWARTZ

8 Old Gate Lane
Newtown, CT 06470

203-648-2815
karenschwartz19@yahoo.com

SUMMARY

Graduate student in Masters Program in Human Nutrition. Assisted individuals in learning the concept of a healthy life style through nutrition and fitness. Great motivator and can adapt to different personalities. Strong ability to communicate nutritional advice to people from different backgrounds. Well developed computer skills, including the use of Microsoft Office applications on both Mac and PC platforms.

WORK EXPERIENCE

Westport School District, Westport, CT — **October 2013 to Present**
Health Assistant, K - 12
Perform initial psychological and physical assessment (take temperature, examine minor wounds and bruises, view throat, etc.), evaluate demeanor, discuss and analyze symptoms, and determine if nursing care is necessary.

Club24 Concept Gyms, Newtown, CT — **April to September 2013**
Assistant Manager

- Acknowledged every member every time and responded to member feedback.
- Created a welcoming and friendly environment for club members and colleagues
- Participated in member and staff functions and events
- Held monthly staff meetings with employees to go over the gyms accomplishments and future goals
- Increased both employee sign ups as well as employee retention
- Answered all customer questions regarding equipment, nutrition and exercise
- Discussed dietetic patterns with individual members aided them in creating a healthy lifestyle balance

Atlas Air Worldwide Holdings, Purchase, NY — **2011 to 2013**
Reliability Analyst

- Performed analysis of aircraft maintenance program to achieve the highest level of safety and economics.
- Monitored Reliability Data for the 767 fleet for adverse trends that could affect the ETOPS fleet and participate in the event investigations process as required. Review, monitor, and evaluate ETOPS related alerts.
- Prepared monthly ETOPS operating summaries and associated reports.
- Communicated with management on the ETOPS fleet reliability at scheduled Reliability Meetings
- Reviewed and evaluated maintenance discrepancies generated from pilot write-ups, maintenance write-ups, and non-routine cards. Initiate actions on findings that show an adverse trend.
- Analyzed effectiveness of proposed and implemented aircraft modifications
- Experienced in maintaining compliance with FAA requirements for a Reliability Program
- Provided data as required by maintenance to determine causes of adverse reliability trends.
- Provided analysis on Maintenance and aircraft problems to the Manager of Maintenance Programs.
- Assisted Maintenance and Engineering with data collection for project justifications.
- Performed other duties as directed by the Reliability Manager, or the Director of Quality Assurance / Quality Control.

EDUCATION

Currently enrolled in **Masters in Human Nutrition**, University of Bridgeport, Bridgeport, CT.
Bachelor of Arts, **Business Administration, concentration in Marketing**, Monmouth University, NJ
Regents University, London, England, Attended junior year abroad.

KAREN M. SCHWARTZ

8 Old Gate Lane
Newtown, CT 06470

203-648-2815
karenschwartz19@yahoo.com

REFERENCES

Susan Neville, Owner
Susan Neville CPA
830 Post Rd E, Westport, CT 06880
(203) 227-8101

Susan Morse, LCSW
1 Washington Ave #4, Sandy Hook, CT 06482
(203) 426-4701

Wes Gonzalez, Manager
Club 24 Concept Gyms
290 Pratt St, Meriden, CT 06450
(203) 314-3343

Linda Egdahl
Private Pastry Chef
33 Fawnwood Drive, Sandy Hook, CT 06482
(203) 270-8113

Amy R. Patnode

1443 New Haven Road Naugatuck, CT 06770
203-558-6704 ◦ amy.r.patnode@gmail.com

OBJECTIVE

Seeking a teaching position in the area of Social Studies.

EDUCATION

University of New Haven — West Haven, CT
Bachelor of Science, Legal Studies — Graduation: May 2011

University of New Haven — West Haven, CT
Bachelor of Science, History — Graduation: May 2011

University of New Haven — West Haven, CT
Paralegal Certification — Graduation: May 2011

University of Bridgeport — Bridgeport, CT
Master in Education, Secondary Education — Graduation: May 2012

RELEVANT COURSEWORK-Undergraduate

American 60's: Change and Turbulence
American Government & Politics
American History since 1607
Civil Procedure
Constitutional Law
Equality Under the Law
Ethics
Europe in the Nineteenth Century
Europe-Renaissance to Enlightenment
Foundations for Western World
Genocide in Modern Times
International Relations
Japan-U.S. Relations
Legislative Process
Modern Asia
Modern Political Analysis
Public Speaking & Group Discussion
State and Local Government
Western World in Modern Times
Women in 20th Century America
U.S. 20th Century

RELEVANT COURSEWORK-Graduate

Civics
Differentiated Instruction
Educating Exceptional Student
History for Teachers
New Technologies for Learning
Psychology Foundations for Education
Reading in Content Area, Secondary
Research& Report Writing
Teaching with Smart Board
Teaching Social Studies
U.S. History for Teachers

EXPERIENCE

Terence S. Hawkins, Esq. — New Haven, CT
Intern — June 2009—August 2009

Terence S. Hawkins, Esq. — New Haven, CT
Administrative Assistant — August 2009—March 2011

Naugatuck High School — Naugatuck, CT
Intern — August 2011—June 2012

Naugatuck High School
Student Teacher

Naugatuck, CT
August 2012-December 2012

Naugatuck Board of Education
Substitute Teacher

Naugatuck, CT
December 2012- present

Middletown Board of Education
Substitute Teacher

Middletown, CT
October 2013- present

COMPUTER SKILLS

Blackboard
GoTo Meeting
JSTOR
LexisNexis
Microsoft Word
Microsoft Excel
Microsoft PowerPoint
Open Office
PowerSchool
Smart Board
West Law

JENNIFER MATHELIER

FT – overnight
have worked overnight

265 Hawley Avenue
Bridgeport, CT 06606
(203) 218-8719
mathelierj1@owls.southernct.edu

Summary of Qualifications:

- Highly-motivated, dependable , and hardworking professional with excellent customer service skills
- Effective ability to work well independently, as well as in a team environment with minimal supervision
- Graduated in top tenth percentile in high School
- Strong verbal and written communication skills
- Fluent in English, Creole & French
- Proficient in Microsoft Applications, and Internet Explorer

Skills:

- Data Entry
- Punctual
- Responsible
- Customer Focus
- Well-Organized
- Cash Handling
- Safety Conscious
- Great Leadership Skills
- Fast Learner
- Trustworthy
- Detail-Oriented

Education:

Southern Connecticut State University — New Haven, CT

Liberal Studies — Expected Graduation Date December 18, 2013

Minor: Psychology and Wellness minor

Relevant Courses: Infant and child Psychology, Social Psychology, Abnormal Psychology, Cognition and Perception Psychology, Seminar: Behavioral theory and Practice.

Professional Experience:

Personal Aid /Companion

- Provides personal care and companionship to clients in a timely and efficient manner
- Accompanies patients to doctor's appointments and other related fun activities
- Prepares food per diet plan and assists with feeding as needed
- Maintains records of client progress and services performed, reports changes to supervisor

Call Center Customer Service Representative

- Provided information about products, entered orders, cancelled accounts, and obtained details of complaints
- Kept records of customer interactions recording details of inquiries, complaints, and comments
- Followed company standards procedures and policies at all times

Customer Service/Shoes Specialist/POS Data entry

- Described merchandise and explained use, operation, and care of merchandise to customers
- Computed sales prices, total purchases, received and processed cash or credit cards payment
- Recommended, selected, and helped locate merchandise based on customer needs and desires

Front Desk Clerk

- Courteously greeted customers and answered their inquiries in a professional manner
- Answered phone and transferred the calls to the appropriate departments
- Performed other duties as assigned by supervisor

Shift supervisor

- Responsible for opening, closing the store, and cash management
- Trained and supervised new employees per company's policies and procedures
- Ensured all customers have a great shopping experience and provided excellent customer service

Work History:

Companions and Homemakers; Fairfield CT	Personal Aid/Companion	2009 – Present
Aerotek Temp-Agency; Norwalk CT	Outbound Sales call Representative	2011 – Present
Really Good Stuff Company; Monroe, CT	Customer Service Rep	2013 – 2013
JC Penny; Milford, CT	Customer Service/Shoes Specialist	2012 – 2013
Fabricare Cleaners; Darien CT	Front Desk Clerk	2011 – 2011
Payless Shoes; Trumbull CT	Shift Supervisor	2007 – 2011

Volunteer Work:

Service for Peace volunteer; Bridgeport CT	2004 – 2007

DANA GARVEY

dana.garveyy@gmail.com

(203) 243-6721

OBJECTIVE

To obtain a position that will contribute to my professional growth, utilize my skills, and be an asset to your company.

EDUCATION

HS Diploma Notre Dame Catholic High School Fairfield, CT

Graduation date: May 2008

Earned Associates Degree –Liberal Arts

University of Hartford West Hartford, CT: December 2010

Bachelor's Degree in Communications- University of Hartford West Hartford, CT: May 2012

EXPERIENCE

Trumbull Smiles Family Dental

Review provider schedules and individual patient charts and assist the care team in coordinating care for visits and for future healthcare needs.

- Handle non-appointment related calls from patients. Resolve the reason for the call or route to the appropriate party.

- Provide an effective communication link between patient and medical staff,

including relaying messages from providers, gathering information from patients for providers, etc.

- Support patients and providers in the medication refill process
- Use registry and other information to inform care team members of preventive care required for each patient seen each day.
- Ensure that all patients are tracked and data entered into systems for follow-up and reporting.
- Regularly review registry information for assigned panel of patients and arrange for care needed to proactively coordinate healthcare needs.

Nov 2011 – Sept 2012

Birmingham Group of Companies - Milford, CT

ASST. Manager
Developed efficiency-enhancing workflow
Accounting Services - QuickBooks
Handled busy phone system
Functioned as primary liaison to customers
Ensured a consistently positive customer experience
Scheduling Appointments

Opened & Closed Office

Filing

June 2011-Aug 2011

Office of Communications – Intern

Editorial Services

Marketing Communications

Media Relations

July 2010 –May 2012.

Women's Educations Leadership Fund-

- Communications assistant
- Fundraising
- NonProfit

v The Women's Education and Leadership Fund was established to foster and support University of Hartford initiatives to enhance the education of women, Empower women to lead, Enrich the University community and beyond. Help bring awareness to the fund and administrative work.

Computer Skills

Adobe Photoshop, Adobe Bridge, Illustrator, MS Excel, Word Press ,PowerPoint, Access, outlook , Social Media, Project management software's, HTML and CSS, QuickBooks

Andrea Marie Cierlelli, LMFT
122 Thompson Avenue
East Haven, CT 06512
203.651.9308

PROFESSIONAL EXPERIENCE

1/11 - Present **Youth Continuum, Incorporated, North Haven, CT**
Program Director, Therapeutic Group Home

Provide direct supervision and oversight for all day to day operations of the therapeutic group home including: therapeutic crisis intervention, completing risk assessments for at-risk adolescent youth, provide group and individual therapy as needed both in the absence of and in conjunction with clinical therapist, participate in weekly psychiatric supervision meetings, screening and interviewing potential residents upon matching from insurance companies, extensive case management services, coordinate and facilitate monthly staff meetings and quarterly trainings for all staff, create staff schedule, maintaining compliance with required clinical therapy hours, physical plant maintenance, documentation requirements, budgeting, cash distribution, monthly and weekly reporting requirements, payroll and direct supervision to shift supervisors and clinician, participate in ongoing agency quality improvement, ensure the group home is operating under the requirements of various regulatory bodies including DCF, COA and PNMI standards.

2007- Present **Southern Connecticut State University, New Haven, CT**
Adjunct Professor, School of Arts & Sciences, Psychology Department

Courses: Adolescent Psychology, Infant and Child Development & Abnormal Psychology. Plan lectures for a dynamic class of forty students, which often includes accommodations for students with various disabilities, browse various texts and choose one that best suits the subject and current with regard to research and case examples, create, administer and grade quizzes, tests, projects and papers, educate students on the APA style of writing and citation as well as provide them with a comprehensive understanding of the subject matter using class lectures, Power Point, visual aids, anecdotal information, examples from the DSM-IV TR and small group work, calculate and submit midterm and final grades in a timely manner, maintain course website and post lecture notes, study guides, pertinent information and links to the website on a weekly basis to encourage students to take an active role in his/her university education.

