IN THE MARYLAND HEALTH CARE COMMISSION

Application for Certificate of Need
for
Prince George's Regional Medical Center
As a Replacement and Relocation of
Prince George's Hospital Center

Co-Applicants

Dimensions Health Corporation
d/b/a Prince George's Hospital Center
and
Mt. Washington Pediatric Hospital, Inc.

October 4, 2013

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MARYLAND HEALTH CARE COMMISSION

_____
MATTER/DOCKET NO.

_____
DATE DOCKETED

HOSPITALS
APPLICATION FOR CERTIFICATE OF NEED

ALL PAGES THROUGHOUT THE APPLICATION, ATTACHMENTS AND EXHIBITS SHOULD BE NUMBERED CONSECUTIVELY.

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1.a. Dimensions Health Corporation d/b/a Prince Georges Hospital Center
Legal Name of Project Applicant (i.e. Licensee or Proposed Licensee)

b. 3001 Hospital Drive

c. Cheverly (City) 20785 (Zip) Prince George's (County)

d. (301) 618-2000
Telephone

e. Neil J. Moore, President, CEO
Name of Owner/Chief Executive

2.a. Mount Washington Pediatric Hospital, Inc.
Legal Name of Project Co-Applicant (i.e., if more than one applicant)

b. 1708 West Rogers Avenue
Street

c. Baltimore (City) 21209 (Zip) Baltimore City (County)

d. 410-578-8600
Telephone

e. Sheldon J. Stein, President and CEO
Name of Owner/Chief Executive

3.a. Prince Georges Regional Medical Center
Name of Facility

The Boulevard At The Capital Centre
(Project Site)

Largo (City) 20774 (Zip) Prince George's (County)

4. _____
Name of Owner (if different than applicant)

5.a. N/A
Representative of Co-Applicant

b. _____
Street

_____
City Zip County

d. _____
Telephone

6. Person(s) to whom questions regarding this application should be directed: (Attach sheets if additional persons are to be contacted)

a.	John A. O'Brien, Chief Operating Officer, Dimensions Healthcare System	a.	Mary Miller, CFO/Vice President of Finance and Business Development
	Name and Title		**Name and Title**
b.	Prince George's Hospital Center 3001 Hospital Drive	b.	Mt. Washington Pediatric Hospital 1708 W. Rogers Avenue
	Street		**Street**
c.	Cheverly 20785 Prince George's	c.	Baltimore 21209 Baltimore City
	City Zip County		**City Zip County**
d.	301-618-2000	d.	(410) 578-5163
	Telephone No.		**Telephone No.**
e.	301-618-3966	e.	(410) 578-0566
	Fax No.		**Fax No.**
f.	John.O'Brien@dimensionshealth.org	f.	MMiller@MWPH.ORG
	E-mail Address		**E-mail Address**
g.	Andrew L. Solberg	g.	Thomas C. Dame, Esq.
	Name and Title		**Name and Title**
h.	A.L.S. Healthcare Consultant Services 5612 Thicket Lane	h.	Gallagher Evelius & Jones LLP 218 N. Charles St., Suite 400
	Street		**Street**
i.	Columbia 21044 Howard	i.	Baltimore 21201 Baltimore City
	City Zip County		**City Zip County**
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	Name and Title		**Name and Title**
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	Street		**Street**
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	City Zip County		**City Zip County**
p.	410-347-1370	p.	
	Telephone No.		**Telephone No.**
q.	410-468-2786	q.	
	Fax No.		**Fax No.**
r.	jtranter@gejlaw.com	r.	
	E-mail Address		**E-mail Address**

7. Brief Project Description (for identification only; see also item #14):

Construction of a new hospital to replace Prince George's Hospital Center ("PGHC"); Relocation of the Mt. Washington Pediatric unit currently at PGHC to the new hospital

8. Legal Structure of Licensee (check one from each column):

a.		b.		c.	
Governmental	____	Sole Proprietorship	____	To be Formed	____
Proprietary	____	Partnership	____	Existing	X
Nonprofit	X	Corporation	X		
		Subchapter "S"	____		

9. Current Physical Capacity and Proposed Changes: (Staff will also provide separately a detailed spreadsheet on which the applicant will display current and proposed physical bed capacity by location.)

	Current Physical Beds	**Beds to be Added or Reduced**	**Total Beds if Project is Approved**
Service			
M/S/G/A	170	-37	133
Pediatrics	12	-11	1
Obstetrics	42	-20	22
ICU/CCU Care	34	-2	32
Psychiatry	38	-10	28
Rehabilitation		0	
Chronic	0	0	0
Other (Mt. Washington Pediatric Hospital)	15	0	15
TOTAL BEDS	311	-80	231

10. Project Location and Site Control:

A. Site Size Approximately 26 acres

B. Have all necessary State and local land use approvals, including zoning, for the project as proposed been obtained? YES ___ NO __X___ (If NO, describe below the current status and timetable for receiving necessary approvals.)

The applicants plan to replace and relocate Prince George's Hospital Center as a new regional medical center in Largo, Maryland on a site known as the "Boulevard at the Capital Centre," the

former location of the Capital Centre Arena. The site is bordered on the west by the Capital Beltway, on the north by Arena Drive, and by Lottsford Road on the east side. The site is comprised of approximately 26 acres assembled from two parcels: (1) the 17-acre "Cap Centre" parcel, which is zoned R-R; and (2) the 8.49 acre "Powell" property, which is zoned M-A-C. A hospital is allowed as a special exception in the R-R zone and not allowed in the M-A-C zone. However, the District Council of the Maryland-National Capital Park and Planning Commission ("M-NCPPC") is expected to approve a pending sector plan and zoning map amendment, which if approved, will re-zone both properties to the M-X-T before the end of calendar year 2013. Also, the Prince George's County Planning Department is drafting legislation that will make the hospital a permitted use in the M-X-T zone at the identified site. If approved by the appropriate authorities, the new sector plan will provide appropriate zoning for the project.

The hospital's proximity to a Metro station qualifies it for expedited transit-oriented development treatment under the County Code. As a result, the project may proceed directly to detailed site plan approval after subdivision approval, and the County is required to complete its development review within a relatively short time frame.

The preliminary timeline for the Largo site zoning adoption & approval process is as follows:

Planning Board Work session	September 19, 2013
Planning Board Adoption of Preliminary Sector Plan	October 3, 2013
PB Transmittal of Adopted Plan to District Council	October 8, 2013
District Council Work session	October 22, 2013
District Council Approval of Adopted Plan	November 12, 2013

Exhibit 1 is a letter dated September 12, 2013 from the Maryland-National Capital Park & Planning Commission, which describes in more detail the zoning process.

C. Site Control: See (5)

(1) Title held by: _____

(2) Options to purchase held by: _____
(i) Expiration date of option _____
(ii) Is option renewable? _____ If yes, please explain
_____
_____
(iii)Cost of 0option _____

(3) Land Lease held by: _____N/A_____
(i) Expiration date of lease _____
(ii) Is lease renewable _____ If yes, please explain
_____
_____
(iii)Cost of Lease _____

(4) Option to lease held by: _____
(i) Expiration date of option _____
(ii) Is option renewable?_____ If yes, please explain
_____
(iii)Cost of option _____

(5) If site is not controlled by ownership, lease, or option, please explain how site control will be obtained. As noted above, the proposed site is comprised of two adjacent parcels of approximately 26 total acres located in Largo, Prince George's County. The "Cap Centre" portion of the site consists of approximately 17 acres that is currently part of the 70 acre parcel known as the "Boulevard of The Capital Centre" retail complex. This 70 acre parcel is owned by the Prince George's County government (Prince George's Revenue Authority), and is currently being leased on a long-term basis to RPAI US Management ("RPAI"). The 17 acre portion will be split off from the current 70 acres being leased by RPAI. and RPAI will relinquish its leasehold rights over that portion of the property to Prince George's County.

An adjacent 8.49 acre parcel, known as the Powell property, will be obtained as well for the medical park campus. The combined 26 acres will be developed as one parcel. Adjacent acreage is planned to be developed as an urban town centre concept with smart growth design.

Access to the medical campus will be via Arena Drive and Lottsford Road, and by Metrorail and Metro buses.

Means of control of property currently consists of the following:

- RPAI currently has control of the 8 acre parcel known as the Powell property through a contingency sale contract.

- A Letter of Intent between RPAI and Prince George's County to convey real estate property rights to each of the parties has been executed. After submission of this application, a contingency sales contract will be executed between the Prince George's County government, Prince George's County Revenue Authority, RPAI-Capital Centre LLC, Dimensions Health Corporation, and University of Maryland Medical System Corporation for the conveyance of land, subject to final Certificate of Need approval to proceed with the development / construction of the new regional medical center. Once the CON is approved, the County will obtain complete ownership and control of the 26 acre parcel. The County will then convey the 26 acres to the regional medical center entity or an affiliate.

(INSTRUCTION: IN COMPLETING ITEMS 11, 12 & 13, PLEASE NOTE APPLICABLE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

11. Project Implementation Target Dates (for construction or renovation projects):
    A. Obligation of Capital Expenditure ___2___months from approval date.
    B. Beginning Construction __1_____ months from capital obligation.
    C. Pre-Licensure/First Use __36_____ months from capital obligation.
    D. Full Utilization _36____ months from first use.

12. Project Implementation Target Dates (for projects not involving construction or renovations):
    A. Obligation of Capital Expenditure _____ months from approval date.
    B. Pre-Licensure/First Use _____ months from capital obligation.
    C. Full Utilization _____ months from first use.

13. Project Implementation Target Dates (for new service projects not involving a capital expenditure):
    A. Obligation of Capital Expenditure _____ months from approval date.
    B. Pre-Licensure/First Use _____ months from capital obligation.
    C. Full Utilization _____ months from first use.

14. Project Description:
    Describe the project's construction and renovation plan, and all services to be provided following completion of the project.

    See page 15

15. Project Drawings:
    Projects involving renovations or new construction should include architectural drawings of the current facility (if applicable), the new facility (if applicable), and the proposed new configuration. These drawings should include, as applicable:

    1) the number and location of nursing stations,
    2) approximate room sizes,
    3) number of beds to a room,
    4) number and location of bath rooms,
    5) any proposed space for future expansion, and
    6) the "footprint" and location of the facility on the proposed or existing site.

    See **Exhibit 2**

16. Features of Project Construction:
    A. Please Complete **"CHART 1. PROJECT CONSTRUCTION CHARACTERISTICS AND COSTS"** describing the applicable characteristics of the project, if the project involves new construction or renovation.
    B. Explain any plans for bed expansion subsequent to approval which are incorporated in the project's construction plan.

None

    C. Please discuss the availability of utilities (water, electricity, sewage, etc.) for the proposed project, and the steps that will be necessary to obtain utilities.

Utilities: There are existing water and sewer utilities located on the site. However, it is a private system. Therefore, after the required subdivision of the site, new onsite water and sewer will need to be brought into the site. Soltesz, Inc. an engineering firm engaged by the applicants, studied adjacent water lines and determined that there appears to be significant water volume

and pressure. Water and sewer capacity appears to be available. Electric service is available and will be provided by PEPCO. Verizon and Washington Gas utilities are located on Arena Drive and are accessible to the project site.

Chart 1. Project Construction Characteristics and Costs

Base Building Characteristics	Tower 1 New Construction	Tower 2 (CA/ACC) New Construction	Total Patient New Construction	Central Utility Plant New Construction	Renovation
Class of Construction					
Class A	X	X	X	X	
Class B					
Class C					
Class D					
Type of Construction/ Renovation					
Low					
Average					
Good	X	X	X	X	
Excellent					
Number of Stories	-	-	-	-	-
-	-	-	-	-	-
Total Square Footage	603,444	68,255	671,699	40,000	
C Level	102,389	22,471	124,860		
First Floor	154,042	18,761	172,803	40,000	
Second Floor	76,551	19,204	95,755		
Third Floor	76,593	7,819	84,412		
Fourth Floor	31,586		31,586		
Fifth Floor	31,599		31,599		
Sixth Floor	31,599		31,599		
Seventh Floor	31,599		31,599		
Eighth Floor	31,599		31,599		
Ninth Floor	31,599		31,599		
Roof	4,288		4,288		
Perimeter in Linear Feet					
Ground Floor	1,669	673	2,342		
First Floor	1,944	575	2,519	622	
Second Floor	2,109	574	2,683		
Third Floor	2,109	368	2,477		
Fourth Floor	1,017		1,017		
Fifth Floor	1,018		1,018		
Sixth Floor	1,018		1,018		
Seventh Floor	1,018		1,018		
Eighth Floor	1,018		1,018		
Ninth Floor	1,018		1,018		
Roof	250		250		

Wall Height (floor to eaves)					
Ground Floor	18	18	18		
First Floor	18	18	18	41	
Second Floor	14	14	14		
Third Floor	24	24	24		
Fourth Floor	14		14		
Fifth Floor	14		14		
Sixth Floor	14		14		
Seventh Floor	14		14		
Eighth Floor	14		14		
Ninth Floor	14		14		
Roof	20		20		
Elevators: New in Hospital	Public - 4	Public – 2			
Type Traction	Patient/Service - 4	Patient/Service - 1		Service - 1	
Number 13	Trauma - 1				
Sprinklers (Wet or Dry System)	Wet	Wet		Wet	
Type of HVAC System	VAV/Reheat	VAV/Reheat		VAV/Reheat	
Type of Exterior Wall	Precast Conc. and Natural Stone w/ Glass Curtain Wall, Terra Cotta Wall system	Precast Conc. and Natural Stone w/ Glass Curtain Wall, Terra Cotta Wall system	Precast Conc. and Natural Stone w/ Glass Curtain Wall, Terra Cotta Wall system	Precast Conc. and Natural Stone w/ Glass Curtain Wall, Terra Cotta Wall system	
Costs	-	-	Costs	-	Costs
Site Preparation			$23,904,693	$895,307	
Normal Site Preparation			$7,723,365	$832,635	
Site Preparation Extraordinary Costs					
Deep Foundations			$500,000		
Demolition			$1,000,000		
Hillside Foundation			$1,500,000		
Landscaping			$900,000		
Pilings			$500,000		
Premium for Paying Prevailing Wage			$581,329	$62,671	
Roads			$500,000		
Rough Grading			$3,500,000		
Sediment Control & Stabilization			$100,000		
Storm Drains			$1,500,000		
Utilities			$5,600,000		
Building Extraordinary Costs					
Canopy			$3,500,000		

Foundation Drainage/Dewatering			$300,000		
Helipad			$1,500,000		
LEED Silver Premium			$10,302,908		
Premium for Concrete Frame Construction			$1,750,000		
Premium for Paying Prevailing Wage			$16,584,385	$675,284	
Redundant Electric Service			$2,500,000		
Redundant Water Service			$300,000		
Signs			$500,000		
Permits Extraordinary Costs					
Jurisdictional Hook-up Fees			$500,000		

*As defined by Marshall Valuation Service. Copies of the definitions may be obtained by contacting staff of the Commission.

PROJECT DESCRIPTION

I. INTRODUCTION

Since the mid -1970s, the County-owned Prince Georges Hospital Center ("PGHC") has experienced financial challenges, as it has become the healthcare safety net for low-income Prince George's County residents. Historically, PGHC has had the highest percentage of Medicaid and self-pay patients than any other hospital in the County.

The Prince George's County government has been committed for many years to providing its residents a broad array of needed health care services. However, efforts to operate PGHC as a department of County government have proven to be challenging and have resulted in frequent financial losses.

Attempts to sell the hospital started as early as 1979 when a proposal by County Executive Larry Hogan was defeated through the persuasion of Council Member Gladys Noon Spellman, who argued that the County could not give up control of decisions to better serve the health care needs of County residents. Under a compromise arrangement, the County created a community not for profit organization to operate the hospitals under a management contract. The County continued to own the assets of the organization, reserved the right to approve major decisions, and appointed several of the board members of the new entity. This new management organization started in 1982 and today is known as Dimensions Health Corporation d/b/a Dimensions Healthcare System ("Dimensions").

Financial success continued to elude the new organization. Governance divisions and questions of facility reinvestment responsibilities were made more

complex by the trends of declining government reimbursements and the rapid increase in the number of uninsured patients seeking care. Between 1997 and 2010, Dimensions did not experience a single financially positive year. As a result, capital reinvestment nearly ceased and the ability to grow community outreach and primary care services were severely hampered. PGHC has paid substantial amounts, as much as $15,000,000 per year, to subsidize physicians to care for its low income service area population. As described below, there have been numerous studies and attempts to make PGHC and Dimensions financially viable. The State of Maryland and Prince Georges County each has invested millions of dollars to allow the health system to continue to care for County residents. After a failed attempt in 2010 to solicit bids and sell the Dimensions facilities as a package[1], the Governor's Office asked a select group of parties to try and develop a long-term viable solution to the financial distress of Dimensions.

Many prior initiatives and decisions to recapitalize, restructure, or dispose of PGHC have failed to produce a lasting solution for the benefit of Prince Georgians. These initiatives have included multiple efforts to sell the hospital (1979, 1999, and 2002), the appointment of several study commissions, task forces, and oversight boards led by prominent leaders (2002, 2003, 2004, and 2008), and the engagement of turnaround professionals (2001 and 2004). The proposal presented in this application is informed by, and builds upon, all the options previously suggested by interested parties from within and outside the County.

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1 In addition to PGHC, Dimensions also operates several other facilities in the County, including Laurel Regional Hospital, the Bowie Health Campus, the Rachel H. Pemberton Senior Health Center, and the Glenridge Medical Center.

The proposal set forth in this CON application is a result of the collaboration of several parties who agreed to assume leading roles in addressing public health problems in Prince George's County and solving the difficult financial and operational status of PGHC. On July 21, 2011, Prince George's County, the University of Maryland Medical System ("UMMS"), the University System of Maryland ("USM"), the State of Maryland, and Dimensions signed a Memorandum of Understanding ("MOU") (**Exhibit 3**) for developing a comprehensive plan for strengthening health care in Prince George's County and solve PGHC's financial dilemma.

After a comprehensive two-year review period, which included a public health study by the University of Maryland School of Public Health, a plan was developed to create a new regional medical center that would have clinical affiliations with an academic medical center, along with ambulatory care initiatives to address primary care and public health access for County residents. To make this vision a reality, the MOU parties have worked together to develop a financial support for the regional medical center.

Prince George's County agreed to contribute $208,000,000 to help fund a new regional medical center. The State of Maryland also agreed to provide $208,000,000 in grants over five years, beginning in 2015, for the construction of a new regional medical center. Prince George's County also agreed to donate land for the new regional medical center, as well as provide funding for some existing liabilities of Dimensions. Currently, UMMS has been providing healthcare planning expertise to Dimensions, as well as working with the University of Maryland School of Medicine to address physician specialty and clinical program needs at PGHC and its service area. The collaborative

efforts of the MOU parties have created a pathway for financial sustainability for a new healthcare delivery system in Prince George's County.

The reaction of stakeholders to the implementation of the MOU and the possibility of a new regional medical center in Prince George's County has been strongly supportive. A recent editorial in the *Washington Post* reflected this sentiment. On August 25, 2013 the *Washington Post* Editorial Board commended the proposed project, stating: "[n]ow, after years of false starts, political dysfunction and uncertain funding, Prince Georgians are closer than ever to getting the top-flight regional hospital they deserve." New leadership in the County and assistance from the State and many other parties have made a regional medical center possible.

PGHC plays a vital and unique role in the health security of the County. The current health system does not meet the needs of the majority of residents, both insured and uninsured. The new regional medical center plan is a long-term solution for addressing both PGHC's financial challenges and the public health issues in Prince George's County.

An academically-affiliated regional medical center enhances the probability that new care models and technologies will speed improvements in raising health status and limiting the effects of health disparities. This plan creates the capacity to train and attract more of the health professionals needed. As explained in the Public Health Impact Study, it is important that the new regional medical center partner with academic institutions and be supported by a comprehensive ambulatory care network so that Prince Georgians will no longer feel compelled to travel to the District of Columbia, Virginia, and elsewhere, to seek health care services.

As shown by the substantial number of letters of support, and the demonstrated commitment of the MOU parties, the many interested parties – citizens, government officials, health care providers, community leaders, academic institutions, and business people – strongly back the proposal for a new regional medical center in Prince George's County to replace PGHC. The diversity, number, and enthusiasm of the expressions of support for the project may be unprecedented in the history of Maryland health planning. Many of these supporters noted the benefits of PGHC's commitment to connect the regional medical center to a health care system that will promote improved access to primary care in Prince George's County as well as the planned linkages to the University of Maryland School of Medicine.

II. PRINCE GEORGE'S HOSPITAL CENTER: HISTORY

Prince George's General Hospital, the 100-bed, one story predecessor of PGHC, opened its doors on March 21, 1944, on its current campus on Hospital Drive in Cheverly, Maryland.

The initial project to build Prince George's General Hospital was made possible in 1940 by the Lanham Act, a congressional appropriation bill to build and equip 50 small hospitals in areas lacking adequate medical facilities. In the beginning, the hospital was operated under the auspices of the Prince George's County Hospital Commission (the "Hospital Commission").

By 1946, less than two years after opening, the hospital's average daily census was continuously at capacity and it became clear that further hospital expansion was necessary. The hospital's board of directors asked the Hospital Commission to obtain an Authority Bond to finance an expansion. Work on a five-story addition began in

1949 and was completed in 1951, increasing the patient capacity to 225 beds. In January 1950, during construction of the new building, the American College of Surgeons notified the hospital that it was approved and accredited to provide a full-fledged internship and residency program. Such rapid growth for a hospital less than ten years old signaled how vital this institution already was to the residents of Prince George's County.

In 1955, patient demand within the County compelled another significant increase in the hospital's bed capacity. The hospital made plans for a new wing to accommodate another 100 patients. However, the community's need quickly outpaced the plans for and construction of this expansion. While construction of the new wing occurred, continued growth necessitated preliminary planning for a further addition to the wing under construction. The new wing was finalized in February 1959.

In its first 15 years, the hospital grew from 100 to 385 beds. During that time, the hospital reached maturity and became the central health care facility in Prince George's County.

By the 1970s, the hospital had established itself as a major medical center in the D.C. metropolitan health care community. In the early 1970s, the hospital received designation as an area-wide trauma center, the second in the State of Maryland, which established a much needed service for the Southern Maryland region. The hospital became a well-respected center of medical education, becoming a teaching facility for seven specialties. It formed affiliations with 12 area colleges and universities, including the University of Maryland and Prince George's Community College.

However, in the 1970s, the County faced management issues and operating deficits, leading to the decision to privatize the County hospital system, including Prince George's General Hospital. In 1982, the Prince George's County Council voted to discontinue the County's Hospital Commission and established a private, not-for-profit corporation to lease and manage the county's public hospitals, including PGHC. The new private corporation was called Community Hospital and Health Care Systems (CHHCS) and was to be governed by a 25-member community-based board. In 1986, CHHCS changed its name to Dimensions Health Corporation. The Dimensions governing board was reduced from 25 to 11 members. By that time, the Dimensions facilities included Prince George's Hospital Center, Laurel Regional Hospital, Bowie Health Center, and Gladys Spellman Specialty Hospital and Nursing Center.

In 1995, PGHC broke ground for another new addition including the Intensive Services Pavilion. The Pavilion added a 24-bed intensive care unit, as well as new suites for surgery, catheterization, and endoscopy.

Beginning in the mid-1990s, Prince George's County's demographic profile shifted, influenced by a significant net in-migration of low-income residents.

Since fiscal year 1999, as a result of the changing demographics of the County and growth in the high proportion of uninsured and underinsured patients that it served, PGHC has been burdened with significant operating losses.

PGHC is the second busiest trauma center in the State, with a growing number of Medicaid and self-pay patients. PGHC's administrators found it increasingly necessary to compensate physicians for on-call coverage to provide needed medical and surgical services 24 hours a day, 365 days a year. To a large extent, such

physician expenses are not included in the hospital's reimbursement rates approved by the HSCRC. Without an offsetting source of funding, these payments for physician services have been a major factor in the deterioration of Dimensions and PGHC's financial position since 1999.

On the brink of the new millennium, Dimensions faced numerous challenges to its financial sustainability and ability to provide needed health care services for all Prince Georgians, regardless of ability to pay. An aging hospital facility plant, millions in unfunded payments for physician services, a limited ability to address capital needs, and challenges in recruiting and retaining the high-level staff, has caused the hospital to be less attractive to the commercially-insured County residents. Studies have shown that County residents with better commercial insurance and transportation choose to receive care in more modern facilities even if they have to leave Prince George's County, thereby perpetuating the hospital's financial stresses. As a result, the proportion of poorer patients receiving medically necessary health care services at PGHC has grown, along with increased uncompensated care debts and the need for more physician subsidy outlays.

Due to the deteriorating financial condition of PGHC and Dimensions, the State provided Dimensions with financial support to assist with the orderly sale or closure of its facilities. In May, 2008, The Maryland General Assembly enacted legislation to create the Prince George's County Hospital Authority (the "Hospital Authority"), whose mission was to implement an open, transparent, and competitive bidding process for the purpose of facilitating the acquisition of Dimensions. Although the Hospital Authority

received three proposals, none of the proposals committed to purchasing all of the Dimensions facilities.

III. THE JULY 2011 MEMORANDUM OF UNDERSTANDING

As noted above, on July 21, 2011, Prince George's County, UMMS, USM, the State, and Dimensions signed the MOU, setting forth an agreed strategy for developing a comprehensive plan for strengthening health care in Prince George's County.

The MOU parties commissioned and funded the University of Maryland School of Public Health to perform a study of the health care needs of Prince George's County: *Transforming Health in Prince George's County: A public health impact study* (2012) (the "Public Health Impact Study"). The study included 1,000 random calls to County residents, a review of past studies and state data, many interviews, and a review of current data. Its conclusions include that a new, accessible medical center with university affiliation, and culturally competent primary care expansion will succeed.

The MOU partners agreed to establish plans for improving health services, increasing access to primary care, and enhancing the County's overall health infrastructure. The School of Public Health's study assisted in the development of a strategy to improve overall health status and health delivery design. The combined analysis resulted in the development and implementation of a strategy to transform the current health system into an efficient, effective and financially viable healthcare delivery system with a new regional medical center, located in Prince George's County, supported by a comprehensive ambulatory care network, which will help improve the health of the residents of Prince George's County and the Southern Maryland region.

Following completion, review, and approval of these studies by the parties, UMMS promised to assist Dimensions in the planning of the proposed project. The parties also promised to develop a plan to transfer the assets and to discharge Dimensions' current debt and liabilities. The County and State will provide funding as needed to sustain operations during the transition and assist in the discharge of liabilities.

IV. POPULATION HEALTH MANAGEMENT: UNIVERSITY OF MARYLAND COLLEGE PARK SCHOOL OF PUBLIC HEALTH STUDY: *TRANSFORMING HEALTH IN PRINCE GEORGE'S COUNTY, MARYLAND: A PUBLIC HEALTH IMPACT STUDY*

The University of Maryland School of Public Health was commissioned by the MOU parties to conduct a public health study, and it produced a report: "Transforming Health in Prince George's County, Maryland: A Public Health Impact Study" (the "Public Health Impact Study"), attached as **Exhibit 4** which addressed the design of a new health care system, assuming the utilizing of population health management principles, and what positive impact such an initiative would have on the health status of the population served. This assessment by The School of Public Health was integral in design consideration and planning for the proposed regional medical center. The Public Health Impact Study's analysis included (1) a survey of Prince George's County residents; (2) interviews with State, County, and local stakeholders; (3) a healthcare workforce assessment; (4) overview of public health resources; (5) examination of hospital discharges and readmissions of County residents; and (6) national interviews with leaders from 13 health care systems to help identify best practices in achieving

integrated, coordinated, high-quality care that improves population health and reduces costs. The following five questions served as a framework for the study:

1. **What are the key health outcomes in the county most amenable to improvement by a new health care system?**
2. **What is the geographic distribution of health care resources and where are the areas of greatest need for primary care?**
3. **What resources can be mobilized in the public health sector to complement the impact of the health care system?**
4. **What are the key issues to maximize uptake and achieve the potential of a health care system for public health?**
5. **What elements of a health care system can affect the key health outcomes and by how much?**

Among the study's key findings were the following:

- **Health Status of Prince George's County Residents** – County residents suffer from higher rates of chronic diseases, including diabetes, heart disease, hypertension, asthma and cancer, than those residing in neighboring counties. Sixty-nine percent of residents surveyed are overweight or obese, based on Body Mass Index calculations. Seventeen percent report being diagnosed with pre-diabetes and 33 percent with pre-hypertension. The study recommends emphasizing primary prevention and strong collaborative primary care networks that can coordinate care management for such conditions and lead to improvements that save lives and reduce costly hospital visits.

- **Health Care Workforce Capacity** – The County has far fewer primary care providers for the population compared to surrounding counties and the state. The areas with the highest primary care need are within the Beltway and in the southern region of the County. The study shows a need for an additional 61 primary care physicians (13% increase) to meet minimum need in these areas, and recommends expanding community-based health facilities and outreach programs.

- **Community-based Care Capacity** – While the County has many assets that can be mobilized to support a new system, the capacity of community-based care, including safety-net clinics, remains severely limited. The study states that

County-led efforts are needed to increase this capacity and to guide the integration of primary care and public health services.

- **Perception of County Health Care Facility** – Many Prince George's County residents seek health care outside of the County, and this is driven by insurance carriers, provider referrals, the availability of specialty care, and perceptions of the quality of care at local hospitals. Residents and key stakeholders emphasized the importance of establishing an academically affiliated regional medical center for the County to improve actual and perceived quality of care. County residents identified services such as nutrition, physical activities, mental health and substance abuse treatment, and family planning as vital to a new health care system. They also reported difficulty in learning about their medical conditions, identifying the need to enhance health literacy as another issue to consider. The study recommends that the planning phase of the new heath system look at these issues.

  In brief summary, The Public Health Impact Study recommended:

  1. **Establish a high quality academically-affiliated regional medical center with a strong and collaborative ambulatory care network.**
  2. **Develop a County-led plan to improve public health, expand access to high quality primary care and support systems integration.**
     - **Create an inclusive central planning process;**
     - **Coordinate efforts to maximize impact;**
     - **Address workforce and facilities needs in areas with insufficient primary care**
     - **Support innovation in health care, prevention and public health care delivery.**
  3. **Develop a clear brand that promotes a high quality health system and encourages residents to return to the County for care**

V. POPULATION HEALTH MANAGEMENT CONSIDERATIONS INTO DESIGN OF REGIONAL MEDICAL CENTER

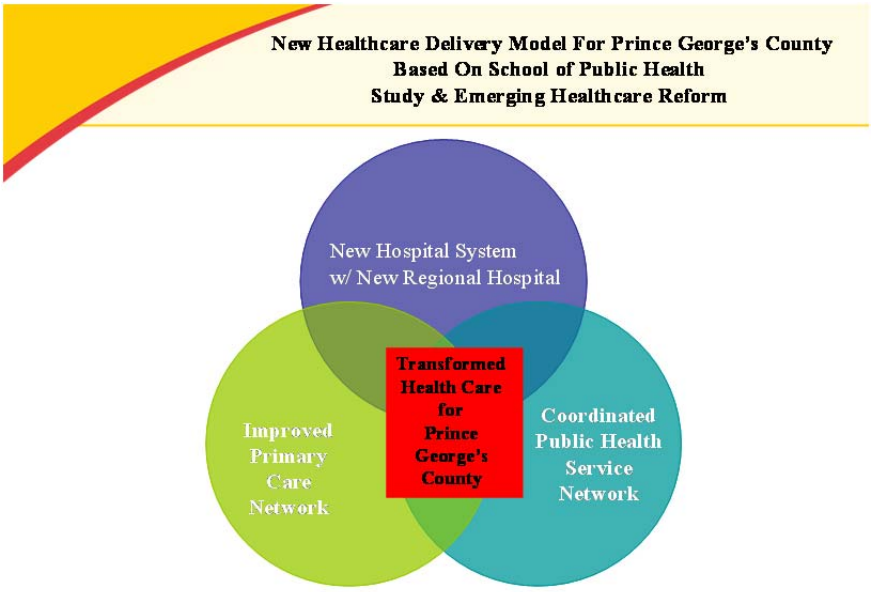
The MOU parties are committed in developing a regional healthcare system that will promote public health and consider population health management principles into

the design of the proposed healthcare system for the County and Southern Maryland region. The proposed new regional medical center and its clinical programs will be designed based upon the findings of the Public Health Impact Study. Significant elements being considered are the following;

1. PGHC took into consideration declining inpatient utilization rates in the service area as a result of population health management.
2. The regional medical center will be forecasted to have an ALOS less than what the current PGHC facility is experiencing.
3. The regional medical center's clinical programs will be designed to include better coordinated community care with primary care physicians as well as within the patients' home environment.
4. The regional medical center will have specialized ambulatory clinics to manage high-risk patients having chronic conditions such as diabetes, COPD, and CHF.
5. The new health system and its MOU partners will work together to promote increased access to primary care resources (both physicians and mid-level practitioners).

This initiative is a unique opportunity to address various elements of a health care system that needs refinement. School of Public Health Dean Jane E. Clark identified this opportunity best when she commented:

"*This unprecedented partnership of academic, government, and health care institutions to establish a new health care system for the County could be a model for transforming health throughout the nation.*"



VI. PRINCE GEORGE'S HOSPITAL CENTER: TODAY

Current Prince George's Hospital Center Service Area

PGHC is located at 3001 Hospital Drive, Cheverly, Maryland. The hospital is located within Zip Code 20785.

The Zip Codes within PGHC's current primary and secondary service areas are illustrated in the following table.[2] Washington D.C. Zip Codes were excluded from this analysis. The vast majority of Zip Codes within PGHC's service area are located within Prince George's County. However, PGHC does serve as a Level II Regional Trauma Center and a Level III NICU serving the Southern Maryland region.

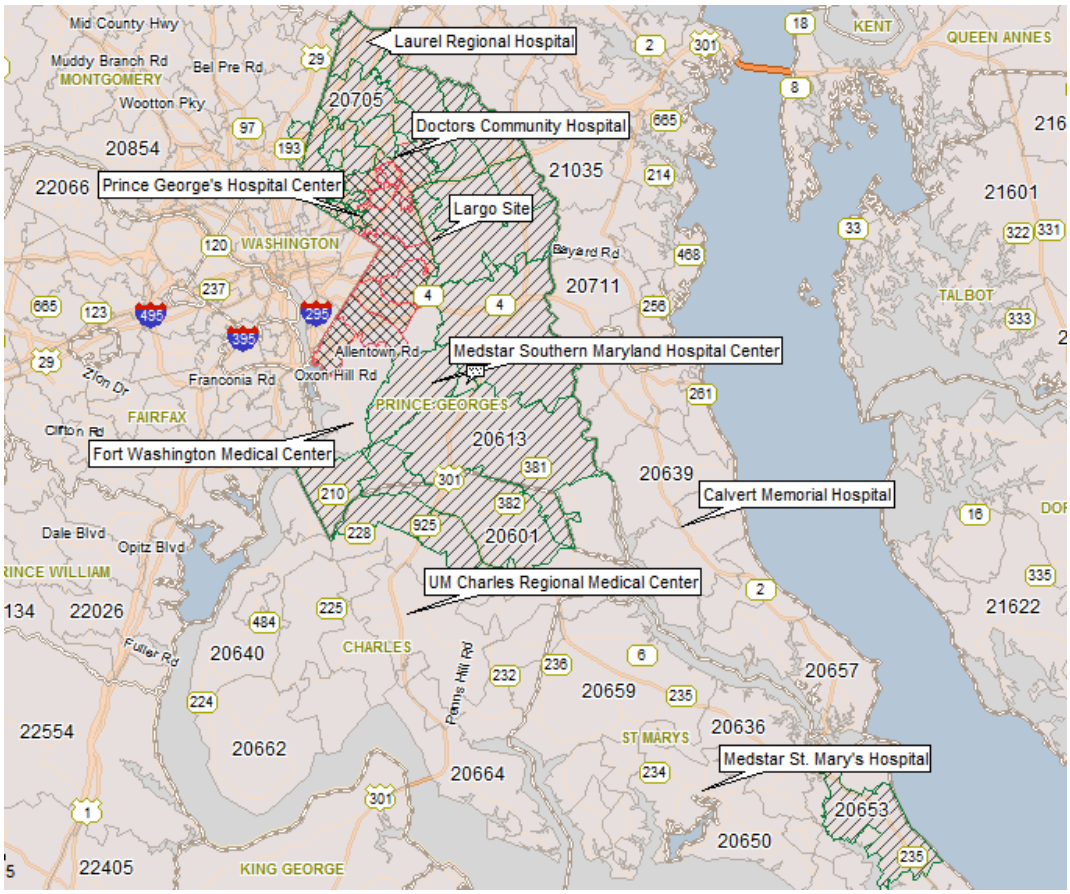
2 Tables 1 – 5, which are required by the Commission, appear later in this application.

Prince George's Hospital Center	FY2012 PSA/SSA*			
PGHC PSA		Discharges	Percent	Accum. Percent
20743	Capitol Heights	1672	12.36%	12.36%
20785	Hyattsville	1642	12.14%	24.50%
20784	Hyattsville	843	6.23%	30.73%
20706	Lanham	821	6.07%	36.80%
20774	Upper Marlboro	707	5.23%	42.02%
20747	District Heights	697	5.15%	47.18%
20737	Riverdale	523	3.87%	51.04%
20745	Oxon Hill	422	3.12%	54.16%
20746	Suitland	375	2.77%	56.93%
20748	Temple Hills	364	2.69%	59.62%
20710	Bladensburg	355	2.62%	62.25%
PGHC SSA				
20721	Bowie	302	2.23%	64.48%
20772	Upper Marlboro	292	2.16%	66.64%
20744	Fort Washington	239	1.77%	68.41%
20783	Hyattsville	204	1.51%	69.91%
20781	Hyattsville	197	1.46%	71.37%
20782	Hyattsville	194	1.43%	72.80%
20770	Greenbelt	182	1.35%	74.15%
20722	Brentwood	148	1.09%	75.24%
20735	Clinton	143	1.06%	76.30%
20716	Bowie	134	0.99%	77.29%
20705	Beltsville	131	0.97%	78.26%
20715	Bowie	129	0.95%	79.21%
20720	Bowie	120	0.89%	80.10%
20708	Laurel	103	0.76%	80.86%
20740	College Park	101	0.75%	81.61%
20707	Laurel	94	0.69%	82.30%
20712	Mount Rainer	86	0.64%	82.94%
20602	Waldorf	51	0.38%	83.32%
20601	Waldorf	42	0.31%	83.63%
20613	Brandwine	39	0.29%	83.91%
20769	Glenn Dale	36	0.27%	84.18%
20903	Silver Spring	34	0.25%	84.43%
20653	Lexington Park	29	0.21%	84.65%
20603	Waldorf	28	0.21%	84.85%
20607	Accokeek	26	0.19%	85.05%
Total PSA/SSA		11,505		
Out of Servcie Area		2,023		
Total Discharges		13,528		
* PSA/SSA less Washington D.C. zipcodes				

Table 6
Zip Codes within PGHC's current primary and secondary service areas

The following map identifies the geographic service area of PGHC's primary and secondary service area Zip Codes.

Figure 1
PGHC's Primary and Secondary
Service Area Zip Codes



Current Services at PGHC

PGHC, a member of Dimensions, is currently licensed for 214 inpatient beds, including 142 MSGA beds, 8 pediatric beds, 36 obstetrical beds, and 28 adult psychiatric beds. The emergency department has 48 treatment spaces.

PGHC is designated as a Maryland Level II Trauma Center by the Maryland Institute for Emergency Medical Services Systems ("MIEMSS").

Along with the trauma program, PGHC also provides cardio-thoracic (including open heart) surgical services. PGHC also is designated by MIEMSS as a ST Elevation Myocardial Infarction (STEMI) Center.

PGHC is designated a Level IIIB Neonatal Intensive Care Unit (NICU).

PGHC currently has within its facility, a 15 bed pediatric specialty hospital operated by Mount Washington Pediatric Hospital (MWPH). The specialty pediatric beds are owned by MWPH and MWPH leases space from PGHC to operate its specialty pediatric beds.

The hospital's radiology unit has American College of Radiology accreditation for mammography, nuclear medicine, computed tomography (CT), ultrasound / vascular and magnetic imaging resonance (MRI) through November, 2014. The PGHC laboratory unit has College of American Pathologists (CAP) accreditation through January, 2015.

PGHC also has two outpatient centers offering diagnostic imaging and laboratory testing, primary care, specialty treatment, and senior health services in Brentwood and Glenridge, Maryland. PGHC manages its emergency department in partnership with the UMMS, the University of Maryland School of Medicine, and the Maryland Emergency Medicine Network Inc.

Physician Practices

The PGHC Medical Staff includes physicians, dentists, podiatrists, and certified nurse midwives. The Medical Staff provides a full range of clinical services including Family Medicine and General Internal Medicine. PGHC also has physicians who practice the following Specialty Services: Anesthesiology, Medical Imaging, Pediatrics,

Psychiatry, Critical Care Medicine, Pathology, Emergency Medicine and Obstetrics/Gynecology. The Medical subspecialists represent Allergy/Immunology, Dermatology, Endocrinology, Gastroenterology, Hematology/Oncology, Radiation Oncology, Infectious Disease, Nephrology, Neurology, Nuclear medicine, Physical Medicine and Rheumatology. Surgical specialists represent Cardiac/Thoracic/Vascular Surgery, Dentistry & Oral Surgery, Neurosurgery, Ophthalmology, ENT, Plastic Surgery, Podiatry, Traumatology and Urology. PGHC also has a hospitalists service that consults with its physicians 24 hours a day.

Challenges and Deficits of Current PGHC Facility

The existing building is in need of a variety of improvements. PGHC's current facilities are not designed for modern, patient centered, family oriented medicine. It is undersized in various critical areas.

PGHC conducted an internal assessment of the current PGHC facility. It conducted departmental interviews, meeting with representatives from many clinical and service-oriented departments. The numerous findings as to existing physical space deficiencies and limitations affected nearly every department in the hospital. A summary of many of the facility deficiencies by department is presented below:

Emergency Department (ED)

- Overall, the ED needs more space – the area is designated as a suite and portions of the corridors are used to house ED exam beds. The use of hall beds does not lend itself to providing the patient needed privacy and ability to speak with the medical team confidentially regarding his/her condition.
- Although part of the Behavioral Health Department, the ED includes an emergency behavioral area that holds and evaluates those patients, sometimes for overnight observation. The area has 5 beds, plus consultation rooms, a waiting area, and a nursing station etc. The unit needs to be able to provide

direct visual and audio observation, when appropriate, of the patients receiving care in this unit. The unit needs to be structurally homicide and suicide safe. This area needs more support space and rooms / beds consistent with the ED's daily behaviorial health patient volumes.

- The ED needs more trauma and regular resuscitation rooms / resuscitation rooms need to have only one or two beds / required to overflow into this area often due to trauma volume.The resuscitation room is an open bay of four beds.
- The ED needs more room to triage ambulance patients in a more private setting than the hallway, as previously noted, which is the most adequate space available due to the current design.
- The ED needs a room for advance triage / treat at triage and quick look. Triage needs to be closer to the ED than where it is currently located.
- The ED needs an appropriate area for decontaminate Haz-Mat patients.
- The helicopter Pad and OR need to be closer and more accessible.
- The CT, Sonogram and MRI should be closer or in the ED.
- There needs to be a lab in the ED – ED currently utilizes a tube system -- if it is down, the staff must go down to 1st floor which is extremely inconvenient.
- There is no ED space for nursing documentation, physician documentation or work areas. This area needs additional space.
- The ED needs more supply storage space. There is only one ED supply closet.
- There is limited space in the ED area for equipment. EKGs, COWS, sonogram machines -- all have to stay in the hallways of the ED cluttering the area. While the ED does not have many extra beds and stretchers, there is no storage space for storing the extras which means that the beds frequently go missing to other departments.
- The ED needs additional waiting areas; it currently uses a separate area for Fast Track.
- There is a need for a separate Pediatric ED area in conjunction with Pediatric inpatient.
- The ED needs a Greeting / Quick Look area and stations. The ED needs a better, more secure greeting space.
- There is no practical storage space for dietary carts. Special delivery trays are often left on top of the nurse station counters. There is no collection area for dirty trays; a pick-up / drop off location is needed.