2008 - 2010 **The Children's Center of Hamden, Hamden, CT**
Clinical Supervisor, Outpatient Mental Health (OPMH) Clinic &
Program Supervisor, Child & Adolescent Respite and Evaluation (C.A.R.E) Program

Provide direct supervision to both clinical and milieu staff, maintain both programs with respect to DCF, JCAHO and Medicaid regulations, provide direct clinical care for up to 8 youth on the CARE unit ages 7-18, coordinate treatment planning, oversee all clinical provider meetings, complete various payroll and staffing coordination tasks, conduct weekly maintenance checks to identify possible safety concerns on the unit, complete intake, admissions and discharges for the CARE and OPMH programs and all accompanying paperwork, complete risk assessments and mental status exams for at risk

review reports, serve as a member of the professional staff organization involved in identifying training needs and organizing/scheduling trainings on an as needed basis, grant writing for the agency, orientation and training of new employees/interns, conduct monthly staff meetings, ensure trauma sensitive framework for all treatment.

2006 - 2008 **The Children's Center of Hamden, Hamden, CT**
Clinical Therapist, Intensive Outpatient Program & Extended Day Treatment Program

Perform daily group/milieu therapy, individual therapy and family therapy to caseload of up to ten adolescent clients at the IOP and EDTP levels of care, extensive case management services involving all treatment providers including, but not limited to: DCF, IFP, YHCAPS, various systems of care, community agencies and the CTBHP. Obtain authorizations for treatment from all insurance providers, coordinate care through case conferences, treatment team meetings and weekly supervision. Diagnose clients and develop treatment plans using the DSM-IV TR. Interface with the consulting psychiatrists and the treatment team to best serve the clients and plan for case coordination and appropriate discharge planning. Provide peer supervision and milieu staff supervision on a weekly basis to educate staff about diagnoses, defense mechanisms and extensive trauma histories of the clients. Provide both home and school visits to observe clients in other environments and in the community. Serve as a member of the cultural competency committee to ensure that the agency is being culturally sensitive to the population it serves.

EDUCATION

2003 - 2005 **Southern Connecticut State University, New Haven, CT**
Master of Marriage and Family Therapy

Intern at SCSU Family Clinic; individual therapy, couples therapy, supervised visitation, anger management group for adult males, family therapy, case management services
Intern at Naugatuck Youth Services; individual, couples and family therapy
Intern at Naugatuck High School; individual therapy with adolescents

1999 - 2003 **Southern Connecticut State University, New Haven, CT**
Honor's College
Bachelor of Arts, Mental Health Psychology, Cum Laude

Thesis title "The Effects of Parenting Styles on Adolescent Drinking Behaviors"
Award for Successful Completion and Defense of Thesis
Theta Chi Upsilon, Alpha Chapter

PROFESSIONAL LICENSURE

Licensed as a Marital and Family Therapist, State of Connecticut
License Number: 001243

PROFESSIONAL CERTIFICATIONS

CPR & First Aid 8/2011
Certified Risking Connections Trainer 11/2009

Jessica Anne Morrison
78 Grand View Street
Providence, RI 02906
JessAMorrison@gmail.com
(484) 678-3199

Qualifications

Ambitious, outgoing, hardworking, charismatic individual with strong interpersonal skills. Works well in group activities and individually. Productive worker who is dependable and resourceful. Well educated, and always eager to learn.

Education

1999-2004 **West Chester University of Pennsylvania**, West Chester, PA 19380
Bachelor of Arts in Psychology, Minor in Music

2008 **Professional Association of Therapeutic Horsemanship International**
Certified Therapeutic Riding Instructor

Experience

Jan. 2012-Present **The Providence Center – Providence, RI**
Intake Specialist – Respect Program

- Triage all telephone calls directed to RESPECT from a variety of referral sources including hospitals, consumers, families, police, etc.
- Gather demographic and CNOM information, check EDS on all non-insured clients
- Gather presenting clinical concerns, risk factors, ASAM and diagnostic criteria when available, and level of care request
- Make determinations of level of care based on clinical information provided by the caller, including medical/clinical necessity
- Investigate and problem solve clinical and/or placement issues to completion
- Data enter information into client record system, and utilize data from system in order to make appropriate referrals or facilitate transfer

May 2011 – Sep. 2011 **Rosewood Centers for Eating Disorders – Wickenburg, AZ**
Regional Outreach Manager - East Coast

- Recruit, maintain and manage referral relationships with current and new customers, meeting benchmarks for admissions on a quarterly basis
- Create, coordinate educational opportunities within the northeast on a quarterly basis
- Promote and represent company programs and services within the healthcare, business, and recovering eating disorder community
- Complete monthly activity reports that include daily marketing visits, follow up correspondence, visits, calls and networking functions
- Assist clinical team with referrals

June 2010-May 2011 **Rogers Memorial Hospital - Oconomowoc, WI**
National Outreach Representative

- Collaborate with other members of the marketing department, program managers and physicians to plan and execute projects within all residential programs with a main focus on eating disorder services.
- Research and analyze quality of programs, services, prices, strengths and weaknesses of national competitors' programs
- Develop new referral contacts
- Monitor and follow admissions for eating disorder services, identify all referral sources and potential leads at a national level
- Develop direct marketing and outreach relationship tactics with key referents in the nation
- Construct and maintain annual eating disorder services budgets
- Provide leadership and direction with manager in the strategic planning and development of national events, workshops and conferences
- Assist Rogers Foundation with fundraising campaigns and events
- Identify and participate in new business development discussions at a national level

April 2009-
June 2010

Rogers Memorial Hospital - Oconomowoc, WI
Regional Outreach Representative

- Research and analyze quality of programs, services, prices, strengths and weaknesses of competitors' programs in the region
- Collaborate with other members of the marketing department, program managers and physicians to plan and execute projects within all residential programs with a main focus on eating disorder services and the chemical dependency residential program
- Monitor and follow admissions, identify all referral sources and potential leads within the region
- Develop direct marketing and outreach relationship tactics with key referents in the region
- Identify and participate in new business development discussions at a regional level
- Assist Rogers Foundation with fundraising campaigns and events
- Provide leadership and direction with manager in the strategic planning and development of regional events, workshops and conferences

October 2007-
April 2009

Rogers Memorial Hospital - Oconomowoc, WI
Community Outreach Representative

- Support Senior National Outreach Representative
- Collaborate with other members of the marketing department, program managers and physicians to plan and execute projects within all residential programs with a main focus on child and adolescent residential programs
- Monitor and follow admissions for child and adolescent residential programs, identify all referral sources and make initial contact
- Assist Rogers Foundation with fundraising campaigns and events
- Assist in maintenance of child and adolescent residential program budgets
- Assist in the strategic planning and development of events, workshops and conferences

<u>Trainings received from 2007-2008 include:</u>

- HMS Sequel Help/Systems

August 2006-
October 2007

Rogers Memorial Hospital - Milwaukee, WI
Intake Specialist

- Perform duties of patient admission
- Collaborate with members of the health care team to promote continuity of care and cost effective practice patterns

- Coordinate admission of patients for eating disorder partial hospitalization program

January 2005-July 2006 **Holcomb Behavioral Health Systems - Exton, PA**
Intake Counselor/Clinical Support Services

- Process new referrals, secure and verify insurance from both commercial and governmental funded sources
- Transmit all referral information to the appropriate person or service within the agency
- Maintain accurate daily, weekly, and monthly service activity information and data on many databases.

Trainings received from 2005-2006 include:

- TB/STD, HIV/AIDS, and Confidentiality In Addiction training from *Mirmont Treatment Center*
- Clinical Documentation, Clinician's Desktop Database software, Microsoft Office

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Other Experience

Sep. 2011 – Present **Greenlock Therapeutic Riding Center – Rehoboth, MA**
Certified Therapeutic Riding Instructor

- Instruct 8 group lessons per week
- Train and exercise therapy horses once a week if appropriate
- Assist in fundraising campaigns and events

May 2009-June 2011 **LifeStriders Therapeutic Riding Center – Delafield, WI**
Certified Therapeutic Riding Instructor

- Instruct 2-3 lessons per week from 2008 - June 2010
- Substitute teacher from June 2010 – June 2011
- Train and exercise therapy horses once a week if appropriate
- Construct lesson plans on a weekly basis

Activities and Interests

- Former Violist and Board of Directors chair member for the *Main Line Symphony Orchestra - Devon, PA*, First Soprano for the *Bel Canto Choir – Milwaukee, WI, and the West Chester University Woman's Choir*; Violist for the *West Chester University String Ensemble, West Chester University Symphony Orchestra*, and member of the *West Chester University Equestrian Club* (President, spring 2000-2003, Vice President , fall 2000)

References:

Available upon request

Can't M + W night
Can work weekends
(Can't work Sat)

AZARIA DRAKEFORD

176 Butler Avenue New Haven, CT 06511 *adrakefo@bridgeport.edu *860.327.2111

PROFESSIONAL PROFILE

Energetic, dedicated youth specialist with strong interpersonal skills. Respond well to difficult situations and skilled at juggling multiple responsibilities. Proven ability to work effectively with people of various ages, cultural backgrounds, and socio-economic statuses. Long-time interest in youth empowerment and leadership. Well-developed problem solving and communication skills.

EDUCATION

University of Bridgeport, Bridgeport, CT
Master of Counseling - Candidate, May 2015
Concentration - Clinical Mental Health

Southern Connecticut State University, New Haven, CT
Bachelor of Sociology, May 2012

RELEVANT COURSEWORK

Child and Adolescent Therapy
Career and Lifestyle Development
Socio Cultural Foundations of Counseling
Helping Relationships

EXPERIENCE SUMMARY

Academic Advisor — December 2011-Present
Yale-Bridgeport GEARUP
New Haven, CT

- Facilitate an early college awareness and social development curriculum tailored to first year high school students and graduating seniors.
- Assist students develop academic progress plans and assist students in meeting high school requirements and exploring career interests.
- Connect students with available academic and social support systems, as well as locating other resources.
- Coordinate and execute field trips and college tours for students
- Maintained records and reports on each student.
- Demonstrate as a role model and resource for all first year students and graduating seniors

Residence Hall Advisor — 5/2009 - 12/2011
Southern Connecticut State University
New Haven, CT

- Extensive interaction with University visitors including students, employers, faculty and staff.
- Coordinated and executed programs focusing on issues and concerns of residents.
- Guided new residents on rules and procedures and responded to questions.
- Became a mediator and helped resolve grievances and responded to complaints.

Orientation Ambassador — 6/2011 - 7/2011
Southern Connecticut State University New Student Orientation
New Haven, CT

- Facilitated programs and workshops to promote academic excellence, co-curricular involvement, and living a healthy and well-adjusted life in college.
- Provided individual and group advisement, guidance and support to over 1200 freshmen through multiple New Student Orientation sessions.
- Established continued support to freshmen throughout their academic careers.

COMMUNITY INVOLVEMENT

Woman I Am, Inc. New Haven, CT-Secretary
Sigma Gamma Rho Sorority, Incorporated-Member
National Association for the Advancement of Colored People, SCSU Chapter-Member
The Open Hearth Association, Hartford, CT-Volunteer

TECHNICAL SKILLS

MS Word, PowerPoint, Excel

Nicole M Ferri, RD, CD-N

(203) 507-6613

nicole.ferri@hotmail.com 10 Ashford Court Wallingford, CT06492

EDUCATION

Keene State College, Keene, NH May 2011
Bachelor of Science: Health Science, Nutrition Option GPA: 3.82
Minor: Psychology Honors Program

DIETETIC INTERNSHIP

The Cleveland Clinic Foundation, Cleveland, OH August 2011-July 2012
- 1800 hours of supervised practice completed: 28 weeks clinical, 7 weeks food service, 3 weeks community, 3 weeks sales/marketing, 2 weeks research
- Areas of care include heart failure, liver/GI, cardiology, neurological ICU, pediatrics, nutrition support, colorectal, oncology, lung transplant, intestinal rehabilitation management, and renal nutrition

EMPLOYMENT

CENTER FOR DISCOVERY
Registered Dietitian Fall 2012-current
Provide nutrition counseling and education to adolescents with eating disorders; facilitate nutrition groups as well as individual sessions to help promote healthy behaviors, beliefs, and attitudes towards food.

HEALTH SOLUTIONS
Health Screener/Health Coach Fall 2012-current
Provide biometric screening, interpretation of health related data, and health coaching to various company employees

PCA WAIVER PROGRAM
Personal Care Assistant Summer 2011
Assisted physically disabled college student with daily activities; tutored student in summer biology class

KEENE STATE COLLEGE
Resident Assistant Fall 2009-Spring 2011
Oversaw and provided guidance for 24-52 freshmen residential students; prepared bi-monthly programs in health and wellness
Head Tutor Fall 2008-Spring 2011
Supervised tutors, provided trainings; tutored 8-10 students per semester in various nutrition and science classes

RESEARCH/PRESENTATION

"Utilization of CACFP in the state of NH" Fall 2010-Summer 2011
Nutrition research presented at the 2011 Keene State Academic Excellence Conference (AEC) and NH Department of Education
Honors Senior Thesis Fall 2010, Spring 2011
Fifty page personal case study presented with other members as a panel discussion at the 2011 AEC
Early Sprouts Poster Presentation Summer 2010
Presented Early Sprouts garden-to-table research at the Society for Nutrition Education Conference in Reno, NV
South African Health Care Summer 2009, Spring 2010
Study abroad experience and research paper presented with other members as a panel discussion at the 2010 AEC

VOLUNTEER EXPERIENCE

Nutrition Assistant, Wallingford, CT Summer 2009
Masonicare Nutrition/Food Service: provided healthy drink options for older adults; audited refrigerators
Practicum student, volunteer, Wallingford, CT Winter 2009, Summer 2010
Maryann Meade, MS/RD Private Practice: assisted with a variety of nutrition-related projects; taught nutrition classes for recovering substance abuse patients

CERTIFICATIONS/MEMBERSHIP

ServSafe Certified (2010)
CPR and First Aid Certified (2012)
Academy of Nutrition and Dietetics member (2010-current)
Pro-Act Certified (2012)

Questions and Answers

From our First CON

The following pages are in response to the Department of Public Health's Completeness Letter sent on June 4th, 2014 in response to Discovery Practice Management's application for a CON to establish a 6-bed residential treatment home for women in Fairfield.

Docket Number: 14-31913-CON

1) The Applicant states on page 15 that it considers its financial information to be confidential. Under Connecticut General Statute §19a-639(4) the Applicant must demonstrate how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the Applicant. Under Connecticut General Statute §19a-639(5), the Applicant must satisfactorily demonstrate how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region. Therefore, please provide:
    a. Audited financial statements for the most recently completed fiscal year or other financial documentation; and
    b. Financial Attachment I (attached).

See Attached Appendix A

The Independent Auditor's statement is included along with the 2013 company balance sheet. Please refer to the cash figure of $871, 605 which will more than suffice to cover necessary expenses for the proposed facility.

Financial Attachment I is included. Please note that no actual results are included since the proposed facility does not yet exist until the CON is granted. Three years of projections are given and are counted as incremental gains since they will not occur without the grant of a CON.

2) Provide a brief history of Discovery Practice Management, Inc. and provide an organizational chart.

Organizational charts are found in Appendix B: Two charts are included; one is the organization chart for the treatment home, while the other chart depicts Discovery Practice Management.

Discovery Practice Management, aka, Center for Discovery has been providing residential treatment for women and teens for over 15 years. At Center for Discovery, we provide residential treatment for women with eating disorders, teens with eating disorders, teens with mental health disorders, and teens with substance abuse issues. Each of our locations is dedicated solely to one of our specialized treatment programs. By keeping each location specialized to one of our treatment programs, we are able to provide the most effective and efficient treatment for our residents. We provide residential treatment via home-like residential treatment centers located in residential neighborhoods. Our locations provide treatment for a small number of residents at one time to maintain an intimate setting and a low resident to staff ratio. Treatment within a residential neighborhood also allows our residents to feel more comfortable in a familiar surrounding as well as providing greater transferability and internalization of the treatment experience to life

after treatment. Our locations do not look, feel or smell like a hospital and we strive to provide an environment where residents feel like and are treated like people, never patients.

Center for Discovery has been dedicated to providing successful residential treatment for years, and over that time we have developed a proprietary treatment model that has helped us create a legacy of success. Our proprietary program allows for one-of-a-kind treatment to be provided to every client to support their healing, growth, and recovery. Each resident is personally involved in creating their treatment program and treatment is individualized for each resident to specifically address the issues and situation they are dealing with. At Center for Discovery, we know that treatment is not only about the diagnosed issues, it is about the contributing factors that underlie those conditions. We understand that while the symptoms may be similar, the underlying factors are unique to each of our clients.

Our team of renowned experts helps guide clients and families to recovery, well-being and a healthy life. It is our firm belief at Center for Discovery that families are critical to the solution. Research has shown that family involvement is instrumental in providing for successful treatment outcomes. At Center for Discovery, it is never about blame. We focus on where you and your family go from here and how you get there. Family is a primary source of support for our residents and is closely involved in the treatment process.

Each of our locations is accredited by the Joint Commission as a residential treatment center and maintains the highest state licensure. JCAHO accreditation is a nationally recognized symbol of quality and reflects our deep commitment to the highest professional and treatment standards. Center for Discovery is trusted by the leading doctors, clinicians, dietitians, and insurance organizations in the country and many of our residents are referred to us through medical and therapeutic professionals.

3) Provide a list of the Discovery Practice Management Inc.'s/Center for Discovery's eating disorder facilities currently in operation. Include the name of the facility, street address, town and state.

See Attached Appendix C

4) Provide a description of the Center for Discovery and how its proprietary treatment will benefit Connecticut residents.

See response to question (2) for description of Center for Discovery.

See Attached Appendix D that depicts Center for Discovery's empirical results for the treatment of eating disorders over the past several years in a residential setting. As you can see, residential treatment is incredibly effective in altering the life-threatening habits of individuals

with eating disorders such as binging, purging, and restricting. Center for Discovery hopes to offer this life saving level of care to the adult women of Connecticut who do not have access to residential treatment in the state.

5) Provide by town name the proposed service area for the new facility.

The service will be provided in Fairfield, CT. The address of the proposed facility is 4536 Congress St., Fairfield, CT.

The service area will primarily be Fairfield County with some clients expected from neighboring Connecticut counties and Westchester, NY.

6) Develop the need for the proposal based on population incidence by geographical area (e.g. town) Estimate the number of adult women within each listed town that need the proposed service. Provide documentation that supports the statements that develop need.

See attachment E for Fairfield County population metrics.

Based off statistics presented in the original CON application and attached Fairfield County metrics, 1% of the adult women between the ages of 18-65 will require our level of treatment, this projects approximately 2700 women in the Fairfield county area and 10,600 women in Connecticut overall. If we adjust the numbers downward and assume only 33% of those clients in need actually seek and receive treatment, we are still left with 891 women in Fairfield County and 3,512 women in Connecticut who require treatment for an eating disorder at the residential level.

7) The proposal included two articles in the initial CON application. Please address each of the following:

a. What is the source for the first article that begins on page 41?

The source is: http://www.eatingdisorderhope.com/information/statistics-studies
Their sources and references can be found at the end of the article and include the American Journal of Psychiatry; International Journal of Eating Disorders; National Institute of Mental Health; and others.

b. Explain how information in the second article beginning on page 47 was utilized in the application.

This article was meant to reinforce the statistics found in Article 1 and to highlight the eating disorder prevalence in adult women and the high degree of eating disorder onset in women in their late teens

and early twenties.

8) Provide a discussion that supports the number of beds proposed on page 8 for the facility.

We have zoning approval for a 6 bed facility and have cleared fire and life safety requirements for housing six individuals in the residential home. In addition, Discovery likes to keep the treatment setting small to allow for more 1 on 1 therapy with the clients and a more conducive healing environment.

9) Concerning the Applicant's child care facilities in Connecticut, please address each of the following:

a. The amended first provisional license for the Congress St. location was effective for a period of 60 days and expired on April 26, 2014. Was the license renewed? If yes, please provide a copy. If no, explain why it was not renewed. Describe the services provided at the facility during the period the license was in effect.

See Attachment F.

The license was renewed. The facility opened in February, 2014 and will be on conditional licenses for 6 months to 1 year with periodic reviews. The facility provides residential eating disorder treatment to adolescents.

b. The copy of child care facility license on page 63 lists the facility's address as 1320 Mill Road. Please confirm that this is the correct and full address for the facility. Does the Applicant expect that this facility's license will be renewed by or on the expiration date of November 19, 2014? If not, please provide an explanation.

The full address of the facility is 1320 Mill Hill Road, Southport, CT 06824. Discovery fully expects the license to be renewed on or before the expiration date in November.

10) Explain how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including but not limited to (1) provision of or any change in the access to services for Medicaid recipients and indigent persons and (2) the impact upon the cost effectiveness of providing access to services provided under the Medicaid program.

Center for Discovery is not contracted with Connecticut State Medicaid. However, we do take single case agreements for Medicaid clients. In addition, Discovery has utilized sliding fees to accommodate individuals whose insurance doesn't cover a large portion of treatment. Discovery has also launched a non-profit scholarship in the Connecticut region that sponsors individuals who qualify for treatment but are unable to

provide any compensation. The fund will sponsor several individuals every year to address indigent care.

11) Provide a discussion on the Applicant's private pay agreement with clients that are uninsured or underinsured. Does the Applicant provide these clients with a sliding fee schedule?

We offer sliding fee schedules based on the proportion of care that insurance can cover and the individual is able to pay. We also have a non-profit scholarship that will cover several individuals every year who are unable to pay for treatment.

12) If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation for good cause for doing so. *Note: good cause shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers.*

While Center for Discovery is not contracted with Medicaid, we are still willing to accept clients within the Medicaid system on individual case agreements, sliding fee schedules, or scholarships.

13) Which license(s) is the Applicant seeking to obtain from the State of Connecticut, Department of Public Health in relation to the proposal?

Discovery seeks to obtain licensure as a Private Freestanding Mental Health Residential Living Center under Sec. 19a-495-551 of the Connecticut Department of Public Health regulations.

14) The program description on page 8 of the initial CON application states that the average length of stay is two to three months. However, the volume projections on page 11 are based on an average length of stay of "just over 40 days". Please revise the relevant sections of the initial CON Application to be consistent for the average length of stay. (See pages 8 and 11). Include volume projections for number of bed days for each projected fiscal year.

The Program Description on Page 8 details an incorrect length of stay. Our adolescent programs see an average length of stay of 2-3 months; however, our adult programs average just over 40 days. Inputs on page 11 are consistent with 40 day stays.

15) Page 17 states that the volume statistics are conservative estimates based on similar 6-bed homes. Please explain how the projections can increase higher than 50 clients based on 40-day average length of stay with a fixed capacity of 2,190 bed days (365 days * 6 beds).

The conservative part of the estimate is the time expected to reach 90% capacity, or 49 clients per year. The projections are conservative in that 90% capacity is not reached until year 3 of operation, in contrast, our adolescent facilities in Connecticut reached 90% capacity within 6 months of opening.

16) Please explain what is meant by a "30 unit (client days) bump year over year" given in response to Question 7e on page 18.

1 unit is equal to 1 client for 1 day. A 30 unit increase per year over the projected opening year values would maintain stable profitability in the face of inflation and rising wages. This would be based on projections of only serving 35 clients in the first year.