- The ED needs a Dietary preparation / kitchen area.
- The Haz Mat area is not large enough.
- The ED needs a larger ambulance off-loading area to accommodate more EMS vehicles and address patient needs.
- There is not an easily accessible way to get to the ED from and to the main hospital. Also, there is only one entrance after 8:00 PM.

Inpatient Care Services/Nursing

Medical/Surgical Units

- Units were originally designed for a census of over 40 with one central nursing station, one clean utility room, one dirty utility room and one medication room.
- Majority of patient rooms contain a bathroom but not a shower. There are showers and tub rooms located centrally in the unit.
- Most units have only six private rooms that contain a shower. Many times these private rooms are occupied with patients who require isolation.
- Majority of patient rooms are semi private which is not ideal for designated support person can stay with the patient in the room 24 hours a day. A semi private room is not large enough to accommodate additional furniture to ensure the designated support persons can be reasonably comfortable.
- Location of visitor and patient elevators is not in the line of sight from the nursing station.
- There is not enough storage space for COWs, infusion pumps, medication carts causing the hallways to be cluttered.
- A patient room is utilized as a staff break room .
- Current space provides an insufficient space for staff lockers and they are too small.
- Need a conference room with audio/visual equipment to facilitate staff meetings, family meetings and/or to facilitate patient/family education.

CCU/ICU

- The means of entrance and exit are not optimal. Staff must go down several flights of stairs, an elevator, travel along a long corridor to exit out of the ED, or further to exit out of the main lobby are currently the only options.

- The ICU location is too far from the ED and most test areas. Staff must travel up an inclined slope to reach the ICU. This is very difficult when pushing heavy beds and equipment.
- Staff and patients must travel out of doors to transport to the MRI. This causes exposure to varying extreme temperatures in both the winter and summer months.
- ICU bed storage space is insufficient. Extra beds are left out in the hallway or transported to the old Gladys Spellman building for storage.
- Segmented PODs make staffing difficult and fragmented.
- The staff break room is too small.
- Staff lockers are too small and there is not an adequate amount of space.
- The soiled utility room is not large enough.
- The conference room space is shared with copier and learning materials for staff and is not conducive to meeting or learning.
- There is no storage or collection area for dietary trays.
- The storage areas for supplies are not adequate.
- There is not adequate space in the patients' room to accommodate visitors. Patient rooms and waiting room cannot accommodate overnight visitors
- The family conference room is small and outdated.
- There are no devices to assist with patient lifting. Placement of Hoyer lifts in every patient room is not optimal.
- Placement of sinks is not optimal. Sinks should be closer to room exit. More sinks should be outside of patient rooms.
- Patient rooms do not provide a private area for ambulatory patients to go to the bathroom.
- Charting area outside of patient rooms is very small and is shared between rooms.
- Optimal patient placement in the room would allow for patients to view out of the window. They currently face in towards the unit.

Behavioral Health Services (BHS)

- The present shower space is too small to assist and monitor patients – need to increase shower space.
- There are no private rooms for patients with special needs.
- The nursing station area is not adequate.
- The medication room area is not adequate.
- Overall, the BHS unit lacks storage space.
- BHS needs a centralized ability to monitor temperature of the environment.
- Need key code access to all doors.
- Fire exits are not accessible from all areas of the unit.

ED Psychiatric Assessment and Stabilization Center (ASC)

- The ASC rooms are small and dark.
- The ASC unit lacks storage space.
- The nursing station is small and lacks privacy for shift / physician reporting.
- Needs cabinets for mobile computers to dispense medications.
- There is no medication room – location of medication dispenser on top of cabinet results in a lack of privacy.
- Thermostat covers easily opened/unsecured – Need centralized ability to monitor temperature of the environment.
- Need key pad access to treatment areas/utility areas.
- There is no elevator near ASC for patients transfer to inpatient unit – have to walk significant distance to elevator.
- There is no storage space for equipment.
- There is no soiled utility room. Staff has to use soiled utility in adjacent ED.
- There is no storage area for clean linen and food.

Mother/Baby Unit

- Unit has one central nursing station, one clean utility room, one dirty utility room and one medication room.

- Majority of patient rooms contain a bathroom but not a shower. There are showers and tub rooms located centrally in the unit.

- Has an insufficient number of private rooms. Many times private rooms are occupied with patients who require isolation.

- There is not enough storage space for COWs, infusion pumps, medication carts.

NICU

- Due to the limited space in the current NICU, staff currently cannot foster the family centered care environment we would like to provide for the parents of our neonates. Examples of areas where the existing physical space provides a hindrance to the NICU staff are as follows:

- Inadequate spacing between infant bedspots is not ideal for infection control and safety issues.

- Limited physical space isa barrier to provide parental privacy for parent-infant bonding.

- Lack of physical space is a barrier to providing in depth parent education.

- Lack of appropriate space for equipment storage causes cluttering of unit, and possible safety issues.

- Due to the location of supply rooms, hoarding of supplies at the bedside is a common practice, thus causing a potential wasting of supplies, and/or contamination of supplies.

- The soiled utility room is inadequately sized for the amount of equipment that generally needs to be cleaned in an intensive care environment.

Pediatrics

- There is a lack of appropriate space for equipment storage that causes patient rooms to sometimes be closed and used for this purpose.

- A lack of appropriate physical space limits the capability for parents to room in comfortably with their sick child.

- The lack of physical space is a hindrance to patient confidentiality and parental privacy when discussing medical condition of their child.

- Pediatrics lacks a pneumatic tube system, so there is a delay in getting lab results, as specimens have to be physically delivered to laboratory.

Dialysis

- Dialysis unit: the hand washing sinks are inadequate.

- Need more space between the beds for patient privacy and to allow staff to care for the patient
- Dialysis machine storage area does not have space for the cleaning and disinfection of the machines.
- Need storage space for supplies and equipment
- Need dedicated medication room area
- Need bathroom for patients

Laboratory

- The hospital building does not permit the installation of a modern pneumatic tube system throughout the hospital, leading to delays in laboratory testing and high expense for nursing delivery of all lab specimens. The current tube system is point-to-point only connecting the ED and Laboratory -- the tube system is very old and down frequently.
- The old building has numerous support walls and discrete rooms prohibiting an open, efficient layout for the laboratory space; it does not allow for expansion of our Roche total automation line.
- The Laboratory would require major renovation to remove all very old fume hoods and linear countertops that are over 40 years old. Also refrigeration space is inadequate and separated from main laboratory. A modular open laboratory space would improve efficiency.
- Laboratory/Blood Bank needs to be located closer to Main Operating Room and Emergency Department.

Infection Control

- NICU: at present, the NICU has only 70 square feet per patient.
- CCU: there is no negative pressure room.
- Emergency Department: a larger ED is needed to address infectious patients. Ideally, the ED would have at least 6 negative pressure rooms with ante-rooms. At present there are only two negative pressure rooms with no ante-room.
- Maternal and Child Health: facility needs at least two negative pressure rooms with ante-room in this area.
- Dialysis unit: the hand washing sinks are inadequate. Need more space between the beds. Dialysis machine storage area does not have sufficient space.

- Central Sterile Processing: Department needs addtional space between clean and dirty area

- Unit Storage areas: Department needs additional space for equipment and supplies storage.

- Sink location: sinks are not conveniently located at the entrance of the room. At present sinks are located inside patient's bath room.

- Store room: the supplies are put on the floor because of space issue.

Materials Management

- There is limited space for storage of supplies and linen on clinical units resulting in remote stocking, hoarding, expiration of supplies, duplicate orders / trips by supply clerks and nurses for supplies and linens.

- There are space constraints on the nursing units for equipment and EMR devices causing hallway blockage, inaccessibility to equipment for patient care and safety hazards.

- There is limited space for vendor access kiosks at security check points.

- There is inconsistent wireless access and no hard docking access for supply ordering in clinical areas.

- Department needs additional storage space for supplies.

- There is no ability to further deploy point of use technology for supply charge capture and reordering – the spaces allocated will not allow for closed cabinetry on the units.

- The OR storage is inadequate for implants, consignment trays and high dollar items and lack systematic controls resulting in potential loss to the organization.

- The receiving dock area is inadequate for the number and frequencies of deliveries requiring trucks to wait excessive times to dock and unload. Require plates for many trucks and/ or lift gates. Staff does not have space for a fork lift or double stacking of pallets due to the height of the ceilings and limited space.

- Deliveries in the hospital are not optimal, comingling with the public spaces and taking time from patient care elevators.

- Emergency supplies are housed in old operating rooms that lack temp and humidity control.

- Unable to store back up linen in the warehouse for injection into the linen system timely and rely upon the vendors to ship directly to the laundry causing delays in patient care.

- The warehouse flooring is cracked and requires exceptional maintenance to support safety.

- The gas cylinder rooms are small and require multiple trips / orders to support the organization to maintain safety. Require at least two more rooms off the receiving dock.

- The ED supply area is grossly inadequate and cannot hold enough supply for the area in 24 hours requiring multiple trips / supply orders and linen runs to accommodate the patient volumes.

- The Pharmacy storage space is inadequate and requires cardboard and other materials to be transported routinely from the hallway site to the receiving dock.

Outpatient Services and Surgery

Main Operating Room

- The location of the service elevators are not large enough and often require passage to public spaces requiring multiple turns, corners, and small passageways often bumping the stretcher to the wall or the archway. Easy access between the OR and the nursing floors is needed so it can be utilized without the patient being seen by the visitors in public areas on the way to the surgery suite.

- There is a problem with storing large equipment. Surgical tables, OSI tables, and accessories, positioning devices, C-arms, microscopes, CUSA, and Video tower carts are stored on the hallway. This equipment is stored wherever a space is available.

- The current door design of the surgery suite is not big enough to accommodate large ICU beds without bumping to the walls/doors causing damage.

- Each OR room does not have a built in cabinet to store most commonly used items. Storage often is by way of a movable cart that takes additional space which is also time consuming to clean.

- The OR does not have a pre-anesthesia holding area where patients are taken prior to their procedures. This is a problem since there is no additional space to redesign the current suite, the patient stays either in PACU or Short Stay area which is not the best workflow. The OR needs a six bay pre-anesthesia holding area.

- The main OR requires an area where lead aprons are readily available to staff for all rooms. It is optimal to have this area close to each of the OR rooms so staff can readily protect themselves from radiation when required but yet should be easy to replace and store the apron where it should be rather than dragging the heavy apron to the next available rack.

- Being a trauma hospital, the surgery suite does not have enough on-call rooms where on-call staff can stay off hours. Anesthesia, RN, Techs, and SAs should have a dedicated call-room. There are times during disaster situations when staff needs to stay on board. This is not available in the current design.

- The male and female locker room has been outgrown and requires additional lockers. The staff lounge should be in the vicinity of the locker rooms but yet away from the Main OR rooms. The current design of the OR lounge is too close to the OR rooms and when food is involved, it attracts pests. The lounge should not share the same hallway to eliminate this problem.

- There is no central area from steam sterilization and chemical sterilization within the surgical suite. In the current design, steam sterilization is in the OR Core, while the Steris chemical sterilization is away from the OR often passing to hallways before reaching the OR. These areas need to be combined.

- The Central Core needs to be bigger. In the current design, there are not enough storage shelves for sterile items including sets. There should be a central area for sterile sets and built in shelves for all other sterile supplies.

- There is a need for a hybrid room that can be used for Cath or Surgery. This should be adjacent to the Heart Room. Current design does not have this room and proximity.

- In the current design, there is not enough office space for admin support.

- There is no receiving area for OR supplies and an area where the administrative work of ordering/receiving supplies. There is no Clinical Specialist/Educator office with classroom, the Surginet Information System Coordinator Office, and Specialty Coordinator offices for Ortho, Cardiac, General, GYN, Vascular, and Misc. There is no office for a Quality STS data reporting coordinator which is required of the program.

- In the current design, there is not enough room to hold meetings for the anesthesia and OR department. There is a need to have a conference room with capability to expand or make it small depending on the amount of participants involved.

- In the current design, the waiting room is too far for personalized interaction with patient's relatives/loved ones. The surgeons and nurses should be able to walk to the waiting room to update family members.

- The central main OR desk is not located in close proximity to the entrances and should be glass enclosed to minimize noise as well as to maintain privacy.

- There is no surgeon's lounge where the surgeons can wait for their next case.

- The scheduling is not in close proximity to the main OR desk and cannot be easily accessed by physicians.

OR Anesthesia

- The anesthesia workroom is not close to the OR suite. The current design puts the anesthesia workroom close by but requires more storage space for supplies. Additional storage space is needed for supplies, carts, and omnicell.

- The Anesthesia department should have a utility room where dirty instruments/equipment can be processed. Current design does not allow this and sometimes cleaning is done further away.

- Steris Machine room is required for anesthesia intubation equipment. This is currently not available.

- The department needs to have a larger storage space for the supplies needed for surgery. Currently, the room is cramped.

- Anesthesia does not have an office space for medical staff.

OR Perfusion Area

- The Perfusion area requires additional storage space for supplies.

Catheterization Lab

- The Cath Lab, and the two small Cath Labs, lack storage space. The carts fill the available wall areas for stents and other supplies. The two Cath Labs should have one central sterile core capable of storing needed supplies centrally and additional overflow storage for other items with an Omnicell that can be accessed by all Labs. Currently, the additional storage is located off site due to lack of storage.

- The scrub sink in the current design is located outside the Cath Lab area in a common hallway. Need to have the scrub sink located in the Cath Lab away from the common public hallway. The two cath labs must also be enlarged to accommodate additional equipment.

- The current design does not include one EP room and one hybrid room. Current design only is for the two Cath Labs and when EPs are performed, it makes one Cath Lab unavailable for Cath procedures.

- There is a need for a hybrid room that is capable of performing catheterization as well as be able to perform surgical procedures when warranted without delay.

- The current design does not include a communication system. Cath needs to have a communication system capable of reaching both cath labs, the front desk, and other areas frequented by staff.

- The current space does not have a documentation room and viewing room.
- There needs to be a central location for lead apron and other protective equipment. Currently, the lead apron rack is on the hallway and blocks access to omnicell and is a safety issue.
- The medical director office is not in the vicinity of the Cath Lab. The nursing director, ADMs, and nurse practitioner administrative offices should also be centrally located within the Cath Lab. Currently, the Director is located on the fourth floor, while the ADMs and NPs are situated outside the area.
- The staff female and male locker rooms with bath rooms are not available. The staff uses the same bath room as the patients. Locker Rooms are shared by both male and female staff members. This will also be used by physicians to change into approved scrub suits.
- The visitor area is not located within the Cath Lab/Transcare. Currently, the visitors are located in the pavilion which is too far when a physician needs to communicate or update patient's relatives.
- The Cath lab is not close to the CCU or have a direct elevator serving the CCU area. The CCU is on the 4th floor and elevator is away thorough a public hallway.

Transcare

- Transcare has 8 open bays. Transcare is not glass enclosed for privacy and needs at least 12 bays capable of taking isolation patients.
- The Nurse's station is not in the middle of the room so that allows a 360 degree view and. The current design is an open bay with not enough space and an open bay with nurses unable to see all the patients from the nurse's station.
- Transcare should have a radial lounge capable of accommodating 4-6 patients at a time. Currently, only 2 patients can be accommodated.
- There is a small supply area for Transcare. Transcare should have a larger room able to store additional supplies and equipment.
- The dirty utility room should be situated away from the patient care area. Currently, due to space shortages, the dirty utility room is facing some patient's beds. The area should be separated where a clean and dirty utility room is utilized.

Cardiology

- Currently, the department has 4 small bays inter mixed with the corner where TEEs are cleaned, sterilized and hang to dry. Cardiology needs at least 5 large bays and one additional bay for stress testing enclosed in glass for privacy.

- Cardiology needs to have a clean and dirty area where TEEs are reprocessed for cleaning and an area where the TEEs are stored safely. There should be appropriate access to ensure that the traffic pattern is observed and we do not mix dirty and clean equipment/instruments.

- The Cardiology Department is not in close proximity with the Cath Lab or together with the Cardiac Services, and in close proximity with the Emergency Department, Transcare, Cardiac Cath Lab and Surgical Services. In the current design, the department is on the 4th floor away from other Cardiac service areas.

- Currently, the department design includes no locker/bathroom.

- There is a small workspace for the administrative staff.

- There is a small physician reading area that is located with the staff workspace. Cardiology needs a separate reading room for physicians that contains 4 computers to read ECHOs and EKGs

- There is no space for staff to perform the billing privately. This is intermixed with all other areas. The department should have a private billing area where records can be kept.

- There is no supply/equipment room for this department. The supplies and equipment are parked in available space, making the area cramped.

Short Stay Center (SSC)

- Currently in the SSC, although the patients have private rooms, it is not big enough to maneuver a bed/stretcher. The patient rooms must be adequate to maneuver a bed/stretcher and at the same time have space for equipment as needed.

- This department requires a bigger storage space for supplies and clean equipment.

- The SSC should have clean and dirty utility areas. Currently, it has a dirty utility area. Blankets and bed sheets are housed in a movable cart that is parked out at an empty wall space.

- The department does not have a male/female locker room with bathroom. The staff uses the patient bathroom when needed. In the future, the department needs to have a male/female locker room that can be shared with PACU and a larger lounge to accommodate both departments.

- Currently the SSC does not have a private room where physicians can talk to a patient's relative privately.

- Laboratory and Radiology are not located close by, but should be accessed directly since most patients require going to those areas back and forth.

- There is no additional area where stretchers may be parked when not in used. Currently, the stretcher gets park where space is available which is not ideal since it may block access to emergency routes.

- There is no office space for an NP / PA where they can work on the patient. There is also no space for administrative offices in the department. The SSC needs to have an NP / PA office and administrative space for ADMs.

PACU

- Currently in the PACU, there is an open bay of 14. The PACU needs glass enclosed bays for patient privacy.

- Currently, there is only a dirty utility area. It is not large enough to accommodate the generated volume of soiled items.

- There is a need for a bigger storage area for supplies and a separate area for portable equipment such as transport monitor, wheelchairs, and other ortho assistive devices.

- There is no locker room for male/female staff member. There is also no private bathroom for staff. They are shared with the patients.

- The administrative office is not centrally located in proximity of the department so staff can be supervised.

- PACU does not have a dictation room for physicians where they can complete their orders and dictate their procedures quietly.

- The PACU does not have a med room. Presently, the omnicell is located close to the nurse's desk that is seen by visitors. The med room should be locked and away from visitors.

- The nurses station is not located in the middle of the area to allow 360 degree viewing of all patients.

- There is no meeting room/conference room that can be utilized by the department for inservices and special events. In the currently, there is no meeting room for this area so meetings are held on the hallway.

Special Procedures

- Special Procedures is an outpatient area that is located away from the OR. Need to have Special Procedures in close proximity with the OR and PACU, so the recovery of patients is centrally managed in PACU.

- There is no large clean/dirty utility room capable of accommodating the generated materials.
- There is no changing room and lockers for outpatients having procedures done.
- There is no consultation room available for incoming outpatients.
- There is a need for storage space for supplies. Currently, supplies are stored where space is available. Storage space should be in the core easily accessible to all the Endo rooms.
- There is no physician dictation/work room for physicians to complete their records.

Respiratory Services

- The department is not located proximal to the Critical Care Unit (it is in the basement).
- There is not adequate storage in the critical care units – ICU, CCU, NICU and ED for respiratory equipment and supplies to eliminate non-value added process steps.
- There is not adequate storage on the remaining inpatient floors for respiratory supplies to eliminate non-value process steps.
- There is no pneumatic tube system between the pharmacy and the patient care floors to facilitate the delivery of patient medication to avoid delays in patient care when doses are missing from the OmniCell.
- There is no clear delineation between dirty utility and clean storage.
- The clean utility area in respiratory department needs adequate shelving for supplies.
- Therapist work area needs additional electrical outlets for use by mobile computers used for EMR.
- Therapist work area needs adequate counter space for computers and printers.
- Ventilator storage area needs adequate electrical outlets to maintain battery charge.
- There is no room available that can be used for shift report, meetings and continuing education.
- The area needs office space for supervisors.

Sterile Processing and Surgery (CSP)
Central Sterile Processing

- The current design of the area does not have the capability to issue small items without someone coming in the CSP area. There should be a window or a quick access that staff can use to issue items.

- CSP does not enough storage shelves for equipment that is routinely issued out such as IV pumps, SCD machines, etc. There is not enough area to store HEPA filters, Isolation carts, Code Carts, and other items such as portable commode.

- CSP needs an expanded dirty receiving area to process dirty instruments and equipment. There should be at least 2 large ultrasonic machines to pre clean all the sets and enough space to park dirty case carts awaiting processing.

- There is only one cart washer that can handle one cart at a time. When the cart washer breaks down, the staff has to manually wash the carts before they can be used.

- There is not enough storage space for case carts. Often times, the case carts are stored in the middle of the hallway. Although current design is located in the same floor as the OR, future design needs to have direct access to dirty case carts coming from the OR.

- The CSP requires a quality work area where additional testing equipment is needed to check and verify instruments and lumened equipment such as flexible scope, suctions and the like.

- Testing logs and biological incubators for all equipment needs to be located centrally. The current design because of space does not allow this.

- Administrative support offices are missing in the current design. There is no receiving area for CSP and oftentimes, supplies are lined up the hallway until they can be put away. The CSP supervisors need an administrative office. The CSP manager must be close to the working area of the CSP for supervision.

- CSP needs three (3) large volume sterilizers.

Imaging Services (IS)

- The Cat scan area is far too small, and unable to move patients around and area delivers little if no privacy for patients.

- The thresholds in the department are too small for some beds to easily pass through.

- The electrical supply in the department seems insufficient for advanced technology and emergencies.

- The bathrooms are our fifty years old and the toilets often clog.
- There is insufficient space area and dictation issues for radiologists.
- IS needs additional storage supply closets.
- IS needs an expanded dressing area for patients – to ensure a more private area.
- Nuclear Medicine is located on a different floor away from the rest of the department and support staff.
- Ultrasound rooms are small and have temperature issues.
- There is no current space for MRI services inside the building.

Pharmacy

- The Pharmacy is currently in a space that was not originally designed to be a Pharmacy. The fixtures and shelving have been retrofitted into a space that is inadequate for the amount of medications, supplies, equipment and workspaces that are necessary to optimally function in the space.
- The layout and design do not support efficient workflow.
- The space challenges have led to medication storage problems. Several locations outside of the Pharmacy are necessary to store Pharmacy equipment.
- The transporting of medications is hampered by the lack of a pneumatic tube system.
- Efficiencies in the medication packaging and distribution are hampered since there is no space to install a medication carousel in the current location.
- Planning is underway for an outpatient Pharmacy. There is no optimal space on the main level the hospital to accommodate a Pharmacy that would be accessible to patients.
- The Pharmacy's clean room where IV medication is prepared is small and does not support the increased volumes due to increasing demands as a result of drug shortages.
- The current Pharmacy department does not have the room to expand to train Pharmacy students and post-graduate pharmacy residents because there is no designated work space for these practitioners.
- There is no space within the Pharmacy for a conference area for meetings, training and staff development activities.

- The medication rooms on the patient care units do not have adequate space to accommodate an efficient workflow for the "state of the art" medication transport carts.

- Deliveries from vendors / suppliers to the Pharmacy cannot be stored on the floor in the containers that they arrived in. They must be immediately unpacked since space will not allow storage in the Pharmacy.

- Sinks are not deep enough. Design and depth of sinks needs to be considered.

- Refrigerator space in the Pharmacy is inadequate because there is no space to accommodate an additional refrigerator.

- There is no space inside of the Pharmacy to accommodate the pharmacy leadership team and clinical staff. Office spaces are outside of the Pharmacy which is not optimal for teamwork and support of front line staff.

Plant Operations (Engineering/Maintenance) and Facility

- The fire alarm panel is in need of upgrade.

- The Ambulatory Care Facility (ACF) heat pumps need to be replaced. The ACF building requires 200 tons of output for cooling, and requires redundancy for piping risers.

- The ACF air handling units (AHU) require replacement.

- Two obsolete chillers in boiler plant require replacement.

- Need to replace 40 year old boiler deareator.

- HVAC distribution is via an inadequate 3-pipe system. Updating to a 4-pipe system would represent significant cost and disruption to the hospital.

- Lighting improvements are needed based on current lighting practices.

- Many building windows need replacing and roofs are nearing end of useful life.

- The buildings are only partially sprinklered.

Clinical Engineering (CE)

- The clinical engineering shop is located in the garage basement, too far from customers.

- CE needs a cleaning area for equipment with sink and negative pressure, currently have a sink for everything, including food prep.

- CE needs a service area for X-Ray equipment, lift system, hoist.

- The basement has very poor cell phone coverage.
- CE does not have enough storage space for old equipment.
- CE needs independent HVAC.

Environmental Services (EVS)

- There are no bed/furniture holding areas.
- Trash closets are too small to hold the trashes generated from the floor until the trash tech pick up. Since there is no trash chute, the trash will be piled up prior to pick up time. This requires pick up of the trash from the closets every two hours. A solid waste trash chute is required – it is essential and safe for the environment. Trash chutes eliminate transporting trash from unit to unit through the hallway and also eliminates transporting trashes through the elevator and patients/visitors does not have to see or pass near trash cart.
- The patient care equipment is currently in the unit hallways and there is no room for storage. This causes the cleaning effort to be difficult and hinders movement forward or backward.
- The Environmental Service closets are small and do not accommodate the cleaning carts/equipment. In order to maintain standards, employees should have larger closets, where all necessary supplies, carts, and equipment would be kept right on the unit and easily available and accessible to staff.

Security

- The overall space that is occupied by the Security Department in general is not adequate for its operational needs. The one area that has limited space and has a large amount of activity is the front foyer -- as you enter the front door of the department. This area is used for various customer services such as patient valuables pick up, vendors signing in and mostly hospital identification processing, badging, etc. This area needs to be larger to accommodate those staff, vendors and visitors who come to the security office.
- The badging office that the administration officer occupies needs to be larger to accommodate the files necessary to keep up with employee hires and the accompanying files.
- Our 24/7/365 control center is too accessible by staff and needs to be more secure. Schedules and other information can be located outside this office. Our safes for valuables are located in this room.
- The roll call room and lockers for the security officers as well as equipment needs to be enlarged and better organized.
- Need a security closet or locker in or near the ED for security equipment.

Kitchen/Cafeteria

- One of the biggest issues in the Kitchen is the flooring – it has been patched and painted for years, but cannot be removed and replaced due to cost and timing for replacement.
- The freezer is in the dry storage area.
- Need Storage area for delivery Carts and other Equipment.
- Service Elevators to patient Floors need to be better located near Dietary Department.

Parking

- The current Garage was built in 1976 -- it needs substantial repairs. The parking structure, 220,000 square feet, is in dire need of repairs. Post tension repairs and sealing of all six levels.
- Currently there is an attendant operated parking booth -- fee parking -- coin operated time cards, according to space, would be optimal versus an attendant operated parking booth.
- Do not have sufficient parking for ED patients and families that will allow them to easily enter the ER.

Helipads

Upper Pad:

- Code 10 (helicopter arrival with patient) response requires one security officer to respond. Their primary function is to have the elevator waiting to transport the trauma team to the roof pad on the designated elevators, and return to the Trauma / ER. There are two designated elevators for Code 10 roof responses. These elevators have been known to malfunction a couple of times a year.

Lower Pad:

- The lower pad poses a safety concern for vehicle and pedestrian traffic.
- Security has to be mobilized to control vehicle traffic each way on Mercy Drive and the intersection connecting Mercy Drive and the hospital's front entrance road and the public bus service road when the lower helipad is in use.
- Pedestrian traffic exiting and entering the ER main entrance must also be controlled by security. This requires 4-5 security officers to perform this task safely.
- With a limited number of security officers on each shift a ground landing decreases the security manpower inside the hospital and limited the security service to the hospital staff and patients.

Corporate Education

- The facility lacks adequate training rooms for all classes and seminars. It needs four spacious rooms that can accommodate a minimum of 25 participants with chairs and tables.
- All classrooms are in need of facilities for washing, i.e, sink and disposal unit. AHA training occurs in these classrooms.
- The facility lacks storage for training materials. Several storage facilities in the office and near the classroom spaces are needed.
- Education currently has no lab space for computer training – the facility needs five computer labs (25 participants per room).
- Dimensions currently does not have place for Simulation Technology. 1-2 jointed rooms are need for Simulation training.
- Bathrooms are not available for staff in Education area.
- Education staff is spread out at two different locations – the facility needs at least 15 individual office spaces for staff and contractual faculty.
- There is no room for reception area and office. A generous size reception area is needed for registration process.

Management Information Systems

- There is a lack of space for IT technicians, especially for network and desktop areas.
- There is poor air circulation in communication closets thereby reducing equipment life.
- The facility needs wide door entry areas for equipment to be moved in-and-out of.
- There is a lack of training rooms and staging areas.
- There is a lack of meeting rooms for the IT teams.
- There are Inconsistent room temperatures, power resources, etc.
- There is a lack of office space for IT managers.
- There is a lack storage space for record retention purposes.
- IT has space and infrastructure needs in several areas including computer operations including data center and related space.

- There is a need for “closet” (small room) locations throughout the hospital to house communications equipments.

IT Current Environment Issues

- Insufficient management offices.
- Cramped work space for analysts.
- No meeting rooms.

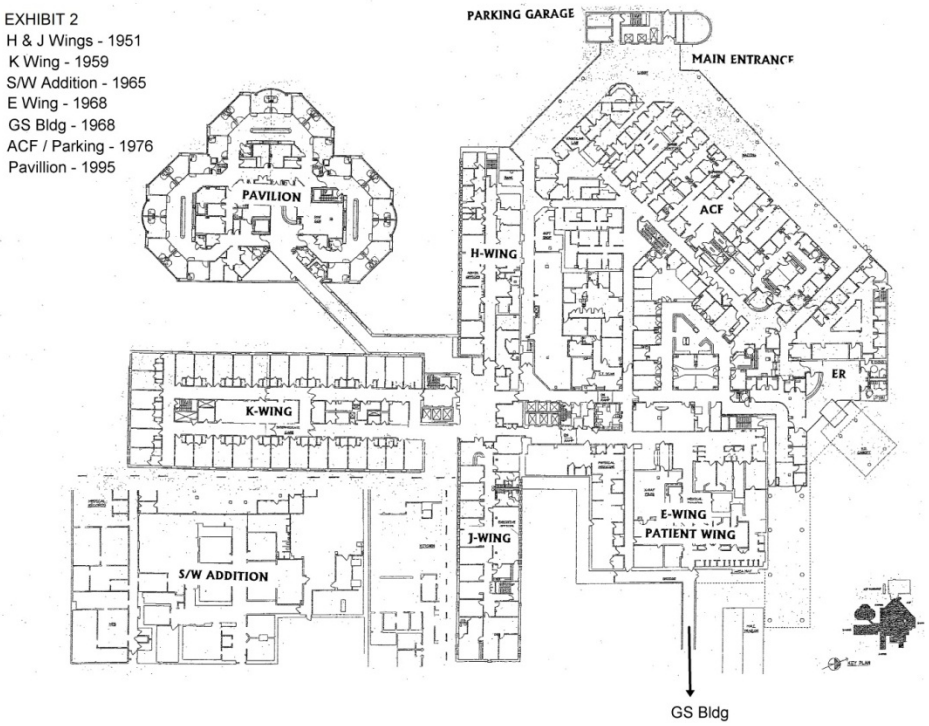
IT Technical Support

- Staff space and lack of contiguous space is an issue.
- Lack of equipment receiving, storage and staging (set-up) is very limited.

IT Infrastructure

- Communications closets are not all located properly and have cooling issues.

The existing facility is comprised of seven components from different eras. The majority of the building, including most of the inpatient units, was constructed in the period from 1951 to 1968. An ambulatory care facility and an intensive services pavillion were built in 1976 and 1995, respectively. A diagram showing the existing building and the years when the different components were constructed follows:



At PGHC's request, HOK Architects reviewed the current facility to determine the most cost effective approach to replacing the PGHC facility. HOK's analysis can be found in the section addressing COMAR 10.24.10.04B (5) Cost-Effectiveness.

VII. THE PROPOSED PROJECT

Project Location

The proposed project involves relocating the current PGHC facility to a site approximately five miles southeast of the present location in Cheverly.

The proposed new location is at The Boulevard at the Capital Centre (south of Arena Drive), Largo, Maryland 20774. The site was chosen based on a criteria set collaboratively by the Prince George's County government and Dimensions. The site selection criteria for the new regional medical center included the following:

1. Maintain PGHC's role as a regional medical center
2. Address public perceptions of PGHC.
3. Improvement in the ability to recruit physicians to serve its service area population.
4. Maintain/Improve access for its service area population and consider:
    1. Centralized location within Prince George's County with access to I-495
    2. Walkable Metro access
    3. Proximate to bus routes
    4. Pedestrian access
5. Enable collaboration with the University of Maryland Medical System and University of Maryland System.
6. Cost-site acquisition and site development
7. Site Characteristics
    1. Engineering and Traffic Considerations
    2. Adequate size
    3. Timing of site availability
    4. Future expansion/development potential

The final sites reviewed included the Woodmore Town Center site; the Landover Mall site; The Boulevard at the Capital Centre site with adjacent Powell property; and

The Boulevard at the Capital Centre site with adjacent Schwartz property. PGHC evaluated these four sites as well as two potential projects on the existing Cheverly campus. The Boulevard at the Capital Center with adjacent Powell property site emerged as the preferred location.

Proposed New Prince George's County Regional Medical Center Service Area

The proposed new Prince George's Regional Medical Center ("PGRMC") will be located in Largo, Maryland at the site location known as "The Boulevard at the Capital Centre." The site is bordered on the west by the Capital Beltway, on the north by Arena Drive, and on the east side by Lottsford Road. The new PGRMC will be located within Zip Code 20774.

The projected Zip Codes within PGRMC's primary and secondary service areas for MSGA patients are illustrated in the following table. The projected service area was calculated using a travel time/distance ranking methodology, identifying and comparing hospital locations to population centroid points within Zip Codes. Again, most of the Zip Codes within the projected total service area are within Prince George's County.

The following table identifies the projected primary and secondary service area for the new PGRMC for MSGA patients. The table also illustrates the number of inpatient discharges being projected for the new PGRMC by Zip Code for the year 2021. Following the table is a map identifying the geographic service area of PGRMC with the primary service area Zip Codes.

MSG (15-64 and 65+)				
Zip Code	Drive-Time Ranking	Projected Discharges	% of Total	Cumulative %
20743	1	1,145	10.7%	10.7%
20785	1	904	8.4%	19.1%
20747	1	899	8.4%	27.5%
20774	1	887	8.3%	35.7%
20721	1	462	4.3%	40.1%
20716	1	368	3.4%	43.5%
20773	1	10	0.1%	43.6%
20753	1	8	0.1%	43.7%
20731	1	6	0.1%	43.7%
20791	1	5	0.0%	43.8%
20775	1	4	0.0%	43.8%
20752	1	4	0.0%	43.8%
20717	1	3	0.0%	43.9%
20792	1	2	0.0%	43.9%
20797	1	0	0.0%	43.9%
20799	1	0	0.0%	43.9%
20706	2	436	4.1%	47.9%
20772	2	434	4.0%	52.0%
20746	2	352	3.3%	55.3%
20784	2	290	2.7%	58.0%
20715	2	277	2.6%	60.5%
20770	2	217	2.0%	62.6%
20720	2	170	1.6%	64.2%
20769	2	57	0.5%	64.7%
20623	2	27	0.2%	64.9%
20768	2	3	0.0%	65.0%
20703	2	2	0.0%	65.0%
20718	2	2	0.0%	65.0%
20762	2	2	0.0%	65.0%
20771	2	1	0.0%	65.0%
20748	3	285	2.7%	67.7%
20735	3	255	2.4%	70.1%
20601	3	129	1.2%	71.3%
20602	3	118	1.1%	72.4%
20603	3	94	0.9%	73.2%
20708	3	88	0.8%	74.1%
20613	3	61	0.6%	74.6%
20608	3	7	0.1%	74.7%
20757	3	1	0.0%	74.7%
20709	3	1	0.0%	74.7%
20719	3	1	0.0%	74.7%
20737	4	93	0.9%	75.6%
20710	4	55	0.5%	76.1%
20738	4	1	0.0%	76.1%
20704	5	1	0.0%	76.1%
20744	6	283	2.6%	78.7%
20745	6	181	1.7%	80.4%
20653	6	106	1.0%	81.4%
20705	6	78	0.7%	82.1%
20740	6	66	0.6%	82.8%
20607	6	45	0.4%	83.2%
20781	6	43	0.4%	83.6%
20749	6	3	0.0%	83.6%
20725	6	1	0.0%	83.6%
20726	6	0	0.0%	83.6%
20707	7	87	0.8%	84.4%
20722	7	31	0.3%	84.7%
20787	7	2	0.0%	84.7%
20741	7	1	0.0%	84.7%
20742	8	1	0.0%	84.8%
20782	9	117	1.1%	85.8%
20712	9	36	0.3%	86.2%
20788	9	0	0.0%	86.2%
In-Service Area Total		9,246	86.2%	
Out of Service Area		1,483	13.8%	
Total		10,729	100.0%	

Table 7
Projected Primary and Secondary Service Area for New PGRMC for MSGA Patients

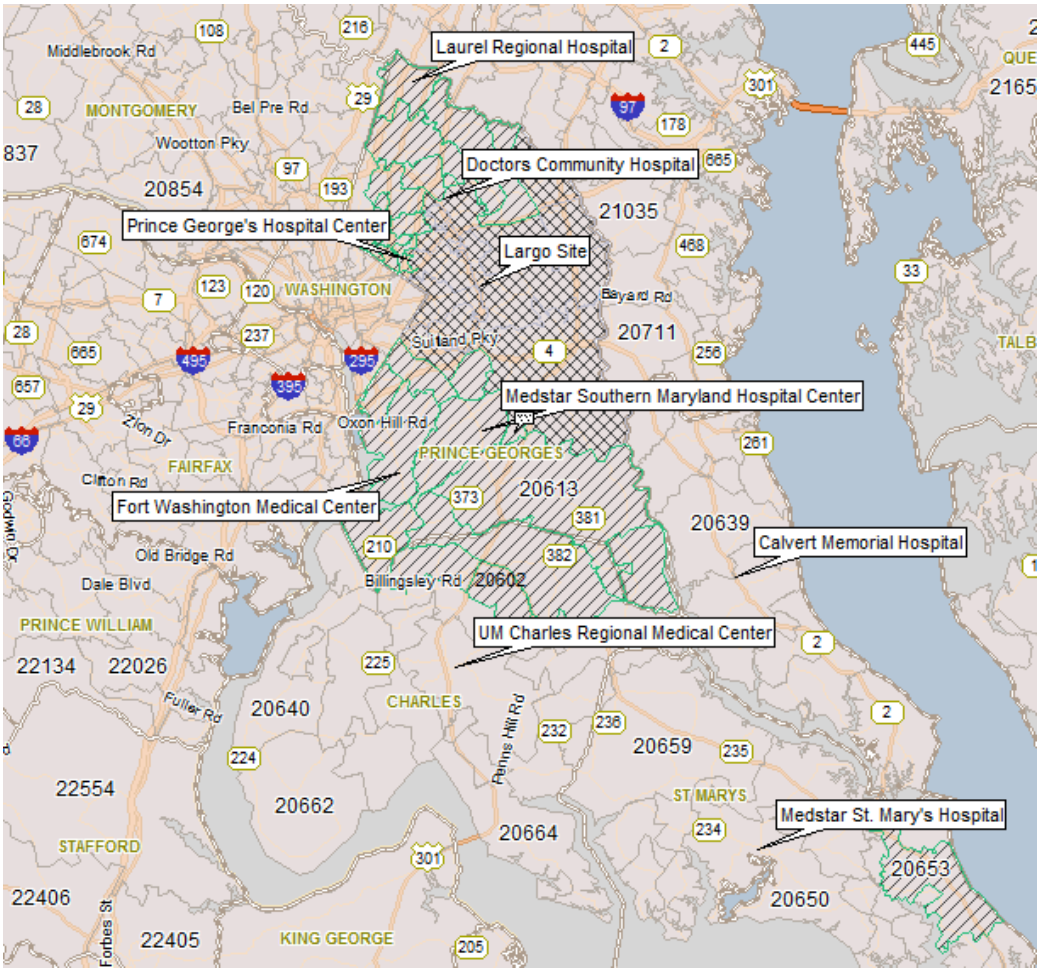


Figure 2
Geographic Service Area of PGRMC With Primary Service Area Zip Codes

Regional Medical Center Proposed Services

The proposed regional medical center is planned to be licensed for 216 inpatient beds, comprised of 165 MSGA beds, 1 Pediatric bed, 22 obstetrical (post-partum) beds, and 28 adult psychiatric beds.

As a separate facility, Mount Washington Pediatric Hospital will operate a 15 bed specialty pediatric hospital within the new facility. These beds are licensed as Special Hospital – Pediatric beds.

The regional medical center is projected to open on January, 2018 with volume maturity in 2021. In fiscal year 2021, the facility is projected to have approximately 16, 509 inpatient discharges.

Like the current PGHC, the regional medical center will be a designated Maryland Level II Trauma Center, a cardiac center with open heart surgery and ST Elevation Myocardial Infarction (STEMI) Center, a designated Level IIIB Neonatal Intensive Care Unit (NICU), and a designated Stroke Center.

The new facility will include ten floors (including a mechanical floor). Each floor will comprise of the following departments / services:

Concourse Floor:

- Dietary / Dining Services
- Materials Management
- Facilities Support
- Pharmacy
- Laboratory
- Physical Therapy
- Women's Health Services
- Cardio/Neuro Diagnostics
- Registration Area
- IT/Telecommunications

Level 1:

- Emergency Department
- Pediatric ED area with 1 inpatient bed and adjacent observation / short-stay pediatric rooms
- Surgical Services / PACU
- Universal Care Unit / Observation Area
- Imaging Department
- Cardiac Catherization Lab
- Endo Suite
- Clinical Support

Level 2:

- Birthing Center
- NICU
- Mount Washington Pediatric Hospital
- On-Call Suite

Level 3:

- Mechanical Floor

Level 4:

- Behavioral Health Unit

Level 5:

- ICU
- Dialysis

Levels, 6, 7, 8 & 9

- Medical Inpatient Units

Adjacent to the main hospital building will be an Ambulatory Care Center, which will include a cancer center to be located on the first floor, outpatient clinics on the second floor, and administrative / conference space located on the third floor.

A parking garage is planned to be located on the medical campus. At the present time, the Prince George's County government is considering building and operating the parking garage.

Use of Existing PGHC Campus After Relocation of Hospital

PGHC, Dimensions and the County have not yet determined the use of the existing PGHC campus. The parties are currently evaluating using the current Gladys Spellman Building and converting the building to an ambulatory center that would have

primary care and specialty care physicians, as well as some specific diagnostic services. PGHC and Dimensions are very conscious about the healthcare needs of the Cheverly community.

VIII. Mount Washington Pediatric Hospital

Mt. Washington Pediatric Hospital ("MWPH"), a specialty pediatric and rehabilitation hospital with 15 licensed beds at Prince Georges Hospital Center, seeks to relocate these 15 beds to the proposed new PG County facility. This move would allow MWPH to continue to serve a pediatric population in need of specialized expertise and services similar to the population it serves in the Baltimore region.

The 15 beds have remained licensed to MWPH under its lease arrangement with PGHC, and the beds would continue to be licensed to MWPH at the new facility. Before the project is described in detail, a description of MWPH and PGHC follows.

MT. WASHINGTON PEDIATRIC HOSPITAL, INC.

MWPH, which provides inpatient and outpatient care for infants and children with rehabilitation and/or complex medical needs, is dedicated to maximizing the growth, development and rehabilitation of its pediatric patients through the delivery of interdisciplinary services and programs and providing appropriate resources available to enable its patients to achieve their maximum potential within their families and their communities.

In the spring of 1922, what was a vacant, colonial-style house on Falls Road near Mt. Washington in northwest Baltimore City became the Happy Hills Convalescent Home for Children. Happy Hills, serving only 20 patients, was the solution to a growing problem in the community: the need to have a place where children could recuperate

from illness and surgery. Today, that small facility has grown to offer comprehensive inpatient and outpatient care to thousands of children each year. By the time Happy Hills was 40 years old in 1962, more than 6,000 patients had passed through its doors on the way to recovery. In 1975, the name was officially changed to Mt. Washington Pediatric Hospital, the name by which it is known today.