17) Page 13 states that the psychiatrist to be on staff at the new facility must be experienced in adolescent psychiatry and treatment. Please amend the description to include the experience that will be appropriate for treating adult women.

See Attachment G : Psychiatrist must have experience in adult psychiatry, preferably at least one year of experience with adult women with eating disorders.

18) Provide supporting documentation to support the statement made on page 18 concerning high levels of relapse when a client steps down from acute care directly to an outpatient program.

See attachment D which contains the following excerpt and references. Please note, this is a preliminary research report containing internal and external statistics that has not yet been published. Its sources of readmission rates are based off of peer reviewed scientific journals.

"Since Center for Discovery began treating eating disorders in 1999, we have treated almost 2000 clients at the residential level. Of those clients, less than 14% have needed to readmit anytime in the 15 years. This readmission rate is significantly lower than those typically found for a higher level-of-care for eating disorders, which can range from 45% to 77.5%.[9,10]"

[9]Steinhausen, H., Grigoroiu-Serbanescu, M., Boyadjieva, S., Neumärker, K., & Metzke, C. W. (2008). Course and predictors of rehospitalization in adolescent anorexia nervosa in a multisite study. *International Journal of Eating Disorders, 41*(1), 29-36.

[10]Lay, B., Jennen-Steinmetz, C., Reinhard, I., & Schmidt, M. H. (2002). Characteristics of inpatient weight gain in adolescent anorexia nervosa: Relation to speed of relapse and re-admission. *European Eating Disorders Review, 10*(1), 22-40.

19) Does the Applicant have relationships with other Connecticut providers that provide a referral base for the proposed facility?

Yes, referrals come from local Mental Health out-patient therapists in Connecticut, Yale New Haven Hospital system, and local physicians and psychiatrists. In addition, many clients seek eating disorder treatment at Long Island Jewish Hospital, New York Presbyterian Outlook Program, and Eating Disorder 180 PHP/IOP in Long Island. These programs are currently serving adults in both Connecticut and New York and currently refer adolescents to our adolescent residential programs.

20) Explain how clients discharged from the proposed inpatient program will obtain outpatient care in their community.

In general, clients step down to an Intensive Outpatient (IOP) level of care after residential treatment. Center for Discovery recently opened an IOP in Greenwich, CT which will be available to all discharging clients. If the location of our Greenwich facility is not conducive for certain clients, our team will locate the nearest IOP center and provide a referral. In other cases, clients will be referred back to their original outpatient therapist or one that we refer them to in their local area.

21) Provide a list of existing providers in Connecticut that have outpatient treatment programs for eating disorders.

Center for Discovery has an IOP located in Greenwich, CT.
Renfrew Eating Disorder Treatment has an IOP in Greenwich, CT.
Walden Behavioral Health has an IOP located in Hartford, CT.

22) Provide documentation demonstrating that the Applicant has a transfer agreement or procedure in place in anticipation that a client may encounter the need for emergency care. Discuss the procedures to be followed and the anticipated roles of the program director, the physician(s), psychiatrist(s) and the acute care hospital.

See attachment H

23) Who is the owner of the building(s) and land where the facility will be located? What is the relationship of the owner to the Applicant?

The owner of the facility is Valley Forge Financial Group (VFFG). VFFG is a stakeholder in Center for Discovery and Discovery Practice Management. They help purchase facilities and offer long-term leases (~15-20 years) to Discovery.

24) Demonstrate how this proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible.

The proposal is financially feasible for the following reasons:

- Discovery already operates the property and has made the capital improvements necessary for meeting applicable fire, zoning and health codes.
- The facility is already furnished and ready for operation, so capital costs going forward are zero.
- Discovery already has insurance contracts with the major providers in Connecticut due to the existence of our residential programs for adolescents.
- Please refer to financial attachments I and II for expected revenues and profitability.
- Discovery Practice Management has sufficient funds and cash flow from its other operations to support the facility in case of a revenue shortfall.

Appendix A

BEHAVIORAL HEALTH HOLDINGS II, INC.
AND SUBSIDIARY

CONSOLIDATED FINANCIAL STATEMENTS,
INDEPENDENT AUDITOR'S REPORT
AND
SUPPLEMENTAL INFORMATION
DECEMBER 31, 2013

BEHAVIORAL HEALTH HOLDINGS II, INC. AND SUBSIDIARY
CONSOLIDATED FINANCIAL STATEMENTS
DECEMBER 31, 2013

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HCVT HOLTHOUSE CARLIN & VAN TRIGT LLP
CERTIFIED PUBLIC ACCOUNTANTS

Independent Auditor's Report

To the Shareholder of
Behavioral Health Holdings II, Inc.:

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Behavioral Health Holdings II, Inc. and subsidiary (collectively, the "Company"), which comprise the consolidated balance sheet as of December 31, 2013, and the related consolidated statements of income, changes in shareholder's equity and cash flows for the year then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of the consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2013, and the results of their operations and their cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

11444 W. Olympic Boulevard, 11th Floor, West Los Angeles, CA 90064 • 4550 E. Thousand Oaks Boulevard, Suite 100, Westlake Village, CA 91362
100 Oceangate, Suite 800, Long Beach, CA 90802 • 117 East Colorado Boulevard, 6th Floor, Pasadena, CA 91105
555 Anton Boulevard, Suite 700, Costa Mesa, CA 92626 • 15760 Ventura Boulevard, Suite 1700, Encino, CA 91436
400 W. Ventura Boulevard, Suite 250, Camarillo, CA 93010 • 115 West 2nd Street, Suite 204, Fort Worth, TX 93010

Independent Auditor's Report
(Continued)

Report on the Supplemental Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying consolidating balance sheet as of December 31, 2013, consolidating statement of income and schedule of management adjusted earnings before interest, taxes, depreciation and amortization ("Management Adjusted EBITDA") for the year ended December 31, 2013 are presented for purposes of additional analysis and not required as part of the consolidated financial statements. This information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements.

This information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Holthouse Carlin & Van Dight LLP

Long Beach, California
April 4, 2014

BEHAVIORAL HEALTH HOLDINGS II, INC. AND SUBSIDIARY

CONSOLIDATED BALANCE SHEET
DECEMBER 31, 2013

ASSETS

Current assets:		
Cash and cash equivalents	$	871,605
Accounts receivable, net		5,907,432
Prepaid expenses and other current assets		433,229
Deferred income taxes		125,647
Total current assets		7,337,913
Property and equipment, net		1,250,675
Deferred financing costs, net		244,448
Goodwill		6,922,000
Intangible assets, net		12,554,286
Other assets		711,279
Total assets	$	29,020,601

LIABILITIES AND SHAREHOLDER'S EQUITY

Current liabilities:		
Revolving line of credit	$	600,000
Accounts payable		495,888
Accrued expenses and other current liabilities		872,133
Current portion of long-term debt		1,235,765
Total current liabilities		3,203,786
Long-term debt, net of current portion		19,745,943
Deferred income taxes		606,520
Total liabilities		23,556,249
Commitments and contingencies (notes 5, 6, 7 and 8)		
Shareholder's equity:		
Common stock, $0.0001 par value, 1,000 shares authorized, 101 shares issued and outstanding		1
Additional paid-in capital		4,512,431
Retained earnings		951,920
Total shareholder's equity		5,464,352
Total liabilities and shareholder's equity	$	29,020,601

See accompanying notes to consolidated financial statements.

13. B i. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
NET PATIENT REVENUE										
Non-Government		$0	$1,432,000	$1,432,000	$0	$1,646,800	$1,646,800	$0	$1,893,820	$1,893,820
Medicare		$0	$0	$0	$0	$0	$0	$0	$0	$0
Medicaid and Other Medical Assistance		$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Government		$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Net Patient Patient Revenue	$0	$0	$1,432,000	$1,432,000	$0	$1,646,800	$1,646,800	$0	$1,893,820	$1,893,820
Other Operating Revenue		$0	$0	$0	$0	$0	$0			
Revenue from Operations	$0	$0	$1,432,000	$1,432,000	$0	$1,646,800	$1,646,800	$0	$1,893,820	$1,893,820
OPERATING EXPENSES										
Salaries and Fringe Benefits		$0	$504,000	$504,000	$0	$524,160	$524,160	$0	$545,126	$545,126
Professional / Contracted Services		$0	$123,750	$123,750	$0	$128,700	$128,700	$0	$133,848	$133,848
Supplies and Drugs		$0	$40,800	$40,800	$0	$42,432	$42,432	$0	$44,129	$44,129
Bad Debts		$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Expense		$0	$61,200	$61,200	$0	$63,648	$63,648	$0	$66,194	$66,194
Subtotal	$0	$0	$729,750	$729,750	$0	$758,940	$758,940	$0	$789,298	$789,298
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense		$0	$125,000	$125,000		$125,000	$125,000		$125,000	$125,000
Total Operating Expenses	$0	$0	$854,750	$854,750	$0	$883,940	$883,940	$0	$914,298	$914,298
Income (Loss) from Operations	$0	$0	$577,250	$577,250	$0	$762,860	$762,860	$0	$979,522	$979,522
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$577,250	$577,250	$0	$762,860	$762,860	$0	$979,522	$979,522
Provision for income taxes			$202,038	$202,038		$267,001	$267,001		$342,833	$342,833
Net Income	$0	$0	$375,213	$375,213	$0	$495,859	$495,859	$0	$636,690	$636,690
Retained earnings, beginning of year		$0	$0	$0	$0	$375,213	$375,213	$0	$871,072	$871,072
Retained earnings, end of year	$0	$0	$375,213	$375,213	$0	$871,072	$871,072	$0	$1,507,761	$1,507,761
FTEs				10			10			10

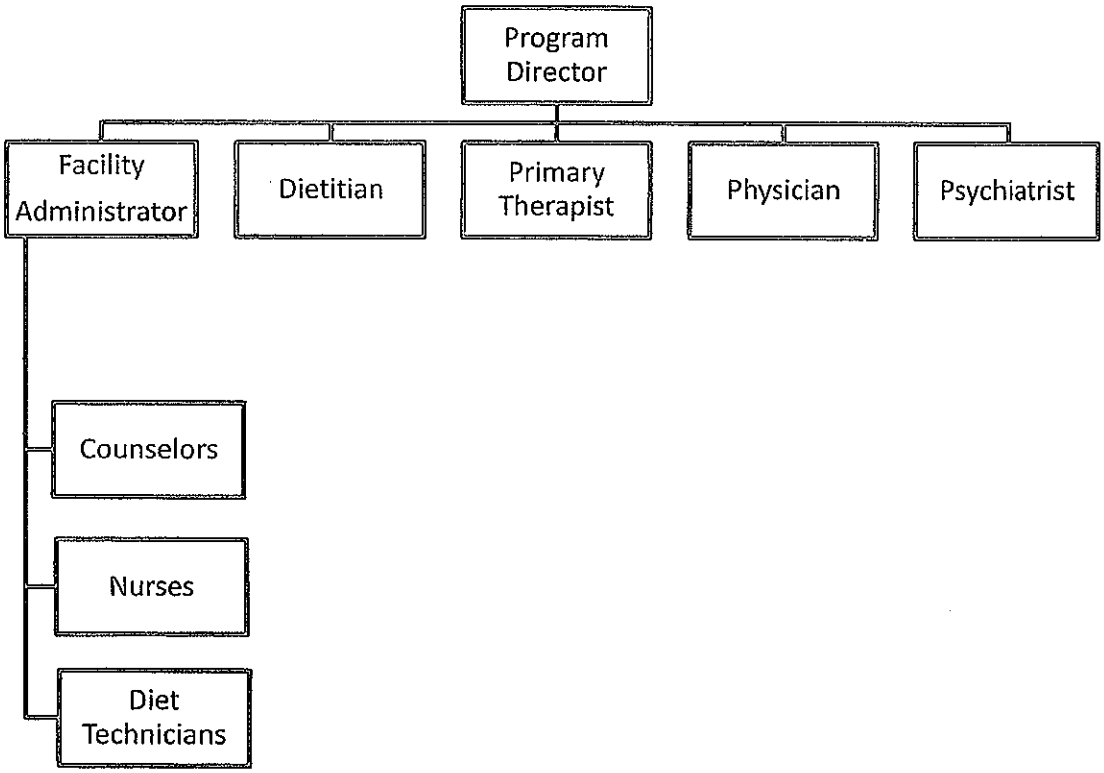
12.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description Residential Eating Disorder Treatment for Women
Type of Unit Description: Client Days
# of Months in Operation 12

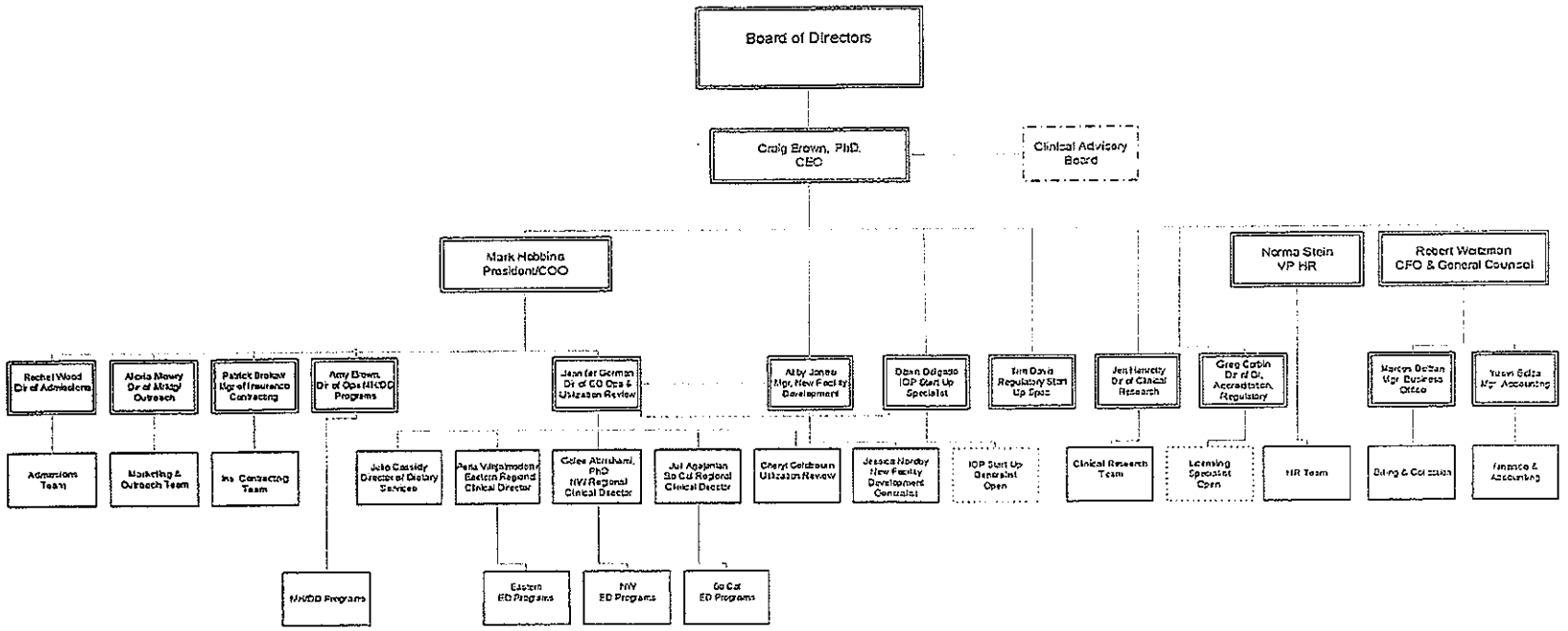
FY _____	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Incremental Expenses:	$854,750									
Total Facility by Payer Category:										
Medicare			0	$0				$0	$0	$0
Medicaid		$0	0	$0				$0	$0	$0
CHAMPUS/TriCare		$0	0	$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$1,000	1,328	$1,328,000				$1,328,000	$792,673	$535,327
Uninsured		$1,300	80	$104,000				$104,000	$62,077	$41,923
Total NonGovernment		$0	1,408	$1,432,000	$0	$0	$0	$1,432,000	$854,750	$577,250
Total All Payers		$0	1,408	$1,432,000	$0	$0	$0	$1,432,000	$854,750	$577,250

Appendix B

Connecticut House Organization Chart



Discovery Practice Management, Inc.



Appendix C

CENTER FOR DISCOVERY®
Transforming Lives

Facility	Address	Service	Client (Ages)	License & JCAHO #'s
Center for Discovery, Bellevue, *King Co.*	16305 SE 37th Street Bellevue, WA 98008	RTC, PHP Eating Disorders	Adult - Female Only (ages 16+) 6 Bd	Adult Family Home Lic-752239, NO Expiration JCAHO-493514, Exp. 4/10/16
Center for Discovery, Chicago, *Cook Co.*	3737 Lawson Road Glenview, IL 60026	RTC, PHP Eating Disorders	Adolescent (ages 11-21) 8 Bd	Child Welfare Agency & Group Home Child Welfare Agency Lic:524264-02 Group Home:Lic-527214, Exp 9/10/17 JCAHO-551681, Exp. 3/26/16
Center for Discovery, Downey, *Los Angeles Co.*	9844 Pangborn Downey, CA 90240	RTC, PHP Eating Disorders	Adolescent (ages 10-19) 6 Bd	Congregate Living Lic-980001593, Exp 11/04/14 JCAHO- 150964, Exp. 2/8/16
Center for Discovery, Edmonds, *Snohomish, Co.*	7511 176th Street SW Edmonds, WA 98026	RTC, PHP Eating Disorders	Adolescent (ages 11-18) 6 Bd	Children's Agency Lic-436020, Exp, 10/20/15 JCAHO-493514, Exp. 4/10/16
Center for Discovery, Fairfield, *Fairfield, Co*	4536 Congress St. Fairfield, CT 06824	RTC, PHP Eating Disorders	Adolescent (ages 10-18) 6 Bd	Child Care Facility & Group Home Lic-CCF/GH 137 ex 5/25/14
Center for Discovery, Fremont, *Alameda Co.*	46890 Rancho Higuera Rd Fremont, CA 94539	RTC, PHP Eating Disorders	Adult - Female Only (ages 16+) 6 Bd	Congregate Living Lic-550001930, Exp 5/16/14 JCAHO-150964, Exp. 2/8/16
Center For Discovery, Greenwich, *Fairfield Co*	7 Riverville Road Suite 2A Greenwich, CT 06831	IOP Eating Disorders	Adolescent Ages: TBD	TBD
Center for Discovery, La Habra, *Orange Co.*	2115 Las Palomas La Habra, CA 90631	RTC, PHP Eating Disorders	Adolescent (ages 10-19) 6 Bd	Congregate Living Lic-550001575, Exp 04/13/14 JCAHO- 150964, Exp.2/8/16
Center for Center for Discovery, Lakewood, *Los Angeles Co.*	4136 Ann Arbor Road, Lakewood, CA 90712	RTC, PHP Eating Disorders	Adolescent (ages 10-19) 6 Bd	Congregate Living Lic-980001602, Exp. 11/04/14 JCAHO-150964, Exp. 2/8/16

Center For Discovery, Newport Beach, Orange Co	1000 Quail Street Suite 290 Newport Beach, CA 92660	IOP Eating Disorder	Adolescent and Adult (10+)	Business License: BT30046281
Center for Discovery, Menlo Park, *San Mateo, Co.*	1895 Altschul Ave Menlo Park, CA 94025	RTC, PHP Eating Disorders	Adolescent (ages 10-19) 6 Bd	Congregate Living Lic-550000127, Exp. 2/26/15 JCAHO-150964, Exp. 2/8/16
Center for Discovery, Rancho Palos Verdes, *Los Angeles Co.*	30175 Avenida Tranquilla R.P.V., CA 90275	RTC, PHP Eating Disorders	Adult - Female Only (ages 16+) 6 Bd	Congregate Living Lic-980001355, Exp. 03/23/14 JCAHO-150964, Exp.2/8/16
Center for Discovery, San Diego, *San Diego Co.*	3013 Woodford Dr. La Jolla, CA 92037	RTC, PHP Eating Disorders	Adolescent (ages 10-19) 6 Bd	Congregate Living Lic-550000153, Exp. 5/21/14 JCAHO-150964, Exp. 2/8/16
Center for Discovery, Southport, *Fairfield Co.*	1320 Mill Hill Road Southport, CT 06824	RTC, PHP Eating Disorders	Adolescent (ages 10-18) 6 Bd	Child Care Facility & Group Home Lic-CCF/GH132, Exp. 11/19/14 JCAHO-532443, Exp. 9/9/16
Center for Discovery, Virginia, *Fairfax*	5343 Summit Drive Fairfax, VA 22030	RTC, PHP Eating Disorders	Adolescent (ages 10-18) 8 Bd	Children's Residential Treatment Center Lic-#2240-14-004 Exp. 6/15/14 JCAHO-553993, Exp. 5/22/14

Appendix D

CENTER FOR DISCOVERY®
OUTCOME DATA

Treating eating disorders since 1997, Center for Discovery has a strong commitment to a research based approach. To that end, the following data were compiled from a review of 741 clients' treatment at the Center for Discovery for active Anorexia Nervosa (AN) and active Bulimia Nervosa (BN).[1]

TABLE 1: Adult AN clients, who entered treatment extremely malnourished, with an average percent of ideal body weight (IBW) in the low 70s, had significant increases of approximately 7.5 percentage points on average. For adolescent clients with AN-Restricting Type, the mean percent of IBW increased by 13.58; for adolescent clients with AN-Purging Type, mean percent of IBW increased by 11.61. These increases represent an improvement from medically compromising averages of between 76.5% and 79.5% IBW at intake to above 90% at discharge. Reaching the benchmark of 90% IBW for developing adolescents is important for a number of reasons including a marked reduction of symptoms of malnutrition[2] and the evidence that psychopathological symptoms can persist for years when weight restoration is incomplete[3]. Furthermore, leading eating disorder researchers[3] cite slow and low weight restoration as dangerous, as it results in not just the eventual risk of bone disease and relapse but also a rise in psychological inertia. Because persistence of low body weight predicts poorer long-term outcome[4] and approximately 20-25% of individuals with AN will become chronically ill[4,6], Center for Discovery is committed to aggressive weight restoration.