The hospital received its first JCAHO accreditation in 1979 and its first CARF accreditation in 1984, becoming the first children's hospital in Maryland accredited for comprehensive inpatient rehabilitation, infant and early childhood development and respite care. By the mid-1980s, Mt. Washington's reputation was reflected in the need to expand beyond the walls of the old estate. The current building was completed and occupied in 1989. Outpatient services were added in 1990, and expanded to offer treatment of diabetes, asthma, and other conditions, as well as sleep studies and developmental diagnostic assessments. Since that time, a variety of outpatient specialty services have been added, including orthopaedics, dermatology, and programs for the treatment of pediatric feeding disorders and childhood obesity.

Mt. Washington Pediatric Hospital is dedicated to maximizing the health and independence of children. MWPH offers pediatric specialty services through four inpatient programs and a variety of outpatient services.

- The CENTER FOR NEONATAL TRANSITIONAL CARE provides management of medically stable preterm and low birth weight infants transitioning from the neonatal intensive care unit to home; these infants are usually born at 25 - 35 weeks of gestation.
- The PEDIATRIC CHRONIC ILLNESS program, which cares for pediatric patients with a variety of medical problems including failure to thrive, HIV, drug withdrawal, chronic diabetes, severe feeding disorders and seizure

control; these children's ages range from birth to 18 with the majority of children 0 - 3 and 15 - 16 years of age.

- The PULMONARY REHABILITATION program, a medical rehabilitation program which treats infants and children with impairment of the respiratory system requiring post-acute hospitalization; the majority of these patients are 0 - 1 years of age.
- The PHYSICAL MEDICINE AND REHABILITATION program is a comprehensive, interdisciplinary rehabilitation delivery system, which provides coordinated, cost-effective, goal-oriented treatment to children and adolescents. Emphasis is placed on maximizing functional outcomes in the areas of mobility, self-care, communication, cognition and psychosocial adjustment for each patient and family. This is accomplished by preventing/minimizing impairments, reducing activity limitations, lessening participation restrictions, and achieving outcomes. This program treats children recovering from major illness, surgeries or following trauma injuries; this patient population falls into the age range of birth to 21 years of age.

Outpatient Programs

MWPH offers a wide range of outpatient services treating a variety of diseases and conditions: pulmonary medicine, behavioral health (including psychology, neuropsychology and psychiatry), nutrition, feeding disorders treatment, dermatology, developmental evaluation, diabetes evaluation and management, endrocrinology, gastroenterology, child and adolescent gynecology, lead treatment, orthopaedics, physical medicine and rehabilitation (including physical, occupational and speech therapies and audiology), sleep testing, and pediatric weight management.

Of these services, a subset are available at the PGHC location, including psychology, physical medicine and rehabilitation (including physical, occupational and speech therapies), and developmental evaluations.

MWPH will play an important role as Maryland hospitals move to a population health model, working to limit utilization and costs. Under these new incentives, hospitals may find more ways to move their pediatric inpatients to a less acute (and less

costly) setting such as Mt. Washington Pediatric Hospital, both in Baltimore and in Prince George's County. This may lead to higher utilization of inpatient beds at both locations. At the same time, demand continues for increased outpatient services, particularly in the areas of behavioral health and in rehabilitation. MWPH would like to expand these services in the new facility.

At the time of the original CON, MWPH was licensed for 102 beds, 56 special hospital pediatric beds and 46 rehabilitation beds. Of the 102 licensed beds, 84 were in use at MWPH's Baltimore campus. The remaining 18 beds have a unique history stemming from an emergency Certificate of Need proceeding. MWPH sought to move 15 of the 18 beds not in service to PGHC.

When MWPH obtained a CON in 1995 to relocate 15 beds from Rogers Avenue in Baltimore City to PGHC, MWPH and PGHC agreed that the hospital would offer a continuum of pediatric specialized services, including inpatient and outpatient care.

THE PROJECT

MWPH proposes to relocate its 15 beds from the current PGHC to the new regional medical center facility in order to continue to provide specialty pediatric services to this population in this county. Initially, it was anticipated that most patients would be referred from PGHC, including those who previously were being referred for care to Washington, D.C. Over the past five years about 7% of admissions to the MWPH unit have come from PGHC. About 35% have come from Johns Hopkins Hospital, 12% have come from Johns Hopkins Bayview Medical Center, and another 10% have come from Children's National Medical Center in Washington, DC.

MWPH will also relocate its existing PGHC based outpatient program to the new site.

MWPH has provided the following staff and services, and will continue to provide these services in the new facility:

A nurse manager oversees the operation at PGHC and serves as the communication and facilitating link between MWPH's operation at PGHC and MWPH in Baltimore, as well as with the administrative team of PGHC. This person ensures the quality of services delivered to the patients, adherence to the policies and procedures of both institutions and appropriate cost effective use of all resources.

A nurse liaison identifies patients who will benefit from MWPH's services and assist in the referral/transfer process to the unit.

MWPH provides 24 hour, seven days per week coverage of physicians and all nurses (at the appropriate mix of licensed to non-licensed professionals).

Such staff includes Registered Nurses and Nurse Technicians as needed. All nursing staff have current Maryland nursing licenses. Nurses are selected by MWPH in accordance with the standards that have been established to provide current pediatric and neonatal skills which are specialized for the care of MWPH's type of patient.

A Social Work Care Manager coordinates the internal care to be provided at the PGHC location, and facilitates the discharge process, utilization review process, and integration of home/community care needs of the patient. This position is critical to this operation in assuring that all services are delivered at the appropriate time and quality. Social work staff are licensed in the State of Maryland and serve this unit by providing for the family interventions and discharge coordination. Experience has shown that

these patients and families require a great deal of time and energy in meeting their social and community resource needs. MWPH social workers have developed an enormous network of contacts and resources that will assist their families once discharged from the institution.

Pediatric expertise in the areas of physical therapy, occupational therapy and speech and language pathology are provided as needed. These services are available five days per week, Monday through Friday. These staff are selected and oriented to assure that all staff have the necessary pediatric skills of developmental assessment and treatment planning. All of these employees possess current practice licenses in the state of Maryland.

Child Life services are provided to meet and address patients' social/emotional, play, developmental and leisure needs in the hospital setting. Respiratory therapy services are currently provided through a contractual arrangement with PGHC.

Clerical support is provided for patient registration, patient intake, insurance verification, correspondence, meeting minutes, phone calls and scheduling.

MWPH employs board certified pediatricians to be on site 24 hours a day, seven days a week, to provide direct medical care to these patients and supervise the clinical operation of the other services. A pediatric nurse practitioner will also provide medical care. MWPH physician program subspecialists, either staff or consultants, will be on site at PGHC as needed.

Pursuant to a lease arrangement, MWPH contracts with PGHC to provide services including: housekeeping, laundry, food, maintenance, heat/utilities, and trash removal. PGHC also provides on a contractual basis: dietary consultations (per

consult), radiology (per test basis), laboratory (per test basis) and supplies (per charge basis).

VI. THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM ("UMMS")

UMMS is assisting Dimensions in the development of the proposed project, consistent with the terms of the MOU discussed above.

UMMS is dedicated to providing quality health care through a market-responsive regional system composed of a world-class academic medical center partnered with University of Maryland School of Medicine and premier community and specialty hospitals.

Over the last 28 years, UMMS has grown significantly to become an eleven-hospital, Maryland-based health care delivery system. The medical system includes a large urban academic medical center, an urban community hospital, a suburban community hospital, six rural hospitals and two specialty hospitals. UMMS' impact on the health and well-being of Marylanders is significant by any measure. UMMS generates nearly $4 billion in economic activity in Maryland. It has 19,000 employees, approximately 2,300 licensed beds, 120,000 annual patient admissions and gross patient revenues of $3 billion. UMMS supports an estimated 13,400 additional jobs through the purchase of goods and services. As the largest health system serving the State of Maryland, UMMS also provided more than $168 million in community benefits in Fiscal Year 2011. These community services include medical education, subsidized programs, community funding, civic involvement, community service programs, and charity care.

- University of Maryland Baltimore Washington Medical Center is a not-for-profit corporation operating as a licensed 319-bed hospital. It opened in 1965, primarily serves residents of northern Anne Arundel County, and became affiliated with UMMS in 2000. It was recently named a "Top 100" hospital for intensive care outcomes.

- University of Maryland Shore Medical Center at Chestertown is a 41-bed acute care hospital located in rural Kent County; it serves residents of Kent and Queen Anne's counties. This facility is affiliated with a 97-bed nursing and rehabilitation center and a home care and hospice agency. This facility joined UMMS in July 2008.

- University of Maryland Charles Regional Medical Center, located in La Plata, Maryland, is a not-for-profit corporation that serves as a licensed 121-bed hospital. The hospital opened in 1939 and serves the residents of Southern Maryland. It joined UMMS in July 2011.

- University of Maryland Shore Medical Center at Dorchester is a 41-bed hospital, providing 24-hour emergency services. This facility principally serves the residents of Dorchester County while also serving as the regional provider of inpatient adult acute behavioral health services. Shore Health System (of which this facility is a part) became affiliated with UMMS in 2006.

- Harford Memorial Hospital is a non-profit acute care facility located in Havre de Grace, Maryland. It is an 89 licensed-bed facility that as a member of Upper Chesapeake Health and became affiliated with UMMS in 2009.

- University of Maryland Rehabilitation and Orthopaedics Institute is a private not for profit corporation that operates a 162-licensed bed hospital specializing in medical/surgical acute care and rehabilitation. It has 10 progressive care/medical/surgical beds and 152 rehabilitation beds which includes 100 rehabilitation beds, 36 chronic and 16 dually licensed chronic/rehabilitation beds. The facility also operates an outpatient therapy facility and a variety of outpatient clinics.

- University of Maryland Medical Center Midtown Campus is a not for profit hospital corporation operating a 208-licensed bed acute and chronic care hospital. A community teaching hospital facility located in Baltimore Maryland, this facility was originally organized in 1881 by a group of Baltimore physicians to serve as a teaching hospital for medical students. It became affiliated with UMMS in 1999.

- University of Maryland Shore Medical Center at Easton is a 132 licensed-bed hospital, which includes the 20-bed Requard Center for Acute Rehabilitation. This facility principally serves the residents of Caroline, Dorchester, Talbot, Queen Anne's and Kent Counties. Shore Health System (of which this facility is a part) became affiliated with UMMS in 2006.

- Mt. Washington Pediatric Hospital (MWPH) is a private not for profit hospital corporation which operates a 102-licensed bed children specialty and rehabilitation facility in Baltimore, seven miles from University of Maryland Hospital. MWPH operates 15 special pediatric rehabilitation beds in leased space at Prince Georges Hospital Center. MWPH has been providing services since 1922. It became affiliated with UMBWMC in September 1997 and, since July 2006, is owned by UMMS and The Johns Hopkins Health System (50% each).

- University of Maryland Hospital is located on the west side of downtown Baltimore, UMMC provides highly specialized tertiary and quaternary care for the entire state and region. It is a 816 licensed-bed facility that provides a broad range of inpatient and outpatient services and functions as a teaching hospital.

- Upper Chesapeake Medical Center is a 185 licensed-bed hospital that serves residents of northeastern Maryland. As a member of Upper Chesapeake Health, the hospital affiliated with UMMS in July 2009 in order to continue delivering excellence in care.

UMMS is governed by a board of directors and is neither owned by the State of Maryland nor governed by the University of Maryland. UMMC is the System's academic medical center, serving the region and Baltimore City with a full continuum of services.

PART II - PROJECT BUDGET

(INSTRUCTION: All estimates for 1.a.-d., 2.a.-h., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

1. **Capital Costs:**

a.	New Construction		HOSPTIAL/ACC	Central Utility Plant	Total
	(1)	Building	$257,572,688	$9,646,917	$267,219,605
	(2)	Fixed Equipment (not included in construction			$0
	(3)	Land Purchase			$0
	(4)	Site Preparation	$23,904,693	$895,307	$24,800,000
	(5)	Architect/Engineering Fees	$17,350,181	$649,819	$18,000,000
	(6)	Permits (Building, Utilities, Etc.)	$5,397,834	$202,166	$5,600,000
		SUBTOTAL	$304,225,395	$11,394,210	$315,619,605

b.	**Renovations**				
	(1)	Building			
	(2)	Fixed Equipment (not included in construction			
	(3)	Architect/Engineering Fees			
	(4)	Permits (Building, Utilities, Etc.)			
		SUBTOTAL	$0	$0	$0
c.	**Other Capital Costs**				
	(1)	Major Movable Equipment	$107,000,000	$31,000,000	$138,000,000
	(2)	Minor Movable Equipment	$42,400,000		$42,400,000
	(3)	Contingencies	$38,555,957	$1,444,043	$40,000,000
	(4)	Other (Specify) UMMS PM, Builder's Risk, Commissioning/Testing, Warehousing, Testing, Traffic Study, Davis Langdon, CM Pricing, Scheduling, Helipad, Survey, Risk Assesment, Code review, ICRA, MET Testing, Curtainwall Testing, Legal, Office Consolidation, Enabling	$15,600,000		$15,600,000
		SUBTOTAL	$203,555,957	$32,444,043	$236,000,000
		TOTAL CURRENT CAPITAL COSTS (a - c)	$507,781,352	$43,838,253	$551,619,605
d.	**Non-Current Capital Costs**				
	(1)	Inflation	$26,488,323	$992,072	$27,480,395
	(2)	Capitalized Construction Interest	$46,486,670	$4,013,330	$50,500,000
TOTAL PROSOSED CAPITAL COSTS (a - e)			$580,756,345	$48,843,655	$629,600,000
2. Financing Cost and Other Cash Requirements:					
	a.	Loan Placement Fees	$6,549,190	$550,810	$7,100,000
	b.	Bond Discount			
	c.	Legal Fees (CON Related)	$184,484	$15,516	$200,000
	d.	Legal Fees (Other)	$92,242	$7,758	$100,000
	e.	Printing			
	f.	Consultant Fees			
		CON Application Assistance	$276,726	$23,274	$300,000
		Other (Specify)	$276,726	$23,274	$300,000

	g.	Liquidation of Existing Debt			
	h.	Debt Service Reserve Fund	$16,326,854	$1,373,145	$17,700,000
	i.	Principal Amortization			
		Reserve Fund			
	j.	Other (Specify)			
	TOTAL (a - j)		$23,706,223	$1,993,776	
3. Working Capital Startup Costs			$109,200,000		
TOTAL USES OF FUNDS (1 - 3)			$713,662,568	$50,837,432	$764,500,000
B. Sources of Funds for Project:					
	1	Cash			
	2	Pledges: Gross _____,			
		less allowance for			
		uncollectables _____			
	3	Gifts, bequests			
	4	Interest income (gross)	$15,100,000		
	5	Authorized Bonds	$224,200,000		
		Bond Proceeds - Bridge Loan	$128,000,000		
		Bond Repayment with State Grants	-$128,000,000		
	6	Mortgage			
	7	Working capital loans			
	8	Grants or Appropriation			
		(a) Federal			
		(b) State	$208,000,000		
		(c) Local	$208,000,000		
	9	Other (Line of Credit)	$109,200,000		
TOTAL SOURCES OF FUNDS (1 - 9)			$764,500,000		

Lease Costs:

a. Land $_____ x _____ = $_____

b. Building $_____ x _____ = $_____

c. Major Movable Equipment

$_____ x _____ = $_____

d. Minor Movable Equipment

$_____ x _____ = $_____

e. Other (Specify) $_____ x _____ = $_____

PART III - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3): **(INSTRUCTION: Each applicant must respond to all criteria included in COMAR 10.24.01.08G(3), listed below.)**

COMAR 10.24.01.08G(3)(a). THE STATE HEALTH PLAN.

List each applicable standard from each appropriate chapter of the State Health Plan and provide a direct, concise response explaining the project's consistency with that standard. In cases where standards require specific documentation, please include the documentation as a part of the application.

ACUTE CARE CHAPTER GENERAL STANDARDS - COMAR 10.24.10.04A

Standard .04A (1) – Information Regarding Charges.

Information regarding hospital charges shall be available to the public. After July 1, 2010, each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;

(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and

(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

PGHC has a written policy in place that meets the requirements of this standard. *See* **Exhibit 5**. The current list of representative services and charges that is readily available to the public, both at PGHC and on the hospital's internet web site (http://www.dimensionshealth.org/wp-content/uploads/2013/09/PGHC_Estimated-Average-Charges-092013.pdf) is attached as **Exhibit 6**. Procedures are in place to respond promptly to individual requests for information regarding current charges for specific services and procedures. *See* Exh. 5 at 1. The staff training that PGHC uses

to ensure that inquiries regarding charges are handled appropriately is described on page 1 of the policy attached as Exh. 5. All of the existing policies and procedures will be used at the new hospital.

Standard .04A(2) – Charity Care Policy.
Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay.

(a) The policy shall provide:

(i) Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.

(ii) Minimum Required Notice of Charity Care Policy.

1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;

2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital; and

3. Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

PGHC provides inpatient and other care to all patients regardless of the ability to pay. In fact, as discussed below, on the basis of a percentage of operating expenses, PGHC leads all Maryland hospitals in providing charity care. A copy of the hospital's Financial Assistance Policy is attached as **Exhibit 7**. Notices regarding the availability of charity care at the hospital are posted in the Emergency Department and in the Admission and in the hallway near the cashier. A copy of that notice is attached as

Exhibit 8. An annual notice is published in the *Gazette* newspaper, copy attached as **Exhibit 9**. Each patient or patient representative is advised of PGHC's charity care policy at the time of admission or outpatient registration. The hospital's Financial Assistance Policy specifically states, "DHS will make a determination of probable eligibility within two (2) business days following a patient's request for charity care services, application for medical assistance, or both." Financial counselors assist individuals to prepare and file all documents required to seek charity care at the Hospital. All existing policies and procedures will be used at the new hospital.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

As reported in the most recent HSCRC Community Benefit Report posted on its website (accessed 9/11/2013), PGHC ranks first out of 46 Maryland hospitals for charity care as a percentage of total operating expenses. In terms of gross dollars, PGHC ranked fourth in amount of charity care ($24,104,900), behind University of Maryland Medical Center, Johns Hopkins Hospital, and Johns Hopkins Bayview.

	Total Charity Care	Total Operating Expenses	Percent
Prince George's Hospital Center	$24,104,900	$203,825,100	11.83%
Chester River Health System	$5,457,747	$55,250,000	9.88%
Bon Secours Hospital	$10,867,591	$120,519,715	9.02%
Maryland General Hospital	$15,217,000	$179,896,000	8.46%
Dorchester General	$3,579,500	$43,326,000	8.26%
Laurel Regional Hospital	$7,918,100	$96,874,600	8.17%
Garrett County Memorial Hospital	$2,865,474	$38,394,160	7.46%
Baltimore Washington Medical Center	$21,373,238	$325,035,000	6.58%
Memorial Hospital at Easton	$9,844,900	$158,501,000	6.21%
Holy Cross Hospital	$23,691,563	$387,341,538	6.12%

	Total Charity Care	Total Operating Expenses	Percent
Calvert Memorial Hospital	$7,100,039	$117,602,616	6.04%
St. Agnes Health Care	$21,195,691	$379,701,946	5.58%
University of Maryland Medical Center (UMMC)	$69,782,764	$1,294,033,000	5.39%
Western Maryland Health System	$15,948,853	$304,887,833	5.23%
Washington Adventist Hospital	$10,766,256	$224,511,599	4.80%
Meritus Medical Center	$13,422,389	$283,953,366	4.73%
Johns Hopkins Bayview	$25,308,000	$543,333,000	4.66%
Montgomery General Hospital	$5,899,800	$137,669,098	4.29%
St. Mary's Hospital	$4,836,119	$121,640,602	3.98%
Union Memorial Hospital	$14,855,717	$397,245,796	3.74%
Peninsula Regional Medical Center	$13,903,600	$374,161,000	3.72%
Mercy Medical Center	$14,458,293	$399,668,124	3.62%
Harbor Hospital	$7,084,202	$202,041,627	3.51%
McCready Memorial Hospital	$745,292	$21,636,518	3.44%
James Lawrence Kernan Hospital	$3,165,000	$103,473,000	3.06%
Shady Grove Adventist Hospital	$8,871,895	$293,106,862	3.03%
Harford Memorial Hospital	$2,693,329	$89,609,000	3.01%
Franklin Square Hospital Center	$12,654,205	$436,640,459	2.90%
Atlantic General Hospital	$2,497,958	$91,074,982	2.74%
Howard County General Hospital	$6,269,194	$230,182,000	2.72%
Frederick Memorial Hospital	$8,977,168	$349,290,000	2.57%
Good Samaritan Hospital	$7,313,699	$299,758,071	2.44%
Union Hospital of Cecil County	$2,772,924	$143,517,898	1.93%
Johns Hopkins Hospital	$32,982,000	$1,725,787,000	1.91%
Suburban Hospital	$4,445,433	$239,149,257	1.86%
Sinai Hospital of Baltimore	$11,933,267	$691,053,000	1.73%
St. Joseph's Medical Center	$5,450,082	$317,898,969	1.71%
Upper Chesapeake Medical Center	$3,498,417	$212,644,000	1.65%
Ft. Washington Medical Center	$687,534	$42,060,748	1.63%
Doctor's Community Hospital	$2,949,975	$191,007,547	1.54%
Northwest Hospital	$3,134,970	$216,497,000	1.45%
Carroll County General Hospital	$2,902,549	$211,404,000	1.37%
Civista Medical Center	$1,346,317	$103,688,628	1.30%
Anne Arundel Medical Center	$6,430,100	$500,951,000	1.28%
Greater Baltimore Medical Center (GBMC)	$4,891,152	$394,015,000	1.24%
Southern Maryland Hospital Center	$1,038,210	$238,296,345	0.44%

Source: HSCRC http://www.hscrc.state.md.us/init_cb.cfm

Standard .04A (3) – Quality of Care.

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;

(ii) Accredited by the Joint Commission; and

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

PGHC is licensed by the Department of Health and Mental Hygiene, is accredited by The Joint Commission, and is in compliance with all Medicare and Medicaid conditions of participation. Copies of the hospital's license and most recent accreditation letter are attached as **Exhibit 10**.

(b) A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90% level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

PGHC scored over the 90% level on 11 of the 21 quality measures for which data are available in the most recent publication of the MHCC's Maryland Hospital Performance Evaluation Guide published on the MHCC website.[3] The scores are shown in Table 8.

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3 (http://mhcc.maryland.gov/consumerinfo/hospitalguide/hospital_guide/reports/find_a_hospital/care_report_option1.asp?hospital_nm=210037&EntryPoint=). According to the website, the data were last updated 4/28/2013. Measurement Timeframe: Jan 2012-Dec 2012.

Table 8
PGHC Quality Measure Performance Scores

	Measure	Hospital Performance
Heart Attack (AMI) Performance Over Time		
	Giving you aspirin when you arrive	96%
	Giving you aspirin when you leave	96%
	Giving the recommended medication	97%
	Giving you beta blockers when you leave	96%
	AMI patients whose time from hospital arrival to primary PCI is 90 minutes or less	75%
Heart Failure (HF) Performance Over Time		
	Giving full instructions when you leave the hospital	91%
	Performing the recommended heart function test	98%
	Giving the recommended medication	96%
Immunization		
	Pneumococcal Immunization (PPV23)	83%
	Influenza Immunization	84%
Pneumonia (PN)		
	Blood cultures	91%
	Appropriate initial antibiotic selection	94%
Surgical Care Improvement Project (SCIP) Performance Over Time		
	Preventing Infection	
	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	89%
	Prophylactic Antibiotic Selection for Surgical Patients	72%
	Prophylactic Antibiotic Discontinued Within 24 Hours After Surgery End Time	81%
	Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Blood Glucose	N/A
	Surgery Patients with Appropriate Hair Removal prior to surgery	98%
	Urinary catheter removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with day of surgery being day zero	80%
	Surgery Patients with Perioperative Temperature Management	96%
	Managing Heart Drugs	
	Surgery patients who received the appropriate Beta-Blocker during the perioperative period	82%

	Measure	Hospital Performance
	Preventing Blood Clots	
	Surgery patients whose doctors ordered treatments to prevent blood clots	77%
	Surgery patients who received treatment at the appropriate time to help prevent blood clots	74%
Children's Asthma Care (CAC) Performance Over Time		
	Children Who Received Reliever Medication While Hospitalized for Asthma	NA
	Children Who Received Systemic Corticosteroid Medication	NA
	Children and their Caregivers Who Received a Home Management Plan of Care Document	NA

Source: MHCC Website; accessed 9/11/2013

PGHC has taken steps to address core quality measure performance. The relevant steps for the measures for which PGHC performed under 90% are addressed below, along a description of the interventions PGHC has taken to improve its performance.

AMI patients whose time from hospital arrival to primary PCI is 90 minutes or less

- Electronic transmission of EKG ahead of patient arrival.
- Interventional Cardiologist is now in house from 8am-6:30pm
- Staff post-procedure review of each STEMI w/in 24hrs, 48hrs on wknd
- Monthly reports are shared with EMS for quality review
- Follow up information is also shared with referring institutions for quality review
- STEMI EMS patients bypass ED when Cardiology Interventionalist is in house.
- One call system will be in place before the end of the year.
- Satisfaction of quality metrics by staff is being tied to re-appointment, retention and promotion.

Pneumococcal Immunization (PPV23)

- The percent for the first quarter of this CY 2013 is 91.6%.

Influenza Immunization

- The data are for the first year after institution of a new rule making it mandatory (except for medical/religious exceptions). PGHC expects that it will be above 90% in the future.

Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision

- PGHC has employed a Core Measures Nurse to improve performance on all core measures.
- The institution of use of electronic medical records (EMR) will enable nursing staff to both enter data and view in real time whether the antibiotics have been given to the patient.
- PGHC has instituted an automatic selection of antibiotics for a given procedure.
- Satisfaction of quality metrics by staff is being tied to re-appointment, retention and promotion.

Prophylactic Antibiotic Selection for Surgical Patients

- Orders entered in the EMR, through rules, will automatically choose the appropriate antibiotic.
- Antibiotic will be initiated by Anesthesia during the appropriate time frame prior to surgery.
- The pre-operative Time Out includes confirming the commencement of the appropriate prophylactic antibiotic.

Prophylactic Antibiotic Discontinued Within 24 Hours After Surgery End Time

- The new EMR allows for a rule that guarantees cessation of antibiotics within 24 hours of surgery end time.
- The Core Measure Quality Nurse monitors all postoperative patients to ensure compliance.
- Compliance with quality metrics will be considered in the reappointment, retention, and promotion of staff.

Urinary catheter removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with day of surgery being day zero

- EMR will issue daily reminders to provider re catheter.
- Nurses will assess the need for continuation of the catheter on their rounds during each shift.
- The Core Measure Nurse monitors all postoperative patients for compliance.
- Compliance with quality metrics will be considered in the reappointment, retention, and promotion of staff.

Surgery patients who received the appropriate Beta-Blocker during the perioperative period

- Through pre-operative medication reconciliation it is the responsibility of the Anesthesia staff to ensure that the appropriate Beta-Blocker has been/is given within 24 hours of surgery.
- The postoperative medication reconciliation necessitated by the EMR will require the surgeon to continue the Beta-Blocker or give reasons why it will not be given.
- The Core Measure Nurse monitoring postoperative patients will check for compliance.

- Compliance with quality metrics will be considered in the reappointment, retention, and promotion of staff.

Surgery patients whose doctors ordered treatments to prevent blood clots

- EMR order sets require institution of VTE prophylaxis within 24 hours of surgery
- Core Measure Nurse monitors during the postoperative period
- Compliance with quality metrics will be considered in the reappointment, retention, and promotion of staff.

Surgery patients who received treatment at the appropriate time to help prevent blood clots

- Institution of EMR will improve prevention.
- Core Measures Nurse will monitor.
- Satisfaction of quality metrics by staff is being tied to re-appointment, retention and promotion.
  PGHC believes that these interventions will improve its performance on the core measures.

PROJECT REVIEW STANDARDS

COMAR 10.24.10.04B

Standard .04B(1) – Geographic Accessibility.

> **A new acute care general hospital or an acute care general hospital being replaced on a new site shall be located to optimize accessibility in terms of travel time for its likely service area population. Optimal travel time for general medical/surgical, intensive/critical care and pediatric services shall be within 30 minutes under normal driving conditions for 90 percent of the population in its likely service area.**

PGHC engaged Spatial Insights, Inc. to calculate the moderate driving time[4] from each Zip Code to both the project site (Largo) and the existing facility (Cheverly). Using the existing PGHC service area, the Largo site is slightly closer to the population than the Cheverly site. The average driving time to the Cheverly site is 18.98 minutes, while the average driving time to the Largo site from the same Zip Codes is 18.56 minutes. This is shown in Table 9.

Currently, 87.3% of the PGHC service area population lives within a 30 minute drive of the Cheverly site. In comparison, 89.8% of the PGHC service area population lives within a 30 minute drive of the Largo site.

4 PGHC sought to replicate the methodology the MHCC used in its analysis of driving time in Commissioner Barbara McLean's proposed decision on the CON application for the relocation of Washington Adventist Hospital (Docket No. 09-15-2295) (see Proposed Decision, Pp. 157-162).

Table 9
Driving Time from Zip Codes in the PGHC Service Area To the Existing Cheverly and Proposed Largo Sites
Population = 2021

PGHC Service Area to Cheverly				PGHC Service Area to Largo		
Zip Code	Drive Time	2021 Total Population	DriveTimeXPop.	Drive Time	2021 Total Population	DriveTimeXPop.
20601	35.27	26,244	925,619	29.67	26,244	778,653
20602	39.77	28,552	1,135,518	34.17	28,552	975,626
20603	43.12	33,607	1,449,120	37.52	33,607	1,260,922
20607	34.63	11,805	408,810	35.42	11,805	418,136
20608	49.7	902	44,835	44.1	902	39,783
20613	36.4	13,693	498,441	30.8	13,693	421,757
20623	30.73	2,895	88,968	21.38	2,895	61,898
20653	94.48	29,222	2,760,911	88.88	29,222	2,597,266
20703	11.55			9.83		
20704	13.6			16.08		
20705	14.58	28,846	420,576	17.07	28,846	492,403
20706	9.18	40,565	372,385	7.43	40,565	301,397
20707	21.85	29,109	636,040	23.78	29,109	692,221
20708	16.53	26,020	430,108	18.47	26,020	480,586
20709	15.3			17.23		
20710	2.62	10,347	27,109	10.7	10,347	110,713
20712	5.93	7,299	43,281	15.05	7,299	109,844
20715	19.58	25,948	508,067	17.22	25,948	446,829
20716	19.27	22,055	425,007	15.37	22,055	338,991
20717	20.58	-	-	14.22	-	-
20718	18.53			16.2		
20719	19.03			18.18		
20720	14.88	25,849	384,632	12.52	25,849	323,629
20721	15.33	30,754	471,456	7.85	30,754	241,418
20722	4.2	4,869	20,449	13.32	4,869	64,851
20725	21.13			23.07		
20726	19.98			21.92		
20731	7.08			7.18		
20735	24.43	38,725	946,047	18.83	38,725	729,188
20737	4.5	22,156	99,703	10.72	22,156	237,514
20738	5.1			11.27		
20740	10.75	28,568	307,105	13.38	28,568	382,238
20741	7.98			14.05		
20742	10.03	10,162	101,928	16.22	10,162	164,833
20743	7.7	40,220	309,695	7.05	40,220	283,552
20744	23.53	56,291	1,324,526	24.18	56,291	1,361,115

PGHC Service Area to Cheverly				PGHC Service Area to Largo		
Zip Code	Drive Time	2021 Total Population	DriveTimeXPop.	Drive Time	2021 Total Population	DriveTimeXPop.
20745	17.07	29,843	509,415	17.42	29,843	519,860
20746	13.07	30,460	398,112	13.45	30,460	409,687
20747	12.77	41,175	525,808	9.3	41,175	382,930
20748	15.23	37,114	565,252	13.87	37,114	514,776
20749	25.87			26.6		
20752	11.03			12.82		
20753	12.3			9.52		
20757	14.97			14.23		
20762	20.5	3,925	80,460	11.83	3,925	46,432
20768	8.73			10.67		
20769	14.77	7,775	114,836	13.42	7,775	104,340
20770	8.15	26,923	219,420	10.35	26,923	278,650
20771	10.2	3	31	10.65	3	32
20772	28.12	48,584	1,366,196	18.77	48,584	911,931
20773	27.07			17.25		
20774	16	49,051	784,816	6.45	49,051	316,379
20775	16.3			6.68		
20781	3.88	12,350	47,916	12.77	12,350	157,704
20782	7.97	52,003	414,463	16.72	52,003	869,488
20783	12.22	48,361	590,976	19.3	48,361	933,374
20784	5.48	28,898	158,358	7.58	28,898	219,043
20785	5.7	37,238	212,257	5.5	37,238	204,810
20787	6.23			13.8		
20788	6.32			15.47		
20791	7.03			7.55		
20792	16.07			6.45		
20797	7.08			7.18		
20799	12.17			2.35		
20903	14.55	24,025	349,569	18.68	24,025	448,793
20904	19.45	61,885	1,203,660	21.93	61,885	1,357,134
20912	12.88	25,374	326,813	20.83	25,374	528,534
Total	18.98	1,159,690	22,008,692	18.56	1,159,690	21,519,262
> 30 Minutes	49.77	146,921	7,312,220	55.65	117,782	6,554,043
% < 30 Minutes		87.3%			89.8%	

Sources: Driving Time was provided by Spatial Insights
Population is from Claritas, projected to 2021 using the Compound Average Growth Rate from 2013-2018

Using the MHCC methodology for defining service area described in the Proposed Decision on the 2009 CON Application for the Relocation of Washington Adventist Hospital (Docket No. 09-15-2295), PGHC has developed a slightly different service area for the Largo site. This method is based on ranking the proximity of the hospital to the population in comparison to other hospitals. PGHC's use of this methodology is described elsewhere in this application. The service area for the Largo Site resulting from the application of the MHCC methodology includes four fewer Zip Codes than the existing Cheverly service area. Consequently, the driving time for the Largo service area population to the Largo site differs slightly from the existing PGHC service area to the Largo site that was shown above. The average driving time to the Largo site for the Largo service area is 18.25 minutes (versus the 18.56 minutes for the existing PGHC service area population). 88.22% of the population in the Largo service area population has driving times to Largo of less than 30 minutes. These calculations are shown in Table 10.

Table 10
Driving Time from Zip Codes in the Largo Service Area
To the Proposed Largo Sites
Population = 2021

Zip Code	Drive Time	2021 Total Population	Drive Time X Pop.
20601	29.67	26,244	778,653
20602	34.17	28,552	975,626
20603	37.52	33,607	1,260,922
20607	35.42	11,805	418,136
20608	44.1	902	39,783
20613	30.8	13,693	421,757
20623	21.38	2,895	61,898
20653	88.88	29,222	2,597,266
20703	9.83	-	-
20704	16.08	-	-
20705	17.07	28,846	492,403

Zip Code	Drive Time	2021 Total Population	Drive Time X Pop.
20706	7.43	40,565	301,397
20707	23.78	29,109	692,221
20708	18.47	26,020	480,586
20709	17.23	-	-
20710	10.7	10,347	110,713
20712	15.05	7,299	109,844
20715	17.22	25,948	446,829
20716	15.37	22,055	338,991
20717	14.22	-	-
20718	16.2	-	-
20719	18.18	-	-
20720	12.52	25,849	323,629
20721	7.85	30,754	241,418
20722	13.32	4,869	64,851
20725	23.07	-	-
20726	21.92	-	-
20731	7.18	-	-
20735	18.83	38,725	729,188
20737	10.72	22,156	237,514
20738	11.27	-	-
20740	13.38	28,568	382,238
20741	14.05	-	-
20742	16.22	10,162	164,833
20743	7.05	40,220	283,552
20744	24.18	56,291	1,361,115
20745	17.42	29,843	519,860
20746	13.45	30,460	409,687
20747	9.3	41,175	382,930
20748	13.87	37,114	514,776
20749	26.6	-	-
20752	12.82	-	-
20753	9.52	-	-
20757	14.23	-	-
20762	11.83	3,925	46,432
20768	10.67	-	-
20769	13.42	7,775	104,340
20770	10.35	26,923	278,650
20771	10.65	3	32
20772	18.77	48,584	911,931
20773	17.25	-	-
20774	6.45	49,051	316,379

Zip Code	Drive Time	2021 Total Population	Drive Time X Pop.
20775	6.68	-	-
20781	12.77	12,350	157,704
20782	16.72	52,003	869,488
20784	7.58	28,898	219,043
20785	5.5	37,238	204,810
20787	13.8	-	-
20788	15.47	-	-
20791	7.55	-	-
20792	6.45	-	-
20797	7.18	-	-
20799	2.35	-	-
Total	18.25	**1,000,045**	18,251,427
> 30 Minutes	48.51	117,782	5,713,491
% < 30 Minutes		88.22%	

There are six Zip Codes that have longer driving times to the Largo site (20602, 20603, 20607, 20608, 20613, and 20653). Two are in the most southerly part of Prince George's County. Three are in Charles County, and one is in St. Mary's County. These six Zip Codes are shown in Figure 3. Also, the locations of existing hospitals are identified, as is the Largo Site. Figure 3 shows that the populations of these Zip Codes have less than a 30-minute drive to MSGA and Pediatric services. PGHC believes that the population has optimal driving time access, as defined by Standard .04B(1).

Figure 3
Zip Codes in the Largo Service Area with
More than 30 Minutes Driving Time to the Largo Site

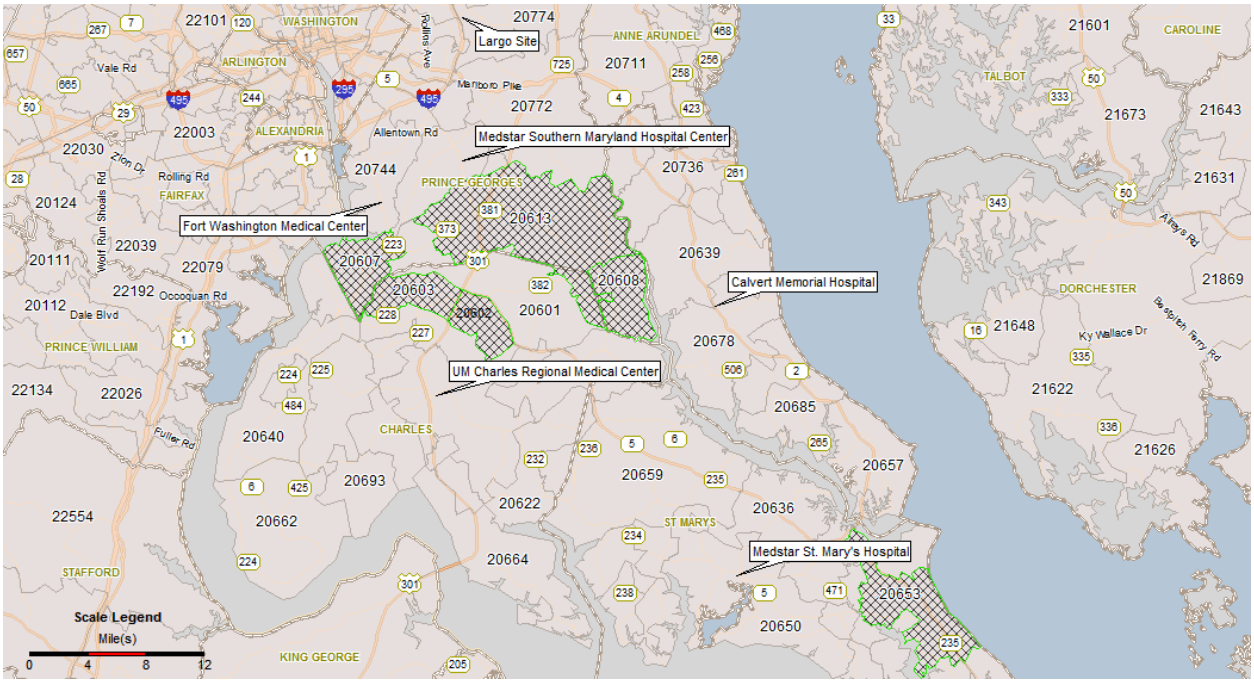

Table 10 shows that the populations of all of these Zip Codes have less than a 30-minute drive to MSGA and Pediatric services. PGHC believes that at least 90% of the service area population has optimal driving time access, as defined by the Standard.

Table 10
Driving Time from Selected Zip Codes To a Hospital

	Largo Site	Fort Washington Medical Center	Medstar Southern Maryland Hospital Center	UM Charles Regional Medical Center	Medstar St. Mary's Hospital	Calvert Memorial
20602	34.17	26.63	16.5	13	19	36
20603	37.52	19.18	19.85	24	30	47
20607	35.42	8.77	20.7	28	36	53
20608	44.1	38.12	26.43	29	18	29
20613	30.8	24.82	13.13	28	23	33
20653	88.88	82.48	71.22	53	26	45

Sources: Driving times to the Largo site, Fort Washington Medical Center, and Medstar Southern Maryland Hospital Center were provided by Spatial Insights. Driving times to UM Charles Regional Medical Center, Medstar St. Mary's Hospital, and Calvert Memorial Hospital were calculated using Google Maps.

Standard .04B(2) – <u>Identification of Bed Need and Addition of Beds.</u>

Only medical/surgical/gynecological/addictions ("MSGA") beds and pediatric beds identified as needed and/or currently licensed shall be developed at acute care general hospitals.

(a) Minimum and maximum need for MSGA and pediatric beds are determined using the need projection methodologies in Regulation .05 of this Chapter.

(b) Projected need for trauma unit, intensive care unit, critical care unit, progressive care unit, and care for AIDS patients is included in the MSGA need projection.

(c) Additional MSGA or pediatric beds may be developed or put into operation only if:

(i) The proposed additional beds will not cause the total bed capacity of the hospital to exceed the most recent annual calculation of licensed bed capacity for the hospital made pursuant to Health-General §19-307.2; or

(ii) The proposed additional beds do not exceed the minimum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter.

(iii) The proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant hospital for bed capacity that exceeds the minimum jurisdictional bed need projection; or

(iv) The number of proposed additional MSGA or pediatric beds may be derived through application of the projection methodology, assumptions, and targets contained in Regulation .05 of this Chapter, as applied to the service area of the hospital.

<u>MSGA Beds</u>

PGHC is licensed to operate 214 acute care beds in FY13, including 142 MSGA beds, 36 obstetrical beds, eight pediatric beds, and 28 psychiatric beds. PGHC

proposes to reconfigure its acute care beds at the replacement hospital and operate 165 MSGA beds, 22 obstetrical beds, one pediatric bed, and 28 psychiatric beds at the new location. Since PGHC's total MSGA bed capacity will not exceed the most recent calculation of jurisdictional bed need, the proposed project is consistent with Subsection (c)(ii) of this standard because the minimum jurisdictional MSGA bed need for Prince George's County in 2018 is 671 MSGA beds. *See* 37 *Maryland Register* 589-91 (March 26, 2010). The MHCC's Annual Report on Selected Maryland Acute Care and Special Hospital Services Fiscal Year 2013 shows that there are 623 licensed MSGA beds in Prince George's County. Finally, in terms of pediatric beds, Subsection (c) of this standard is inapplicable as PGHC is not proposing additional pediatric beds.

Defining new service area

To project the number of admissions that it should expect in the new service area, PGHC utilized the methodology outlined in Commissioner Barbara McLean's proposed decision on the CON application for the relocation of Washington Adventist Hospital (Docket No. 09-15-2295) (see Proposed Decision, Pp. 157-162). In this case, the service area for PGHC is shifting from one based on its current location in Cheverly, MD to its new location in Largo, MD.

PGHC split the historical inpatient discharge data into five cohorts – MSGA (15-64), MSGA (65+), Obstetrics (OB), Pediatrics (PED), and Psychology (PSY). To determine the Zip Code areas to include in the expected 85% service area for the Largo site, PGHC used drive times generated by Spatial Insights from Zip Codes in Prince George's County, and selected surrounding Zip Codes to each Maryland, District of Columbia, and Virginia hospital.