TABLE 1: AVERAGE PERCENT OF IBW IN ANOREXIC CLIENTS

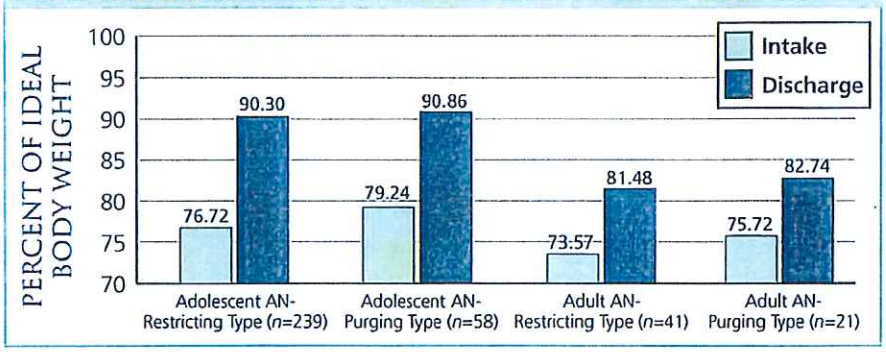
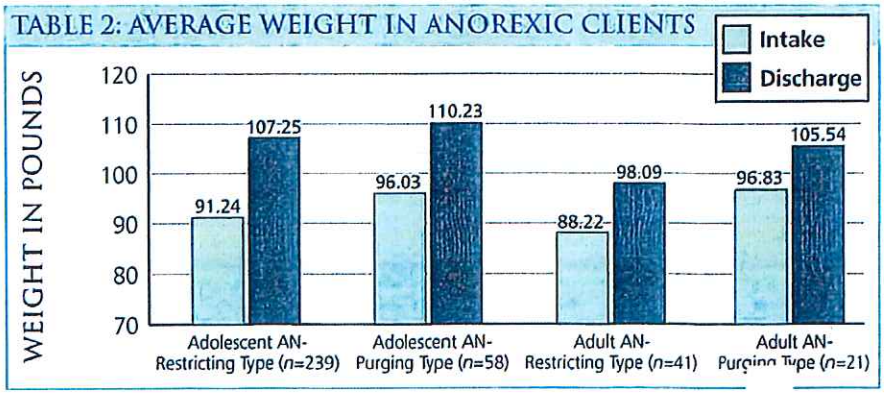


TABLE 2: The mean body weight of adolescent clients with AN-Restricting Type increased by 16.01 lbs from intake to discharge; for clients with AN-Purging Type mean weight increased by 14.20 lbs. For adults, mean weight increased by 9.87 lbs for clients with AN-Restricting Type and by 8.71 lbs for clients with AN-Purging Type. During their length of stay (adolescent AN-R *m*=57.5 days; adolescent AN-P *m*=52.5 days; adult AN-R *m*=36.5 days; adult AN-P *m*=27.6 days), Center for Discovery clients gained 1.95 lbs per week on average, which is well above the benchmark of 1.76 lbs per week that outcome research suggests provide clients significantly less clinical deterioration following treatment than that of lower weight gains.[7]

TABLE 2: AVERAGE WEIGHT IN ANOREXIC CLIENTS

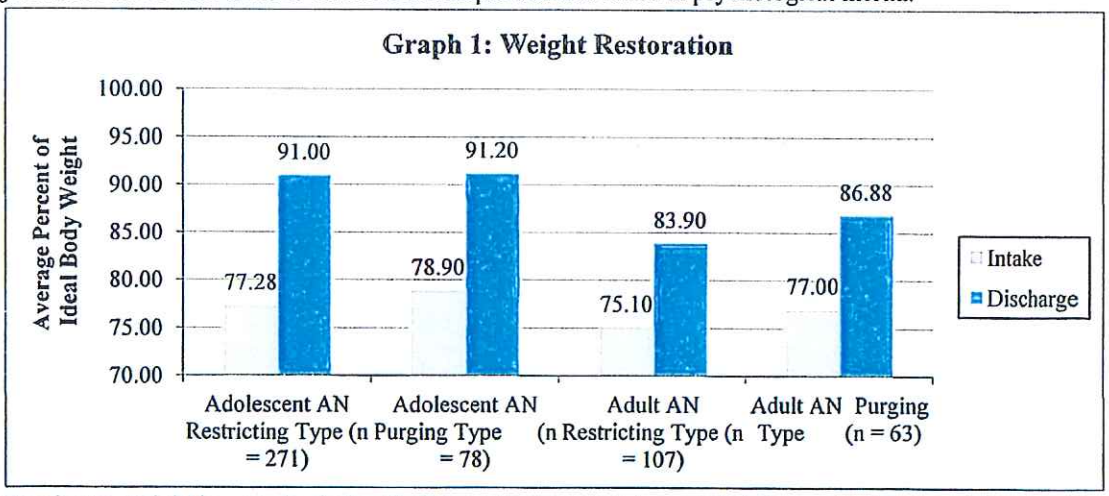


Treating eating disorders since 1999, Center for Discovery has a strong commitment to evidence-based practice. To this end, Discovery has been collecting data on our clients and, in several separate research endeavors, has begun to be able to answer pertinent questions related to 1) the process of treatment, 2) the post-discharge experience, and 3) the need for readmission.

The process of treatment

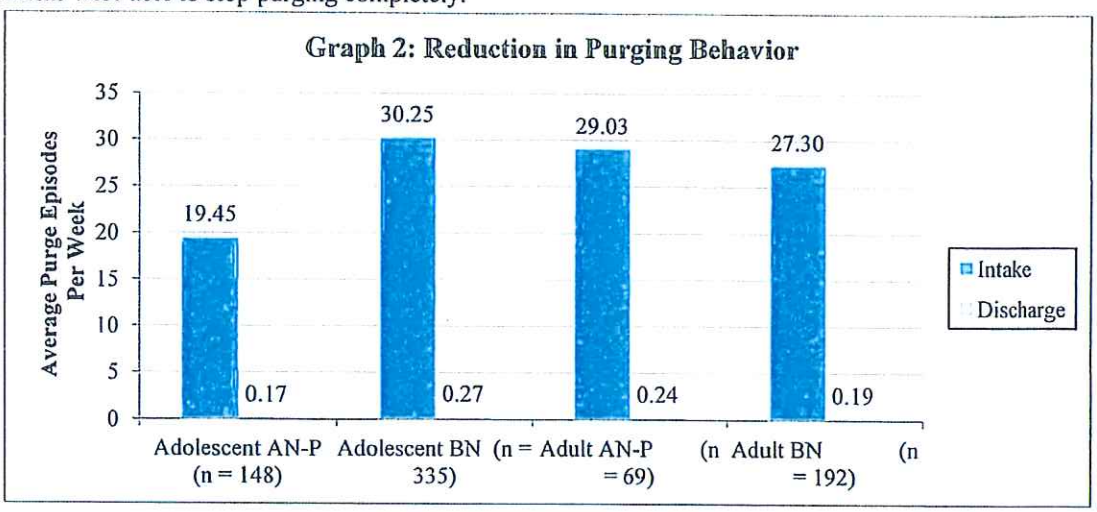
Center for Discovery collects intake and discharge data on clients with eating disorders and has recently teamed with North Shore LIJ and The Feinstein Institute for Biomedical Research to begin to analyze this de-identified data. We are especially interested in the outcome of residential treatment and factors that may correlate with need of residential treatment, with treatment success, and with need for readmission. In the interim of the external data analyses, we have run preliminary analyses. The following results are from data collected from clients who received treatment at Center for Discovery between January 2006 through April 2014 ($N = 1730$).

Graph 1: Adult clients with active[1] anorexia (AN), who entered treatment extremely malnourished, with an average percent of ideal body weight (IBW) in the mid-70s, had significant increases of approximately 9.1 percentage points on average. For adolescent clients with active AN-Restricting Type (AN-R), the mean percent of ideal body weight (IBW) increased by 13.7; for adolescent clients with active AN-Purging Type (AN-P), mean percent of IBW increased by 12.3. These increases represent an improvement from medically compromising averages of between 77.3% and 78.9% IBW at intake to above 90% at discharge. Reaching the benchmark of 90% IBW for developing adolescents is important for a number of reasons including a marked reduction of symptoms of malnutrition[2] and the evidence that psychopathological symptoms can persist for years when weight restoration is incomplete[3]. Furthermore, leading eating disorder researchers[3,4] cite slow and low weight restoration as dangerous, as it results in not just the eventual risk of bone disease and relapse but also a rise in psychological inertia.

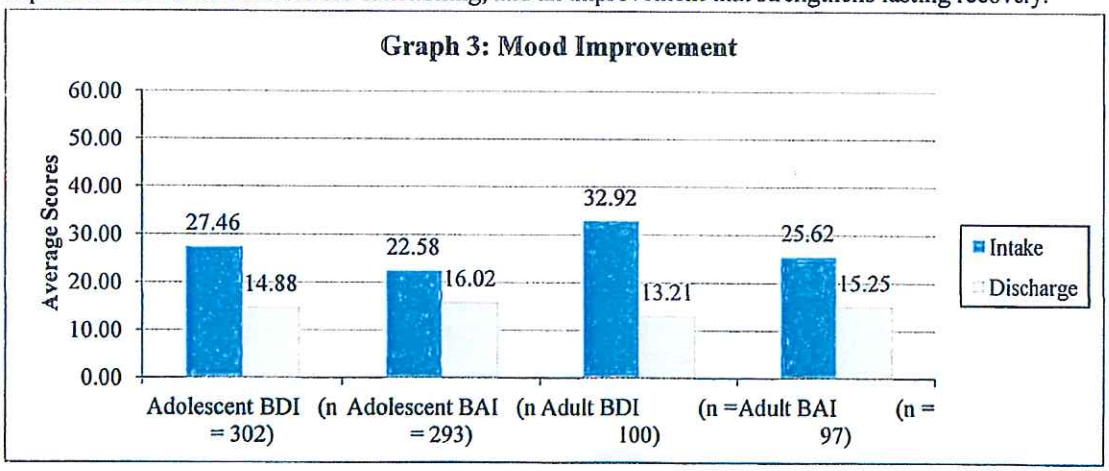


Turning to weight in pounds, during their length of stay (adolescent AN-R, $m = 59.1$ days; adolescent AN-P, $m = 56.6$ days; adult AN-R, $m = 43.0$ days; adult AN-P, $m = 46.1$ days), Center for Discovery clients with active AN gained 1.92 pounds per week on average – a rate of restoration that is hard to achieve at lower levels of care and increases the likelihood of lasting recovery.[5] Because persistence of low body weight predicts poorer long-term outcome[4] and approximately 20-25% of individuals with AN will become chronically ill[4,6], Center for Discovery is committed to timely weight restoration.

Graph 2: Center for Discovery provides the necessary structure for a swift cessation of purging behavior, a symptom often difficult to extinguish in lower levels-of-care. On average, adolescents and adults with either AN-P or BN, who were exhibiting purge behaviors upon admission, were able to reduce these behaviors by 99%. Furthermore, during an average length of stay (adolescent AN-P, $m = 50.2$ days; adolescent BN, $m = 41.4$ days; adult AN-P, $m = 39.3$ days; adult BN, $m = 33.1$ days), the vast majority of clients were able to stop purging completely.



Graph 3: Because Center for Discovery takes a holistic approach, symptoms of depression and anxiety are important targets for treatment. Graph 3 presents average scores on the Beck Depression Inventory (BDI) and Beck Anxiety Inventory (BAI) at the time of intake and discharge for adult and adolescent clients with a diagnosis of either AN or BN. On average, our adolescent clients entered treatment at Center for Discovery within the **moderate** range of depression and anxiety, whereas adult clients began treatment within the **severe** range for depression and anxiety.[8] However, both adolescent and adult clients scored within the **mild** range of depression and anxiety at the time of discharge, a vast improvement in mood and related functioning, and an improvement that strengthens lasting recovery.



Center for Discovery is dedicated to restoring weight, greatly reducing purge behavior, and improving mood, and we make great strides in these areas during clients' treatment with us. However, symptom improvement in treatment, no matter how great, is just the first step. Lasting recovery, although built upon the foundation of the work clients do in treatment, is forged once clients leave the structure of Center for Discovery. Thus, Discovery researchers knew following up with families after discharge would be imperative and initiated a research project to study clients' post-discharge experience.

The post-discharge experience:

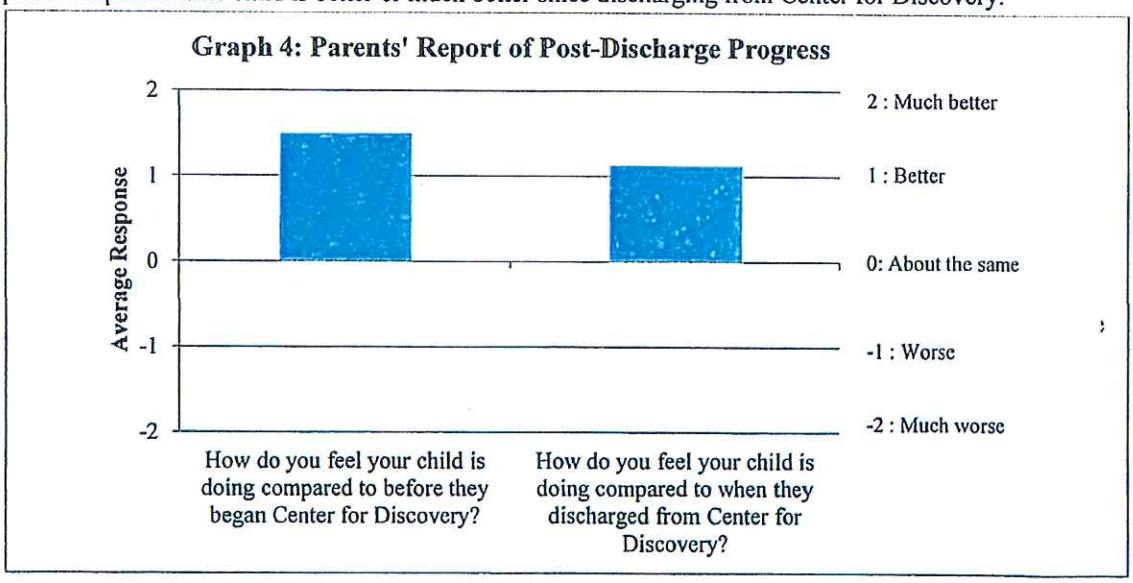
The following information was collected from parents of our adolescent clients ($n = 68$) who were 6 months to 1 year post-discharge from Center for Discovery's eating disorder residential treatment.

- 95.6 % of clients engaged in aftercare within 7 days of discharge (i.e., began PHP/IOP or attended outpatient treatment appointments)
- For clients who had been diagnosed with AN and were discharged at or above 90% of ideal body weight, 88.9% were reported as having maintained their weight
- For the clients with a history of purging, 78.6% were reported as being purge-free the month before contact
- 81.0% of clients discharged to a lower level of care did not need to be stepped back up to a higher level of eating disorder treatment at Discovery *or* any other treatment setting
- Additionally, parents were asked to answer the following two questions using the below scale:

How do you feel like your child is doing compared to ***before they began*** *Center for Discovery?*
How do you feel like your child is doing compared to when they ***discharged from*** *Center for Discovery?*

Much better	Better	About the same	Worse	Much worse
2	1	0	-1	-2

Examining the first question, the vast majority of parents reported that their child is doing much better since before they began treatment at Center for Discovery. The answer to the second question, which was designed to measure whether improvements achieved while in treatment were maintained after discharge, was a bit of a surprise to our researchers. Although we have routinely watched clients make great strides during their treatment, we could only hope that clients did not backslide after leaving the structure of Center for Discovery. However, the data suggests that not only are improvements maintained, but that Center for Discovery clients actually continue to get better following their discharge. In fact, 84% of parents reported their child is better or much better since discharging from Center for Discovery.



In summary, 6 months to 1 year after discharge, clients who had received treatment from Center for Discovery were not only maintaining the improvements they had made in treatment, but had actually continued to improve, with over ¾ of clients with a history of purging having ceased this behavior and approximately 90% of clients with AN having maintained their weight within a healthy range.

The need for readmission:

Since Center for Discovery began treating eating disorders in 1999, we have treated almost 2000 clients at the residential level. Of those clients, less than 14% have needed to readmit anytime in the 15 years. This readmission rate is significantly lower than those typically found for a higher level-of-care for eating disorders, which can range from 45% to 77.5%.[9,10]

Through all of our research endeavors, Center for Discovery hopes to enhance our program, give confidence to families and clients even before they step through our doors, afford insurance companies incentives for authorizing the necessary length of treatment, and enrich the field's understanding of eating disorder treatment. However, it is only with the help of our clients and their families that our research is possible – this collaboration fuels our ability to continue helping in the fight against eating disorders.

If you or a loved is suffering, please call 866-407-2876.

[1]Active AN indicates clients who were below 85% of IBW upon admission to Center for Discovery.

[2]Strober, M., Freeman, R., & Morrell, W., (1997). The long-term course of severe Anorexia Nervosa in adolescents: Survival analysis of recovery, relapse, and outcome predictors over 10-15 years in a prospective study. *The International Journal of Eating Disorders, 22*(4), 339-360.

[3]Strober, M., & Johnson, C. (2012). The need for complex ideas in Anorexia Nervosa: Why biology, environment, and Psyche all matter, why therapists make mistakes, and why clinical benchmarks are needed for managing weight correction. *International Journal of Eating Disorders, 45*(2), 155-178.

[4]Steinhausen, H.C. (2002). The outcome of Anorexia Nervosa in the 20th century. *American Journal of Psychiatry, 159,* 1284-1293.

[5]Lund, B. C., Hernandez, E. R., Yates, W. R., Mitchell, J. R., McKee, P. A. & Johnson, C. L. (2009). Rate of inpatient weight restoration predicts outcome in Anorexia Nervosa. *International Journal of Eating Disorders, 42,* 301–305.

[6]Viricel, J., Bossu, C., Galusca, B., Kadem, M., Germain, N., Nicolau, A., et al. (2005). Restrospective study of Anorexia Nervosa: Reduced mortality and stable recovery rates. *La Presse Médicale, 34,* 1505-1510.

[7]Lund, B. C., Hernandez, E. R., Yates, W. R., Mitchell, J. R., McKee, P. A. & Johnson, C. L. (2009). Rate of inpatient weight restoration predicts outcome in Anorexia Nervosa. *International Journal of Eating Disorders, 42,* 301–305.

[8]For BDI, 0-9 is minimal, 10-18 is mild, 19-29 is moderate, and 30-63 is severe. For BAI, 0-7 is minimal, 8-15 is mild, 16-25 is moderate, and 26-63 is severe.

[9]Steinhausen, H., Grigoroiu-Serbanescu, M., Boyadjieva, S., Neumärker, K., & Metzke, C. W. (2008). Course and predictors of rehospitalization in adolescent anorexia nervosa in a multisite study. *International Journal of Eating Disorders, 41*(1), 29-36.

[10]Lay, B., Jennen-Steinmetz, C., Reinhard, I., & Schmidt, M. H. (2002). Characteristics of inpatient weight gain in adolescent anorexia nervosa: Relation to speed of relapse and re-admission. *European Eating Disorders Review, 10*(1), 22-40.

Appendix E

State & County QuickFacts

Fairfield County, Connecticut

People QuickFacts	Fairfield County	Connecticut
Population, 2013 estimate	939,904	3,596,080
Population, 2012 estimate	933,733	3,591,765
Population, 2010 (April 1) estimates base	916,829	3,574,097
Population, percent change, April 1, 2010 to July 1, 2013	2.5%	0.6%
Population, percent change, April 1, 2010 to July 1, 2012	1.8%	0.5%
Population, 2010	916,829	3,574,097
Persons under 5 years, percent, 2012	5.9%	5.4%
Persons under 18 years, percent, 2012	24.1%	22.1%
Persons 65 years and over, percent, 2012	14.0%	14.8%
Female persons, percent, 2012	51.3%	51.3%
White alone, percent, 2012 (a)	80.6%	82.0%

Black or African American alone, percent, 2012 (a)	11.9%	11.2%
American Indian and Alaska Native alone, percent, 2012 (a)	0.5%	0.5%
Asian alone, percent, 2012 (a)	5.2%	4.2%
Native Hawaiian and Other Pacific Islander alone, percent, 2012 (a)	0.1%	0.1%
Two or More Races, percent, 2012	1.8%	2.1%
Hispanic or Latino, percent, 2012 (b)	17.8%	14.2%
White alone, not Hispanic or Latino, percent, 2012	65.3%	70.3%
Living in same house 1 year & over, percent, 2008-2012	89.2%	87.9%
Foreign born persons, percent, 2008-2012	20.2%	13.5%
Language other than English spoken at home, pct age 5+, 2008-2012	28.2%	21.2%
High school graduate or higher, percent of persons age 25+, 2008-2012	89.0%	89.0%
Bachelor's degree or higher, percent of persons age 25+, 2008-2012	44.6%	36.2%
Veterans, 2008-2012	43,159	228,291
Mean travel time to work (minutes), workers age 16+, 2008-2012	28.1	24.8
Housing units, 2013	362,457	1,487,982
Homeownership rate, 2008-2012	69.7%	68.3%
Housing units in multi-unit structures, percent, 2008-2012	35.3%	34.5%
Median value of owner-occupied housing units, 2008-2012	$447,500	$285,900
Households, 2008-2012	332,968	1,360,184
Persons per household, 2008-2012	2.70	2.54
Per capita money income in past 12 months (2012 dollars), 2008-2012	$48,900	$37,807
Median household income, 2008-2012	$82,614	$69,519
Persons below poverty level, percent, 2008-2012	8.8%	10.0%

Business QuickFacts	**Fairfield County**	**Connecticut**
Private nonfarm establishments, 2012	26,814	88,210[1]
Private nonfarm employment, 2012	405,226	1,463,732[1]
Private nonfarm employment, percent change, 2011-2012		

	1.7%	1.5%[1]
Nonemployer establishments, 2012	87,297	261,922
Total number of firms, 2007	108,910	332,150
Black-owned firms, percent, 2007	4.7%	4.4%
American Indian- and Alaska Native-owned firms, percent, 2007	0.4%	0.5%
Asian-owned firms, percent, 2007	3.3%	3.3%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.0%
Hispanic-owned firms, percent, 2007	5.9%	4.2%
Women-owned firms, percent, 2007	28.6%	28.1%
Manufacturers shipments, 2007 ($1000)	20,028,377	58,404,898
Merchant wholesaler sales, 2007 ($1000)	78,881,637	107,917,037
Retail sales, 2007 ($1000)	15,702,222	52,165,480
Retail sales per capita, 2007	$17,661	$14,953
Accommodation and food services sales, 2007 ($1000)	1,861,946	9,138,437
Building permits, 2012	2,138	4,669

Geography QuickFacts	**Fairfield County**	**Connecticut**
Land area in square miles, 2010	624.89	4,842.36
Persons per square mile, 2010	1,467.2	738.1
FIPS Code	001	09
Metropolitan or Micropolitan Statistical Area	Bridgeport-Stamford-Norwalk, CT Metro Area	

1: Includes data not distributed by county.

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so also are included in applicable race categories.

D: Suppressed to avoid disclosure of confidential information
F: Fewer than 25 firms
FN: Footnote on this item for this area in place of data
NA: Not available

Appendix F

DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities

Joette Katz
Commissioner

Dannel P. Malloy
Governor

May 5, 2014

Craig M. Brown, Ph.D, Chief Executive Officer
Discovery Practice Management, Inc.
4281 Katella Avenue, Suite 111
Los Alamitos, CA 90720

Re: Second Provisional License-Center for Discovery and Adolescent Change- Fairfield

Dear Dr. Brown,

Enclosed you will find the Second Provisional License for the Center for Discovery and Adolescent Change located at 4536 Congress Street, Fairfield, CT. This licensed is issued effective April 27, 2014 for a period of time not to exceed sixty days. The Department may issue up to six provisional licenses during this initial licensing period. The Center for Discovery and Adolescent Change program will remain on a provisional license until the Department has verified that all regulatory requirements have been met. Should you have any questions regarding this license or the licensing process please do not hesitate to contact me at 860-550-6310 or via email at tom.cuchara@ct.gov.

Sincerely,

Tom Cuchara, Regulatory Consultant
DCF Licensing Unit

SECOND PROVISIONAL

STATE OF CONNECTICUT
DEPARTMENT OF CHILDREN AND FAMILIES

This is to certify, that, in accordance with the provisions of 17a-145 and 17a-151 of the General Statutes of the State of Connecticut, as amended, DISCOVERY PRACTICE MANAGEMENT, INC., located at 4281 KATELLA AVENUE, SUITE 111 in the Town of LOS ALAMITOS, CALIFORNIA is hereby licensed as a CHILD CARE FACILITY to provide GROUP HOME services to children at the locations listed below - for the licensed bed capacity (LBC) and gender listed beside each location.

This license is issued effective FEBRUARY 25, 2014 for a period of SIXTY DAYS and is conditional upon compliance with all regulations of the Department of Children and Families and may be revoked for cause at any time.

License No. CCF / GH 137
Signed and dated this 5th day of May, 2014 at Hartford, CT.