The Maryland Zip Codes were then sorted by proximity to PGHC's current location and the 2012 discharges were summed until they equaled or exceeded 85% of PGHC's total 2012 discharges. This was done for each cohort individually. For MSGA discharges, this 85% occurred with the Zip Codes for which PGHC was the ninth closest hospital and these Zip Codes contributed 78.2% of PGHC's 2012 MSGA (15-64) discharges and 84.7% of PGHC's 2012 MSGA (65+) discharges.

For OB discharges, this occurred with the Zip Codes for which PGHC was the fourth closest hospital and these Zip Codes accounted for 91.1% of PGHC's 2012 OB discharges. In determining the closest hospital for OB, PGHC was compared only to those hospitals offering OB services. These definitions or rankings were then applied to Zip Codes surrounding the future Largo site for PGRMC, the relocated PGHC. Zip Codes for which PGRMC would be the ninth most proximate hospital or closer for MSGA and the fourth or closer hospital for OB beds were identified. This was determined by ranking the proximity of all hospitals excluding the existing PGHC.

Table 11 shows the Zip Codes in the PGRMC MSGA service area using the MHCC methodology.

Table 11
Zip Codes in the PGRMC at Largo Service Area
Hospital Ranking
Projected Admissions
MSGA
2021

Zip Code	Drive-Time Ranking	Projected Discharges (15-64)	Projected Discharges (65+)	Total Projected Discharges	% of Total	Cumulative %
20743	1	645	501	1,145	10.7%	10.7%
20785	1	537	367	904	8.4%	19.1%
20747	1	565	334	899	8.4%	27.5%
20774	1	474	413	887	8.3%	35.7%

Zip Code	Drive-Time Ranking	Projected Discharges (15-64)	Projected Discharges (65+)	Total Projected Discharges	% of Total	Cumulative %
20721	1	224	239	462	4.3%	40.1%
20716	1	176	192	368	3.4%	43.5%
20773	1	3	8	10	0.1%	43.6%
20753	1	4	4	8	0.1%	43.7%
20731	1	5	1	6	0.1%	43.7%
20791	1	3	1	5	0.0%	43.8%
20775	1	2	2	4	0.0%	43.8%
20752	1	3	1	4	0.0%	43.8%
20717	1	2	0	3	0.0%	43.9%
20792	1	2	0	2	0.0%	43.9%
20797	1	0	-	0	0.0%	43.9%
20799	1	0	-	0	0.0%	43.9%
20706	2	234	202	436	4.1%	47.9%
20772	2	235	199	434	4.0%	52.0%
20746	2	210	142	352	3.3%	55.3%
20784	2	176	113	290	2.7%	58.0%
20715	2	117	160	277	2.6%	60.5%
20770	2	134	83	217	2.0%	62.6%
20720	2	100	69	170	1.6%	64.2%
20769	2	35	22	57	0.5%	64.7%
20623	2	16	10	27	0.2%	64.9%
20768	2	2	1	3	0.0%	65.0%
20703	2	2	1	2	0.0%	65.0%
20718	2	2	0	2	0.0%	65.0%
20762	2	2	-	2	0.0%	65.0%
20771	2	1	-	1	0.0%	65.0%
20748	3	179	106	285	2.7%	67.7%
20735	3	157	98	255	2.4%	70.1%
20601	3	91	38	129	1.2%	71.3%
20602	3	79	39	118	1.1%	72.4%
20603	3	70	24	94	0.9%	73.2%
20708	3	63	25	88	0.8%	74.1%
20613	3	37	24	61	0.6%	74.6%
20608	3	4	3	7	0.1%	74.7%
20757	3	1	0	1	0.0%	74.7%
20709	3	1	0	1	0.0%	74.7%
20719	3	0	0	1	0.0%	74.7%
20737	4	72	21	93	0.9%	75.6%
20710	4	39	16	55	0.5%	76.1%

Zip Code	Drive-Time Ranking	Projected Discharges (15-64)	Projected Discharges (65+)	Total Projected Discharges	% of Total	Cumulative %
20738	4	1	-	1	0.0%	76.1%
20704	5	1	0	1	0.0%	76.1%
20744	6	173	110	283	2.6%	78.7%
20745	6	128	53	181	1.7%	80.4%
20653	6	77	30	106	1.0%	81.4%
20705	6	54	23	78	0.7%	82.1%
20740	6	41	25	66	0.6%	82.8%
20607	6	31	15	45	0.4%	83.2%
20781	6	32	11	43	0.4%	83.6%
20749	6	1	2	3	0.0%	83.6%
20725	6	1	0	1	0.0%	83.6%
20726	6	0	-	0	0.0%	83.6%
20707	7	58	28	87	0.8%	84.4%
20722	7	21	10	31	0.3%	84.7%
20787	7	1	1	2	0.0%	84.7%
20741	7	1	0	1	0.0%	84.7%
20742	8	0	1	1	0.0%	84.8%
20782	9	72	45	117	1.1%	85.8%
20712	9	24	12	36	0.3%	86.2%
20788	9	0	0	0	0.0%	86.2%
	In-Service Area Total			**9,246**	**86.2%**	

Change in market share due to relocation

For each of the Zip Codes in PGRMC's projected service area, the expected market share at PGRMC was based on PGHC's average market share for Zip Codes of a comparable proximity. Using 2012 data, PGHC calculated the average market share for all of the Zip Codes where PGHC was the closest hospital. PGHC then applied this average market share to all Zip Codes where PGRMC would be the closest hospital.

For example, in 2012, PGHC had an average market share of 22.1% of MSGA (15-64) discharges in Zip Codes where it ranked as the closest hospital. In the old location, PGHC ranked as the third closest hospital to Zip Code 20716 (Bowie) and

possessed a market share of 6.9%. Upon moving to Largo, PGRMC would be the closest hospital to Zip Code 20716. As a result, PGHC assumes that PGRMC will have a market share in Zip Code 20716 of 22.1%.

Similarly, in the old location, PGHC ranked as the closest hospital to Zip Code 20710 (Bladensburg) and possessed a market share of 30.8% of MSGA (15-64) discharges. Upon moving to Largo, PGRMC would be the fourth closest hospital to Zip Code 20710. In 2012, PGHC's average market share in Zip Codes where it ranked as the fourth closest hospital was 4.5%. As such, PGHC assumes that PGRMC will have a market share in Zip Code 20710 of 4.5%.

Impact of changes in population and use rates

The change in PGHC's service area to PGRMC's service area results in a 16.5% reduction in the total service area population. Based on PGRMC's future service area, population growth assumptions through 2021 were obtained from Claritas at the five cohort levels (MSGA 15-64, MSGA 65+, OB, PED, PSY). For OB, PGHC used the population of women age 15-45. For Pediatrics, PGHC used the population age 0-14, and for Psychiatric, PGHC used the population 15 and older.

PGHC performed analysis regarding expected changes in utilization rates by cohort by year through FY2021. For example, PGHC, like many hospitals, has experienced a significant conversion of admissions with one day lengths of stay ("ODS") converting to observation. The impact of this is to reduce use rates. PGHC looked at the admissions in its proposed service area and analyzed the use rates without the impact of ODS conversions. Table 12 shows that, without the ODS impact, the use

rates have been relatively flat over the recent years, increasing in 2009 and decreasing in 2010 and 2012.

Table 12
ODS Analysis

	MSGA (15+)						
Rankings Service Area	**FY 2001**	**FY 2008**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**Average**
Population	614,578	655,467	661,308	667,149	672,990	678,831	
% Change		*6.7%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	
Admissions	53,701	64,237	66,289	64,583	64,346	62,144	
Annual Change		1,505	2,052	(1,706)	(237)	(2,202)	
% Change		*2.8%*	*3.2%*	*-2.6%*	*-0.4%*	*-3.4%*	
ODS	10,378	13,408	14,269	13,834	13,030	11,337	
Annual Change		433	861	(435)	(804)	(1,693)	
% Change		*29.2%*	*6.4%*	*-3.0%*	*-5.8%*	*-13.0%*	
Use Rate	87.4	98.0	100.2	96.8	95.6	91.5	
Annual Change		1.5	2.2	(3.4)	(1.2)	(4.1)	(1.0)
% Change		*1.7%*	*2.3%*	*-3.4%*	*-1.2%*	*-4.3%*	
ODS Annual Change Use Rate		0.7	1.3	-0.7	-1.2	-2.5	(0.5)
% ODS Ann Change of UR Ann Change		43.5%	58.2%	19.0%	100.2%	61.3%	48%
Use Rate Change w/o ODS		2.18	3.54	(2.78)	0.00	(1.57)	0.3
% Use Rate Change w/o ODS		2.5%	3.6%	-2.8%	0.0%	-1.6%	0.3%

In fact, PGHC has been aggressive in converting ODS to observation. PGHC's Observation cases have increased significantly in the last five years.

	Inpatient	**Oupatient**	**Total**
FY: 2008			758
FY: 2009			1,471
FY: 2010	124	2,261	2,385
FY: 2011	171	3,006	3,177
FY: 2012	878	4,519	5,397

PGHC projects that the ODS conversion will continue through 2015 and that then the use rates will stabilize.

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
MSGA (15-64) Use Rate Δ	-8.0%	-3.0%	-0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
MSGA (65+) Use Rate Δ	-8.0%	-3.0%	-0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Population growth and utilization rates were projected to increase and decrease by cohort as presented below.

	2012-2021 % Change	
Cohort	**Population**	**I/P Use Rate Change**
MSGA (15-64)	1.9%	-11.2%
MSGA (65+)	51.9%	-11.2%
OB	-4.8%	-2.0%
PED	2.6%	0.0%
PSY	8.7%	0.0%

Projected 2021 use rates were applied to 2021 population at the cohort level for the proposed PGRMC service area to determine expected service area discharges by cohort. Total discharges by Zip Code were determined using each Zip Code's proportion of the service area in 2012.

Recapture assumptions

With a baseline of projected PGRMC discharges established for the PGRMC service area, PGHC then considered the initiatives and growth areas anticipated for the new hospital. PGHC analyzed data by service line back to 2001 to determine historical trends and potential for reasonable market recapture. PGHC concluded that there were significant growth opportunities in the cardiac, vascular, oncology, orthopedics, and trauma service lines. These conclusions were based on interviews with physicians, recruitment plans, and new clinics and programs. In many cases, PGHC is projecting

that it will simply achieve a market share that is lower than that achieved within the last five years. Table 13 shows the 2012 market share by service line, the number of admissions it expects to gain as a result of recapture (which is separate from changes resulting from population changes and relocation), the projected 2021 market share, and the reason why PGHC believes the recapture is reasonable.

Table 13
2012 Market Share by Service Line
Projected Number of Recaptured Admissions
Projected 2021 Market Share, and Rationale

Service Line	2012 Market Share	Recapture	2021 Market Share	Reason
Burn		0		No recapture volume projected.
Dental / Oral		0		No recapture volume projected.
Cardiac Arrhythmia	8.3%	97	15.4%	PGHC expects to recapture admissions based upon the implementation of a recently developed Cardiovascular Program Strategic Plan (described below).
Cardiac Surgery	0.6%	160	27.7%	PGHC expects to recapture admissions based upon the implementation of a recently developed Cardiovascular Program Strategic Plan (described below). Currently in process of recruiting one or more cardio-thoracic surgeon to practice at PGHC now and later at the new regional medical center,
Cardiology	8.5%	513	15.8%	PGHC expects to recapture admissions based upon the implementation of a recently developed Cardiovascular Program Strategic Plan (described below).
Interventional Cardiology	12.6%	63	20.1%	PGHC expects to recapture admissions based upon the implementation of a recently developed Cardiovascular Program Strategic Plan (described below). PGHC is presently recruiting an additional interventional cardiologist
Vascular	8.4%	27	13.5%	PGHC expects to recapture admissions based upon the implementation of a recently developed Cardiovascular Program Strategic Plan (described below).
Vascular Surgery	8.3%	76	14.9%	PGHC expects to recapture admissions based upon the implementation of a recently developed Cardiovascular Program Strategic Plan (described below).
Gastroenterology	5.6%	116	8.5%	PGHC achieved 9.2% market share in 2010.
Gynecology	4.1%	34	6.5%	PGHC achieved 7.5% market share in 2010 and 7.1% market share in 2011.
HIV	14.6%	17	21.2%	PGHC is in the process of establishing a sickle cell clinic, which will expand its current array of services for HIV patients. Also, PGHC has a residency association with The Ross School of Medicine for this service line.

Service Line	2012 Market Share	Recapture	2021 Market Share	Reason
Medical Oncology/ Hematology	4.5%	340	12.8%	PGHC is establishing a comprehensive cancer program that may possibly affiliate with the UMMS Greenebaum Cancer Center.
Medicine	8.1%	202	11.1%	PGHC achieved greater than 12% market share through 2011. PGHC is in the process of establishing a family medicine residency program.
Nephrology	5.4%	57	9.1%	PGHC achieved greater than 10% market share in 2010 and 2011.
Neurology	10.1%	115	13.6%	PGHC is in the process of establishing a stroke center, and has already employed a neurologist who will serve as director of the center.
Neurosurgery	5.6%	28	9.7%	PGHC recently lost one neurosurgeon, and is currently recruiting two neurosurgeons to build capacity and volume.
Ophthalmology	8.3%	6	12.0%	PGHC achieved 13.5% market share in 2011.
Orthopedics	8.8%	275	14.1%	PGHC recently expanded the orthopedic department by adding three fellowship-trained physicians, allowing the hours of the orthopedic clinic to be soon expanded which will provide more consultation time for local physician referrals.
Otolaryngology	4.5%	24	8.1%	PGHC achieved 8.7% market share in 2010, and even greater in previous years. A new physician recently joined the practice.
Rehab	0.0%	0	0.0%	No recapture volume projected.
Respiratory	6.8%	122	9.6%	PGHC achieved 10% market share and greater through 2010.
Spine-Back/Neck Procedures	3.0%	44	8.9%	PGHC is recruiting two neurosurgeons to build capacity and market share.
Substance Abuse	14.5%	2	16.6%	PGHC achieved 17.5% market share and greater through 2011
Surgery	5.9%	173	9.4%	PGHC recruited a new surgeon. Also, the hospital expanded clinic hours. PGMC expects an increase in elective general surgery volume.
Urology	5.1%	89	8.5%	PGHC has made capital investments, including surgical equipment, to increase urology capabilities and volume.
Other Miscellaneous Service Lines		33		

Service line market share increases related to clinical program development will be supported by the recruitment of needed specialists into the region. Dimensions is currently working with the University of Maryland School of Medicine ("UMSOM") to assist with some of these physician specialty needs. For example, Dimensions now contracts with UMSOM to provide emergency medicine specialists to staff its emergency departments at PGHC, Laurel Regional, and at the Bowie Emergency

Medical Center. Also, Dimensions plans to expand primary care resources into its service area. One example is the recruitment / employment of primary care resources for the medical center located in Suitland.

With respect to increasing its market share for cardiovascular services, PGHC's Cardiovascular Program Strategic Business Plan sets forth multi-year business objectives for operational and infrastructure enhancements, developing the cardiovascular service line into a leading regional clinical program, supported by resources from UMMS and UMSOM. Some initiatives now underway include:

- replacement or improvement of capital equipment;
- expansion and development of clinical and strategic leadership;
- contracting with UMSOM for UMSOM-affiliated cardio-thoracic surgeons to revitalize the cardiac surgery and vascular surgery program;
- developing clinical protocols and staff education, supported by the University of Maryland Medical Center; and
- development of a detailed outreach plan in the community including plans to open an ambulatory cardiac clinic to help improve local access to cardio-thoracic specialists.

PGHC has recently made and will continue to make significant investments in physical and human resource capital to develop and transition not only its cardiovascular service line but other service lines as well.

Recaptured discharges were applied to PGRMC projected 2021 discharges by cohort based on each Zip Code's proportion of total discharges at the cohort level.

2021 Discharges

PGHC projected the discharges and impact in 2021, the year that PGRMC is expected to reach full occupancy. Applying the assumptions described above regarding population, use rates, and market share, PGHC projected 2021 service area discharges. In addition to discharges from within the service area, PGHC developed assumptions regarding out of service area discharges that reflected 11% to 17% increases over the service area discharges by cohort. Combined, the total inpatient discharges for PGHC in 2012 and PGRMC in 2021 are presented below by cohort.

	Inpatient Discharges [1]		
Cohort	**2012**	**2012**	**% Change**
MSGA (15-64)	5,259	6,420	22.1%
MSGA (65+)	2,341	4,309	84.1%
OB	2,376	2,275	-4.3%
PED	34	43	26.5%
PSY	1,361	1,413	3.8%
Total	11,371	14,460	27.2%

Note (1) Excludes Newborns

Average Length of Stay

PGHC compared its 2012 average length of stay in their service area to 2012 Maryland Statewide average length of stay. PGHC also considered PGRMC's initiatives that are expected to impact length of stay. PGHC made assumptions for changes in average length of stay over the period 2012–2021.

	ALOS	
Cohort	2012	2021
MSGA (15-64)	5.28	4.47
MSGA (65+)	6.68	5.39
OB	2.83	2.65
PED	2.63	2.63
PSY	5.45	5.76
Overall	5.03	4.53

PGHC applied 2021 average length of stay assumptions by cohort to projected 2021 PGRMC discharges by cohort to determine 2021 patient days at the new facility.

Occupancy rate

According to the Maryland State Health Plan standards, the prescribed occupancy rates for this CON application are as follows:

Service	Occupancy Rate
MSGA	85%
OB	75%
PED	50%
PSY	85%

Bed need

PGHC applied the prescribed occupancy rates to projected 2021 patient days at the new facility to arrive at the following bed needs by cohort.

Cohort	Bed Need
MSGA (15-64)	103
MSGA (65+)	62
OB	22
PED	1
PSY	28
Total	216

Pediatric Beds

As explained above, PGHC used the same methodology to project the need for Pediatric beds. Table 14 shows the Zip Codes in the PGRMC Pediatric service area using the MHCC methodology.

Table 14
Zip Codes in the PGRMC at Largo Service Area
Hospital Ranking
Projected Admissions
MSGA
2021

Zip Code	Drive-Time Ranking	Projected Discharges	% of Total	Cumulative %
20743	1	4	9.4%	9.4%
20747	1	4	8.5%	17.8%
20785	1	3	6.8%	24.7%
20774	1	2	5.7%	30.4%
20721	1	2	3.8%	34.1%
20716	1	1	2.1%	36.2%
20717	1	0	0.1%	36.3%
20792	1	0	0.1%	36.4%
20791	1	0	0.1%	36.5%
20731	1	-	0.0%	36.5%
20773	1	-	0.0%	36.5%
20753	1	-	0.0%	36.5%
20775	1	-	0.0%	36.5%
20752	1	-	0.0%	36.5%
20797	1	-	0.0%	36.5%
20799	1	-	0.0%	36.5%
20706	2	3	5.8%	42.3%
20784	2	2	5.0%	47.3%
20772	2	2	4.8%	52.0%
20746	2	2	3.7%	55.8%
20715	2	1	3.1%	58.9%
20720	2	1	2.7%	61.5%
20770	2	1	2.5%	64.0%
20769	2	0	1.0%	65.1%
20762	2	0	0.3%	65.3%
20623	2	0	0.1%	65.4%
20703	2	-	0.0%	65.4%
20718	2	-	0.0%	65.4%
20768	2	-	0.0%	65.4%
20771	2	-	0.0%	65.4%
20735	3	1	1.3%	66.7%
20603	3	1	1.3%	67.9%
20748	3	1	1.2%	69.1%
20708	3	0	1.1%	70.2%

Zip Code	Drive-Time Ranking	Projected Discharges	% of Total	Cumulative %
20602	3	0	0.9%	71.1%
20601	3	0	0.9%	72.0%
20613	3	0	0.4%	72.4%
20608	3	0	0.1%	72.5%
20719	3	-	0.0%	72.5%
20757	3	-	0.0%	72.5%
20709	3	-	0.0%	72.5%
20737	4	1	2.9%	75.3%
20710	4	0	1.1%	76.4%
20738	4	-	0.0%	76.4%
20704	5	0	0.0%	76.4%
20744	6	1	2.3%	78.8%
20653	6	1	2.2%	80.9%
20745	6	1	2.2%	83.1%
20705	6	1	1.5%	84.6%
20740	6	0	0.7%	85.3%
20781	6	0	0.6%	85.9%
20607	6	0	0.3%	86.2%
20725	6	0	0.0%	86.2%
20749	6	-	0.0%	86.2%
Total		**37**		

PGHC did not make any adjustments to the use rates for Pediatrics. When out of area admissions (6 admissions) and recapture in specific specialties (4 admissions) are factored in, PGHC projects that it will have 47 pediatric admissions. Based on these projections, PGHC proposes to reduce its number of Pediatric beds from 8 beds to 1 bed. Since this will be integrated with observation beds and the Pediatric ED, there will not be any inefficiencies and will still maintain the same level of access that service area residents currently have. It will enable pediatric patients who should be admitted close to home to be able to do so.

Standard .04B(3) – <u>Minimum Average Daily Census for Establishment of a Pediatric Unit</u>.

An acute care general hospital may establish a new pediatric service only if the projected average daily census of pediatric patients to be served by the hospital is at least five patients, unless:

(a) The hospital is located more than 30 minutes travel time under normal driving conditions from a hospital with a pediatric unit; or

(b) The hospital is the sole provider of acute care general hospital services in its jurisdiction.

Inapplicable. This project does not involve establishment of a new pediatric service.

Standard .04B(4) – <u>Adverse Impact.</u>

A capital project undertaken by a hospital shall not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. The Commission will grant a Certificate of Need only if the hospital documents the following:

(a) If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted average Charge Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group. In addition, if the project involves replacement of physical plant assets, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise demonstrate why the physical plant assets require replacement in order to achieve the primary objectives of the project; and

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As part of a full rate application to be filed with the Health Services Cost Review Commission ("HSCRC"), PGHC is requesting an increase in rates equal to 40% of the increase in capital costs (depreciation and interest) associated with the proposed project.

The total cost of the project is $764 million of which $615 million are depreciable assets, and $224.0 million of the depreciable assets will be funded with proceeds from the issuance of tax exempt bonds. Depreciation and interest expense (i.e. capital costs) related to the project are projected to equal $42.3M in FY2018 with the opening of the new hospital facility.

Capital Costs Related to the Project
($ in millions)

	2018
Depreciation	$27.8
Interest	14.5
Total Capital Costs	$42.3
% of Capital to Include in Rates	40%
Capital in Rates	$16.9

Applying PGHC's mark-up of 1.182 to the capital to be included in rates results in an estimate of gross revenue related to the project of $19,995,700, which is expected to equate to a 7.0% increase on the 2017 projected HSCRC rates.

In the last Spring 2011 ROC, PGHC was identified as being 8.76% above the average of its Peer Group (see **Exhibit 11**).

PGHC Most Recent ROC Performance

Date of ROC	% Below Peer Group
Spring 2011	8.76% Above

Because PGHC was above its Peer Group average on the ROC, the calculation of PGHC's Debt to Capitalization and comparison to the average of its Peer Group is presented below.

Prince George's Hospital Center
Comparison to Peer Group Debt to Capitalization
($ in thousands)

Hospital	Long Term Debt	Fund Balance	Debt to Capitalization
Mercy Medical Center	$ 425,003	$ 328,225	0.56
Sinai Hospital	302,419	225,073	0.57
Union Memorial Hospital	14,900	135,900	0.10
Harbor Hospital Center	9,200	15,900	0.37
Maryland General Hospital	70,966	57,511	0.55
Johns Hopkins Bayview Medical Center	235,697	29,048	0.89
Bon Secours Hospital	1,775,921	843,516	0.68
Peer Group Total Weighted Average	$ 2,834,106	$ 1,635,173	0.63
Prince Georges Hospital Center	$ 28,072	$ 52,285	0.35

Source: FY12 Audited Financial Statements

In 2012, PGHC's Debt to Capitalization ratio was below the average for its peer group.

Because this CON application is for the replacement of PGHC's physical assets, the calculation of PGHC's Average Age of Plant and comparison to the average of its Peer Group is presented below.

Prince George's Hospital Center
Comparison to Peer Group Average Age of Capital
($ in thousands)

Hospital	Accumulated Depreciation	Current Depreciation	Average Age of Plant
Mercy Medical Center	$ 245,222	$ 32,315	7.59
Sinai Hospital	172,524	22,081	7.81
Union Memorial Hospital	259,371	18,204	14.25
Harbor Hospital Center	146,259	7,456	19.62
Maryland General Hospital	147,920	10,583	13.98
Johns Hopkins Bayview Medical Center	258,574	24,907	10.38
Bon Secours Hospital	61,749	3,331	18.54
Peer Group Weighted Average	$ 1,291,618	$ 118,877	10.87
Prince Georges Hospital Center	$ 105,017	$ 6,382	16.45

Source: HSCRC data for 2012

In 2012, PGHC's Average Age of Plant exceeded the average for its peer group.

(b) If the project reduces the potential availability or accessibility of a facility or service by eliminating, downsizing, or otherwise modifying a facility or service, the applicant shall document that each proposed change will not inappropriately diminish, for the population in the primary service area, the availability or accessibility to care, including access for the indigent and/or uninsured.

PGHC does not propose to eliminate any services.

PGHC proposes to reduce number of Pediatric beds from eight to one. As CON Formset Table 1 (Statistical Projections, See response to COMAR 10.24.01.08G(3)(b). Need) shows, PGHC's Pediatric unit has operated at an average daily census of approximately one patient per day for the last two years. In the new facility, PGHC is proposing to integrate the one bed with four observation/short stay beds and five treatment bays with the Pediatric Emergency Department. This will enable the hospital to maintain access for the patients who need admission and need not be transferred to another hospital (likely, CNMC in Washington, D.C.) and share Pediatric nursing staff among all three levels of care.

PGHC also is proposing to reduce the number of Obstetrics beds from the currently licensed 36 to 22. This will also not reduce access for Obstetrical patients but will allow the OB unit to operate more efficiently.

None of the proposed changes in this project will impact access for indigent and/or uninsured patients. PGHC will continue to care for patients regardless of their ability to pay.

Standard .04B(5) – <u>Cost-Effectiveness.</u>

A proposed hospital capital project should represent the most cost effective approach to meeting the needs that the project seeks to address.

(a) To demonstrate cost effectiveness, an applicant shall identify each primary objective of its proposed project and shall identify at least two alternative approaches that it considered for achieving these primary objectives. For each approach, the hospital must:

(i) To the extent possible, quantify the level of effectiveness of each alternative in achieving each primary objective;

(ii) Detail the capital and operational cost estimates and projections developed by the hospital for each alternative; and

(iii) Explain the basis for choosing the proposed project and rejecting alternative approaches to achieving the project's objectives.

I. THE NEED TO REPLACE PGHC

A. The Problem of an Aging Facility.

The need to replace PGHC in some way has been recognized for many years. The age and the deficiencies of the current buildings are demonstrated in pages 32 – 52 of this application. Even during the development of this CON application (on 9/15/2013), an electrical panel which serves the plant, housing two transformers, caught fire and was severely damaged, resulting in the cancellation of all elective surgeries, OB, and Cath Lab admissions and the ED going on Yellow Alert for 19 hours.

As a result of the aging physical plant, PGHC has had a difficult time recruiting physicians to practice in its service area, has lost market share to other, more modern hospitals (particularly, making Prince Georgians feel the necessity to travel to Washington, D.C. for care), and has seen its volumes decline to unacceptable levels. As a result, Dimensions cannot afford the cost of its significant service to the community without substantial state and county subsidies.

II. DEVELOPMENT OF OBJECTIVES AND SITE ALTERNATIVES

Consistent with the MOU, the School of Public Health study, and the needs of a modern regional medical center, Dimensions and the Prince George's County government identified the following objectives for the proposed regional medical center and for selecting its optimal location:

1. Maintain PGHC's role as a regional medical center

2. Address public perceptions of PGHC

3. Improvement in the ability to recruit physicians to serve its service area population
4. Maintain/Improve access for its service area population and consider:
    i. Centralized location within Prince George's County with access to I-495
    ii. Walkable Metro access
    iii. Proximate to bus routes
    iv. Pedestrian access
5. Enable collaboration with the University of Maryland Medical System and University of Maryland System
6. Cost-site acquisition and site development
    v. Site Characteristics
    vi. Engineering and Traffic Considerations
    vii. Adequate size
    viii. Timing of site availability
    ix. Future expansion/development potential

Six original options were considered:

1. Replace the entire facility on its current campus
2. Major additions/renovations on the existing site
3. Relocate the hospital to the Woodmore Town Center Site
4. Relocate the hospital to the Landover Mall Site
5. Relocate the hospital to the Powell Property along with the Boulevard at The Capital Centre Site
6. Relocate the hospital to the Schwartz Property along with Capital Centre site

In 2013, the architectural firm HOK was engaged to:

1. Conduct a comprehensive facility assessment of the existing PGHC site and facilities, including:

a. identifying options for upgrading the campus to meet current codes and benchmark standards,
b. allowing for integration of new advanced technology, and
c. accommodating the current and projected programs over the next 20 years.

2. Design a new regional medical center at the chosen site.

PGHC engaged an engineering consulting team, comprised of Soltesz Inc. and Sabra, Wang & Associates, Inc., to review the four new site options and advise on previous plan approvals, utility analysis, environmental and site constraints, topography, site boundary, wetland, floodplain, stream information, entrance and site circulation (including emergency access), traffic counts at over 18 adjacent intersections (including calculating and distributing traffic forecasts for over a dozen previously approved developments in the area, projecting traffic forecasts for the hospital site, and evaluating intersection traffic operations), and storm water management needs for each of the sites.

III. EVALUATION OF EXISTING SITE AND FACILITY

A. EXISTING FACILITY ASSESSMENT

With respect to the existing site, HOK prepared a PGHC Facility Assessment Report, which is attached as **Exhibit 12.**

The goal of the study was to provide an overall evaluation of the facilities to assist the planning process for maintaining, replacing, and/or modernizing space. The report is composed of three major sections:

1. Site analysis consisting of accessibility, way-finding, and safety assessment.
2. Building analysis consisting of departmental space, functionality, and flexibility assessment.

3. Engineering systems analysis considering current condition and anticipated useful life of mechanical, electrical, plumbing, fire protection, and technology building systems.

A color coded scheme illustrates the potential of each building section for supporting hospital processes and patient care:

	POOR	Space is below current standards and requires significant upgrades, replacement or demolition
	FAIR	Space needs moderate upgrades or replacement to meet the required standards
	GOOD	Space requires little or no upgrades to extend the useful life

Sample diagrams follow that depict the key findings by level:

Figure 4
FUNCTION / KEY ROOM SIZE

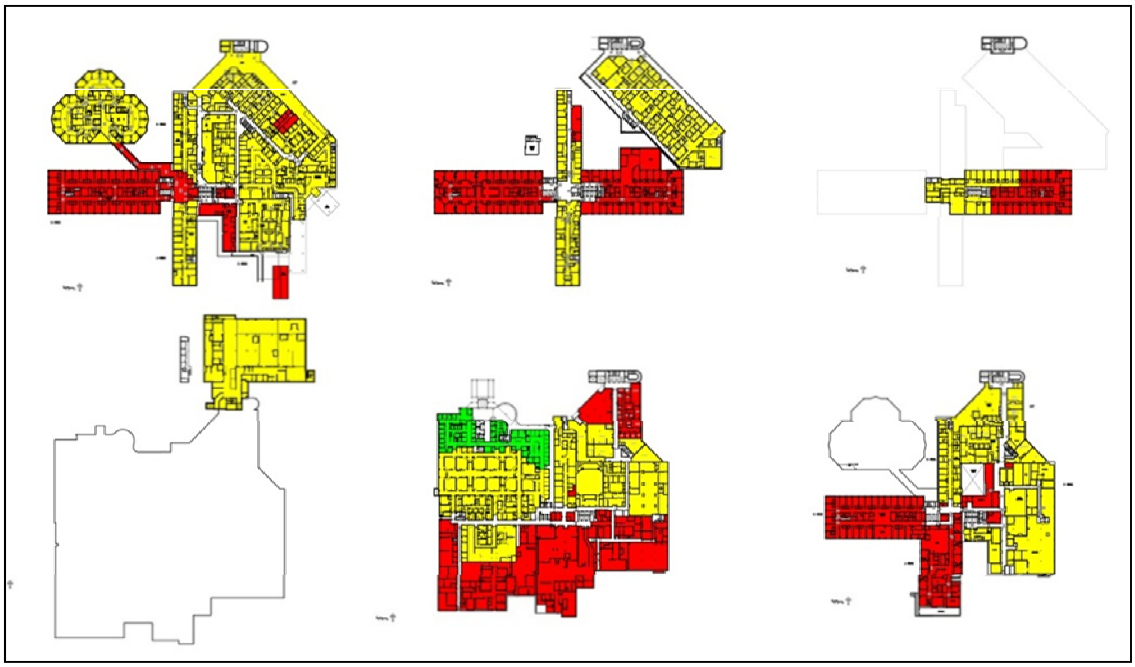


Figure 5
ADJACENCIES

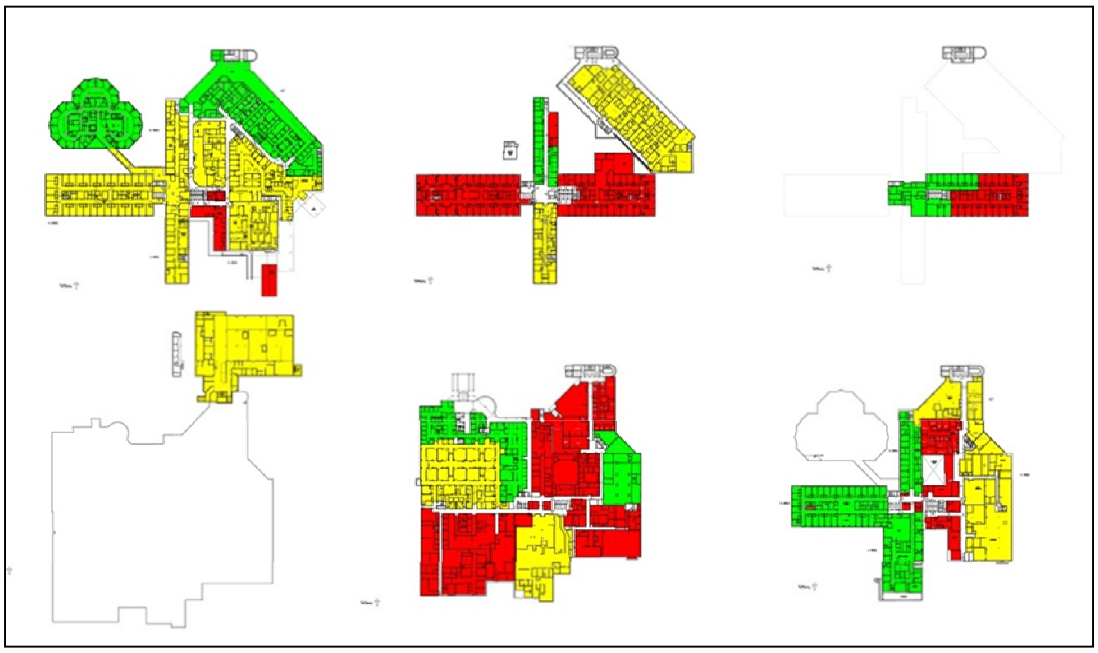


Figure 6
FLEXIBILITY

The study showed a significant number of key building deficiencies, including:

- Critical program adjacencies are missing:
    - Surgery and Central Sterile, MRI and CT, Imaging and ED, ED and ICU
- Key room sizes are small compared to industry standards
    - Patient rooms, Dialysis, Physical Therapy, ED, Pharmacy
- Inflexibility to adapt to modern key room sizes or planning standards due to structural/interior impediments:
    - Patient rooms, Imaging, Lab
- Staff and clinical support areas poorly designed to support smooth staff/patient flow:
    - Pharmacy, Lab, ED, Imaging, Central Sterile
- Quality of interiors does not measure up to the industry's current direction toward creation of therapeutic environment:
    - Patient rooms / Waiting Areas / Staff Work Areas

The findings do not support the continued use of the existing hospital building for acute care functions. The age and configuration of the existing facility are below current standards, and the quality of the patient experience in the current facility is compromised by these factors. The structural grid does not meet the minimum 30'X30' size and in most areas has an irregular pattern, making it difficult for changes. Floor to floor heights of only 10'5" are well below the industry standard of 16' for diagnostic floors and 14' for patient unit floors.

The engineering systems are in need of significant upgrades or replacement, which render continued use or expansion of the existing facility questionable relative to the benefits of providing new engineering systems in a new facility, where both could concurrently offer the latest in medical space planning, patient care, and patient / visitor / staff amenities. Although modest investment in engineering infrastructure has occurred over the years, it is evident that infrastructure equipment and distribution has aged beyond its useful life.

Key building system and infrastructure deficiencies include:

- Chiller plant cooling capacity is maximized and not connected to emergency power
- Air handling systems need renewal at ACF, J and E wings
- Hydronic systems are failing and need renewal at lower level mechanical rooms
- Electrical gear is beyond useful life and manufacturer parts are limited
- Emergency power systems need replacement in K wing and CUP
- Fire alarm system requires complete code upgrade
- Plumbing systems are fragmented and need immediate renewal
- IT equipment room locations are at risk from heat and wet utilities
- Buildings are not fully equipped with sprinklers

PGHC considered conversion of some existing space to outpatient care, which may be appropriate on a case-by-case basis, but the age and condition of the facility suggest that for outpatient care, a new appropriately sized and planned facility on the site would be more appropriate.

It is not recommended to continue to expand the hospital in the current location. The benefits of new idealized planning of acute care space would be compromised by the quality and organization of the existing building spaces.

B. EXISTING SITE ASSESSMENT

The primary vehicular and emergency access is from the north, from the Baltimore/Washington parkway (Route 295) and Landover Road. The hospital is visible from Route 295, but once on Hospital Drive arriving from the north, there is little visual cue, other than signage, to direct arriving patients and visitors to the facility.

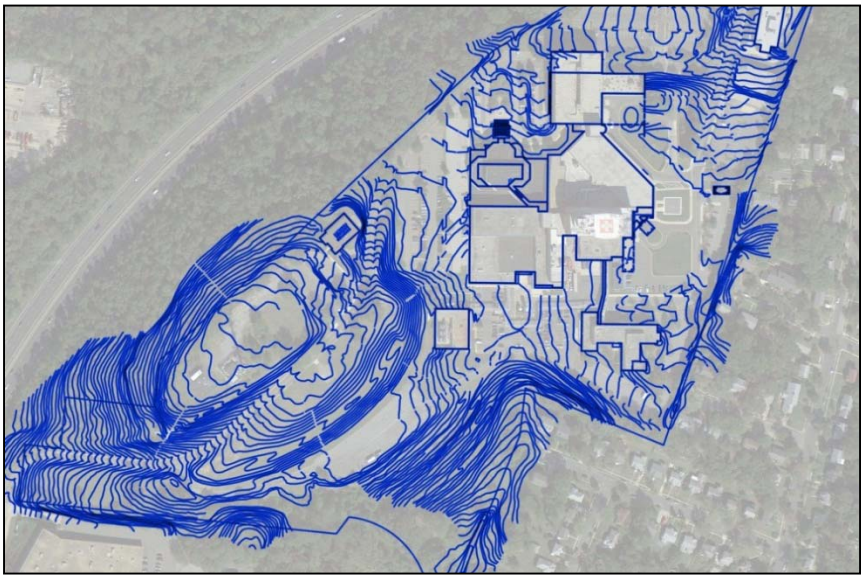
The parking access is convenient to the front door when arriving from the north, but arriving from the south, visitors must travel under the garage and around the building to access the visitor parking. The southern access from Kenilworth on Hospital Drive through an industrial area and neighborhoods is not direct.

There is no separation of emergency ambulance, public automobile, and public bus traffic on the entrance road. The ground based helipad is immediately adjacent to the public main entrance and public emergency entrance. The site does not have an internal “ring road” connecting the parking and entry points. The staff lots to the south and west, below the mechanical piping, are confusing and disjointed. Staff has expressed concerns with the condition of the roadways during inclement weather, when accidents have occurred at the bottom of the hill at the Prince George’s County Health Department site, which is the primary site access point.

The existing topography is quite severe across the site. While the hilltop site provides visibility from the community and good views from the upper floors of the hospital across Washington, D.C. to the National Mall and east to Maryland, the grade changes have created significant functional compromises. The main public entry and emergency entry are on level three, while the surgery entry is across campus on level one. The loading dock and support areas enter at level two to the south. The parking deck negotiates the grade changes by locating staff parking at the lower levels and visitor parking on the upper floors. The entrances from the parking garage to the hospital are not intuitive. Parking demand at peak periods is greater than site capacity.

The available parcels to the north and west have equally challenging topography, which will cause significant cut or fill for proper placement of diagnostic functions and entrances. Refer to Figure 7.

Figure 7
EXISTING TOPOGRAPHY

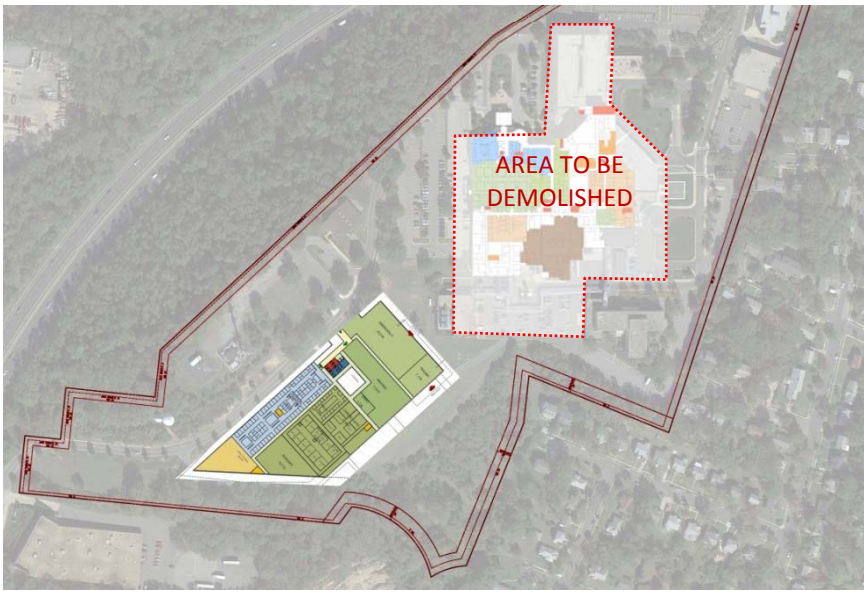


IV. THE EXISTING SITE ALTERNATIVES

A. OPTION 1 – REPLACEMENT HOSPITAL ON THE PGHC SITE

The open site at the southwest parcel, behind the existing central utility plant (CUP) was studied as a possible site for the full replacement of the existing facility. The area of the site, however, does not offer enough space or the proper orientation/configuration for a new hospital, CUP, parking, and medical office building, especially considering the primary public and emergency vehicle access point in the northeast would cause traffic to cross through the existing site during the demolition process. And as noted earlier the severe topography would also require functional adjacency compromises. Refer to Figure 8 below.

Figure 8
POTENTIAL REPLACEMENT HOSPITAL SITE



The resulting building would be oriented away from this public access point. The development of the existing hospital footprint after demolition would hide the new hospital facility and provide an indirect path for visitor and emergency access. Available sites for either surface parking or structured parking are not available, and access from the new building would be circuitous.