James McPherson, Program Manager
Office of Legal Affairs

*Center for Discovery and Adolescent Change - Fairfield, 4536 Congress Street, Fairfield, CT.....LBC 6; Ages 10-18 (Female/Male)

Appendix G

- The Psychiatrist is responsible to consult with the DD, DOO, and COO to ensure appropriate psychiatric/pharmacological interventions. The Psychiatrist sees each resident and completes a psychiatric assessment. If indicated, medications are prescribed, and monitored by the Psychiatrist at least once weekly. In addition, the Psychiatrist consults with the treatment team and attends the weekly treatment planning meetings. *Must be a graduate of an approved medical school and licensed in the state. Must be eligible for membership in the local branch of the State Medical Society. Must be experienced in adult psychiatry and treatment. Preferably minimum 1 year of experience with eating disorders.*

Appendix H

BRIDGEPORT
HOSPITAL
YALE NEW HAVEN HEALTH

February 19, 2014

Tim Davis
Business Development Manager
Center for Discovery
4281 Katella Avenue, Suite 111
Los Alamitos, CA 90720

RE: Transfer Agreement

Dear Mr. Davis:

This letter is in reference to a transfer agreement between Bridgeport Hospital and Center for Discovery – New England effective October 15, 2012, pursuant to which the parties agreed on the form and protocol for patient transfers from Center for Discovery - New England to Bridgeport Hospital (the "Transfer Agreement").

I understand that Center for Discovery – New England has added a new site in Fairfield, CT ("Center for Discovery – Fairfield"), and wishes to add this new site to the "Transfer Agreement." This letter hereby amends the Transfer Agreement to add Center for Discovery – Fairfield, effective on the date of your signature below. All other terms and conditions of the Transfer Agreement remain in effect. Please sign where indicated below to indicate your agreement with the foregoing amendment to the "Transfer Agreement," and return a signed copy of this letter to me.

Very truly yours,

Norman G. Roth
Executive Vice-President & COO

Understood and agreed:

CENTER FOR DISCOVERY

By: _____
Name: Tim Davis
Title: Business Development Manager
Date: 2/19/14

267 Grant Street
P.O. Box 5000
Bridgeport, CT 06610-0120
203.384.3000

TRANSFER AGREEMENT
BETWEEN
BRIDGEPORT HOSPITAL
AND
THE CENTER FOR DISCOVERY – NEW ENGLAND

This Transfer Agreement ("Agreement" is effective this 15 day of OCTOBER, 2012, by and between The Center for Discovery - New England, ("Transferring FACILITY") and Bridgeport Hospital ("Receiving Hospital").

RECITALS

WHEREAS, Transferring FACILITY is a properly licensed intensive residential treatment program for adolescent females and males between the ages of 10 to 19 years old located in Southport, CT.

WHEREAS, Receiving Hospital is a properly licensed general acute care hospital in Bridgeport, CT

WHEREAS, Transferring FACILITY recognizes that at times its patients may require emergency and non-emergency medical services available at the Receiving Hospital.

WHEREAS, the parties desire to enter into this Agreement to address arrangements under which patients under the care of Transferring FACILITY may be transferred to the Receiving Hospital pursuant to the terms and conditions set forth herein.

ARTICLE I – PATIENT TRANSFERS

1.1 Patient Transfers. When a patient transfer is necessary for emergency or non-emergency medical services which are not available at Transferring FACILITY, Transferring FACILITY shall make a concerted effort to transfer the patient as soon as is practical, and Receiving Hospital agrees to accept the patient, provided that all applicable conditions for transfer and admission are met and appropriate facilities and qualified personnel are available to accommodate and provide care to meet the patient's needs.

1.2 Advance Notification. Prior to transferring the patient, Transferring FACILITY must receive confirmation from the Receiving Hospital that it can accept the patient. The purpose of the advance notice is to determine if the Receiving Hospital has available space and qualified personnel to treat the patient. Each party agrees to notify the other party of the names or classifications of individuals who may arrange for or accept transfers. A patient shall only be transferred to Receiving Hospital upon the written order of the patient's attending physician.

1.3 Transfer Consent. Transferring FACILITY shall have responsibility for obtaining any required consent from the patient or the legally responsible person acting on the patient's behalf prior to the transfer. If such consent is not possible, the consent of the patient's physician shall be obtained by Transferring FACILITY.

1.4 Transportation of Patient. Transferring FACILITY shall be responsible for effectuating all transfers with qualified personnel and any transportation equipment medically necessary for safe patient transfer. In all patient transfers from Transferring FACILITY to Receiving Hospital, Transferring FACILITY shall be solely responsible for, and shall indemnify and hold Receiving Hospital harmless from, any and all injuries, damages or losses to the patient or the patient's personal property arising out of or in any way connected with any actions or activities occurring at any time during said transfer of the patient from Transferring FACILITY until the patient enters Receiving Hospital's building and in non-emergency cases, the Receiving Hospital's authorized personnel accept responsibility for such patient in writing.

1.5 Transfer Protocol. Transferring FACILITY and Receiving Hospital shall follow the transfer protocol set forth in Exhibit A with respect to the responsibilities of Transferring FACILITY and the documentation to be provided by Transferring FACILITY.

1.6 Patient's Personal Effects. Transferring FACILITY shall make arrangements for transferring with the patient, or in the case of an emergency, as soon as is practicable after the patient's transfer, appropriate and necessary personal property of the patient.

1.7 Payment for Services. Charges for services performed by either facility under this Agreement shall be collected by the facility rendering the services. Such collection shall come directly from the patient, third-party payors or other sources normally billed by that institution, and neither facility shall have any liability to the other for such charges, except to the extent that such liabilities would exist separate and apart from this Agreement with other healthcare facilities.

ARTICLE II – TERM AND TERMINATION

2.1 Term. Subject to each party's right of termination as set forth below, this Agreement shall be for a term of one (1) year from the date first set forth above and shall be renewed automatically for successive one (1) year periods.

2.2 Termination. Notwithstanding anything herein to the contrary, this Agreement may be terminated at any time as follows:

2.2.1 Mutual Agreement. Whenever Transferring FACILITY and Receiving Hospital shall mutually agree to the termination in writing.

2.2.2 With Cause. With cause by either party upon the default by the other party of any term, covenant or condition of this Agreement, where such default continues for a period of ten (10) days after the defaulting party receives written notice thereof from the other party specifying the existence of such a default.

2.2.3 Without Cause. Without cause by either party upon at least ten (10) days written notice given by either party to the other party in which case the Agreement shall terminate on the date specified in such notice.

2.2.4 Loss of Licensure. Immediately upon written notice should either party have its license to operate suspended or revoked or otherwise fail to be licensed to operate by the appropriate state agency.

ARTICLE III – MISCELLANEOUS

3.1 Non-Exclusivity. Nothing in this Agreement shall be construed or interpreted as requiring either party to transfer its patients to the other party's facility. Transferring FACILITY shall be free to transfer its patients to other general acute care hospitals.

3.2 Independent Contractor Status. Both parties to this Agreement are acting as independent contractors. This Agreement is for the sole purpose of facilitating the transfer of patients and information between the parties. It is not intended and shall not be construed to create any other relationship between the parties. Neither party is authorized to act as the agent of the other party. Nothing contained in this Agreement shall be construed as implying that either party endorses or sanctions the quality of care rendered by the other.

3.3 Insurance. Both parties agree to maintain general and professional liability insurance during the term of this Agreement.

3.4 Governing Law. This Agreement shall be governed by the laws of the State of Connecticut as to interpretation, construction and performance.

3.5 Assignment. No assignment of this Agreement or the rights and obligations thereunder shall be allowed without the prior written consent of both parties, except that either party may assign the Agreement to a successor, subsidiary or to an affiliated entity under common control.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement effective as of the date first set forth above.

TRANSFERRING FACILITY
Center for Discovery - New England

By: James D Buck Runyan
Name: James D. Buck Runyan
Title: C.E.O./Clinical Director

RECEIVING HOSPITAL

BRIDGEPORT HOSPITAL

By: 10/16/12
Name: Norman Roth
Title: Chief Operating Officer

Center for Discovery	Approved By:	Origination Date:03/15/97
Policy and Procedure Manual	Governing Board Approval Date: 10/01/03	Revision Date: 07/02/03
Subject: Resident Transfer		Chapter: 14 Policy number: 14.6

Policy

The Discovery Adolescent Program recognizes that a resident/client may need a higher or more intense level of treatment than is within the scope of our treatment services. A systematic, orderly transfer to an appropriate level of care is followed in such instances.

Purpose

To ensure that each resident/client participates, is educated to the reasons, and intent of a transition to another level of treatment, that the resident/client has the opportunity to provide input in the decision making process.

Procedure/Responsibility

The Director of Clinical Services
All treatment Staff

Under normal circumstances each resident/client is discharged in accordance with the CTP and its' criteria for discharge. Each resident/client in a collaborative approach with the treatment team plans for discharge throughout the treatment experience. All required appropriate agencies and persons are notified at least seventy two hours in advance of the actual discharge date. Such persons or agencies include but are not limited to family, parents, guardian, probation dept., courts, state, county, and local agencies, third party payers, and referral sources. Each member of the resident's treatment team educates the resident to the discharge plan, aftercare, and post discharge referrals.

In the event an emergency discharge is indicated, the above procedures apply and in addition, the following procedures are initiated:

- All treatment and Administrative staff are notified
- The treatment teams meets to discuss the best therapeutic approach
- A twenty four hour probation or "cool down" period may be initiated
- During this period, all appropriate persons and agencies are notified
- Should the resident/client require a higher more intense level of care, discharge occurs within six hours
- All referring agencies, persons, and sources are educated to this procedure upon admission.
- The Discovery Adolescent Program will provide transportation if necessary
- The resident/client is kept abreast of all events as they occur and input is taken form him/her.

Food Refusal

Center for Discovery follows a planned, defined protocol when determining the appropriateness of transferring a client to a higher level of care. To assure that any possible transfer is properly screened and evaluated prior to the actual physical transfer, it is necessary for the facility physician to be notified in the event of food refusal.

It is staff responsibility to notify the Dietitian when a client is refusing food and boost supplementation. Center for Discovery is held medically responsible for each client's medical stabilization and food refusal is closely monitored and assessed to ensure that each client remains medically stable under our care. When a client refuses their planned meal/snack and their boost supplementation, the Dietitian is to be notified.

The Dietitian is responsible for communicating with the Program Director and the Facility Physician to determine the appropriate care for each client on an individual basis. Vitals are to be monitored closely by milieu staff, as well as any beverage and food intake. It is the responsibility of milieu staff to effectively communicate this information to the Dietitian, whether in person or over the phone if not during normal business hours.

Through communication with the Dietitian, Program Director, and Physician, the milieu staff will be notified if the client is a candidate for bed rest. If a client is put on bed rest, they are to remain on bed rest until the physician gives approval, which is generally until the client begins to eat consistently and appropriately to maintain medical stabilization. A client on bed rest is to be resting in their bed, with no movement, and closely monitored by a staff member sitting in their room with them. When it is time for a meal or snack, the client's meal or snack is to be brought to them in their room. One staff member is to eat snack or meal in the client's room with the client.

The physician will make a decision on whether the client needs transport for medical stabilization before returning back to Center for Discovery. This usually occurs after 72 hours of refusal or sooner if a client is seen as medically unstable.

The following guidelines are to serve as general parameters by which the determination to transfer a client to a higher level of care are assessed. It is understood that these are general guidelines and will possibly vary from case to case.

- Acute refusal of all food and liquids for a period of 72 hours
- Acute refusal for <72 hours if vitals become orthostatic (lying to standing pulse change >30) or resting supine heart rate becomes bradycardic (<50)
- Acute food refusal with syncope
- Low caloric intake (~<500 kcal/day) with development of orthostasis or bradycardia

Ultimately, the decision to transfer to a high level of care rests on the shoulders of the accepting physician of the hospital where admission is sought, but hospital admission is generally sought when the above criteria are present