Dimensions' Ranking of this Option

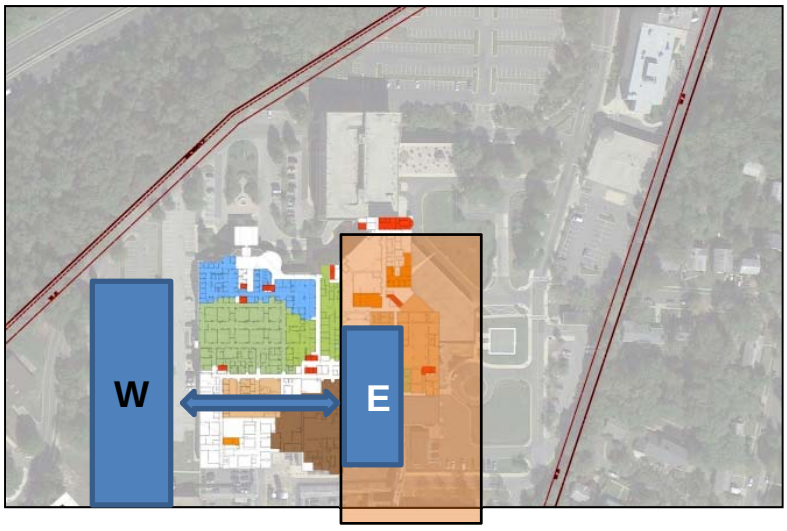
Maintain PGHC's role as a regional medical center	*Address public perceptions of PGHC.*	*Improvement in the ability to recruit physicians to serve its service area population.*	*Maintain/Improve access for its service area population*
Dimensions believes that this would marginally improve PGHC's ability to remain a regional medical center. However, it is concerned that The continued association with the historical campus would limit the benefits of perception. *Score: 7*	The continued association with the existing site would limit the improvements in perception. *Score: 7*	Because the improvements in perception would be limited, Dimensions believes that it would only marginally improve the ability to recruit physicians. *Score: 7*	This would maintain, but not improve access. *Score:5*

Enable collaboration with the University of Maryland Medical System and University of Maryland System.	*Cost*	*Site Characteristics including Engineering and Traffic Considerations*
This would enable collaboration. However, Dimensions is concerned that the marginal improvements in perception would limit the synergistic value of UMMS collaboration. *Score: 7*	Costs would be comparable to building a new facility at a different site. *Score: 7*	Moderate engineering issues. No improvement in traffic issues. *Score: 5*

B. OPTION 2 – MAJOR ADDITION/RENOVATIONS

As Option 2, HOK prepared a concept plan for major additions and renovations to the existing facility. Based on the Facility Assessment, the West Site immediately adjacent to the existing hospital ORs and ICUs offers the best opportunity to expand the facility and maintain the best functioning areas of the existing hospital. In order to preserve the existing Labor and Delivery area, the H and J Wing would remain, but the E Wing and ACF Building would be demolished to allow for the construction of a new Main Entrance and Ambulatory Care Center to the East.

Figure 9
ADDITION/RENOVATION/DEMOLITION



The West Addition would accommodate the relocated Emergency and Imaging Departments at Level 1 to form a Diagnostic Platform with the existing Surgery, Day Surgery and PACU. The new East Addition would house the Ambulatory Care Center/Cancer Center and new Main Entrance for the Hospital as well. A new public access corridor would connect the East and West Additions.

Level 2 would include an interstitial space over the West Diagnostic Platform with ambulatory clinics in the East Pavilion. Level 3 West would house Clinical Support with ambulatory clinics in the East Addition. The West Addition would also accommodate 36 Bed Nursing Units at Level 4-9.

Refer to Figures 10A-10D, below.

Figure 10A
Concept Level 1

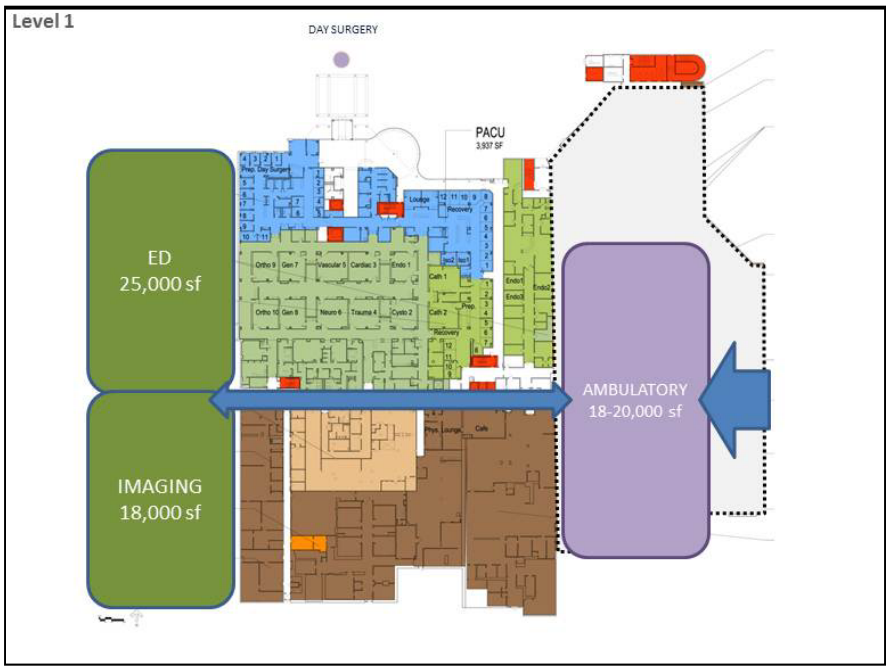


Figure 10B
Concept Level 2

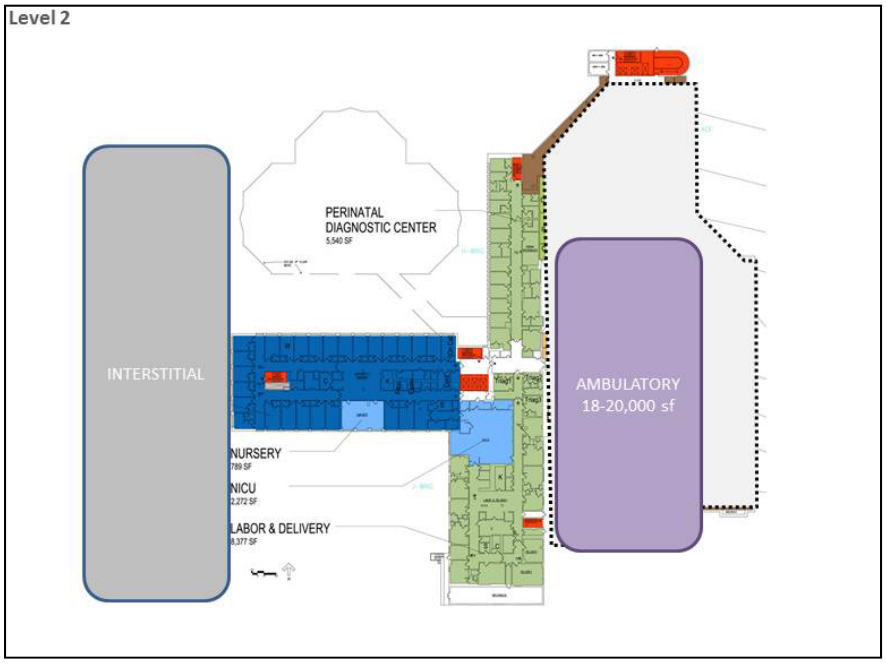


Figure 10C
Concept Level 3

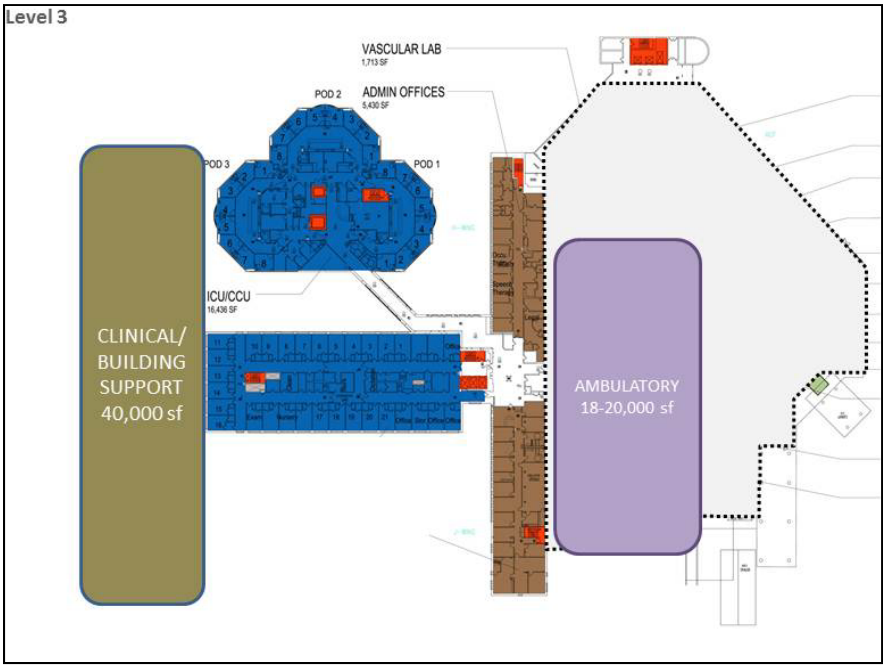
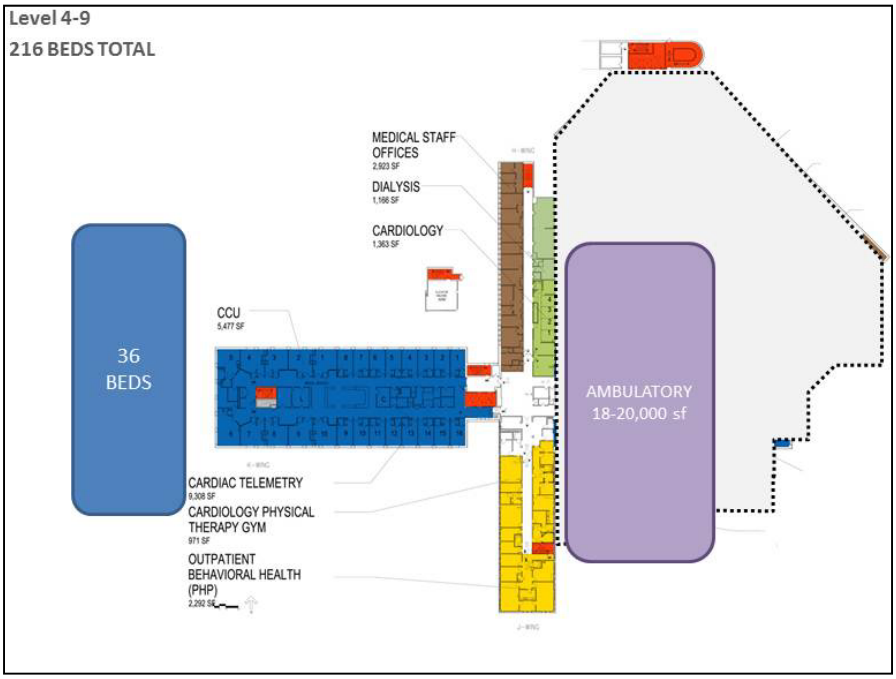


Figure 10D
Concept Level 4-9



The Concept Plan depicted above has a number of major deficiencies as compared to relocating the hospital to the new site:

- Due to the severe topography and limited site placement, the main entrance must still be placed to the east, in conjunction with the Ambulatory Care Main Entrance.
- The plan does not resolve the existing flow problems between Surgery/CSP or ICU/ED.
- The total schedule for completing the multi-phased project will require a minimum of 10 years to complete:
    - West Addition/CUP/Parking Deck 3 years
    - East Demolition/Enabling 1 year
    - East Addition 2 years
    - Major Renovations (4 phases) 4 years
- There will be major disruption to all areas in the hospital during the new West construction, East demolition, East construction, and multiple phases of renovation to bring the hospital to the desired standards for optimizing the delivery of health care.
- The total cost including a significant escalation premium over the 10 years could exceed $600 Million.

Table 15
Projected Base Construction Costs of The Major Addition/Renovation Option

	EXISTING
Sitework	25,000,000.00
Offsite improvements	7,500,000.00
Central Utilities Plant	41,200,000.00
Hospital Building	159,907,500.00
ACCBuilding	42,560,000.00
Parking Deck	15,000,000.00
PEPCO Utilities	5,600,000.00
Owner Contingency	10,000,000.00
Owner enabling	10,000,000.00
Hospital Renovations	48,900,000.00
Renovation Risk	10,000,000.00
Demolition	5,000,000.00
UMMSPM	6,000,000.00
Builder's Risk	2,000,000.00
Commissioning/testing	1,000,000.00
Total	**389,667,500.00**

These costs do not include financing costs, permits, A&E fees, moveable equipment, or escalation premiums.

Dimensions' Ranking of this Option

Maintain PGHC's role as a regional medical center	*Address public perceptions of PGHC.*	*Improvement in the ability to recruit physicians to serve its service area population.*	*Maintain/Improve access for its service area population*
Dimensions believes that this would marginally improve PGHC's ability to remain a regional medical center. However, it is concerned that The continued association with the historical campus and use of existing buildings would significantly limit the benefits of perception. *Score: 6*	The continued association with the existing site and buildings would significantly limit the improvements in perception. *Score: 6*	Because the improvements in perception would be limited, Dimensions believes that it would only marginally improve the ability to recruit physicians. *Score: 6*	This would maintain, but not improve access. *Score:5*

Enable collaboration with the University of Maryland Medical System and University of Maryland System.	*Cost*	*Site Characteristics Including Engineering and Traffic Considerations*
This would enable collaboration. However, Dimensions is concerned that the marginal improvements in perception would limit the synergistic value of UMMS collaboration. *Score: 6*	Because of the 10 year phasing, costs could actually be higher than building a new facility at a different site. *Score: 5*	Significant engineering issues. No improvement in traffic issues. *Score: 4*

C. RECOMMENDATION

Due to the significant disruption, higher cost, poor access, extended time frame, and inability to address all of the program and adjacency requirements properly, HOK recommended the replacement and relocation of the hospital to a new site. The benefits of new idealized planning of acute care space would be compromised at the existing building. The HOK recommendations are consistent with the County and PGHC's decision to evaluate other sites.

V. NEW SITE ALTERNATIVES

A. COMPARISON OF ALTERNATIVE SITE LOCATIONS

As part of PGHC's collaboration with Prince George's County, the County is providing the site. It considered available building sites within the County, and, ultimately identified four sites that would provide enough property at a reasonable cost to the County. The four sites were Morgan Boulevard Metro Station Area, Woodmore Town Center Site, Landover Mall site, and the Largo/Capital Centre site.

On February 28, 2013, the Prince George's County government hosted a public forum for citizens to voice their opinions on where they believe a new regional medical center should be located. Several hundred citizens attended the forum. The majority of

the citizens spoke in favor of the Largo site location followed by the Landover site location. There was minimal interest expressed for the Morgan Boulevard and Woodmore sites. As a result, the County and Dimensions eliminated the consideration of Morgan Boulevard site at that time and proceeded with the Woodmore Town Center Site, Landover Mall site, and the Largo/Capital Centre site. The Largo/Capital Centre site offered two alternatives for parcel allocation. One alternative was termed the "Powell property site," while the other was an adjacent parcel called the "Schwartz property site."

The engineering consulting team comprised of Soltesz Inc. and Sabra, Wang & Associates, Inc. reviewed four site options located in central Prince George's County for the purpose of determining the best site of developing a regional medical center to replace the existing PGHC facility located in Cheverly. The engagement required that the consulting team study each site relative to civil engineering, environmental issues, transportation aspects, and zoning issues to determine the substantive and comparative differences between the four sites studied.

The four sites were identified as:

1. Woodmore Town Center site;
2 Landover Mall site;
3 "Boulevard at the Capital Center" / Powell property site; and
4 Boulevard at the Capital Centre site / Schwartz property.

Sites 3 and 4 are two variations of locating the site at the "Boulevard at the Capital Centre."

Each of the four sites is located in Central Prince George's County between Route 214 (Central Avenue, Exit 15 along I-495/95) at the southern end of the study area to the Route 202 (Landover Road) Exit 17 on I-95 at the northern end. The sites varied between the east and the west sides of Interstate 495/95 (the Capital Beltway). Access to this major travel artery was considered important. However, other infrastructure such as water, sewer, power, and storm water management facility availability was also evaluated when comparing the four sites. Finally individual site access and physical property acreage and space were reviewed to determine conceptual compatibility for a regional medical center facility use.

Of the four sites studied, not all are zoned for hospital use. Several of the sites have some form of Prince George's County entitlement approvals. There are no known significant environmental constraints for any of the sites. Background traffic information was provided by the Maryland National Capital Park and Planning Commission (M-NCPPC) during a meeting with the agency's traffic section. Information on the wet utilities such as water and sewer was provided by the Washington Suburban Sanitary Commission (WSSC).

1. <u>Study Scope:</u>

Each site was reviewed independently. Previous plan approvals were considered as pertinent information and taken into consideration. Previous approvals of other adjacent development sites most dramatically influenced traffic analysis at critical off-site intersections, water and sewer capacity, and infrastructure needs.

Utility analysis was undertaken to identify each site's needs based on information available from WSSC. Environmental and site constraint information was obtained from

a variety of table top sources or actual field data, depending on the site. Topography, site boundary, wetland, floodplain, and stream information was obtained and located on each property so that a conceptual building program could be established. Once concept building programs were identified, entrance and site circulation, including emergency access, was reviewed.

Traffic information was obtained by compiling and collecting updated baseline (year 2013) traffic counts at over 18 adjacent intersections, calculating and distributing traffic forecasts for over a dozen previously approved developments in the area, projecting traffic forecasts for the hospital site, and evaluating intersection traffic operations.

During the review process it was determined that for the purposes of this study, the stormwater management needs for each of the sites was similar in nature and that there would be no significant difference in the intent of any stormwater management design. Therefore, design of stormwater facilities did not become a factor in the analysis.

2. <u>New Site Alternatives:</u>

a. Option 3: Woodmore Town Center Site

<u>Description:</u> The proposed "Woodmore Town Center" site is a grouping of proximate properties located on the east side of the Capital Beltway. A variety of owners control the property including Petrie-Ross, the Roman Catholic Archdiocese of Washington DC, and Prince George's County. During the review process, different property configurations were reviewed to identify the most likely combination for a successful hospital campus. Road access to the site is primarily located at the Route

202 and McCormick/St Joseph's Drive intersection. Campus Way could be used as secondary ingress/egress.

The final configuration of the site is surrounded by a new retail center that includes a Costco and a Wegmans along with multiple other users. An existing Roman Catholic Church is located at the intersection of St Joseph's and Route 202. The proposal would include relocating the church in order to better consolidate the land bay for the hospital campus. Finally, existing and proposed (under construction) residential subdivisions complete the property adjacency descriptions. The land bay under consideration totals approximately 25 acres of land zoned M-X-T (Mixed Use Transportation).

Utilities: The site has very good access to both wet and dry utilities. Development activities on site are recent and the site provides new water and sewer facilities. Although the site capacity was not modeled specifically for a hospital, a comparison of the available remaining water and sewer capacity indicates that a hospital / RMC should be able to be constructed with no significant upgrades to the water and sewer utilities. Dry utilities are located on St. Joseph's Drive.

Environmental: The final site configuration appears to include some jurisdictional wetlands and streams; however, they are at the edge of the property and would not interfere with the site infrastructure or building construction. Tree Conservation Plans would be required and the resultant forest conservation obligations would need to be met.

Zoning: All properties included with this selection are zoned M-X-T. The properties have a variety of entitlement approvals associated with them ranging from no

approvals to approval of a Preliminary Plan of Subdivision/Final Plat. Under a standard Prince George's County development process for the M-X-T zone, a Conceptual Site Plan (CSP) would appear to be required as a first step but there is no consistent approval across all the properties. Ultimately a Detailed Site Plan would be required for District Council review. Hospital Use is not an allowed use in the M-X-T zone.

Traffic: Probably the most significant concern with this site relates to the traffic conditions at off-site intersections. Specifically, the intersection at Route 202/St Joseph's Road fails an adequacy test. Under conditions found on that road in a 2013 traffic environment, it was determined through a standard review process that no further reasonable improvement could be made to support additional traffic at the levels necessary to accommodate a hospital / RMC at this intersection. The consulting team determined that only by proposing a grade separated intersection/interchange could the site be made viable for the proposed use. Addressing this issue would require significant investment.

It should be noted that the majority site owner obtained approval for a significant amount of development already, dating back to approximately 2006 when the owner received approval of his Adequate Public Facility testing during the Preliminary Plan of Subdivision process. This was presented during a meeting by the owner's representative. However, the majority owner's numbers are dated and PGHC must use current traffic count numbers to adequately serve the life safety needs of this use. Given this requirement, there is a significant infrastructure cost requirement to make this site adequate.

Apart from the failing intersection, site access seems inadequate. The proposed land bay appears to be split by the existing St Joseph's right-of-way. Additional road relocations may be necessary, to consolidate the land bay more efficiently. Secondary ingress/egress to the site is only available through existing residential neighborhoods. Unless improved, these existing traffic conditions will negatively impact emergency service trips. The nearest Metrorail service is approximately 1.8 miles away, but other public transportation is available. An upgrade to those services would be necessary and may result in increased costs.

Table 16
Estimated Site Costs
Woodmore Town Center

Prince George' County Hospital Woodmore Town Center		
Site Improvement Task	**Quantity of Work**	**Estimated Cost**
Rough Grading the Site	30.5 Acres	$120,000
Roadway Realignment	1700 ft	$2,500,000
Grade Separated Intersection		$40,000,000
Relocation of Church		$11,000,000
Comparable site work: (Earthwork, site lighting, storm water management, landscaping, etc.)		$21,875,000
TOTAL		**$75,495,000**

Dimensions' Ranking of this Option

Maintain PGHC's role as a regional medical center	*Address public perceptions of PGHC.*	*Improvement in the ability to recruit physicians to serve its service area population.*	*Maintain/Improve access for its service area population*
Dimensions believes that this would significantly PGHC's ability to remain a regional medical center. *Score: 10*	The fresh start at a new site will significantly improve perception. *Score: 10*	Dimensions believes that it would significantly improve the ability to recruit physicians. *Score: 10*	This would improve access, though the traffic issues would limit the improvements. *Score:8*

Enable collaboration with the University of Maryland Medical System and University of Maryland System.	*Costs*	*Site Considerations including Engineering and Traffic Considerations, Parcel Size, etc.*
This would enable collaboration. *Score: 10*	Costs would be comparable to building a new facility at a different site. Most expensive site costs of the new sites. *Score: 7*	Moderate engineering issues. Significant traffic issues. *Score: 7*

b. Option 4: Landover Mall Site

Description: The proposed Landover Mall site was home to the Landover Mall before its demolition. It is located at the southwest side of the intersection of the Capital Beltway (I-95/495) and Landover Road (Route 202). The original offer was for 16 acres, but the review process determined that a larger site was required. The owner has suggested that additional acreage is available. Road access to the site is primarily located at the Route 202 Exit off of I-95/495.

The land bay under consideration is zoned M-X-T (Mixed Use Transportation). Currently the site is mostly undeveloped with the exception of the standing Sears store. This retail structure is under the control of the property owner and is planned for

demolition. The regional medical center would be planned to fit in one quadrant of the site allowing up to 8 million square feet of retail and residential development as suggested by the Landover Sector Plan.

Utilities: There is existing water and sewer provided to the site which was previously used for the mall; however, it is not sized to meet the combined requirements of the proposed development and the regional medical center. The site has an approved WSSC authorization which represents a significant amount of development and is a good judge of downstream requirements. A new 27" sewer line will need to be installed along Evarts Road. This is a significant improvement that will require environmental permits and road improvements. There is significant water volume and pressure in the area and no off-site water improvements are expected. Power and telecom would be brought to the site using the existing overhead lines. The consulting team was unable to determine if there is an ability to provide redundant power sources. The current location of the site is the southeast corner near I-495/95 and Route 202. The sewer and water connections will occur near the corner of Brightseat Road and Evarts Road. Therefore, both water and sewer will need to be routed through the site along a grid system of roads agreed upon with the developer.

Environmental: The final site configuration does not appear to contain any jurisdictional wetland, floodplain, or stream locations. Tree Conservation Plans would be required and the forest conservation obligations would need to be met.

Zoning: All properties included with this selection are zoned M-X-T. The property does not have any entitlement approvals. Under a standard Prince George's County development process for the M-X-T zone, a Conceptual Site Plan (CSP) would

appear to be required. Ultimately a Detailed Site Plan would be required for District Council review. Hospital Use is not an allowed use in the M-X-T zone.

Traffic: Probably the most significant issue with this site concerns the traffic conditions at the off-site intersections. Specifically, the intersection at Route 202/Brightseat Road fails the adequacy test. The regional medical center as a stand-alone project could potentially only require at grade improvements; however, this is an unlikely scenario and to accommodate the anticipated development at this site, a much more significant traffic improvement will be required. The consulting team has determined that grade separated improvements will be necessary for the Route 202/Brightseat Road intersection, as well as an overpass for "Brightseat Road Extended." The Brightseat Road Extended improvements will require land acquisition from private property owners. Land cost negotiations can be lengthy and cannot be guaranteed. The sector plan confirms that a major interchange at Brightseat Road and Route 202 is required in order to obtain full development at the existing Landover Mall site. Brightseat Road extended would allow for additional access to the Arena Drive exit from I-95/495. This is significant for the site because it will provide two access points from I-95/495 and additional means of egress to other portions of the county

Site access into the property is predicated on a continued ability to use the existing slip ramp located on Route 202. This exiting ramp along with the additional entrances will provide adequate ingress/egress. However, the on-site infrastructure is practically non-existent, and all interior roadwork and utilities will have to be factored into the cost of the project. Secondary ingress/egress to the site is adequate and available along existing arteries. The nearest Metrorail service is approximately 3 miles

away, although other public transportation is available. An upgrade to those services would be necessary and may result in increased costs.

Table 17
Estimated Site Costs
Landover Mall

Prince George' County Hospital at Landover Mall		
Site Improvement Task	Quantity of Work	Estimated Cost
Access Point 1 (Including Wet Utilities)	1300 ft	$1,500,000
Access Point 2 (Including Wet Utilities)	900 ft	$1,250,000
Existing Brightseat Signal Modification	n/a	$300,000
Mill And Overlay Existing Brightseat Road	n/a	$300,000
27" Sewer Line (Including Road)	1225 ft	$1,100,000
Landover Rd/Brightseat Intersection Improvement	n/a	$3,000,000
Right of Way Acquisition from 5035 Associates LTD & REA Marshalls Partnership	140,000 sf	$1,400,000
Removal of Existing Buildings	n/a	$700,000
Comparable site work: (Earthwork, site lighting, storm water management, landscaping, etc.)		$21,875,000
TOTAL		**$31,425,000**

Dimensions' Ranking of this Option

Maintain PGHC's role as a regional medical center	*Address public perceptions of PGHC.*	*Improvement in the ability to recruit physicians to serve its service area population.*	*Maintain/Improve access for its service area population*
Dimensions believes that this would significantly PGHC's ability to remain a regional medical center. *Score: 10*	The fresh start at a new site will significantly improve perception. *Score: 10*	Dimensions believes that it would significantly improve the ability to recruit physicians. *Score: 10*	This would improve access, though the traffic issues would limit the improvements. *Score:8*

Enable collaboration with the University of Maryland Medical System and University of Maryland System.	*Cost*	*Site Characteristics including Engineering and Traffic Considerations, Parcel Size, etc.*
This would enable collaboration. *Score: 10*	Costs would be comparable to building a new facility at a different site. Second most expensive site costs of the new sites. *Score: 8*	Significant engineering issues. Significant traffic issues. *Score: 6*

Schwartz Property Site Along with Capital Centre Site

c. Option 5: Schwartz Property Site Along with Capital Centre site

Description: The proposed Schwartz Property site is adjacent to the Capital Centre site and is located on the west side of the Capital Beltway (I-95/495). The site is comprised of two land bays separated by a public road that leads to the Largo (Blue Line) Metrorail site. The property owner indicates that he has the right to build on a portion of the adjacent Metro site parking lot presumably to replace the surface parking with a parking structure. No independent verification of this was obtained. Road access to the site is located along Lottsford Road via either Arena Drive or Harry S. Truman Drive.

The land bay under consideration totals approximately 16 acres of land zoned M-A-C (Major Activity Center). Currently the site is undeveloped. The owner demonstrated a significant amount of entitlement approvals had already been obtained for the site. These approvals would require revisions to accommodate the regional medical center. The site also provides a significant amount of road frontage along a

public right-of-way. Pedestrian access from the surrounding area is well developed and includes a pedestrian bridge from the Largo Metro site to the Capital Centre site.

Utilities: Water and sewer are obtained by accessing the existing water and sewer on Lottsford Road. There is no approved WSSC authorization for this site; however, based on observation and discussions with WSSC, there are no significant downstream improvements that appear to be required. Power will be brought to the site by PEPCO with a single feed from the substation. The substation is powered by two separate feeders, which allows for redundancy in the system. Both gas and telecom are located on Lottsford Road and will provide for an easy connection to the site.

Environmental: The final site configuration does not appear to contain any jurisdictional wetland, floodplain, or stream locations. Tree Conservation Plans would be required and the resulting forest conservation obligations would need to be met.

Zoning: All properties included with this selection are zoned M-A-C. A hospital is not an allowed use in the M-A-C zone.

Picture: The Pedestrian bridge from the Metro site
to the Boulevard at the Capital Centre site.

Traffic: The traffic conditions at the site are no different than the traffic conditions described for the Capital Centre site. Both sites are served by the same roads. Public transportation is readily available, although it is likely that additional bus service would need to be routed, as with the other site options.

Table 18
Estimated Site Costs
Schwartz Property

Prince George' County Hospital Schwartz Property		
Site Improvement Task	Quantity of Work	Estimated Cost
Rough Grade Site	16.4 Acre	$400,000
Intersection Upgrade/entrance improvements	n/a	$2,000,000
Comparable site work: (Earthwork, site lighting, storm water management, landscaping, etc.)		$21,875,000
TOTAL		$24,275,000

Dimensions' Ranking of this Option

Maintain PGHC's role as a regional medical center	*Address public perceptions of PGHC.*	*Improvement in the ability to recruit physicians to serve its service area population.*	*Maintain/Improve access for its service area population*
Dimensions believes that this would significantly improve PGHC's ability to remain a regional medical center. *Score: 10*	The fresh start at a new site will significantly improve perception. *Score: 10*	Dimensions believes that it would significantly improve the ability to recruit physicians. *Score: 10*	This would improve Access. Adjacent Metro station an advantage. *Score: 10*

Enable collaboration with the University of Maryland Medical System and University of Maryland System.	*Cost*	*Site Characteristics including Engineering and Traffic Considerations, Parcel size, etc.*
This would enable collaboration. *Score: 10*	Costs would be comparable to building a new facility at adifferent site. Least expensive site costs of the new sites. *Score: 10*	The road traversing the middle of the property is a major concern, as it severely limits the site's use..No traffic issues. *Score: 6*

d. Option 6: Boulevard at The Capital Centre Site (RPAI/Powell)

Description: The proposed Capital Centre site (16-17 acre portion of 70 acre parcel) is currently occupied by a significant amount of retail square footage referred to as the Boulevard at the Capital Centre. The proposed regional medical center site would also include the adjacent Powell property (8.5 acres), located on the east side of the Capital Beltway between the Arena Drive and Central Avenue Exits. Road access to the site is located along Arena Drive and a combination of Lottsford Road/Harry S Truman Drive.

The land bay under consideration totals approximately 8.5 acres of land zoned M-A-C (Major Activity Center) and approximately 16 acres of land zoned R-R (Rural Residential). The current configuration of the land bay under review exists as a combination of a portion of the Capital Center Mall (including existing and occupied buildings) and the adjacent Powell property. The Powell property is currently undeveloped. In order to develop the property as a hospital campus, the existing buildings would need to be demolished. The site is adjacent to an existing Metrorail facility. This relationship between a hospital and a Metrorail facility is clearly a significant benefit to operations and provides this property combination an advantage

that the other sites cannot provide. It would be expected that additional bus services would be planned for the area as well.

This Picture is of the large parking area where the hospital site would be located. The metro site is to the right. The existing buildings to be demolished are on the left and the Powell site is located in the far center.

Utilities: There is existing water and sewer located on the site; however, it is a private system, so after the required subdivision of the site, new onsite water and sewer must be brought in. WSSC was not aware of any material downstream sewer constraints. In addition, Soltesz found significant water volume and pressure in the adjacent water lines. Water and sewer capacity appears to be available. Electric service will be provided by PEPCO. A single service will be brought to the site, but the substation that is near the site has two feeders providing power. Verizon and Washington Gas are located on Arena Drive and are accessible.

Environmental: The final site configuration does not appear to contain any jurisdictional wetland, floodplain, or stream locations. Tree Conservation Plans would be required and the resulting forest conservation obligations would need to be met.

Zoning: All properties included with this selection are zoned either R-R or M-A-C. A portion of the property has entitlement approvals. Eventually a Detailed Site Plan and/or Special Exception would be required for County Council review. A Hospital is not an allowed use in the M-A-C zone. It is an allowed use by way of a Special Exception in the R-R zone.

Traffic: The main access to the site will be along Arena Drive. A right turn lane will likely need to be added along Arena Drive, but all of the intersections around the site in both the existing and proposed condition are adequate. The site can also be accessed from Harry S Truman Drive. This provides quick access to the Route 214 exit from I-95/495. Site access is more than adequate from all directions. This is important for emergency access vehicles. The site is adjacent to the Largo Metrorail facility. There is an existing pedestrian bridge to the site from the Metrorail site that will be within a 10 minute walk radius pattern. In addition to the Metro site, there is an existing bus drop off area located at the existing Metro facility.

Table 19
Estimated Site Costs
Boulevard At The Capital Centre

Prince George' County Hospital Boulevard At The Capital Centre		
Site Improvement Task	Quantity of Work	Estimated Cost
Mill/Overlay Arena Drive	1,300 ft	$100,000
Turn Lane Addition	1300 ft	$75,000
Water Add In	1,035 ft	$400,000
Sewer Add In	1,035 ft	$400,000
Proximity To Tunnel Construction		$500,000
Contribute For Recreation		$50,000
Rough Grade Site	10 Acre	$100,000
Removal of Existing Buildings	n/a	$1,000,000
Comparable site work: (Earthwork, site lighting, storm water management, landscaping, etc.)		$21,875,000
TOTAL		**$24,500,000**

Dimensions' Ranking of this Option

Maintain PGHC's role as a regional medical center	*Address public perceptions of PGHC.*	*Improvement in the ability to recruit physicians to serve its service area population.*	*Maintain/Improve access for its service area population*
Dimensions believes that this would significantly PGHC's ability to remain a regional medical center. *Score: 10*	The fresh start at a new site will significantly improve perception. *Score: 10*	Dimensions believes that it would significantly improve the ability to recruit physicians. *Score: 10*	This would improve Access. Adjacent Metro station an advantage. *Score: 10*

Enable collaboration with the University of Maryland Medical System and University of Maryland System.	*Cost*	*Site Characteristics including Engineering and Traffic Considerations, Parcel Size, etc.*
This would enable collaboration. *Score: 10*	Costs would be comparable to building a new facility at a different site. Second least expensive site costs of the new sites. (Only $225,000 more than the Schwartz property option.) *Score: 9*	Moderate engineering issues. No traffic issues. Less site development restrictions than Schwartz property option. *Score: 9*

e. Study Conclusion

Based on the civil engineering study, the Boulevard at the Capital Centre site, in some combination of the Powell or Schwartz property was considered the best alternative site. Favorable factors included viable traffic conditions at critical intersections, adjacency to a Metrorail station, adequate infrastructure support for the site, available land bay, and overall estimated less costs for site development.

3. Dimensions' Selection

The engineering study components made it clear that the two variations of the "Boulevard At The Capital Centre" location were the best of the options considered. Among the two variations (the Powell Property and the Schwartz Property), the option to combine the approximate 17 acre parcel (portion of the Boulevard at the Capital Centre parcel) with the 8.5 acre Powell parcel was selected as the best option by both Prince George's County and Dimensions. This combined 26 acre parcel will provide more options in developing the medical campus with fewer restrictions.

Summary of Dimensions Ranking Scores

	Maintain PGHC's role as a regional medical center	Address public perceptions of PGHC	Improve-ment in the ability to recruit physicians to serve its service area population	Maintain/ Improve access for its service area population	Enable collaboration with Univ. of Maryland Medical System and Univ. of Maryland System	Cost	Site characteris-tics, incl. engineering and traffic considera-tions, parcel size, etc.	**TOTAL**
Replace the entire facility on its current campus	7	7	7	5	7	9	5	47
Major additions/ renovations on the existing site.	6	6	6	5	6	5	4	38
Relocate the hospital to the Woodmore Town Center Site	10	10	10	8	10	7	7	62
Relocate the hospital to the Landover Mall Site	10	10	10	8	10	8	6	62
Relocate the hospital to the Boulevard @The Capital Centre Site	10	10	10	10	10	9	9	68
Relocate the hospital to the Schwartz Property Site Along with Capital Centre site	10	10	10	10	10	10	6	66

(b) An applicant proposing a project involving limited objectives, including, but not limited to, the introduction of a new single service, the expansion of capacity for a single service, or a project limited to renovation of an existing facility for purposes of modernization, may address the cost-effectiveness of the project without undertaking the analysis outlined in (a) above, by demonstrating that there is only one practical approach to achieving the project's objectives.

Inapplicable.

(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital to a new site that is not within a Priority Funding Area as defined under Title 5, Subtitle 7B of the State Finance and Procurement Article of the Annotated Code of Maryland shall demonstrate:

(i) That it has considered, at a minimum, an alternative project site located within a Priority Funding Area that provides the most optimal geographic accessibility to the population in its likely service area, as defined in Project Review Standard (1);

(ii) That it has quantified, to the extent possible, the level of effectiveness, in terms of achieving primary project objectives, of implementing the proposed project at each alternative project site and at the proposed project site;

(iii) That it has detailed the capital and operational costs associated with implementing the project at each alternative project site and at the proposed project site, with a full accounting of the cost associated with transportation system and other public utility infrastructure costs; and

(iv) That the proposed project site is superior, in terms of cost-effectiveness, to the alternative project site or sites located within a Priority Funding Area.

The proposed site is within a Priority Funding Area. (see **Exhibit 13**).

Standard .04B (6) – <u>Burden of Proof Regarding Need.</u>

A hospital project shall be approved only if there is demonstrable need. The burden of demonstrating need for a service not covered by Regulation .05 of this Chapter or by another chapter of the State Health Plan, including a service for which need is not separately projected, rests with the applicant.

PGHC acknowledges that it has the burden of proof to demonstrate need for services for which need is not separately projected in the State Health Plan. Please see the narrative under 10.24.01.08G(3)(b) (Need), where need for acute rehabilitation beds, emergency department space, surgical capacity and obstetrical beds are discussed.

Standard .04B(7) – <u>Construction Cost of Hospital Space.</u>

(a) The cost per square foot of hospital construction projects shall be no greater than the cost of good quality Class A hospital construction given in the Marshall and Swift Valuation Quarterly, updated to the nearest quarter using the Marshall and Swift update multipliers, and adjusted as shown in the Marshall

and Swift guide as necessary for terrain of the site, number of levels, geographic locality, and other listed factors.

(b) Each Certificate of Need applicant proposing costs per square foot above the limitations set forth in the Marshall and Swift Guide must demonstrate that the higher costs are reasonable.

PGRMC will be comprised of the hospital building (with a rooftop mechanical penthouse) and a separate building that is the Hospital Central Utility Plant ("CUP") The Concourse level in the hospital is entirely at grade level, except for the area that will house the linear accelerators and related Cancer treatment rooms, which are below ground. Because the majority of the floor is not below ground, PGHC considered it a normal hospital floor (not a basement), as the MHCC has historically done. The CUP will be connected to the hospital via an underground tunnel. Consequently, PGHC has performed one MVS analyses for the Hospital Building and Mechanical Penthouse (using separate MVS benchmarks) and another separate analysis for the Hospital CUP. As shown below, the cost per square foot of the new construction is lower than the MVS benchmark. A complete Marshall Valuation Service ("MVS") analysis is included as **Exhibit 14.**

I. Marshall Valuation Service
Valuation Benchmark– New Construction - Hospital

Type		Hospital
Construction Quality/Class		Good/A
Stories		10
Perimeter		1,613
Average Floor to Floor Height		17.0
Square Feet		667,411
f.1	Average floor Area	66,741

A. Base Costs		
	Basic Structure	$336.71
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$336.71
Adjustment for Departmental Differential Cost Factors		1.06
Adjusted Total Base Cost		$356.67
B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$356.67
C. Multipliers		
Perimeter Multiplier		0.909804254
	Product	$324.50
Height Multiplier		1.12
	Product	$362.18
Multi-story Multiplier		1.035
	Product	$374.86
D. Sprinklers		
	Sprinkler Amount	$2.03
Subtotal		$376.89
E. Update/Location Multipliers		
Update Multiplier (8/13)		1.06
	Product	$399.50
Location Multipier (7/13)		1.07
	Product	$427.47
Calculated Square Foot Cost Benchmark		**$427.47**

The MVS estimate for this project is impacted by the Adjustment for Departmental Differential Cost Factor. In Section 87 on page 8 of the Valuation Service, MVS provides the cost differential by department compared to the average cost for an entire hospital. The calculation of the average factor is shown below.

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
ACUTE PATIENT CARE				
ACUTE CARE	95,312	Inpatient Unit	1.06	101,031
INTENSIVE CARE	22,288	Inpatient Unit	1.06	23,625
POST-PARTUM	17,584	Inpatient Unit	1.06	18,639
NEONATAL INTENSIVE CARE UNIT	16,912	Inpatient Unit	1.06	17,927
MT. WASHINGTON PEDIATRICS	12,096	Inpatient Unit	1.06	12,822
DIAGNOSTICS & TREATMENT				
SURGERY	36,000	Operating Suite, Total	1.59	57,240
CARDIAC CATH LAB	11,760	Operating Suite, Total	1.59	18,698
GI - ENDOSCOPY	2,280	Operating Suite, Total	1.59	3,625
ADULT/PEDS ED	30,000	Emergency Suite	1.18	35,400
TRAUMA	8,280	Emergency Suite	1.18	9,770
UNIVERSAL CARE / OBSERVATION	29,640	Inpatient Unit	1.06	31,418
IMAGING	22,440	Radiology	1.22	27,377
NON-INVASIVE CARDIOLOGY	3,480	Offices	0.96	3,341
NEURODIAGNOSTICS	1,200	Laboratories	1.15	1,380
LABOR & DELIVERY	10,680	Obstetrical Suite Only	1.44	15,379
C-SECTION	3,120	Operating Suite, Total	1.59	4,961
DIALYSIS	2,040	Laboratories	1.15	2,346
PT/OT	2,880	Physical Medicine	1.09	3,139

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
CLINICAL SUPPORT				
LABORATORY / PATHOLOGY	9,870	Laboratories	1.15	11,351
PHARMACY	3,675	Pharmacy	1.33	4,888
OTHER CLINICAL SUPPORT	6,510	Offices	0.96	6,250
NON CLINICAL SUPPORT				
DIETARY / DINING	17,040	Dietary	1.52	25,901
MATERIALS / BIO MED / EVS	11,280	Storage and Refrigeration	1.6	18,048
CENTRAL STERILE	7,680	Central Sterile Supply	1.54	11,827
FACILITIES & SUPPORT SERVICES	17,040	Offices	0.96	16,358
IT / TELECOM	2,880	Offices	0.96	2,765
OFFICES & EDUCATION				
OFFICE / ADMINISTRATION	9,870	Offices	0.96	9,475
ON CALL	6,500	Offices	0.96	6,240
CONFERENCE CENTER	4,935	Public Space	0.8	3,948
SUPPORT/OTHER/PUBLIC	68,459	Public Space	0.8	54,767
MECHANICAL/ELECTRICAL	89,000	Mechanical Equipment and Shops	0.7	62,300
BEHAVIORAL HEALTH				
CLINICAL PROGRAMS				
ACUTE BEHAVIORAL HEALTH	23,072	Inpatient Unit	1.06	24,456
PARTIALIZATION / OUTPATIENT	3,584	Outpatient Department	0.99	3,548
ASSESSMENT STABILIZATION	2,800	Inpatient Unit	1.06	2,968
AMBULATORY/CANCER				

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
CLINICAL PROGRAMS				
CANCER INFUSION	6,300	Laboratories	1.15	7,245
RADIATION ONCOLOGY	13,520	Radiology	1.22	16,494
OTHER OP CLINIC	13,200	Outpatient Department	0.99	13,068
SUPPORT/OTHER/PUBLIC	14,204	Public Space	0.8	11,363
MECHANICAL	8,000	Mechanical Equipment and Shops	0.7	5,600
TOTAL	667,411		1.0592862	706,979

II. Marshall Valuation Service
Valuation Benchmark– New Construction – Mechanical Penthouse

Type	Mechanical Penthouse
Construction Quality/Class	Good/A
Stories	7
Perimeter	250
Average Floor to Floor Height	20.00
Square Feet	4,288
Average floor Area	4,288
A. Base Costs	
Basic Structure	$82.55
Elimination of HVAC cost for adjustment	0
HVAC Add-on for Mild Climate	0
HVAC Add-on for Extreme Climate	0
Total Base Cost	$82.55
B. Additions	
Elevator (If not in base)	$0.00
Other	$0.00
Subtotal	$0.00
Total	$82.55

C. Multipliers

Perimeter Multiplier	0.997784
Product	$82.37
Height Multiplier	1.069
Product	$88.05
Multi-story Multiplier	1.035
Product	$91.13

D. Sprinklers

Sprinkler Amount	$1.53
Subtotal	$92.66

E. Update/Location Multipliers

Update Multiplier	1.06
Product	$98.22
Location Multipier	1.07
Product	$105.10

Calculated Square Foot Cost Benchmark **$105.10**

III. Consolidated MVS Benchmark

		MVS Benchmark	Sq. Ft.		Total Cost Based on MVS
Standard					
"Tower" Component		$427.47	667,411	$	285,297,236.48
Mechanical Penthouse		$105.10	4,288	$	450,657.75
Consolidated	**$**	**425.41**	671,699	$	285,747,894.23

IV. Cost of New Construction

The Project

A. Base Calculations	Actual	Per Sq. Foot
Building	$257,572,688	$383.46
Fixed Equipment	In Building	$0.00
Site Preparation	$23,904,693	$35.59
Architectural Fees	$17,350,181	$25.83
Permits	$5,397,834	$8.04
Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	$304,225,396	$452.92

However, as related below, this project includes expenditures for items not included in the MVS average.

B. Extraordinary Cost Adjustments

	Project Costs	
Canopy	$3,500,000	Building
Foundation Drainage/Dewatering	$300,000	Building
LEED Silver Premium	$10,302,908	Building
Redundant Electric Service	$2,500,000	Building
Redundant Water Service	$300,000	Building
Jurisdictional Hook-up Fees	$500,000	Permits
Premium for Concrete Frame Construction	$1,750,000	Building
Demolition	$1,000,000	Site
Storm Drains	$1,500,000	Site
Rough Grading	$3,500,000	Site
Landscaping	$900,000	Site
Sediment Control & Stabilization	$100,000	Site
Roads	$500,000	Site
Helipad	$1,500,000	Building
Deep Foundations	$500,000	Site
Utilities	$5,600,000	Site
Signs	$500,000	Building
Pilings	$500,000	Site
Hillside Foundation	$1,500,000	Site
Premium for Paying Prevailing Wage	$16,584,385	Building
Premium for Paying Prevailing Wage	$581,329	Site
Total Cost Adjustments	$53,918,621	18.8%

Explanation of Extraordinary Costs

- Signs, Canopy, Jurisdictional Hook-up Fees, Impact Fees, Paving and Roads, Storm Drains, Rough Grading, Landscaping, Sediment Control & Stabilization,

Demolition, Deep Foundation, Pilings, and Hillside Foundation – These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A – Good General Hospital per Section 1, page 3 of the Marshall Valuation Service.

- LEED Silver Premium – PGHC has included a 4% premium (based on Building Costs only) due to constructing this building to LEED Silver standards. The potential for a 0%-7% premium is recognized by MVS in Section 99, Page 1.

- Redundant Electric and Water Service – As a safety measure, PGHC is planning to construct redundant electric and water service. This is not a feature of most hospitals.

- Helipad – As the second busiest trauma center in the state, PGRMC will have two rooftop helipads and one area on the ground where a helicopter can land. This is not a feature of most hospitals.

- Foundation Drainage/Dewatering – Since only Normal Site Preparation is included in the benchmark (see Section 1, page 3 of the Marshall Valuation Service), the need for foundation drainage and dewatering is not included.

- Utilities – This project requires the extension of public utilities to the perimeter of the hospital related portion of the site. These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A – Good General Hospital per Section 1, page 3 of the Marshall Valuation Service.

- Premium for Concrete Frame Construction – Concrete frame construction is significantly more costly than steel frame. Only the Premium has been considered an extraordinary cost.

- Premium for Paying Prevailing Wage – Because both State and County funds will be used to construct PGRMC, Dimensions' contractors will have to pay "prevailing" wages, rather than "scale." Dimensions' consultant, Andrew Solberg, telephoned Marshall and Swift's Technical Assistance staff on 9/27/13 and asked John Thompson whether this would constitute a premium over the average cost per square foot presented in the MVS, even when adjusted for update and local multipliers. Mr. Thompson stated that paying prevailing wage would definitely be a premium over the average. He stated that he had previously been an electrician and, on buildings on which he was paid scale, the pay was approximately $11/hour. However, on projects on which he was paid prevailing wage, he was paid approximately $32/hour. PGHC has searched for an average premium that is should use as the basis for its assumption. The Associated

Builders and Contractors cited a study by the Minnesota Taxpayers Association (MTA) that found that the prevailing wage rates on public construction increased project costs between 7 and 10 percent. (http://www.abc.org/EducationTraining/AcademyPages/tabid/340/entryid/820/Default.aspx) PGHC has assumed that the premium will be 7%, the lower end of the range. Because prevailing wage will have to be paid for both site preparation and construction, PGHC has applied it to both.

- Capitalized Construction Interest on Extraordinary Costs - $50,500,000 in capitalized interest shown on the project budget sheet is for the entire costs of the project. However, because PGHC projects that there will be $15,100,000 interest earned on the borrowing, PGHC has pro-rated the net capitalized interest ($35,400,000) between the hospital building and the CUP. The costs associated with this line item also apply to the extraordinary costs. Because the Capitalized Construction Interest only associate with the costs in the "Building" budget line are considered in the MVS analysis, it is appropriate to adjust the cost of each of the above items that are in the Building costs to include the associated capitalized construction interest.

- Architectural and Engineering Fees Related to Extraordinary Costs – A&E Fees are typically a percentage of the total cost of Building and Site Preparation, including extraordinary costs. Consequently, like Capitalized Interest, if the extraordinary costs are removed from the comparison, their related A&E Fees should also be removed. This was accomplished by calculating the percent that the original A&E Fees comprised of the Building and Site Prep costs, multiplying that percentage times the sum of the extraordinary costs, and subtracting that number from the original A&E fees.

Eliminating all of the extraordinary costs reduces the project costs that should be compared to the MVS estimate to $419.76. As noted below, the project's cost per square foot is below the MVS benchmark.

C. Adjusted Project Cost		Per Square Foot
Building	$220,335,396	$328.03
Fixed Equipment		$0.00
Site Preparation	$7,723,365	$11.50
Architectural Fees	$14,089,188	$20.98
Permits	$4,897,834	$7.29
Subtotal	$247,045,783	$367.79
Capitalized Construction Interest	$34,904,545	$51.96
Total	$281,950,328	$419.76

V. Comparison to the MVS Benchmark

MVS Benchmark	$425.41
The Project	$419.76
Difference	-$5.65

VI. Marshall Valuation Service
Valuation Benchmark– New Construction – Hospital CUP

There appears to be no separate benchmark in MVS for central utility plants. When PGHC's consultant, Mr. Solberg, spoke to MVS Technical Assistance staff person John Thompson on 9/27/13 (see above discussion on extraordinary costs), Mr. Solberg asked for some direction on how to address this. Mr. Thompson searched his electronic version of MVS and could find no references to central utility plants. Mr. Solberg suggested that, since it is a hospital utility plant, he could use the hospital base cost, adjusted for the 0.7 Departmental Cost Differential factor for "Mechanical Equipment and Shops." Mr. Thompson concurred that this would be a reasonable way to handle it.

Type		Hospital
Construction Quality/Class		Good/A
Stories		1
Perimeter		622
Average Floor to Floor Height		41.0
Square Feet		40,000
f.1	Average floor Area	40,000

A. Base Costs		
	Basic Structure	$336.71
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$336.71
Adjustment for Departmental Differential Cost Factors		0.70
Adjusted Total Base Cost		$235.70
B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$235.70
C. Multipliers		
Perimeter Multiplier		0.884786667
	Product	$208.54
Height Multiplier		1.69
	Product	$352.59
Multi-story Multiplier		1.000
	Product	$352.59
D. Sprinklers		
	Sprinkler Amount	$3.14
Subtotal		$355.73
E. Update/Location Multipliers		
Update Multiplier		1.06
	Product	$377.08
Location Multiplier		1.07
	Product	$403.47
Calculated Square Foot Cost Standard		**$403.47**

Please note that the 0.7 Departmental Cost Differential factor for "Mechanical Equipment and Shops" was applied above.

VII. The Project

A. Base Calculations	**Actual**	**Per Sq. Foot**
Building	$9,646,917	$241.17
Fixed Equipment		$0.00
Site Preparation	$895,307	$22.38
Architectural Fees	$649,819	$16.25
Permits	$202,166	$5.05
Subtotal	$11,394,210	$284.86

However, the construction of the CUP will also be subject to paying prevailing wage rates.

B. Extraordinary Cost Adjustments

	Project Costs	
Premium for Paying Prevailing Wage	$675,284	Building
Premium for Paying Prevailing Wage	$62,671	Site

C. Adjusted Project Cost		**Per Square Foot**
Building	$8,971,633	$224.29
Fixed Equipment		$0.00
Site Preparation	$832,635	$20.82
Architectual Fees	$649,819	$16.25
Permits	$202,166	$5.05
Subtotal	$10,656,254	$266.41
Capitalized Construction Interest	$2,832,290	$70.81
Total	$14,226,500	$355.66
MVS Benchmark	$403.47	
The Project	$355.66	
Difference	-$47.81	
	-11.85%	

Standard .04B(8) – <u>Construction Cost of Non-Hospital Space.</u>

The proposed construction costs of non-hospital space shall be reasonable and in line with current industry cost experience. The projected cost per square foot of non-hospital space shall be

compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide for the appropriate structure. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the non-hospital space shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost. In general, rate increases authorized for hospitals should not recognize the costs associated with construction of non-hospital space.

Inapplicable.

Standard .04B(9) – <u>Inpatient Nursing Unit Space.</u>

Space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type of unit being developed shall not be recognized in a rate adjustment. If the Inpatient Unit Program Space per bed of a new or modified inpatient nursing unit exceeds 500 square feet per bed, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost for the space that exceeds the per bed square footage limitation in this standard, or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

The average square feet/bed of the inpatient nursing units in the proposed facility is under 500 sf/bed, using the definition in the Acute Care Chapter. The average sf/bed varies by the type of nursing unit. The analysis for the Pediatric beds is for the integrated pediatric Inpatient/Observation/ED unit. The detailed analyses are included in **Exhibit 15**.

ROOM/FUNCTION	NEW-ADDITIONAL NSF	BEDS	SF/BED
MEDICAL/SURGICAL	13,020	34	382.9
MEDICAL/SURGICAL	13,020	33	394.5
INTENSIVE CARE	12,415	32	388.0
PERINATAL/ LDRP	9,840	22	447.3
BEHAVIORAL HEALTH	12,870	28	459.6
PEDIATRICS	2,480	FOR 1 INPT., 4 SHORT STAY AND 5 ED PEDS TREATMENT	248

Standard .04B(10) – Rate Reduction Agreement.

A high-charge hospital will not be granted a Certificate of Need to establish a new acute care service, or to construct, renovate, upgrade, expand, or modernize acute care facilities, including support and ancillary facilities, unless it has first agreed to enter into a rate reduction agreement with the Health Services Cost Review Commission, or the Health Services Cost Review Commission has determined that a rate reduction agreement is not necessary.

In the last Spring 2011 ROC, PGHC was identified as being 8.76% above the average of its Peer Group (see Exh. 11).

PGHC Most Recent ROC Performance

Date of ROC	% Below Peer Group
Spring 2011	8.76% Above

To date, PGHC has not entered a rate reduction agreement with the HSCRC. There are several issues to consider when determining whether a rate reduction agreement is appropriate.

1) The Spring 2011 ROC was published more than two years prior to this application.

2) The inpatient Charge per Case (CPC) and outpatient Charge per Visit (CPV) targets were combined in the ROC measurement. The Charge per Visit methodology was discontinued after only one year of use. Since 2011, Maryland

hospitals have shifted a number of inpatient cases to observation status. Excluding the outpatient CPV from any comparison is incomplete.

3) The majority of Maryland hospitals are no longer subject to the CPC methodology. They are currently subject to the Charge per Episode (CPE) methodology or the Total Patient Revenue (TPR) methodology, both of which provide incentives to reduce readmissions.

4) Annual rate updates below expense inflation over a sustained period have reduced operating profits.

In light of these issues, PGHC believes that the HSCRC's rate setting policy and methodologies in 2011 are outdated and not relevant to rate setting policies and methodologies in 2013. While a useful tool in the past, use of the Spring 2011 ROC is not applicable to compare current hospital rates.

Standard .04B(11) – <u>Efficiency.</u>

A hospital shall be designed to operate efficiently. Hospitals proposing to replace or expand diagnostic or treatment facilities and services shall:

(a) Provide an analysis of each change in operational efficiency projected for each diagnostic or treatment facility and service being replaced or expanded, and document the manner in which the planning and design of the project took efficiency improvements into account; and

(b) Demonstrate that the proposed project will improve operational efficiency when the proposed replacement or expanded diagnostic or treatment facilities and services are projected to experience increases in the volume of services delivered; or

(c) Demonstrate why improvements in operational efficiency cannot be achieved.

The replacement facility for PGHC allows for significant operational changes and efficiencies to be incorporated into the plans. The lean concept of "pulling" both

services and staff expertise to the patients is aimed to reduce handoffs, transports, and unproductive time, while at the same time improve the quality of patient care. This will lead to a more efficient use of the space, and reduce the time patients spend in the hospital, recovering and completing tests and procedures. The effective of lean operations is measure in the value brought to the patient and the ultimate eliminating of waste or non-value service. PGHC's new facilities will incorporate the latest in technology to better serve its patient. Wireless communication systems, such as patient and instrument tracking, automations and robotics in such areas as lab and surgery, telemedicine and video conferencing, remote imaging and patient monitoring, are a few of the technologies that will help improve patient flow and cost of care.

The plans create a highly efficient trauma and emergency process, allowing for short distances and a high level of collaboration among the key critical departments. A dedicated trauma size elevator will transport patients from and to a helipad located on the roof of the hospital.

The acute care functions that share common processes will be more streamlined and have greater flexibility through more efficient use of staff's time and technology. Behavioral health patients will be accessed and treated through a stabilization and assessment center where patients can be discharged or admitted to a dedicated behavioral health inpatient unit.

The end result is a more efficient hospital structure, allowing greater utilization through less square footage, along with providing high value care while reducing the cost of operations.

Diagnostic and Treatment

The key components of Diagnostic & Treatment ("D&T") include the trauma and emergency care areas organized on a single "Interventional Platform," with other D&T functions of surgery, cath lab, cardiology, and radiology.

The surgical area is comprised of rooms for trauma, cardiovascular, neurovascular, orthopedic, and general surgery, as well as a hybrid-OR for combined cardiovascular and surgical cases. Rooms are sized to accommodate all case types and complexities, and share support functions and processes for patient prep and recovery. Adjacent to the operating rooms are the interventional rooms for cardiac cath, electrophysiology, and radiological procedures. Rooms are designed to optimize flexibility and utilization, and share with the surgery unit and the universal care unit ("UCU").

The radiology department will be centrally located to effectively serve the trauma/emergency area, surgery/cath, and all inpatient and outpatient diagnostic imaging. A MRI suite will accommodate inpatient, outpatient, and emergency scans. Women's imaging for mammography and bone density will be located on the first level adjacent to the Women's Center entrance.

The emergency department will be configured for optimal flow, safety, and privacy. Walk-ins will rapidly flow through an assessment diagnostics area, quickly seeing a provider, and triaged to either a fast-track unit or to the high acuity exam rooms depending on severity. Trauma patients will access either the trauma rooms or resuscitation rooms directly from an ambulance entry.

All functions are organized and located on a single floor with close proximities, and adjacency to a UCU that can be shared by these functions for higher utilization and care quality. The UCU provides all prep and recovery functions for procedures as well as the observational beds for admissions decisions and observation. Observation beds in the UCU will have a private toilet room for overnight accommodations.

Acute and Critical Care Nursing Units

The acute care units are organized in floors of all-private rooms of 28, 32, 33, or 34 beds. The rooms are planned to be universal and adapted to the level of acuity to reduce the number of patient transfers. The nursing model of care will focus on increasing the nurse time in patient rooms, relying on technology, ability to observe patients, and improved logistics for supplies and transportation.

The Intensive Care Unit is 32-bed unit optimizing flexibility. Each room is self-sufficient. Cross-trained staff allow for greater utilization. The unit will contain models of beds for surgical and medical patient, cardiovascular, trauma, and intermediate or progressive care.

Universal Care Unit

All procedural functions are organized and located on the first floor with close proximities among the ED, surgery, endoscopy and cardiac cath suites. Adjacent is the Universal Care Unit (“UCU”) that can be shared by these functions for higher utilization, flexibility and care quality. The UCU provides all prep and recovery functions for all procedures, as well as the observational beds for admissions decisions, pre-admit testing, and medical adult observation.

The UCU is designed to serve those patients who do not require inpatient hospitalization but may require nursing care for several hours or overnight. This unit is designed to increase accessibility, operational efficiency, and capacity for the emergency and surgery departments, while also providing space for outpatients and observation status patients requiring up to 24 hours of nursing care. Advances in technology such as minimally invasive procedures are shifting patient census from inpatient to outpatient and reducing recovery time and the need for inpatient admissions. The flexibility of accommodating procedure patients and observation patients reduces the need to duplicate dedicated ED observation and prep recovery or inpatient rooms, which often may not be occupied by an admitted patient.

Women's Center

A Women's Center for maternal and neonatal care is located on a single floor for ease of operations and identity. This program will have a dedicated entry with OB services located on the first level and the maternity and children's program above. The OB unit is comprised of Triage and Labor, Delivery and Recovery (LDR), two LDRP rooms, normal nursery, adjacent to C-section rooms and post-anesthesia recovery. The neonatology intensive care unit (NICU) will be adjacent to the LDR suite is for direct patient access from the delivery rooms. A dedicated access from the emergency and trauma is required for critical transfers. The post-partum unit is located nearby with room-in capabilities. The ante-partum rooms are located adjacent to the post-partum unit.

Acute Behavioral Health

An Assessment and Stabilization Center (ASC) will be adjacent to the ED, where patients can be observed and assessed for treatment. The ASC is vital in assessing patients, finding proper care, alleviating the emergency room, and admitting to the hospital's acute unit. The acute behavioral health unit is a locked unit with separate male and female rooms, with a focus on treating the patient acute issues, and utilizing both hospital partialization and intensive outpatient programs, post the acute stay to better serve its patients.

Ambulatory and Cancer Center

An ambulatory center that will house various specialties providing complementary outpatient services will be located adjacent to the hospital . Clinical programs will include an orthopedic clinic; multidisciplinary clinics; a comprehensive women's program (including screening, diagnostics, educations, and examinations); an education and conference center; and retail functions, including an outpatient pharmacy. Also included will be a regional cancer center comprised of both radiation therapy and medical oncology. Located adjacent to the hospital and within the Ambulatory Center, the center will create a one-stop center for cancer care, providing infusion and radiation therapy, education, and physician visits. The center will have convenient access to the hospital's pharmacy, surgery, and imaging services.

Ancillary & Support

The ancillary and support functions such as laboratory, pharmacy, materials management, food services, and plant operations are located in a level below the D&T floor. Logistics of transport and supplies can access the facility through the lower level,

and with the ease of movement below (without interfering with patient flow) materials and staff can circulate to dedicated service elevators, to “back of the house” zones on clinical areas. Loading docks are located behind the logistic platform.

Public Lobby

A ground level concourse will provide access to the various programs with the hospital and ambulatory center. Patients can conveniently access registration, education, and diagnostic testing in cardiology, neurology, and lab draws. A conference center is planned for in-house and public meetings that include an auditorium, classrooms, library, and simulation labs.

FTEs/Unit Volume

PGHC has built efficiency into its projections. Table 20 shows representative measures of Nursing FTEs/inpatient day for the nursing units, consistent with Tables 1 (for patient days) and 5 (for FTEs). All of the measures show declines in FTEs/unit volume, except for Pediatrics. Pediatric nurses will also care for observation and ED patients. Consequently, using patient days as the denominator can be misleading. PGHC anticipates that the integrated Pediatric Inpatient/Observation/ED unit will also be more efficient.

Table 20
Representative Measures of Existing and Proposed FTEs/Unit Volume
Nursing
2014 and 2021

Medical Surgical Floor Nurses	Pt. Days 2014	FTEs 2014	FTE/ADC	Pt. Days 2021	FTEs 2021	FTE/ADC	Comments
120611000 NURSING E 900 (MS-TELE/ON		41.19			43.48		
120612000 NURSING E 700 (MS-TELE)		39.30			41.48		
120612500 NURSING E-800 (MS-ORTHO/T		44.71			47.20		
120624000 NURSING K400 - PCRU		87.29			92.15		
Total	30,727	212.50	2.52	37,693	224.32	2.17	

Medical Surgical Floor Nurses	Pt. Days 2014	FTEs 2014	FTE/ADC	Pt. Days 2021	FTEs 2021	FTE/ADC	Comments
ICU/CCU Floor Nurses							
120660000 NURSING - CCU	2,650	20.50		3,251	21.64		
120663000 NURSING - ICU/CCC	8,396	86.50		10,299	91.31		
Total	11,046	107.00	3.54	13,550	112.95	3.04	
120640000 NURSING E 600 PEDIATRICS	180	10.20	20.68	124	10.77	31.76	Note: Nurses will also Care for Observa-tion and Pediatric ED
120651000 NURSING K 200 - ANTE/POST	5,863	45.90	2.86	6,025	42.40	2.57	
120666000 NURSING - PSYCH	6,991	33.70	1.76	8,139	35.57	1.60	
ED	**ED Visits 2014**	**FTEs 2014**	**FTE/Visit**	**ED Visits 2021**	**FTEs 2021**	**FTE/Visit**	
Total - Emergency Services	51,377	105.80	0.75	61,014	111.69	0.67	
Same Day Surgery	**Cases 2013**	**FTEs 2014**	**FTE/Case**	**Cases 2021**	**FTEs 2021**	**FTE/Case**	
120706000 SAME DAY SURGERY	2,063	8.10	1.43	2,608	8.55	1.20	
Med/Surg and Pediatrics	30,907	223	2.63	37,817	235	2.27	

Standard .04B(12) – <u>Patient Safety.</u>

The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety. A hospital proposing to replace or expand its physical plant shall provide an analysis of patient safety features included for each facility or service being replaced or expanded, and document the manner in which the planning and design of the project took patient safety into account.

PATIENT SAFETY

Research has shown that the most common and costly errors include:

- Communication Errors
- Hospital Acquired Infections
- Patient Falls
- Medication Errors
- Transfers and Hand-offs

Fortunately, the majority of Medical Errors are preventable with proper design.

COMMUNICATION ERRORS

Communication failures have been identified as the leading cause of medication errors, delays in treatment, and wrong-site surgeries (Source: Joint Commission on Accreditation of Health Organizations). Communication Errors will be minimized in the proposed design as a result of the following:

- The proposed Nursing Unit design is based on Multi-Acuity Universal Care Patient rooms so that the patient is moved as infrequently as possible.
- The plan utilizes multi-disciplinary work spaces and visual connections among staff work areas to promote regular communication and discussion.
- Lean Operational planning has been integrated into the Diagnostic & Treatment platform and Universal Care Unit to reduce the number of patient transfers.

HOSPITAL ACQUIRED INFECTIONS

The prevalence of Hospital Acquired Infections increases with the duration of hospitalization, and more than 1/3 of all nosocomial infections involve airborne transmissions, which are associated with Staph, Tuberculosis, Legionella, SARS, Clostridium Baumenei and Immuno-compromised Patients, as well as a variety of less virulent pathogens. Hospital Acquired Infections will be reduced in the proposed design as a result of the following:

- Readily accessible positioning of sinks and hand disinfectants.
- Use of inherently Antimicrobial surfaces.
- Use of copper surfaces where appropriate (studies have shown a 41% reduction in infections with copper surfaces).
- Utilizing 100% fresh air systems can successfully reduce airborne infections to near zero

PATIENT FALLS

Studies have shown that 40% of patient falls are toilet related, and another 41% of all falls occur during transitions from beds to chairs. 28% of all falls are from the

patient bed, and 10% fall from a chair, and 9% fall from the toilet or commode. 30% of all falls lead to patient injury, with 1-5% of the falls resulting in a serious injury. Patient falls in the Patient Room will be reduced as a result of the following design features:

- The Nursing Unit configuration provides decentralized nursing and clear lines of sight into patient rooms.
- The Patient Room Toilet is placed closest to the patient.
- The Patient has continuous access to a grab bar from bed to toilet.
- Maximum glazing at the Patient Room Entry door and side panel increases visualization of the patient by staff.

Refer to Figure 11: Patient Room and Figure 12: Sensor Lighted Patient Grab Bar

Figure 11
PATIENT ROOM

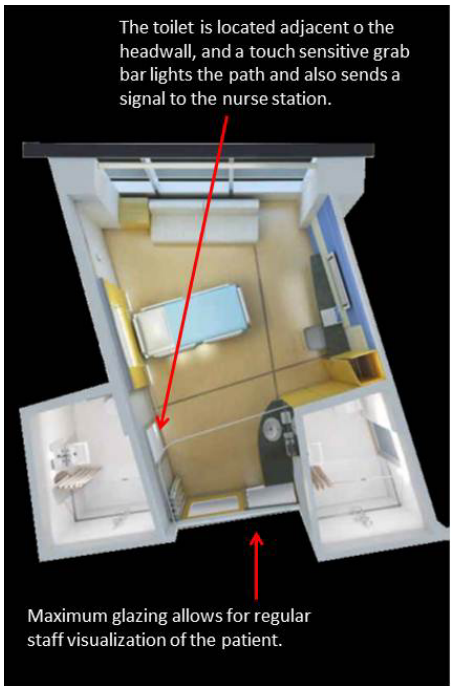


Figure 12
SENSOR LIGHTED PATIENT GRAB BAR

HOK's Research Group recently completed a study at Miriam Hospital of the Impact of Nursing Unit and Patient Unit Design to Staff and Patients for their Nursing Unit which has very similar Patient Safety design features. The findings of that study reinforced the principles that will be applied to the new Prince George's Regional Medical Center:

Bathroom Location and Design

- Easier bathroom transfers related to fewer falls.

Patient Room Design

- Patients on same-handed units reported lower noise levels and improved sleep quality.
- Patients in rooms with canted walls reported the positive distraction of looking out the window to the outdoors more than other patients
- Patients and families rated the overall room experience significantly more positively than in the control nursing unit.

Bedside Documentation

- Just a small increase in the charting at bedside was related to a 10% decrease in patient falls

Nursing Unit Design

- There was a 39% reduction in the number of trips between the patient room and the nurse station.
    - 25% reduction in the time spent gathering supplies
    - 12% reduction due to the ability to do data entry in the patient room
- There was a 70% reduction in the number of trips between the patient room and the central medications room due to the medication location at the nurse server outside each patient room.

MEDICATION ERRORS

Research has shown that Adverse Drug Events complicated 2.43% of admissions. The extra length of hospital stay attributable to an Adverse Drug Event was 1.74 days. The use of CPOE and EMAR Technology will reduce the medication errors:

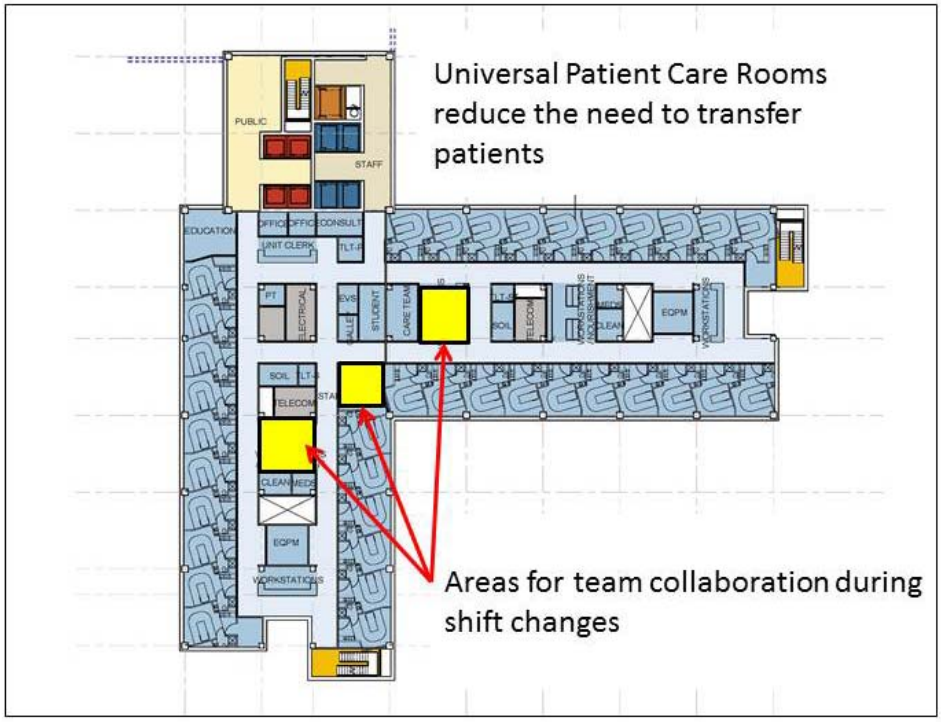
- Eliminates confusion among drug names that sound alike
- Prompts for drug interaction, allergy, or overdose
- Associated with a 55% reduction in prescribing errors

TRANSFERS AND HAND-OFFS

About 80% of serious medical errors result from miscommunication when a patient is transferred from one caregiver to another. Dangerous errors and oversights can occur in the gap when a patient is moved to another unit or turned over to a new nurse or doctor during a shift change. The solution proposed at PGRMC follows:

- The Nursing Units are designed with Acuity Adaptable Rooms to minimize transfers
- Flexible multidisciplinary work spaces provide areas for team collaboration during shift changes

Figure 13
NURSING UNIT DESIGN



Standard .04B(13) – <u>Financial Feasibility.</u>

A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.

(a) Financial projections filed as part of a hospital Certificate of Need application must be accompanied by a statement containing each assumption used to develop the projections.

(b) Each applicant must document that:

(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;

(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the

applicant hospital or, if a new hospital, the recent experience of other similar hospitals;

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or, if a new hospital, the recent experience of other similar hospitals; and

(iv) The hospital will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations, with the exception that a hospital may receive a Certificate of Need for a project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project when the hospital can demonstrate that overall hospital financial performance will be positive and that the services will benefit the hospital's primary service area population.

As presented in Part III of this application, the proposed project is projected to be financially feasible. The financial feasibility of PGHC's project is based on the following assumptions:

(a) Utilization projections that are consistent with observed historic trends (Part III COMAR 10.24.01.08G(3)(b) – Table 1)

(b) Revenue estimates that are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by PGHC (Part III COMAR 10.24.01.08G(3)(d) – Table 3)

(c) Staffing and overall expense projections that are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated

future staffing levels as experienced by PGHC (Part III COMAR 10.24.01.08G(3)(f) – Table 5)

(d) Depreciation, interest, and other operating costs associated with the new building and renovated space (Part III COMAR 10.24.01.08G(3)(d) – Table 3)

Based on these assumptions, PGHC is projected to experience a positive Excess of Revenue over Expense in the first year of operations.

As Table 3 shows, PGHC will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved by 2021.

Standard .04B(14) – <u>Emergency Department Treatment Capacity and Space.</u>

> **(a) An applicant proposing a new or expanded emergency department shall classify service as low range or high range based on the parameters in the most recent edition of *Department Design: A Practical Guide to Planning for the Future* from the American College of Emergency Physicians. The number of emergency department treatment spaces and the departmental space proposed by the applicant shall be consistent with the range set forth in the most recent edition of the American College of Emergency Physicians *Emergency Department Design: A Practical Guide to Planning for the Future*, given the classification of the emergency department as low or high range and the projected emergency department visit volume.**
>
> **(b) In developing projections of emergency department visit volume, the applicant shall consider, at a minimum:**
>
> **(i) The existing and projected primary service areas of the hospital, historic trends in emergency department utilization at the hospital, and the number of hospital emergency department service providers in the applicant hospital's primary service areas;**

(ii) The number of uninsured, underinsured, indigent, and otherwise underserved patients in the applicant's primary service area and the impact of these patient groups on emergency department use;

(iii) Any demographic or health service utilization data and/or analyses that support the need for the proposed project;

(iv) The impact of efforts the applicant has made or will make to divert non-emergency cases from its emergency department to more appropriate primary care or urgent care settings; and

(v) Any other relevant information on the unmet need for emergency department or urgent care services in the service area.

PGHC is seeking an expansion from 48 to 53 treatment bays, as shown below. There will be 48 adult treatment areas and 5 pediatric treatment areas.

	Adult		Pediatric	
	Existing	**Proposed**	**Existing**	**Proposed**
General	19	20		5
Fast Track	10	13		
GYN (in Fast Track #)	0			
Resuscitation	4	4		
Trauma	2	4		
Psych	5 (1 Seclusion)	6 (1 Seclusion)		
Rapid Diagnostic and other Triage	3			
Ambulance Staging	4			
Sexual Assault	1	1		
Total	48	48		5
Triage	2	2		

The trauma area will also include one procedure room, which is similar to the procedure rooms in the OR and is not considered a treatment area.

The current ED is inefficiently designed. In fact, some of the existing general treatment bays are actually portions of a hallway that have been subdivided into treatment areas.

Prince George's County has the highest number of uninsured residents of all of the Maryland jurisdictions.

Table 21
Uninsured Residents by Jurisdiction
2013

Jurisdiction	Number	Percent of Population
Prince George's	117,467	21%
Montgomery	100,200	16%
Baltimore City	77,910	19%
Baltimore	71,967	14%
Anne Arundel	41,102	12%
Howard	18,964	10%
Harford	17,215	11%
Frederick	16,930	12%
Washington	13,050	15%
Wicomico	11,287	19%
Charles	11,198	12%
Carroll	10,898	11%
Cecil	8,328	13%
St. Mary's	7,870	12%
Allegany	6,367	15%
Calvert	5,864	11%
Worcester	5,102	17%
Caroline	4,050	20%
Queen Anne's	3,742	13%
Talbot	3,557	17%
Garrett	3,458	19%
Dorchester	3,294	17%
Somerset	2,398	18%
Kent	1,980	18%

Source: County Health Rankings & Roadmaps;
http://www.countyhealthrankings.org/app/maryland/2013/measure/additional/3/data/sort-0;
Accessed 9/12/2013

In addition, Prince George's County has the second highest number of Medicaid eligible residents of any Maryland jurisdiction.

Table 22
Medicaid Eligible Residents by Jurisdiction
September 2013

COUNTY	13-Sep
Baltimore City	238,500
Prince George's	166,601
Baltimore County	139,813
Montgomery	130,011
Anne Arundel	66,814
Washington	32,713
Harford	31,431
Howard	28,811
Frederick	28,700
Wicomico	26,327
Charles	22,145
Cecil	20,437
Allegany	17,868
St. Mary's	17,372
Carroll	16,992
Calvert	11,501
Dorchester	10,288
Worcester	9,952
Caroline	9,356
Queen Anne's	7,348
Garrett	7,111
Somerset	7,046
Talbot	6,434
Kent	3,941
Out of State	834
TOTALS	1,058,346

Source: http://www.chpdm-ehealth.org/eligibility/new/index.cfm

The impact of these populations on ED utilization is well documented. PGHC has made great efforts to decrease unnecessary ED visits. For example, PGHC

annually spends approximately $15 million in physician subsidy payments to attract and retain physicians to care for the low income and indigent populations in Prince George's County.

The Emergency Department (ED) has established an inter-disciplinary team that consists of physicians, ED nurse leadership, staff nurses, and the ED Case Manager. Outpatient care plans have been created for ED frequent visit patients. These patients are identified via PICIS (EMR data base). A report is generated in PICIS that lists all patients that have more than 5 visits to the ED since the implementation of PICIS in January 2013.

The care plans are created for each patient based on their most frequent complaint. Each care plan also consists of the patient's medical history, allergies, home medications and Primary Care Physician (PCP) if applicable. Each patient is given a medical screening exam regardless of the complaint. All acute issues are addressed. The most recent labs and diagnostic reports are recorded (if current they are not repeated unless medically indicated). The discharge plan includes referrals to various outpatient facilities including: Their PCP, Medical Mall, Glenridge Clinic, and the Health Department (and also others as appropriate). The ED Medical Director signs the care plan. Each patient is given a copy of the care plan and asked to sign indicating that they have been given a copy of the plan and have an understanding of the plan. When the patient presents to the ED again, the ED Case Manager or a member of the inter-disciplinary team will review the plan with the patient. The team meets every two months to re-evaluate the care plans, return patient visits and make changes to the plan based on the most recent visit data.

Medical Mall Services of Maryland provides community-based care coordination services for patients admitted to Prince George's Hospital Center. These services act as an extension of the hospital case management department. The goal of the program is to improve health outcomes and reduce unnecessary readmissions. Prince George's Hospital Center was the first hospital in the region to participate in this innovative effort to help reduce hospital readmissions for patients in the region. This ongoing project was initiated by the Delmarva Foundation -- the Centers for Medicare & Medicaid Services (CMS) quality improvement organization (QIO) for the State of Maryland. Through the work of the Delmarva Foundation and Medical Mall Health Services, the program has reduced overall readmission by 20%. Medical Mall incorporates continuous quality improvement metrics into the program and reports the outcomes to the Delmarva Foundation and to CMS.

Medical Mall calls the program "Health Connect" and it has now been expanded to include other high-risk groups to include the behavioral health population and persons with HIV/AIDS. The Health Connect program uses a modified Coleman model of service delivery to reduce readmissions. The Care Transitions model, developed by Eric Coleman, MD, MPH, is an Agency for Healthcare Research and Quality (AHRQ) evidence-based intervention designed to reduce healthcare costs and readmissions. The intervention is a 4-week intervention that begins prior to the patient's discharge from the hospital. An advanced practice nurse and community health worker provides a detailed assessment 48 hours prior to discharge. The inpatient assessment includes a medication reconciliation, assessment of the home care environment, and analysis of their ability to self-manage their disease, review of family history of disease, completion

of a personal health record, and a review of their discharge disease management plan. After discharge, the Health Connect team makes a second contact with the patient within 72 hours of discharge. This second contact is made by the community health worker and is used to assess if the disease management plan is being adhered to post discharge.

The multi-disciplinary team led by a Nurse Practitioner addresses any problems identified. The pre and post assessment is submitted back to the primary admitting physician for the patient as a formal report for the patient medical record. The next milestone of the intervention is at day 7. Each patient is required to have a primary care visit at day 7. The day 7 primary care visit is used to continue to assess the patient's ability to maintain their disease management plan, review the effect of medication adjustments that may have occurred, review patient compliance, and to address any problems in disease management. Next, patient contact is made by phone or in person at week 3 and at week 4. Each patient contact is summarized and reported to the admitting physician to maintain continuity of care. Lastly, each patient with a chronic disease is connected to a health house near their community where they receive disease self-management education along with other members of their community in a setting and time that is most convenient to the patient. The disease self-management education is provided under the supervision of the multi-disciplinary team and taught by trained lay leaders from the community. The Health Connect program's key feature is the integration of community health workers in the multi-disciplinary team in an effort to provide peer led education to assist the patient with meeting the disease self-management goals set forth by their physician.

PGHC's ED volume grew 13.1% from FY 2007 through FY 2013, growing from 45,068 visits in 2007 to 50,962 visits in 2013. (50,962/45,068 = 1.131) The historical volumes are shown in Table 23.

Table 23
Historical ED Volume
PGHC
2007 – 2010

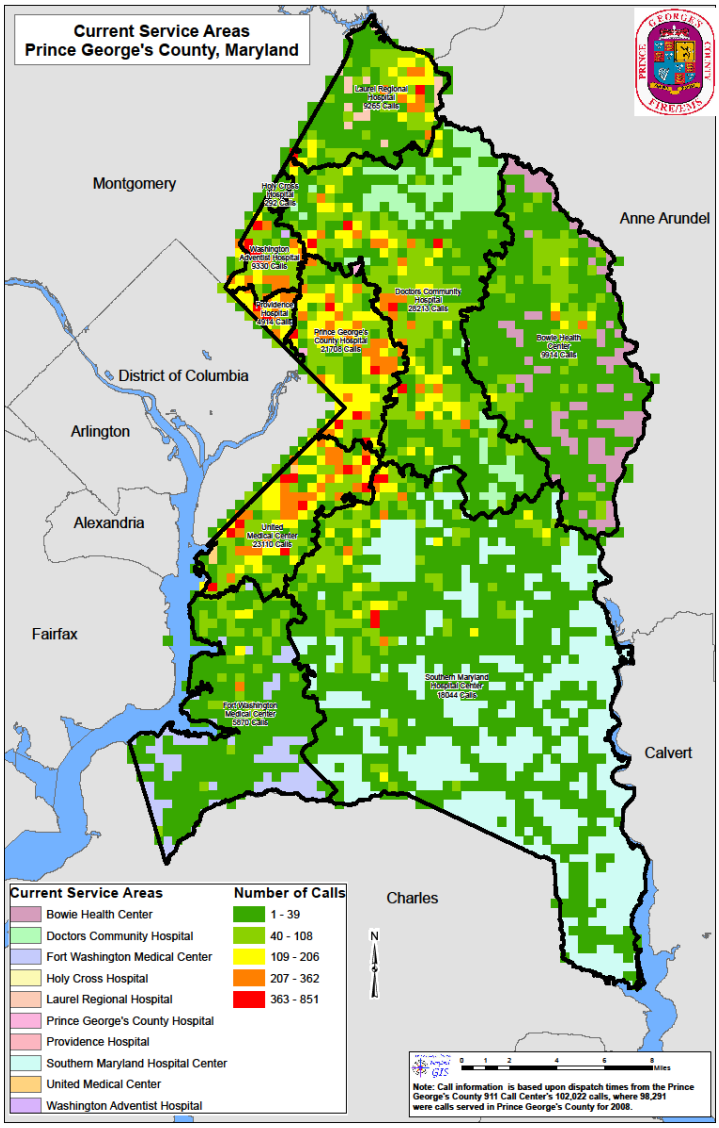
Year	Total Visits
2007	45,086
2008	42,844
2009	45,561
2010	48,145
2011	49,100
2012	52,506
2013	50,962

Source: PGHC

PGHC anticipates that the ED volume will continue to grow. PGHC is the second most active trauma center in the State, attracting ED visits from all over the County. PGHC sees no reason for this to change at the new site.

PGHC has consulted with the Prince George's County Fire/EMS Department to determine the impact of the relocation to Largo on EMS transports to the hospital. According to the EMS Department, the number of transport calls in the new catchment area will be significantly greater than in PGHC's existing catchment Area. Figure 14 shows the catchment areas for each of the Emergency Departments in Prince George's County and the number of transport calls in each catchment area in 2012.

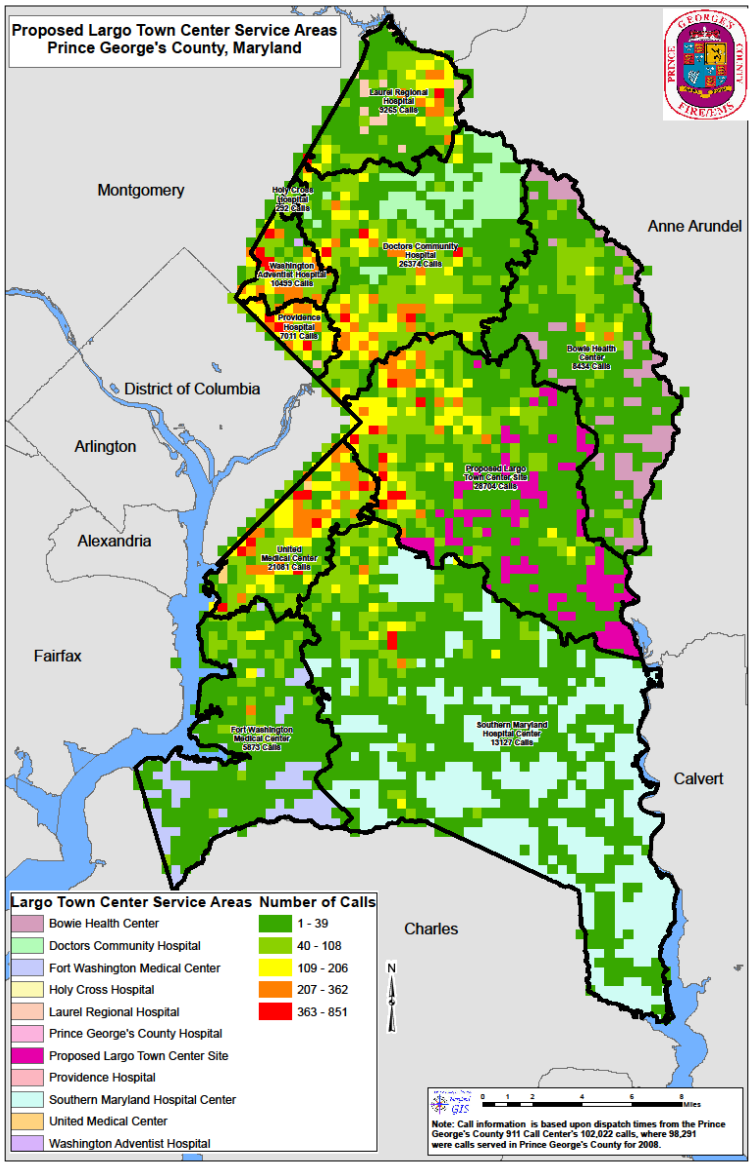
Figure 14
Existing EMS Catchment Areas



This map shows that there were 21,900 calls from PGHC's catchment area in 2012. The EMS Department anticipates this to change when PGHC moves to Largo. Figure 15 shows the revised catchment areas resulting from the relocation of PGHC to Largo. It shows that the number of transport calls in the PGHC/Largo catchment area would have been 28,702 in 2012. According to the EMS Department, two thirds of transport calls result in actual transports. Further, while the hospital to which patients

are transported may be affected by patient preference, the EMS Department has advised PGHC to assume that nearly all of the transports in PGHC's catchment area do and will go to PGHC. This means that the existing catchment area resulted in 14,601 transports to PGHC in 2012 and would have resulted in 19,136 transports if PGHC was already located in Largo.

Figure 15
Resultant EMS Catchment Areas



Because PGHC does not anticipate that its service area for non-transport ED visits will change, PGHC assumed that its non-transport ED visits would be affected by population growth.[5] Of course, the estimated 19,136 transport visits in the EMS Largo catchment area would also change as the population in the EMS defined catchment area changes. Including these factors, PGHC projects that it will see 61,014 ED visits in 2021, as demonstrated below.

Total Population, 2012	1,086,341
ED Visits, 2012	52,309
Transport Calls, 2012	21,900
Call to Transport Conversion	0.6667
Estimated Transports, 2012	14,601
Non-Transport Visits	37,708
Use Rate of Non-Transport Visits/Population	0.0347
Total Population, 2021	1,167,647
Non-Transport Visits 2021	40,531
Transport Calls, Largo Catchment Area 2012	28,702
Call to Transport Conversion	0.6667
2012 Transports from Largo Catchment Area	19,136
2012 Pop of Largo EMS Catchment Area	268,663
2021 Pop of Largo EMS Catchment Area	287,588
Pop Ratio 2021/2013	1.07
Projected Transports	20,484
Total Projected Visits	61,014

The proposed ED's size is near the bottom of the range of the departmental gross square feet ("DGSF") benchmark in the American College of Emergency Physicians ("ACEP") Guide entitled *Emergency Department Design*. On pages 69-71, the Guide presents, in chart form, the factors that should be considered in planning the size of the ED. The information on the proposed PGRMC is presented below. The ACEP Guidelines use "Low Range" and "High Range" thresholds for certain measures

5 PGHC used 2012 as its base year in order to calculate a non-transport use rate using the 2012 transport data.

to determine the appropriate size for an ED. Criteria 1-11 in Table 24 show the factors that go into determining if an ED should be planned larger or smaller. If the facts for any given hospital under the criteria fall in the "Low Range" category, the ED could be smaller than if the majority falls in the "High Range" Category. Criteria 12 and 13 show the number of DGSF and the number of treatment bays that would be required in both the high and low range categories at various projected ED volumes.

Table 24 shows, based on the ACEP Guide, an ED at PGHC's projected volumes would require between 30,133 and 40,492 DGSF. PGHC's ED will be 31,900 DGSF in size, and this includes 3,000 square feet for radiology. If the radiology space was not included, PGHC's ED and Trauma area would be below the low end of ACEP Guide's suggested range of DGSF at PGHC's projected volumes. Therefore, PGHC believes that it is proposing a design that is efficient and not too large.

Table 24
American College of Emergency Physicians ("ACEP") Guide
Emergency Department Design
"Low Range" and "High Range" Thresholds
and PGHC Comparison
Emergency Department

		Low	High	Existing Hospital	Proposed Hospital
1	ALOS	<2.5 Hours	>3.5 Hours	4.4	3.1
2	Location of Observation Beds	Outside ED	Inside ED	Outside	Outside
3	Time to Admit	<60 Minutes	> 90 Minutes	258	90
4	Turnaround Time Dx Tests	<31 Minutes	> 60 Minutes	Lab - 349 Rad - 318	60
5	% Admitted Patients	< 18%	> 23%	18.00%	18.00%
6	% Nonurgent/%Urgent	>1.1/1	>1/1.1	1/1.4	**1/1.4**
7	Age of Patient	<20% Age 65+	>25% Age 65+	8.9%	*13%*
8	Admin/Teaching Space	Minimal	Extensive	Extensive	**Extensive**
9	Imaging w/n ED	No	Yes	No	**Yes**
10	Specialty Components	No	Yes	Yes	**Yes**
11	Flight/Trauma Services	No	Yes	Yes	**Yes**

		Low	High	Existing Hospital	Proposed Hospital
	Projected DGSF			**21,220**	**29,400**
	Projected Annual Visits			52,500	61,014
12	DGSF 60,000 Visits	29,750	39,950		
	DGSF 70,000 Visits	33,000	44,550		
	DGSF Calculated at PGHC Volumes	**30,080**	**40,416**		
13	Treatment Bays 60,000 Visits	35	47		
	Treatment Bays 70,000 Visits	40	54		
	Treatment Bays Calculated at Projected Volumes	**36**	**48**		
	Proposed Number of Treatment Bays				**53**

PGHC recognizes that it is asking for more ED bays than the Guide suggests it would need at PGHC's projected volumes. However, PGHC is proposing to have those bays in a footprint that is at the bottom of the range of the Commission's benchmark for size. The Commission should provide flexibility to PGHC in the way it proposes to use its efficient footprint.

In two approved CON applications of which PGHC is aware [Montgomery General Hospital (Docket # 06-16-21860) and University of Maryland Medical Center (Docket No. 09-24-2300)], applicants have proposed more treatment bays than indicated by the ACEP Guidelines in less square footage than indicated by the Guidelines. The Commission approved both CON applications and provided them with flexibility in the way they used their efficient footprints, as PGHC requests here.

Standard .04B(15) – <u>Emergency Department Expansion.</u>

> **A hospital proposing expansion of emergency department treatment capacity shall demonstrate that it has made appropriate efforts, consistent with federal and state law, to maximize effective use of existing capacity for emergent medical needs and has appropriately integrated emergency department planning with planning for bed capacity, and diagnostic and treatment service capacity. At a minimum:**

(a) The applicant hospital must demonstrate that, in cooperation with its medical staff, it has attempted to reduce use of its emergency department for non-emergency medical care. This demonstration shall, at a minimum, address the feasibility of reducing or redirecting patients with non-emergent illnesses, injuries, and conditions, to lower cost alternative facilities or programs;

(b) The applicant hospital must demonstrate that it has effectively managed its existing emergency department treatment capacity to maximize use; and

(c) The applicant hospital must demonstrate that it has considered the need for bed and other facility and system capacity that will be affected by greater volumes of emergency department patients.

Please see the response to Standard .04B(14) – Emergency Department Treatment Capacity and Space.

PGHC has taken several steps to make its ED more efficient and to improve waiting times. While in 2012, the median time from ED arrival to ED departure for admitted patients was 495 minutes, the year to date median waiting time is 264 minutes, representing significant improvement. PGHC has incorporated an extra provider during high volume hours. PGHC has also instituted a quick triage process instituted which involves a brief initial evaluation to get patients to the appropriate area ASAP. The time between the decision to admit a patient from the ED to the moment the patient actually leaves the ED has improved from 270 minutes to 209 minutes. This was accomplished by using extra provider during high volume hours, revamping stock medications, and using expedited orders.

Standard .04B(16) – <u>Shell Space.</u>

(a) Unfinished hospital shell space for which there is no immediate need or use shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective.

(b) If the proposed shell space is not supporting finished building space being constructed above the shell space, the applicant shall provide an analysis demonstrating that constructing the space in the proposed time frame has a positive net present value that:

(i) Considers the most likely use identified by the hospital for the unfinished space;

(ii) Considers the time frame projected for finishing the space; and

(iii) Demonstrates that the hospital is likely to need the space for the most likely identified use in the projected time frame.

(c) Shell space being constructed on lower floors of a building addition that supports finished building space on upper floors does not require a net present value analysis. Applicants shall provide information on the cost, the most likely uses, and the likely time frame for using such shell space.

(d) The cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the construction cost of the shell space will be excluded from consideration in any rate adjustment by the Health Services Cost Review Commission.

There is no shell space built into this project.

COMAR 10.24.12 - OB SERVICES CHAPTER

<u>.04 Review Standards</u>

(1) Need. All applicants must quantify the need for the number of beds to be assigned to the obstetric service, consistent with the approach outlined in Policy 4.1. Applicants for a new perinatal service must address Policy 4.1.

To project the number of admissions that it should expect in the new service area, PGHC utilized the methodology outlined in Commissioner Barbara McLean's proposed

decision on the CON application for the relocation of Washington Adventist Hospital (Docket No. 09-15-2295) (see Proposed Decision, Pp. 157-162). In this case, the service area for Prince George's Hospital Center (PGHC) is shifting from one based on its current location in Cheverly, MD to its new location based in Largo, MD.

As explained above, PGHC split the historical inpatient discharge data into five cohorts – MSGA (15-64), MSGA (65+), Obstetrics (OB), Pediatrics (PED), and Psychology (PSY). To determine the Zip Code areas to include in the expected 85% service area for the Largo site, Dimensions used drive times generated by Spatial Insights from Zip Codes in Prince George's County, and selected surrounding Zip Codes to each Maryland, District of Columbia, and Virginia hospital.

The Maryland Zip Codes were then sorted by proximity to PGHC's current location and the 2012 discharges were summed until they equaled 85% of PGHC's total 2012 discharges. This was done for each cohort individually. For OB, this occurred with the Zip Codes for which PGHC was the fourth closest hospital and these Zip Codes accounted for 91.1% of PGHC's 2012 OB discharges. In determining the closest hospital for OB, PGHC was compared only to those hospitals offering OB services. These definitions or rankings were then applied to Zip Codes surrounding the future Largo site for PGRMC, the relocated PGHC. Zip Codes for which PGRMC would be the fourth most proximate hospital or closer hospital for OB beds were identified. This was determined by ranking the proximity of all hospitals excluding the existing PGHC.

Change in market share due to relocation

For each of the Zip Codes in PGRMC projected service area, the expected market share at PGRMC was based on PGHC's average market share for Zip Codes of a comparable proximity. Using 2012 data, Dimensions calculated the average market share for all of the Zip Codes where PGHC was the closest hospital. Dimensions then applied this average market share to all Zip Codes where PGRMC would be the closest hospital, as it did in projecting MSGA bed need.

Impact of changes in population and use rates

The change in PGHC's service area to PGRMC's service area results in a 16.5% reduction in the total service area population. Based on PGRMC's future service area, population growth assumptions through 2021 were obtained from Claritas at the five cohort levels (MSGA 15-64, MSGA 65+, OB, PED, PSY). For OB, PGHC used the population of women age 15-45. PGHC calculated that the use rate for OB admissions was 62.59 per 1,000 women age 15-44. PGHC reduced this use rate by 2% to 61.33/1,000 in 2013 and did not adjust the use rate further for future years. Table 25 shows the new hospital's projected primary and secondary service areas for Obstetrics, the ranking of the Largo site's proximity, and the projected number of admissions. In 2012, PGHC had a 16.9% market share in the service area in OB. This is projected to decline to 16.6% in 2021, solely as a result of population and use rate changes and the relocation impact resulting from the MHCC methodology. PGHC anticipates 234 additional patients as a result of recapture (a 2.4% market share impact) due to having new facilities.

Table 25
Zip Codes in the PGRMC at Largo Service Area
Hospital Ranking
Projected Admissions
Obstetrics
2021

Zip Code	Drive-Time Ranking	Projected Discharges	% of Total	Cumulative %
20785	1	161	7.1%	7.1%
20706	1	155	6.8%	13.9%
20743	1	151	6.6%	20.5%
20747	1	130	5.7%	26.2%
20784	1	124	5.5%	31.7%
20774	1	115	5.0%	36.7%
20770	1	107	4.7%	41.5%
20721	1	69	3.0%	44.5%
20720	1	62	2.7%	47.2%
20716	1	60	2.7%	49.9%
20715	1	58	2.5%	52.4%
20769	1	19	0.8%	53.3%
20703	1	2	0.1%	53.3%
20773	1	1	0.1%	53.4%
20775	1	1	0.0%	53.4%
20768	1	1	0.0%	53.4%
20791	1	0	0.0%	53.4%
20717	1	0	0.0%	53.5%
20792	1	0	0.0%	53.5%
20771	1	0	0.0%	53.5%
20753	1	0	0.0%	53.5%
20731	1	0	0.0%	53.5%
20752	1	0	0.0%	53.5%
20797	1	0	0.0%	53.5%
20799	1	0	0.0%	53.5%
20718	1	0	0.0%	53.5%
20748	2	47	2.1%	55.6%
20746	2	47	2.1%	57.6%
20772	2	42	1.8%	59.5%
20602	2	41	1.8%	61.3%
20735	2	39	1.7%	63.0%
20708	2	38	1.7%	64.6%
20653	2	33	1.5%	66.1%

Zip Code	Drive-Time Ranking	Projected Discharges	% of Total	Cumulative %
20603	2	32	1.4%	67.5%
20601	2	28	1.2%	68.7%
20613	2	11	0.5%	69.2%
20762	2	7	0.3%	69.5%
20623	2	2	0.1%	69.6%
20608	2	1	0.0%	69.6%
20719	2	0	0.0%	69.6%
20757	2	0	0.0%	69.7%
20709	2	0	0.0%	69.7%
20737	3	55	2.4%	72.1%
20710	3	23	1.0%	73.1%
20738	3	0	0.0%	73.1%
20744	4	89	3.9%	77.0%
20745	4	71	3.1%	80.1%
20781	4	36	1.6%	81.7%
20607	4	22	0.9%	82.7%
20704	4	1	0.0%	82.7%
20749	4	1	0.0%	82.7%
Total		1,882		

When out of area patients are accounted for, PGHC projects that the new facility will admit 2,275 OB patients in 2021. PGHC applied the 2012 Statewide Average Length of Stay for OB (2.65 days), resulting in 6,028 patient days. PGHC further assumed a 75% occupancy, resulting in the need for 22 beds.

(2) The Maryland Perinatal System Standards. Each applicant shall demonstrate the ability of the proposed obstetric program and nursery to comply with all essential requirements of the most current version of Maryland's Perinatal System Standards, as defined in the perinatal standards, for either a Level I or Level II perinatal center:

PGHC is designated as a Perinatal Referral Center Level IIIB from the Maryland Institute for Emergency Medical Services Systems ("MIEMSS"). PGHC resubmitted its redesignation application in May 2013 with a subsequent on-site survey on June 25, 2013. PGHC received MIEMSS' findings on September 3, 2013. MIEMSS identified five

areas where standards were not met, as shown below. PGHC filed its plan of correction with MIEMSS on September 28, 2013. PHGHC will keep the MHCC updated on MIEMSS' response to the plan of correction.

Standard	Title	Findings
COMAR 30.08.12.03	ORGANIZATION	Standards Met; Areas Identified for Improvement
COMAR 30.08.12.04	OBSTETRICAL UNIT CAPABILITIES	Standards Met
COMAR 30.08.12.05	NURSERY UNIT CAPABILITES	Standards Not Met
COMAR 30.08.12.06	OBSTETRICAL PERSONNEL	Standards Met
COMAR 30.08.12.07	PEDIATRIC PERSONNEL	Standards Met
COMAR 30.08.12.08	OTHER PERSONNEL	Standards Not Met
COMAR 30.08.12.09	LABORATORY	Standards Met
COMAR 30.08.12.10	DIAGNOSTIC IMAGING CAPABILITIES	Standards Met
COMAR 30.08.12.11	EQUIPMENT	Standards Not Met
COMAR 30.08.12.12	MEDICATIONS	Standards Met
COMAR 30.08.12.13	EDUCATION PROGRAMS	Standards Met; Areas Identified for Improvement
COMAR 30.08.12.14	PERFORMANCE IMPROVEMENT	Standards Not Met
COMAR 30.08.12.15	POLICIES AND PROTOCOLS	Standards Not Met

(3) Charity Care Policy. Each hospital shall have a written policy for the provision of charity care for uninsured and under-insured patients to promote access to obstetric services regardless of an individual's ability to pay.

(a) The policy shall include provisions for, at a minimum, the following:

(i) annual notice by a method of dissemination appropriate to the hospital's patient population (for example, radio, television, newspaper);

(ii) posted notices in the. admissions office, business office and emergency areas within the hospital;

(iii) individual notice provided to each person who seeks services in the hospital at the time of community outreach efforts, prenatal services, preadmission, or admission, and

(iv) within two business days following a patient's initial request for charity care services, application for medical assistance, or both, the facility must make a determination of probable eligibility.

(b) Public notice and information regarding a hospital's charity care policy shall be in a format understandable by the target population.

As explained above, the replacement hospital's charity care policy will be consistent with these requirements. Please see Exh. 8.

(4) Medicaid Access. Each applicant shall provide a plan describing how the applicant will assure access to hospital obstetric services for Medical Assistance enrollees, including:

(a) an estimate of the number of Medical Assistance enrollees in its primary service area, and the number of physicians that have or will have admitting privileges to provide obstetric or pediatric services for women and infants who participate in the Medical Assistance program.

PGHC provides care to all individuals, regardless of ability to pay or identity of payor. According to Maryland Department of Health and Mental Hygiene's Maryland Medicaid eHealth Statistics, there were an average of 163,427 Medicaid enrollees in Prince George's County in FY 2013 (http://www.chpdm-ehealth.org/mco/mco-enrollment_action.cfm). The website provides data for each month in the fiscal year. PGHC averaged the monthly data. It is the policy of PGHC to accept a patient for Medicaid obstetric services if the patient is a Maryland resident and has a pending Medicaid application filed.

All of the obstetricians with privileges at PGHC participate in the Medical Assistance Program. There are six employed obstetricians and nine private, privileged obstetricians. There are also two employed maternal fetal medicine physicians. All privileged PGHC obstetricians and maternal fetal medicine physicians accept Medicaid patients per the above guidelines.

(5) Staffing. Each applicant shall provide information on the proposed staffing, associated number and type of FTEs, projected expenses per FTE category and total expenses, for labor and delivery, post partum, nursery services, and other related services, including nurse staffing, non-nurse staffing and physician coverage, at year three and at maximum projected volumes; if applicable, current staffing and expenses should also be included.

Employee Category	2014 Budgeted FTEs		2021 FTEs	Average Salary per FTE (1)	2021 Total Expense
Labor and Delivery					
CLERICAL SPECIALIST	4.3	0.33	4.0	$ 41,067	$ 163,113
NSG ASST DEPT MGR	4.7	0.36	4.3	105,133	456,420
PATIENT CARE TECH	7.1	0.54	6.6	39,017	255,879
REG NURSE, OCFP	1.5	0.11	1.4	100,983	139,916
REGISTERED NURSE	22.0	1.68	20.3	93,561	1,901,272
REGISTERED NURSE II	0.9	0.07	0.8	99,743	82,919
REGISTERED NURSE – L&D EMERGENCY	-	0.00	-	-	-
AGENCY RN	0.9	0.07	0.8	125,143	104,034
Subtotal	41.4	3.16	38.2	81,158	3,103,552
Post Partum					
CLERICAL SPECIALIST	6.3	0.48	5.8	41,067	238,980
NEWBORN HEARING SCREENING TECH	1.0	0.08	0.9	37,567	34,700
NSG ASST DEPT MGR	2.9	0.22	2.7	105,133	281,622
NSG ASST DEPT MGR WE	1.2	0.09	1.1	108,444	120,202
PATIENT CARE TECH	6.3	0.48	5.8	39,017	227,047
REG NURSE, OCFP	1.2	0.09	1.1	100,983	111,933
REGISTERED NURSE	22.1	1.69	20.4	94,229	1,923,552
REGISTERED NURSE II	0.9	0.07	0.8	99,743	82,919
VITAL STATS COORD	2.0	0.15	1.8	48,206	89,055
AGENCY RN	2.0	0.15	1.8	112,629	208,068
Subtotal	45.9	3.50	42.4	78,261	3,318,076
NICU					

Employee Category	2014 Budgeted FTEs		2021 FTEs	Average Salary per FTE (1)	2021 Total Expense
CLERICAL SPECIALIST	4.2	-0.32	3.9	41,067	159,320
EQUIPMENT TECHNICIAN	1.4	-0.11	1.3	31,209	40,359
NSG ASST DEPT MGR	4.1	-0.31	3.8	105,133	398,153
NSG ASST DEPT MGR WE	0.6	-0.05	0.6	108,444	60,101
REG NURSE, OCFP	1.2	-0.09	1.1	117,814	130,588
REGISTERED NURSE	18.2	-1.39	16.8	89,768	1,509,097
REGISTERED NURSE III	3.3	-0.25	3.1	106,025	323,658
AGENCY RN	2.0	-0.15	1.8	125,144	231,188
Subtotal	35.0	-2.67	32.3	88,220	2,852,463
Emergency Labor & Delivery					
REGISTERED NURSE	4.2	-0.32	3.9	72,999	283,197
Subtotal	4.2	-0.32	3.9	72,999	283,197
Total Salaries	**126.5**	**-9.65**	**116.9**	**$ 81,790**	**$ 9,557,288**
Benefits @ 25%					2,389,322
Total Salaries and Benefits					**$11,946,610**

Note (1): Average salary per FTE reflects 2014 budget with no inflation

(6) Physical Plant Design and New Technology. All applicants must describe the features of new construction or renovation that are expected to contribute to improvements in patient safety and/or quality of care, and describe expected benefits.

Please see the response to Standard 10.24.10.04B(12) (Patient Safety) on pages 165-171 of the Application, which is incorporated herein by reference.

(7) Nursery . An applicant for a new perinatal service shall demonstrate that the level of perinatal care, including newborn nursery services, will be consistent with the needs of the applicant's proposed service area.

Inapplicable

(8) Community Benefit Plan. Each applicant proposing to establish a new perinatal service will develop and submit a Community Benefit Plan addressing and quantifying the unmet community needs in obstetric and perinatal care within the applicant's anticipated service area population, This Plan should include an outreach program component, and should provide a detailed description of the manner in which the proposed perinatal service will meet these needs, and the resources required, At a minimum, the Community Benefit Plan must include:

(a) a needs assessment related to obstetric and nursery services for the proposed program's service area population, including a description of the manner in which the proposed perinatal service will satisfy unmet needs identified in the needs assessment,

(b) measurable and time-limited goals and objectives for health status improvements pursuant to which the Plan can be evaluated; and

(c) information on the structure, staffing and funding of the Plan;

(d) documentation of community support and involvement in program planning for the Plan by other agencies, organizations or institutions which win be involved, directly or indirectly, with the Plan;

(e) an implementation scheme for the Community Benefit Plan.

(f) Applicants must commit to implementation of the Community Benefit Plan and continuing commitment to the Plan as a condition of Commission approval, and as an ongoing condition of providing obstetric services.

(g) Applicants must agree to submit an Annual Report to the Commission which will include:

(i) an evaluation of the achievement of the goals and objectives of the Community Benefit Plan; and

(ii) information on staffing levels and the total costs of any programs implemented as part of the Community Benefit Plan.

Inapplicable

(9) Source of Patients. An applicant for a new obstetric service shall demonstrate that the majority of its patients will come from its primary service area.

Inapplicable

(10) Non-metropolitan Jurisdictions. A proposed obstetrics program in non-metropolitan jurisdictions, as defined in the chapter, shall demonstrate that physicians with admitting privileges to provide obstetric services have offices for patient visits within the primary service area of the hospital.

Inapplicable

(11) Designated Bed Capacity. An applicant for a new obstetric service shall designate a number of the beds from within the hospital's licensed acute care beds that will comprise the proposed obstetric program.

Inapplicable

(12) Minimum Volume.

(a) An applicant for a new obstetrics program must be able to demonstrate to the Commission's satisfaction that the proposed program can achieve a minimum volume of 1,000 admissions annually in metropolitan jurisdictions, or 500 cases annually in non-metropolitan jurisdictions, within 36 months of initiation of the program.

(b) As a condition of approval; the applicant shall accept a requirement that it will dose the obstetric program, and its authority to operate will be revoked, if:

(i) it fails to meet the minimum annual volume for any 24 consecutive month period, and

(ii) it fails to provide good cause for its failure to attain the minimum volume, and a feasible corrective action plan for how it will achieve the minimum volume within a two year period.

Inapplicable.

(13) Impact on the Health Care System.

(a) An application for a new perinatal program will he approved only if its likely impact on the volumes of obstetric discharges at any existing

obstetric program, after the three year start-up period, will not exceed 20 percent of an existing program's current or projected volume.

(b) When determining whether to approve an application for an obstetrics program, the Commission will consider whether an existing program's payer mix of obstetrics patients will significantly change as a. result of the proposed program, and the existing program will have to care for a disproportionate share of the indigent obstetrics patients in its service area; and

(c) When determining whether to approve an application for an obstetrics program the Commission will also consider the impact on a hospital with an existing program that has undertaken a capital expenditure project for which it has pledged pursuant to H-G Article § 19·120(k) not to increase rates for that project, so long as the pledge was based, at least in part, on assumptions about obstetric volumes.

(d) The Commission may consider evidence:

(i) from an applicant as to why rules (a) through (e) should not apply to the applicant, or;

(ii) from a very low volume program (fewer than 500 annual obstetric discharges) as to why a lower volume impact should apply.

Inapplicable.

(14) Financial Feasibility. Hospitals applying for a Level I or II perinatal program must clearly demonstrate that the hospital has the financial and non-financial resources necessary to implement the project, and that the average charge per admission for new perinatal programs will be less than the current statewide average charge for Level I and Level II perinatal programs. When determining whether to approve an application for an obstetric program, the Commission will consider the following:

(a) the applicant's projected sources of funds to meet the program s total expenses for the first three years of operation,

(b) the proposed unit rates and/or average charge per case for the perinatal services;

(c) evidence that the perinatal service will be financially feasible at the projected volumes and at the minimum volume standards in this Plan, and

(d) the written opinions or recommendations of the HSCRC.

Inapplicable.

(15) Outreach Program. Each applicant with an existing perinatal service shall document an outreach program for obstetric patients in its service area who may not have adequate prenatal care, and provide hospital services to treat those patients. The program shall address adequate prenatal care, prevention of low birth weight and infant mortality, and shall target the uninsured, under-insured, and indigent patients in the hospital's primary service area, as defined in COMAR 10.24.01.01.B

As a safety-net hospital, PGHC is committed to providing care to individuals who have limited or no access to healthcare due to financial, insurance, and/or health status. This care is provided to target populations, such as women in need of obstetric services, to include prenatal and preventative maternal child care. In order to meet these needs, PGHC collaborates with community partners that serve as referral sources for entry into the hospital and health system which includes Laurel Regional Hospital and Glenridge Medical Center, affiliates of PGHC. In addition to system members, the Prince George's County Health Department, community health centers, local physicians, social services agencies, and other organizations in the county and surrounding area identify women who need prenatal care, prevention of low birth weight and infant mortality, and uninsured, under-insured, and indigent patients. Women who believe they may be pregnant or in need of obstetric services may also refer themselves. PGHC accommodates referrals for obstetric and gynecologic care for underserved women primarily in Prince George's County from any of these sources.

In addition, PGHC offers community health and wellness programs for the community, including:

- Beautiful Beginnings Tour

- Childbirth Preparation Classes
- Free HIV Testing
- Smoking Cessation
- Support Groups: Alcoholics Anonymous, Preemie Parent, Survivors of Rape/Sexual Assault, WomenHeart

These programs are free to all community members. If a woman in need of OB services is identified as needing prenatal care through one of these programs, she may be referred to an appropriate source for care such as the Health Department or other care providers in the community including PGHC.

In 2011, PGHC became a part of a joint initiative with the Pregnancy Aid Centers, Inc. ("PAC") to increase prenatal care for women in need. The PAC is a nonsectarian, non-profit, community-based women's health clinic and social service agency operating in Prince George's County. The initiative was established to address the needs of low income and uninsured high-risk pregnant women residing in Prince George's County. Through this collaboration, Dimensions Healthcare Associates ("DHA"), an affiliate of Dimensions Healthcare System, and PAC expanded existing services offered at PAC to better address the disparity in the infant mortality rate among African-Americans and Latinas by improving prenatal health provided African-American and Latina women and adolescents.

The program offers co-management of patient care by a DHA physician and PAC nurse midwife or nurse practitioner. Management consists of determining a care plan for medically high-risk and low-risk maternity patients including referral to PGHC for delivery and surgical services if necessary. High risk patients may also be referred to the Health Department, or other appropriate care providers in the community for health services.

COMAR 10.24.07 - PSYCHIATRIC SERVICES CHAPTER

The current State Health Plan Overview standards and policies and the current standards of the Overview of Acute Care Section in the State Health Plan shall also apply to the Acute Psychiatric Section. In instances of inconsistency between these standards and the (1983-1988) State Health Plan, these standards supersede. The following specific standards are expressly overridden: OAC 4, OAC 5, OAC 11, and OAC 15, a, b, and c.

Standard AP la. The projected maximum bed need for child, adolescent, and adult acute psychiatric beds is calculated using the Commission's statewide child, adolescent, and adult acute psychiatric bed need projection methodologies specified in this section of the State Health Plan. Applicants for Certificates of Need must state how many child, adolescent, and adult acute psychiatric beds they are applying for in each of the following categories: net acute psychiatric bed need, and/or state hospital conversion bed need.

Inapplicable. PGHC does not provide child and adolescent psychiatry.

Standard AP lb. A Certificate of Need applicant must document that it has complied with any delicensing requirements in the State Health Plan or in the Hospital Capacity Plan before its application will be considered.

Inapplicable. There are no delicensing requirements in the State Health Plan, the hospital capacity plan regulations no longer exist, and there are no existing beds to delicense.

Standard AP lc. The Commission will not docket a Certificate of Need application for the "state hospital conversion bed need" as defined, unless the applicant documents written agreements with the Mental Hygiene Administration. The written agreements between the applicant and the Mental Hygiene Administration will specify:

(i) the applicant's agreement to screen, evaluate, diagnose and treat patients who would otherwise be admitted to state psychiatric hospitals. These patients will include: the uninsured and underinsured, involuntary, Medicaid and Medicare recipients;

(ii) that an equal or greater number of operating beds in state facilities which would have served acute psychiatric patients residing in the jurisdiction of the applicant hospital will be closed

and delicensed, when the beds for the former state patients become operational;

(iii)that all patients seeking admission to the applicant's facility will be admitted to the applicant's facility and not be transferred to the state psychiatric hospital unless the applicant documents that the patient cannot be treated in its facility; and

(iv) that the applicant and the Mental Hygiene (MHA) Administration will be responsible for assuring financial viability of the services, including the payment of bad debt by DHMH as specified in the written agreement between MHA and the applicant.

Inapplicable.

Standard AP 1d. Preference will be given to Certificate of Need applicants applying for the "net adjusted acute psychiatric bed need", as defined, who sign a written agreement with the Mental Hygiene Administration as described in part (i) and (iii) of Standard AP lc.

Inapplicable.

Standard AP 2a. All acute general hospitals with psychiatric units must have written procedures for providing psychiatric emergency inpatient treatment 24 hours a day, 7 days a week with no special limitation for weekends or late night shifts.

PGHC has written procedures for providing psychiatric emergency inpatient treatment 24 hours a day, 7 days a week, with no special limitation for weekends or late night shifts. The replacement facility will have similar procedures as well.

As part of a hospital that will be operating 24/7, the adult acute inpatient psychiatric unit has appropriate staffing at all times. A licensed psychiatrist and a licensed psychiatric crisis clinician are on call at all times, 24/7, as will be the case for other medical and surgical specialties.

<u>Standard AP 2b.</u> Any acute general hospital containing an identifiable psychiatric unit must be an emergency facility, designated by the Department of Health and Mental Hygiene to perform evaluations of persons believed to have a mental disorder and brought in on emergency petition.

The Emergency Department at PGHC is designated by the Director of the Department of Health and Mental Hygiene to perform evaluations of persons believed to have a mental disorder and brought in on emergency petition. PGHC expects that the ED at the replacement facility will serve this function as well.

PGHC Behavioral Health Services, Assessment and Stabilization Center is a comprehensive, hospital based psychiatric service separate from the Hospital's main ED. After psychiatric patients are medically cleared in the main ED, they are transferred to the Assessment and Stabilization Center to obtain the clinical assessment, evaluation, medical activities and interventions necessary to stabilize their psychiatric or co-occurring psychiatric and substance use. Resolution of conditions or behaviors are the criteria used for discharge readiness and/or transfer to an inpatient unit to ensure patient's clinical management and resolution of the specific behaviors or conditions that precipitated hospitalization. Included within the Assessment and Stabilization Center (ASC) are 23 Hour Observation Beds.

ASC operates 24/7 with appropriate staffing at all time. Registered Nurses, Crisis Counselors are on site 24/7 and licensed psychiatrists are on site and on-call at all times, as well as other medical and surgical specialist. The replacement facility will continue this service.

<u>Standard AP 2c.</u> Acute general hospitals with psychiatric units must have emergency holding bed capabilities and a seclusion room.

While PGHC attempts to avoid using seclusion, there are two "seclusion rooms" on the unit which are generally used for other purposes. PGHC meets this standard. The replacement facility also will include one seclusion room and will meet the standard.

<u>Standard AP 3a.</u> Inpatient acute psychiatric programs must provide an array of services. At a minimum, these specialized services must include: chemotherapy, individual psychotherapy, group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies.

The inpatient acute psychiatric program at PGRMC will include an array of services, including individual psychotherapy, group therapy, family meetings and education, social services, and Art Therapy and Addiction Counseling. When promoting these services, PGRMC will have access to models from other inpatient adult psychiatric programs, as well as other best practices in the mental health field. The new hospital will not have a child or adolescent inpatient unit.

The full range of psychological therapies will be provided by staff dedicated to the unit, to include licensed therapists, psychiatry nurses, and other staff specially trained in providing care to psychiatric inpatients. Additional treatment, such as Physical Therapy, Respiratory Therapy, and medical intervention will be provided by departments that serve the entire campus. Case Management will be stationed on the inpatient unit as part of the dedicated licensed staff.

If an adult, acute psychiatric inpatient on the unit requires chemotherapy prior to discharge, the patient is transferred to a specialty unit within PGHC. A chemo-certified nurse will administer the drugs to the psychiatric inpatient.

<u>Standard AP 3b.</u> In addition to the services mandated in Standard 3a., inpatient child and adolescent acute psychiatric services must be provided by a multidisciplinary treatment team which provides services that address daily living skills, psychoeducational and/or vocational development, opportunity to develop interpersonal skills within a group setting, restoration of family functioning and any other specialized areas that the individualized diagnostic and treatment process reveals is indicated for the patient and family. Applicants for a Certificate of Need for child and/or adolescent acute psychiatric beds must document that they will provide a separate physical environment consistent with the treatment needs of each age group.

Not applicable. Inpatient child and adolescent services will not be provided at the new hospital.

<u>Standard AP 3c.</u> All acute general hospitals must provide psychiatric consultation services either directly or through contractual arrangements.

PGHC has licensed psychiatric physicians available on staff and through contractual arrangements 24/7. They provide psychiatric services to include but not be limited to:

- Psychiatric crisis management (i.e., arrange psychiatric admissions to the unit or transfers to an appropriate facility)
- Psychosocial crisis assessments
- Psychiatric referrals
- Individual and group therapy are provided on the psychiatric unit

A Maryland licensed psychiatrist is the medical director for the adult acute inpatient psychiatric unit at PGHC. The Medical Director assures consultative services are available, as required, throughout the campus either directly or through those contracts. The replacement facility will do the same.

<u>Standard AP 4a.</u> A Certificate of Need for child, adolescent or adult acute psychiatric beds shall be issued separately for each age category. Conversion of psychiatric beds from one of these services to another shall require a separate Certificate of Need.

Inapplicable. This is not a conversion project.

<u>Standard AP 4b.</u> Certificate of Need applicants proposing to provide two or more age specific acute psychiatric services must provide that physical separations and clinical/programmatic distinctions are made between the patient groups.

Inapplicable. Inpatient psychiatric services will only be provided to adults.

<u>Standard AP 5.</u> Once a patient has requested admission to an acute psychiatric inpatient facility, the following services must be made available:

i. **intake screening and admission;**
ii. **arrangements for transfer to a more appropriate facility for care if medically indicated; or**
iii. **necessary evaluation to define the patient's psychiatric problem and/or**
iv. **emergency treatment.**

As key components of a comprehensive voluntary/involuntary adult psychiatric service, all services required by this standard will be provided on the inpatient unit and Assessment and Stabilization Center at PGHC for patients who arrive with a psychiatric primary diagnosis. Those patients are triaged by an ED nurse and assessed by an emergency physician to rule out a medical primary diagnosis. If assessed with a medical primary diagnosis or requiring emergency medical treatment, the patient will be treated in the ED, admitted to inpatient care, or transferred to an appropriate facility for medical care upon orders of the ED physician. If assessed with a psychiatric primary diagnosis, the patient is transferred to Behavioral Health Services, Assessment and Stabilization Center for a psychiatric evaluation to define the patient's psychiatric problem. If the patient requests admission to a psychiatric inpatient unit, the ASC Clinicians obtain insurance authorization and contact hospitals with the appropriate type of psychiatric beds. Once a bed is identified, and the outside facility agrees to accept the patient, the ASC Clinician arranges transportation. The ASC RN completes

required paperwork for transfer and provides an original set and copies to the ambulance crew that arrives to transfer the patient to the psychiatric facility.

Patients admitted to PGHC inpatient unit will be escorted to the unit by ASC staff. Until a bed is found, the patient is held in ASC until transferred or stabilized and cleared for release by the consulting psychiatrist.

As a member of the Dimensions, PGHC utilizes policies and procedures for these services and will modify them as appropriate for the adult acute inpatient unit at the new facility.

Standard AP 6. All hospitals providing care in designated psychiatric units must have separate written quality assurance programs, program evaluations and treatment protocols for special populations including: children, adolescents, patients with secondary diagnosis of substance abuse, and geriatric patients, either through direct treatment or referral.

PGHC meets this standard for patients who require short-term inpatient care and outpatient services. Inpatient services will include voluntary and involuntary admissions,

As a member of the Dimensions network, the new hospital will have access to quality assurance programs, program evaluations and treatment protocols for adult acute inpatient psychiatric populations, which it can replicate with appropriate modifications at the new facility.

Standard AP 7. An acute general or private psychiatric hospital applying for a Certificate of Need for new or expanded acute psychiatric services may not deny admission to a designated psychiatric unit solely on the basis of the patient's legal status rather than clinical criteria.

PGHC does not deny admission to its adult acute psychiatric unit or any other unit of the Hospital based on a patient's legal status, nor will the replacement facility.

Standard AP 8. **All acute general hospitals and private freestanding psychiatric hospitals must provide a percentage of uncompensated care for acute psychiatric patients which is equal to the average level of uncompensated care provided by all acute general hospitals located in the health service area where the hospital is located, based on data available from the Health Services Cost Review Commission for the most recent 12 month period.**

Upon review of FY2012 data, Prince George's County Hospital's percentage of uncompensated care for acute psychiatric patients was 28.32%. This amount exceeded the average for all hospitals in Prince George's County (10.38%) and the State (6.85%). PGHC reviewed 1,376 inpatient psychiatric accounts for FY 2012 and found 182 patients were eligible for and received $651,982 in charity care allowances in accordance with Hospital policy. These allowances ranged from a full write-off to small self-pay balances depending on the individual patient's situation. The average charity care allowance was $3,582. There is no data set which shows the same data for other hospitals, so it is impossible to compare the charity care specific to the psychiatry service.

Standard AP 9. **If there are no child acute psychiatric beds available within a 45 minute travel time under normal road conditions, then an acute child psychiatric patient may be admitted, if appropriate, to a general pediatric bed. These hospitals must develop appropriate treatment protocols to ensure a therapeutically safe environment for those child psychiatric patients treated in general pediatric beds.**

Inapplicable. Child and acute psychiatric beds are available within a 45 minute travel time under normal road conditions at Potomac Ridge in Rockville and Washington Adventist Hospital in Takoma Park.

Standard AP 10. Expansion of existing adult acute psychiatric bed capacity will not be approved in any hospital that has a psychiatric unit that does not meet the following occupancy standards for two consecutive years prior to formal submission of the application.

Inapplicable. PGHC does not seek to expand existing capacity.

Standard AP 11. Private psychiatric hospitals applying for a Certificate of Need for acute psychiatric beds must document that the age-adjusted average total cost for an acute (< 30 days) psychiatric admission is no more than the age-adjusted average total cost per acute psychiatric admission in acute general psychiatric units in the local health planning area.

Inapplicable. The new hospital will not be a psychiatric hospital.

Standard AP 12a. Acute inpatient psychiatric services must be under the clinical supervision of a qualified psychiatrist.

The Medical Director of the inpatient unit is a qualified psychiatrist.

Standard AP 12b. Staffing of acute psychiatric programs should include therapists for patients without a private therapist and aftercare coordinators to facilitate referrals and further treatment. Staffing should cover a seven day per week treatment program.

PGHC's acute inpatient psychiatric program meets this standard through direct employment of and contractual arrangements with Maryland licensed therapists, counselors, and RNS. The staff is available 7/24.

Standard AP 12c. Child and/or adolescent acute psychiatric units must include staff who have experience and training in child and/or adolescent acute psychiatric care, respectively.

Inapplicable. This project does not involve child or adolescent inpatient care.

Standard AP 13. Facilities providing acute psychiatric care shall have written policies governing discharge planning and referrals between the program and a full range of other services including inpatient, outpatient, long-term care,

aftercare treatment programs, and alternative treatment programs. These policies shall be available for review by appropriate licensing and certifying bodies.

PGHC has written discharge planning policies and works with psychiatric experts to assure and meet this standard for the adult acute inpatient psychiatric unit, building upon the referral arrangement and community networks originated by Prince George's Hospital Behavioral Health Services to provide seamless transition of patients to a full range of other services once discharged.

PGHC's referral relationships include inpatient, outpatient, long-term care, aftercare treatment programs, and alternative treatment programs. These are available for review by appropriate licensing and certifying bodies.

Standard AP 14. Certificate of Need applications for either new or expanded programs must include letters of acknowledgement from all of the following:

i. the local and state mental health advisory council(s);
ii. the local community mental health center(s);
iii. the Department of Health and Mental Hygiene; and
iv. the city/county mental health department(s).

Letters from other consumer organizations are encouraged.

Inapplicable. PGHC is not seeking an approval for either a new or expanded program.

COMAR 10.24.11: GENERAL SURGICAL SERVICES

.05 Standards

A. General Standards.

(1) Information Regarding Charges.

Information regarding charges for surgical services shall be available to the public. A hospital or an ambulatory surgical facility shall provide to the public, upon inquiry or as required by applicable regulations or law, information concerning charges for the full range of surgical services provided.

Please see the response to COMAR 10.24.10.04A-Standard .04A (1) – Information Regarding Charges.

(2) Charity Care Policy.

(a) Each hospital and ambulatory surgical facility shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide ambulatory surgical services on a charitable basis to qualified indigent persons consistent with this policy. The policy shall have the following provisions:

(i) Determination of Eligibility for Charity Care. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the facility shall make a determination of probable eligibility.

(ii) Notice of Charity Care Policy. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the surgical facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's arrival for surgery, facilities should address any financial concerns of patients, and individual notice regarding the facility's charity care policy shall be provided.

(iii) Criteria for Eligibility. Hospitals shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. ASFs, at a minimum, must include the following eligibility criteria in charity care policies. Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge. At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of ASFs described in these regulations.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

(c) A proposal to establish or expand an ASF for which third party reimbursement is available, shall commit to provide charitable surgical services to indigent patients that are equivalent to at least the average amount of charity care provided by ASFs in the most recent year reported, measured as a percentage of total operating expenses. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If an existing ASF has not met the expected level of charity care for the two most recent years reported to MHCC, the applicant shall demonstrate that the historic level of charity care was appropriate to the needs of the service area population.

(d) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a Certificate of Need for a surgical facility project, shall commit to provide charitable services to indigent patients. Charitable services may be surgical or nonsurgical and may include charitable programs that subsidize health plan coverage. At a minimum, the amount of charitable services provided as a percentage of total operating expenses for the health maintenance organization will be equivalent to the average amount of charity care provided statewide by ASFs, measured as a percentage of total ASF expenses, in the most recent year reported. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If the health maintenance organization's track record is not consistent with the expected level for the population in the proposed service area, the applicant shall demonstrate that the historic level of charity care was appropriate to the needs of the population in the proposed service area.

Please see the response to COMAR 10.24.10.04A-Standard .04A(2) – Charity Care Policy.

(3) Quality of Care.

A facility providing surgical services shall provide high quality care.

(a) An existing hospital or ambulatory surgical facility shall document that it is licensed, in good standing, by the Maryland Department of Health and Mental Hygiene.

(b) A hospital shall document that it is accredited by the Joint Commission.

(c) An existing ambulatory surgical facility shall document that it is:

(i) In compliance with the conditions of participation of the Medicare and Medicaid programs; and

(ii) Accredited by the Joint Commission, the Accreditation Association for Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, or another accreditation agency recognized by the Centers for Medicare and Medicaid as acceptable for obtaining Medicare certification.

(d) A person proposing the development of an ambulatory surgical facility shall demonstrate that the proposed facility will:

(i) Meet or exceed the minimum requirements for licensure in Maryland in the areas of administration, personnel, surgical services provision, anesthesia services provision, emergency services, hospitalization, pharmaceutical services, laboratory and radiologic services, medical records, and physical environment.

(ii) Obtain accreditation by the Joint Commission, the Accreditation Association for Ambulatory Health Care, or the American Association for Accreditation of Ambulatory Surgery Facilities within two years of initiating service at the facility or voluntarily suspend operation of the facility.

Please see the response to COMAR 10.24.10.04A-Standard .04A (3) – Quality of Care.

(4) Transfer Agreements.

(a) Each ASF and hospital shall have written transfer and referral agreements with hospitals capable of managing cases that exceed the capabilities of the ASF or hospital.

(b) Written transfer agreements between hospitals shall comply with the Department of Health and Mental Hygiene regulations implementing the requirements of Health-General Article §19-308.2.

(c) Each ASF shall have procedures for emergency transfer to a hospital that meet or exceed the minimum requirements in COMAR 10.05.05.09.

Please see **Exhibit 16**, which includes copies of PGHC's transfer agreements.

B. Project Review Standards.

(1) Service Area.

An applicant proposing to establish a new hospital providing surgical services or a new ambulatory surgical facility shall identify its projected service area. An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall document its existing service area, based on the origin of patients served.

PGHC expects the service area for surgery will be the same as its MSGA Service area.

(2) Need- Minimum Utilization for Establishment of a New or Replacement Facility.

An applicant proposing to establish or replace a hospital or ambulatory surgical facility shall demonstrate the need for the number of operating rooms proposed for the facility. This need demonstration shall utilize the operating room capacity assumptions and other guidance included in Regulation .06 of this Chapter. This needs assessment shall demonstrate that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the initiation of surgical services at the proposed facility.

(a) An applicant proposing the establishment or replacement of a hospital shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for inpatient and outpatient surgical procedures by the new or replacement hospital's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed new or replacement hospital by surgical specialty or operating room category; and

(iii) In the case of a replacement hospital project involving relocation to a new site, an analysis of how surgical case volume is likely to change as a result of changes in the surgical practitioners using the hospital.

(b) An applicant proposing the establishment of a new ambulatory surgical facility shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for outpatient surgical procedures by the proposed facility's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed facility by surgical specialty or, if approved by Commission staff, another set of categories; and

(iii) Documentation of the current surgical caseload of each physician likely to perform surgery at the proposed facility.

PGHC currently has ten ORs and is proposing to maintain ten ORs at the new facility. PGHC's OR configuration includes one dedicated Trauma OR, two dedicated Cardiac Surgery ORs (one for surgery and one for backup, which is standard among hospitals with Cardiac Surgery programs), and seven ORs for non-Cardiac or Trauma cases. Table 26 shows the OR volumes for 2008-2013.

Table 26
Historical OR Volumes
PGHC
2008-2013

	Cases						Minutes				
	Inpatient				Outpatient		Inpatient				Outpatient
	Total	Cardiac	Trauma	Non-Cardiac or Trauma			Total	Cardiac	Trauma	Non-Cardiac or Trauma	
FY: 2008	2,917	54	114	2,749	1,805		304,674	19,865	14,859	269,950	121,734
FY: 2009	2,863	31	97	2,735	1,933		289,576	8,835	12,659	268,082	128,478
FY: 2010	2,731	27	101	2,603	1,781		277,843	8,150	12,571	257,122	117,692
FY: 2011	2,577	39	87	2,451	1,826		274,154	11,340	11,327	251,487	116,652
FY: 2012	2,614	8	84	2,522	1,824		286,725	2,323	10,338	274,064	123,328
FY: 2013	2,434	22	91	2,321	2,063		303,751	7,143	11,824	284,784	154,261

Source: PGHC, Volumes include only OR Cases, excluding endoscopies, cystoscopies, C-sections, and other procedure room cases.

Table 27 shows the historical and average minutes per case at PGHC

Table 27
Historical OR Minutes per Case
PGHC
2008-2013

	Inpt. Non-Cardiac or Trauma Minutes/Case	Outpt. Minutes/Case
FY: 2008	98.22	67.44
FY: 2009	98.03	66.45
FY: 2010	98.77	66.09
FY: 2011	102.61	63.87
FY: 2012	108.67	67.62
FY: 2013	122.69	74.76
Average	104.83	67.71

PGHC recognizes that the volumes have declined, as have admissions in general, as PGHC's physical plant has aged and the hospital has not had the capacity to compete with other hospitals with more modern operating room suites. Also, several PGHC surgeons have recently retired, and it has been difficult to recruit new surgeons

to replace them because of the hospital's physical plant and the hospital's unclear future over the last ten years. However, PGHC believes that its volumes will grow in the future, as hospital volumes grow. (See the discussion of projected MSGA volumes.) PGHC has initiated the recruitment of several surgeons to replace those who have retired. In addition, PGHC will work with local referring physicians to recapture patients who have been traveling into Washington, D.C. for surgery.

Just as it currently has three ORs to accommodate its trauma and cardiac surgery programs, PGHC proposes three ORs for these programs in the new facility. PGHC projects future need for its non-cardiac or trauma ORs based on the projected growth in MSGA admissions from 2012-2021. PGHC has used the average number of minutes per case between 2008 and 2013 and has used 25 minutes per case for cleanup time. These projections are shown below. The result is that PGHC will require 6.23 ORs for non-Cardiac or trauma cases. When the Cardiac and trauma ORs are included, PGHC is proposing to maintain the ten ORs that it currently uses.

2012 MSGA Admissions	7,502
Non-Cardiac or Trauma OR Cases/Admissions, 2012	0.34
Projected MSGA Admissions, 2021	10,726
Projected Inpatient Non-Cardiac or Trauma OR Cases 2021	3,606
Ratio Outpatient/Non-Cardiac or Trauma Inpatient OR Cases, 2012	0.72
Projected Outpatient Cases, 2021	2,608
Avg. Inpatient Non-Cardiac or Trauma Minutes/Case	104.83
Avg. Outpatient Minutes/Case	67.71
Projected Inpatient Non-Cardiac or Trauma Minutes, 2021	378,010
Projected Outpatient Minutes, 2021	176,547
Subtotal	554,556

Cleanup Minutes/Case	25
Projected Cleanup Minutes	155,334
Total Minutes, 2021	709,890
Optimal Capacity/OR in Minutes	114,000
Needed Non-Cardiac or Trauma ORs 2021	6.23

(3) Need - Minimum Utilization for Expansion of An Existing Facility.

An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall:

(a) Demonstrate the need for each proposed additional operating room, utilizing the operating room capacity assumptions and other guidance included at Regulation .06 of this Chapter;

(b) Demonstrate that its existing operating rooms were utilized at optimal capacity in the most recent 12-month period for which data has been reported to the Health Services Cost Review Commission or to the Maryland Health Care Commission; and

(c) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the completion of the additional operating room capacity. The needs assessment shall include the following:

(i) Historic trends in the use of surgical facilities at the existing facility;

(ii) Operating room time required for surgical cases historically provided at the facility by surgical specialty or operating room category; and

(iii) Projected cases to be performed in each proposed additional operating room.

Not applicable. PGHC is not increasing the number of ORs.

(4) Design Requirements.

Floor plans submitted by an applicant must be consistent with the current FGI Guidelines.

(a) A hospital shall meet the requirements in Section 2.2 of the FGI Guidelines.

(b) An ASF shall meet the requirements in Section 3.7 of the FGI Guidelines.

(c) Design features of a hospital or ASF that are at variance with the current FGI Guidelines shall be justified. The Commission may consider the opinion of staff at the Facility Guidelines Institute, which publishes the FGI Guidelines, to help determine whether the proposed variance is acceptable.

Please see **Exhibit 17**, which is a letter from the Architectural firm HOK attesting that the surgical suite meets FGI Guidelines.

(5) Support Services.

Each applicant shall agree to provide as needed, either directly or through contractual agreements, laboratory, radiology, and pathology services.

PGHC is a hospital and provides laboratory, radiology, and pathology services on-site. The same will be true at the new hospital.

(6) Patient Safety.

The design of surgical facilities or changes to existing surgical facilities shall include features that enhance and improve patient safety. An applicant shall:

(a) Document the manner in which the planning of the project took patient safety into account; and

(b) Provide an analysis of patient safety features included in the design of proposed new, replacement, or renovated surgical facilities;

Please see the response to COMAR 10.24.10.04B- Standard .04B(12) – Patient Safety.

(7) Construction Costs.

The cost of constructing surgical facilities shall be reasonable and consistent with current industry cost experience.

(a) Hospital projects.

(i) The projected cost per square foot of a hospital construction or renovation project that includes surgical facilities shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors.

(ii) If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include:

1. The amount of the projected construction cost and associated capitalized construction cost that exceeds the Marshall Valuation Service® benchmark; and

2. Those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

(b) Ambulatory Surgical Facilities.

(i) The projected cost per square foot of an ambulatory surgical facility construction or renovation project shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors.

(ii) If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost by 15% or more, then the applicant's project shall not be approved unless the applicant demonstrates the reasonableness of the construction costs. Additional independent construction cost estimates or information on the actual cost of recently constructed surgical facilities similar to the proposed facility may be provided to support an applicant's analysis of the reasonableness of the construction costs.

Please see the response to COMAR 10.24.10.04B-Standard .04B(7) – Construction Cost of Hospital Space.

(8) Financial Feasibility.

A surgical facility project shall be financially feasible. Financial projections filed as part of an application that includes the establishment or expansion of surgical facilities and services shall be accompanied by a statement containing each assumption used to develop the projections.

(a) An applicant shall document that:

(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the likely service area population of the facility;

(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant facility or, if a new facility, the recent experience of similar facilities;

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant facility, or, if a new facility, the recent experience of similar facilities; and

(iv) The facility will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific

services affected by the project within five years of initiating operations.

(b) A project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project may be approved upon demonstration that overall facility financial performance will be positive and that the services will benefit the facility's primary service area population.

Please see the response to COMAR 10.24.10.04B(13) - Financial Feasibility.

(9) Preference in Comparative Reviews.

In the case of a comparative review of CON applications to establish an ambulatory surgical facility or provide surgical services, preference will be given to a project that commits to serve a larger proportion of charity care and Medicaid patients. Applicants' commitment to provide charity care will be evaluated based on their past record of providing such care and their proposed outreach strategies for meeting their projected levels of charity care.

Not applicable.

10.24.01.08G(3)(b). Need.

For purposes of evaluating an application under this subsection, the Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

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

Responses should include a quantitative analysis that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. For applications proposing to address the need of special population groups identified in this criterion, please specifically identify those populations that are underserved and describe how this Project will address their needs.

PGHC

MSGA Bed Need

Please see the response to Standard .04B(2) – Identification of Bed Need and Addition of Beds.

Obstetrical Bed Need

Please see the response to COMAR 10.24.12 - OB Services Chapter, Standard 04.1 – Need.

Psychiatry Bed Need

To project the number of admissions that it should expect in the new service area, PGHC utilized the methodology outlined in Commissioner Barbara McLean's proposed decision on the CON application for the relocation of Washington Adventist Hospital (Docket No. 09-15-2295) (see Proposed Decision, Pp. 157-162). In this case, the service area for PGHC is shifting from one based on its current location in Cheverly, MD to its new location based in Largo, MD.

PGHC split the historical inpatient discharge data into five cohorts – MSGA (15-64), MSGA (65+), Obstetrics (OB), Pediatrics (PED), and Psychology (PSY). To determine the Zip Code areas to include in the expected 85% service area for the Largo site, Dimensions used drive times generated by Spatial Insights from Zip Codes in Prince George's County, and selected surrounding Zip Codes to each Maryland, District of Columbia, and Virginia hospital.

The Maryland Zip Codes were then sorted by proximity to PGHC's current location and the 2012 discharges were summed until they equaled 85% of PGHC's total 2012 discharges. This was done for each cohort individually. These definitions or rankings were then applied to Zip Codes surrounding the future Largo site for PGRMC, the relocated PGHC. Zip Codes for which PGRMC would be the ninth most proximate hospital or closer for Psych were identified. This was determined by ranking the proximity of all hospitals excluding the existing PGHC.

Change in market share due to relocation

For each of the Zip Codes in PGRMC's projected service area, the expected market share at PGRMC was based on PGHC's average market share for Zip Codes of a comparable proximity. Using 2012 data, Dimensions calculated the average market share for all of the Zip Codes where PGHC was the closest hospital, as it did in projecting MSGA bed need. Dimensions then applied this average market share to all Zip Codes where PGRMC would be the closest hospital.

Impact of changes in population and use rates

The change in PGHC's service area to PGRMC's service area results in a 16.5% reduction in the total service area population. Based on PGRMC's future service area, population growth assumptions through 2021 were obtained from Claritas at the five cohort levels (MSGA 15-64, MSGA 65+, OB, PED, PSY). For Psychiatric, PGHC used the population 15 and older. PGHC calculated that the use rate for Psychiatry admissions was 5.25 per 1,000 population. PGHC did not adjust the use rate for future years. Table 28 shows the new hospital's projected primary and secondary service areas for Psychiatry, the ranking of proximity to the Largo site, and the projected number of admissions. In 2012, PGHC had a 26.0% market share in the service area in psychiatry. This is projected to rise to 28.5% in 2021, solely as a result of population changes and the relocation impact resulting from the MHCC methodology. PGHC anticipates only 11 additional patients as a result of recapture (a 0.3% market share impact).

Table 28
Zip Codes in the PGRMC at Largo Service Area
Hospital Ranking
Projected Admissions
Psychiatry
2021

Zip Code	Drive-Time Ranking	Projected Discharges	% of Total	Cumulative %
20743	1	130	9.2%	9.2%
20747	1	94	6.6%	15.9%
20785	1	93	6.6%	22.5%
20774	1	85	6.0%	28.5%
20716	1	40	2.9%	31.3%
20721	1	38	2.7%	34.0%
20753	1	5	0.3%	34.3%
20775	1	1	0.0%	34.4%
20792	1	1	0.0%	34.4%
20791	1	1	0.0%	34.5%
20731	1	1	0.0%	34.5%
20773	1	-	0.0%	34.5%
20752	1	-	0.0%	34.5%
20717	1	-	0.0%	34.5%
20797	1	-	0.0%	34.5%
20799	1	-	0.0%	34.5%
20706	2	91	6.4%	40.9%
20772	2	71	5.0%	45.9%
20746	2	71	5.0%	50.9%
20784	2	59	4.2%	55.1%
20770	2	47	3.3%	58.4%
20715	2	43	3.0%	61.4%
20720	2	24	1.7%	63.1%
20769	2	11	0.8%	63.9%
20623	2	3	0.2%	64.1%
20703	2	2	0.1%	64.3%
20762	2	1	0.1%	64.3%
20718	2	-	0.0%	64.3%
20768	2	-	0.0%	64.3%
20771	2	-	0.0%	64.3%
20748	3	34	2.4%	66.7%
20735	3	31	2.2%	68.9%
20601	3	18	1.3%	70.2%
20602	3	15	1.0%	71.2%

Zip Code	Drive-Time Ranking	Projected Discharges	% of Total	Cumulative %
20708	3	14	1.0%	72.2%
20603	3	14	1.0%	73.2%
20613	3	8	0.6%	73.8%
20608	3	1	0.1%	73.9%
20757	3	1	0.1%	73.9%
20719	3	-	0.0%	73.9%
20709	3	-	0.0%	73.9%
20737	4	17	1.2%	75.1%
20710	4	5	0.4%	75.5%
20738	4	0	0.0%	75.6%
20704	5	-	0.0%	75.6%
20744	6	24	1.7%	77.2%
20745	6	19	1.4%	78.6%
20653	6	14	1.0%	79.6%
20705	6	12	0.9%	80.5%
20740	6	10	0.7%	81.2%
20781	6	6	0.4%	81.7%
20607	6	5	0.4%	82.0%
20725	6	1	0.0%	82.1%
20749	6	0	0.0%	82.1%
20726	6	-	0.0%	82.1%
20707	7	15	1.1%	83.2%
20722	7	3	0.2%	83.4%
20787	7	0	0.0%	83.4%
20741	7	0	0.0%	83.4%
20742	8	0	0.0%	83.4%
20782	9	6	0.4%	83.8%
20712	9	3	0.2%	84.0%
Total		1,187		

When out of area patients are accounted for, PGHC projects that the new facility will admit 1,413 patients in 2021. PGHC applied the 2012 Statewide Average Length of Stay for psychiatry (5.76 days), resulting in 8,140 patient days. This results in a need for 26.24 (or 27) beds at 85% occupancy.

Though the projected average daily census shows a need for 27 beds at 85% occupancy, PGHC would like to maintain the current licensure level of 28 beds. PGHC has studied the distribution of census and the number of days that each census occurred. These are shown in Table 29.

Table 29
Distribution of Census
PGHC
2012 and 2013

	2012	2013
Days with 1 census	0	0
Days with 8 census	0	1
Days with 9 census	0	0
Days with 10 census	1	1
Days with 11 census	2	2
Days with 12 census	2	5
Days with 13 census	9	5
Days with 14 census	13	13
Days with 15 census	10	7
Days with 16 census	20	27
Days with 17 census	22	23
Days with 18 census	28	28
Days with 19 census	34	34
Days with 20 census	39	43
Days with 21 census	33	37
Days with 22 census	30	41
Days with 23 census	32	40
Days with 24 census	26	15
Days with 25 census	20	15
Days with 26 census	21	7
Days with 27 census	11	11
Days with 28 census	10	2
Days with 29 census	1	3
Days with 30 census	1	4
Days with 31 census	1	1

Source: PGHC

As these data show, PGHC had a total of nearly two weeks per year in which the census exceeded 27 beds. This causes significant backup in the ED and in "observation." The lack of availability of psychiatry beds is a chronic problem

systemwide, to the extent that MIEMSS has proposed a reporting device whereby hospitals with Psychiatry Units will post their census to a central reporting center which will be accessible to other hospitals. This could add to the PGHC census. Consequently, for all these reasons, PGHC is proposing to maintain its current licensed capacity of 28 beds.

Emergency Department

Please see the response to Standard .04B(14) – Emergency Department Treatment Capacity and Space.

Operating Rooms

Please see the response to COMAR 10.24.11: General Surgical Services, Standard (2) Need- Minimum Utilization for Establishment of a New or Replacement Facility.

Mount Washington Pediatric Hospital

MWPH proposes to relocate its 15 beds from the current PGHC to the new Prince Georges County facility in order to continue to provide specialty pediatric services to this population in Prince George's County.

When the beds were originally located to PGHC, it was anticipated that most patients would be referred from PGHC, including those who previously were being referred for care to Washington, D. C. Instead, the MWPH unit at PGHC has become a statewide resource. Referral sources have defined MWPH's service area, rather than simply location. Table 30 shows the number of referrals to the MWPH unit at PGHC by referral source for the last five years. Over the past five years about 7% of admissions to the MWPH unit have come from PGHC. About 35% have come from Johns Hopkins

Hospital and another 12% have come from Johns Hopkins Bayview Medical Center. Another 10% have come from Children's National Medical Center in Washington, DC.

Table 30
Admissions by Zip Code
MWPH at PGHC
FY 2013

Referring Hospital	FY09	FY10	FY11	FY12	FY13	Total	Total %
AAMC					12	12	2%
BAYVIEW	16	8	14	13	10	61	12%
BWMC				3	2	5	1%
CHILDRENS	9	11	16	13		49	10%
CNMC				3	26	29	6%
FRANKLIN					1	1	0%
GEORGETOWN	1	1	4	3	7	16	3%
HARBOR			1			1	0%
HCH					5	5	1%
HOWARD			3		3	6	1%
JHH	40	35	26	36	33	170	35%
JHHOP				1		1	0%
MERCY				1		1	0%
OTHER	5	15	10	14	4	48	10%
PGHC	8	14	6	3	2	33	7%
SOUTH MD			2	2		4	1%
ST AGNES				1	1	2	0%
UMMS	6	9	5	7	19	46	9%
Total	85	93	87	100	125	490	100%

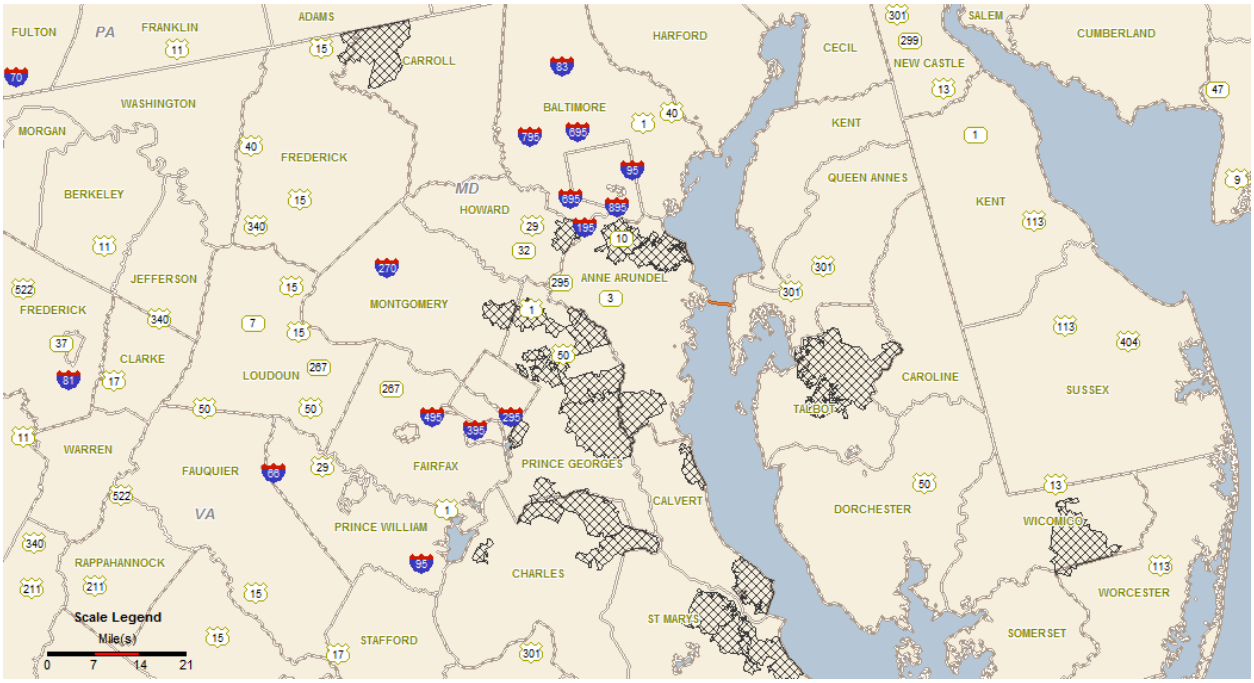
Patients coming to MWPH's unit at PGHC reside in many areas of the State. Table 31 shows the Zip Codes providing the top 70 percent of admissions.

Table 31
Admissions by Zip Code
MWPH at PGHC
FY 2013

Zip Code	Admissions	%	Cum. %
20603	5	4%	4%
20653	5	4%	8%
20732	5	4%	12%
20784	5	4%	16%
20601	4	3%	19%
20657	4	3%	22%
20785	4	3%	26%
21061	4	3%	29%
20637	3	2%	31%
20705	3	2%	34%
20715	3	2%	36%
20720	3	2%	38%
20722	3	2%	41%
20745	3	2%	43%
21122	3	2%	46%
21787	3	2%	48%
21804	3	2%	50%
20619	2	2%	52%
20634	2	2%	54%
20636	2	2%	55%
20658	2	2%	57%
20711	2	2%	58%
20737	2	2%	60%
20772	2	2%	62%
20774	2	2%	63%
20904	2	2%	65%
21060	2	2%	66%
21075	2	2%	68%
21601	2	2%	70%
38 Others	38	30%	100%
Grand Total	**125**		

Figure 16 shows these Zip Codes graphically. Admissions to the MWPH unit at PGHC come from many areas of the state.

Figure16
MWPH Service Area
FY 3013



Because MWPH is a statewide resource, it is using the statewide pediatric population as the base of its projections. MWPH used only the MDP population for age 0-4, as MWPH at PGHC seldom has any patients older than four years old.

MWPH then developed a use rate for 2012 and 2013. For 2014, MWPH used the average of the 2012 and 2013 use rates. For 2015 through 2021, MWPH used the average of 2014 and 2015. MWPH did this because MWPH believes that using the 2014 use rate would not adequately account for three factors:

1. Currently, some parents choose to use MWPH in Baltimore or Children's National Medical Center in Washington, D.C., rather than have their children admitted to MWPH at PGHC. MWPH will be in a new facility, and MWPH

believes that this will cause parents to more readily admit their children to the unit.

2. As population health management takes effect, acute care facilities that refer to MWPH will increase their referrals in order to reduce their own utilization.
3. With a stronger UMMS relationship, referrals from other UMMS hospitals' NICUs to MWPH will increase.

MWPH believes that this approach is conservative because the 2015-2021 use rate is lower than the 2013 actual use rate.

The MWPH at PGHC Average Length of Stay ("ALOS") varies considerably year by year, depending on MWPH's clinical patient mix. With so few admissions, several long-staying patients have a significant impact on ALOS.

	FY09	FY10	FY11	FY12	FY13	Average
ALOS	31.8	25.6	27.2	21.3	23.4	25.85

For 2014, MWPH used the average ALOS of the five-year period. Thereafter, MWPH added a quarter of a day to the ALOS each year. MWPH believes that, as acute care facilities attempt to reduce their utilization, they will discharge patients to MWPH sooner, usually resulting in a somewhat longer ALOS at the MWPH unit at PGHC.

MWPH assumed a 65% occupancy percentage, which is the occupancy percentage identified in the State Health Plan for acute pediatric units sized between 7 and 24 beds.

These assumptions result in a need for 14.4 beds in 2021, as shown below. Hence, MWPH is requesting approval of the 15 beds that it currently has licensed.

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
MD.PopAge0-4	368,568	370,624	372,691	374,770	376,743	378,727	380,721	382,725	384,740	385,850
Admissions	100	125								
UseRate/1,000	0.271	0.337	0.304	0.321	0.321	0.321	0.321	0.321	0.321	0.321
ProjectedAdmissions			113	120	121	121	122	123	123	124
ALOS		23.4	25.85	26.10	26.35	26.60	26.85	27.10	27.35	27.60
PatientDays		2,923	2,652	3,137	3,184	3,231	3,279	3,327	3,375	3,416
ADC		8.0	7.3	8.6	8.7	8.9	9.0	9.1	9.2	9.4
BedNeed at 65%Occupancy		12	11	13	13	14	14	14	14	14.4

[(INSTRUCTION: Complete Table 1 for the Entire Facility, including the proposed project, and Table 2 for the proposed project only using the space provided on the following pages. Only existing facility applicants should complete Table 1. All Applicants should complete Table 2. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY)]

TABLE 1: STATISTICAL PROJECTIONS - ENTIRE FACILITY - PGHC
Excludes Newborn

	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first fullyear at full utilizaton)						
Fiscal Year	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21
1. Admissions										
a. M/S/G/A	5,492	4,839	5,419	6,081	6,288	6,496	6,743	7,221	7,698	8,176
b. Pediatric	131	67	111	36	36	36	37	41	44	47
c. Obstetric	2,418	2,295	2,447	2,333	2,333	2,333	2,305	2,275	2,275	2,275
d. Intensive Care	1,112	1,151	1,180	1,324	1,369	1,415	1,468	1,572	1,676	1,780
e. Coronay Care	818	673	510	573	592	612	635	680	725	770
f. Psyhciatric	1,394	1,381	1,463	1,336	1,336	1,336	1,340	1,365	1,389	1,413
g. Rehabilitation							-			
h. Chronic							-			
i. Other							-			
i. Total	11,365	10,406	11,130	11,683	11,955	12,228	12,530	13,153	13,807	14,461
2. Patient Days										
a. M/S/G/A	33,026	30,267	30,727	36,215	35,683	35,265	31,866	33,267	35,480	37,693
b. Pediatric	173	106	180	96	96	96	98	107	115	124
c. Obstetric	6,725	5,885	5,863	6,368	6,320	6,273	6,174	6,025	6,025	6,025
d. Intensive Care	8,233	8,404	8,396	9,895	9,750	9,636	8,707	9,090	9,695	10,299
e. Coronay Care	2,706	2,416	2,650	3,123	3,077	3,041	2,748	2,869	3,060	3,251
f. Psyhciatric	7,529	7,392	6,991	7,302	7,434	7,566	7,655	7,860	7,999	8,139
g. Rehabilitation							-			
h. Chronic							-			
i. Other							-			
i. Total	58,392	54,470	54,807	62,999	62,360	61,876	57,249	59,218	62,374	65,531
3. Average Length of Stay										
a. M/S/G/A	6.0	6.3	5.7	6.0	5.7	5.4	4.7	4.6	4.6	4.6
b. Pediatric	1.3	1.6	1.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6
c. Obstetric	2.8	2.6	2.4	2.7	2.7	2.7	2.7	2.6	2.6	2.6
d. Intensive Care	7.4	7.3	7.1	7.5	7.1	6.8	5.9	5.8	5.8	5.8
e. Coronay Care	3.3	3.6	5.2	5.5	5.2	5.0	4.3	4.2	4.2	4.2
f. Psyhciatric										

	5.4	5.4	4.8	5.5	5.6	5.7	5.7	5.8	5.8	5.8
g. Rehabilitation	-	-	-	-	-	-	-	-	-	-
h. Chronic	-	-	-	-	-	-	-	-	-	-
i. Other	-	-	-	-	-	-	-	-	-	-
i. Average	5.1	5.2	4.9	5.4	5.2	5.1	4.6	4.5	4.5	4.5
4. Occupancy Percentages										
a. M/S/G/A	66.5%	70.3%	77.9%	91.9%	90.5%	89.5%	72.5%	68.5%	73.1%	77.6%
b. Pediatric	5.9%	3.6%	6.2%	3.3%	3.3%	3.3%	6.0%	29.3%	31.6%	33.9%
c. Obstetric	51.2%	44.8%	44.6%	48.5%	48.1%	47.7%	58.3%	75.0%	75.0%	75.0%
d. Intensive Care	94.0%	95.9%	95.8%	113.0%	111.3%	110.0%	103.7%	113.2%	120.7%	128.3%
e. Coronay Care	74.1%	66.2%	72.6%	85.6%	84.3%	83.3%	75.3%	78.6%	83.8%	89.1%
f. Psyhciatric	73.7%	72.3%	68.4%	71.4%	72.7%	74.0%	74.9%	76.9%	78.3%	79.6%
g. Rehabilitation										
h. Chronic										
i. Other										
i. Average	66.1%	66.6%	70.2%	80.7%	79.8%	79.2%	73.0%	75.1%	79.1%	83.1%
5. Number of Licensed Beds										
a. M/S/G/A	136	118	108	108	108	108	121	133	133	133
b. Pediatric	8	8	8	8	8	8	5	1	1	1
c. Obstetric	36	36	36	36	36	36	29	22	22	22
d. Intensive Care	24	24	24	24	24	24	23	22	22	22
e. Coronay Care	10	10	10	10	10	10	10	10	10	10
f. Psyhciatric	28	28	28	28	28	28	28	28	28	28
g. Rehabilitation										
h. Chronic										
i. Other										
i. Total	242	224	214	214	214	214	215	216	216	216

6. Outpatient Visits										
a. Emergency	49,241	49,777	51,377	51,800	52,228	52,662	53,855	56,241	58,628	61,014
b. Outpatient Visits	58,065	57,070	57,766	57,766	57,766	57,766	58,837	61,200	63,832	66,464
c. Other - Observation Cases	5,397	5,439	5,780	5,828	5,876	5,925	5,949	6,024	6,075	6,126
d. Total	112,703	112,286	114,923	115,393	115,870	116,353	118,641	123,466	128,535	133,604

* Number of beds and occupancy percentage should be reported on the basis of licensed

TABLE 1: STATISTICAL PROJECTIONS - ENTIRE FACILITY - MWPH

	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)						
Fiscal Year	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21
1. Admissions										
a. M\S/G/A										
b. Pediatric	692	791	816	827	832	836	840	845	849	852
c. Obstetric										
d. Intensive Care										
e. Coronary Care										
f. Psychiatric										
g. Rehabilitation										
h. Chronic										
i. Other (Specify)										
j. TOTAL	692	791	816	827	832	836	840	845	849	852

Table 1 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)						
Fiscal Year	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21
2. Patient Days										
a. M\S/G/A										
b. Pediatric	20,207	22,056	24,797	25,309	25,669	26,004	26,336	26,703	27,045	27,350
c. Obstetric										
d. Intensive Care										
e. Coronary Care										
f. Psychiatric										
g. Rehabilitation										
h. Chronic										
i. Other (Specify)										
j. TOTAL	20,207	22,056	24,797	25,309	25,669	26,004	26,336	26,703	27,045	27,350
3. Average Length of Stay										

a. M\S/G/A										
b. Pediatric	29.2	27.88	30.39	30.6	30.85	31.11	31.35	31.6	31.85	32.1
c. Obstetric										
d. Intensive Care										
e. Coronary Care										
f. Psychiatric										
g. Rehabilitation										
h. Chronic										
i. Other (Specify)										
j. TOTAL	29.2	27.88	30.39	30.6						32.1

Table 1 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)						
Fiscal Year	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21
4. Occupancy Percentage*										
a. M\S/G/A	-	-	-	-						-
b. Pediatric	54%	59%	67%	68%	69%	70%	71%	72%	73%	73%
c. Obstetric	-	-	-	-						-
d. Intensive Care	-	-	-	-						-
e. Coronary Care	-	-	-	-						-
f. Psychiatric	-	-	-	-						-
g. Rehabilitation	-	-	-	-						-
h. Chronic	-	-	-	-						-
i. Other (Specify)	-	-	-	-						-
j. TOTAL	54%	59%	67%	68%	69%	70%	71%	72%	73%	73%
5. Number of Licensed Beds										
a. M\S/G/A										
b. Pediatric	102	102	102	102	102	102	102	102	102	102
c. Obstetric										
d. Intensive Care										
e. Coronary Care										
f. Psychiatric										
g. Rehabilitation										
h. Chronic										
i. Other (Specify)										
j. TOTAL	102	102	102	102	102	102	102	102	102	102

Table 1 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)						
Fiscal Year	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21
6. Outpatient Visits										
a. Emergency										
b. Outpatient dept.	38,695	40,745	41,444	42,688	43,968	45,287	46,725	48,127	49,571	51,058
c. Other (Specify)										
d. TOTAL	38,695	40,745	41,444	42,688	43,968	45,287	46,725	48,127	49,571	51,058

TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT - PGHC

Note: PGHC is not providing Table 2 (which would be the same as Table 1) based on conversations with CON Staff on other projects. PGHC recognizes that CON Staff has the right to request PGHC to complete Table 2.

	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20____	20____
1. Admissions				
a. M/S/G/A				
b. Pediatric				
c. Obstetric				
d. Intensive Care				
e. Coronary Care				
f. Psychiatric				
g. Rehabilitation				
h. Chronic				
i. Other (Specify)				
j. TOTAL				
2. Patient Days				
a. M/S/G/A				
b. Pediatric				
c. Obstetric				
d. Intensive Care				
e. Coronary Care				
f. Psychiatric				
g. Rehabilitation				
h. Chronic				
i. Other (Specify)				

Table 2 cont.	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20____	20____
3. Average Length of Stay				
a. M/S/G/A				
b. Pediatric				
c. Obstetric				
d. Intensive Care				
e. Coronary Care				
f. Psychiatric				
g. Rehabilitation				
h. Chronic				
i. Other (Specify)				
4. Occupancy Percentage*				
a. M/S/G/A				
b. Pediatric				
c. Obstetric				
d. Intensive Care				
e. Coronary Care				
f. Psychiatric				
g. Rehabilitation				
h. Chronic				
i. Other (Specify)				

Table 2 cont.	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20____	20____
5. Number of Licensed Beds				
a. M/S/G/A				
b. Pediatric				
c. Obstetric				
d. Intensive Care				
e. Coronary Care				
f. Psychiatric				
g. Rehabilitation				
h. Chronic				
i. Other (Specify)				

(INSTRUCTION: All applicants should complete this table.)

TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT – MWPH at PGHC

	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)						
Fiscal Year	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21
1. Admissions										
a. M\S/G/A										
b. Pediatric										
c. Obstetric										
d. Intensive Care										
e. Coronary Care										
f. Psychiatric										
g. Rehabilitation										
h. Chronic										
i. Other (Specify)	100	125	113	120	121	121	122	123	123	124
j. TOTAL	100	125	113	120	121	121	122	123	123	124

Table 1 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)						
Fiscal Year	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21
2. Patient Days										
a. M\S/G/A										
b. Pediatric										
c. Obstetric										
d. Intensive Care										
e. Coronary Care										
f. Psychiatric										
g. Rehabilitation										
h. Chronic										
i. Other (Specify)	2,129	2,923	2,921	3,132	3,188	3,218	3,275	3,333	3,364	3,422
j. TOTAL	2,129	2,923	2,921	3,132	3,188	3,218	3,275	3,333	3,364	3,422

3. Average Length of Stay										
a. M\S/G/A										
b. Pediatric										
c. Obstetric										
d. Intensive Care										
e. Coronary Care										
f. Psychiatric										
g. Rehabilitation										-
h. Chronic										-
i. Other (Specify)	21.29	23.38	25.85	26.10	26.35	26.60	26.85	27.10	27.35	27.60
j. TOTAL	21.29	23.38	25.85	26.1	26.35	26.6	26.85	27.1	27.35	27.6

Table 1 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)						
Fiscal Year	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21
4. Occupancy Percentage*										
a. M\S/G/A	-	-	-	-						-
b. Pediatric	-	-	-	-						-
c. Obstetric	-	-	-	-						-
d. Intensive Care	-	-	-	-						-
e. Coronary Care	-	-	-	-						-
f. Psychiatric	-	-	-	-						-
g. Rehabilitation	-	-	-	-						-
h. Chronic	-	-	-	-						-
i. Other (Specify)	39%	53%	53%	57%	58%	59%	60%	61%	61%	63%
j. TOTAL	39%	53%	53%	57%	58%	59%	60%	61%	61%	63%

5. Number of Licensed Beds										
a. M\S/G/A										
b. Pediatric										
c. Obstetric										
d. Intensive Care										
e. Coronary Care										
f. Psychiatric										
g. Rehabilitation										
h. Chronic										
i. Other (Specify)	15	15	15	15	15	15	15	15	15	15
j. TOTAL	15	15	15	15	15	15	15	15	15	15

Table 1 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)						
Fiscal Year	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21
6. Outpatient Visits										
a. Emergency										
b. Outpatient dept.	3,601	3,469	3,504	3,504	3,504	3,504	3,832	5,470	6,125	6,125
c. Other (Specify)										
d. TOTAL	3,601	3,469	3,504	3,504	3,504	3,504	3,832	5,470	6,125	6,125

COMAR 10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

For purposes of evaluating an application under this subsection, the Commission shall compare the cost-effectiveness of providing the proposed service through the proposed project with the cost-effectiveness of providing the service at alternative existing facilities, or alternative facilities which have submitted a competitive application as part of a comparative review.

Please explain the characteristics of the Project which demonstrate why it is a less costly or a more effective alternative for meeting the needs identified.

For applications proposing to demonstrate superior patient care effectiveness, please describe the characteristics of the Project which will assure the quality of care to be provided. These may include, but are not limited to: meeting accreditation standards, personnel qualifications of caregivers, special relationships with public agencies for patient care services affected by the Project, the development of community-based services or other characteristics that the Commission should take into account.

PGHC

See Section .06B(3) above.

MWPH

MWPH has a nearly twenty-year relationship with PGHC which has been very successful. Furthermore, MWPH is owned jointly by University of Maryland Medical System and Johns Hopkins Health System, and, as PGHC collaborates more closely with UMMS, the relationship will improve, as medical staff, nursing staff, and other components of care become integrated. Also, PGHC is proposing an enhanced relationship with Children's National Medical Center ("CNMC") in Washington, D.C. CNMC is both a competitor to MWPH and, also, a significant referral source. MWPH looks forward to increased coordination with CNMC. MWPH recognized early in the

planning process that it would not make any sense to seek to lease space at any alternative facility.

Closure of the unit was never a serious or prudent consideration. Closure would reduce access for families across the State.

Furthermore, as discussed under 10.24.01.08G(3)(d)-Viability of the Proposal, the MWPH unit at PGHC helps to contribute to MWPH's overall financial health.

MWPH believes that the continuation of its relationship with PGHC is the most cost effective alternative.

In addition, MWPH is a lower-cost alternative for inpatient care. Most of the patients referred to the PG unit of MWPH are transferred from the referring hospitals' Neonatal Intensive Care Units. These children are not "graduates" of the NICUs, but, rather, "NICU upperclassmen" who would have spent more time in the NICU, were they not transferred to MWPH's unit. The HSCRC Revenue and Volumes Report for FY 2013 demonstrates that MWPH is considerably less costly per patient day than continuing to care for these patients in the NICU. Table 32 shows the number of patient days in the NICU cost center at the four largest Maryland referral sources to MWPH, their Inpatient Revenue for that cost center, and the average revenue per day (average room rates). This is compared to the Pediatric and Pediatric Step Down Cost Centers at MWPH (also, room rates). The average revenue per day at MWPH is lower than at any of the referring hospitals.

Table 32
Number of Patient Days in the NICU Cost Center, NICU Inpatient Revenue, And Average Revenue per Day
Selected Hospitals-FY 2013

Hospital	Center	Patient Days	Inpt Revenue	Revenue/Day
Bayview	NICU	5,557	$7,165,025	$1,289
Hopkins Hospital	NICU	14,893	$25,903,499	$1,739
University of MD	NICU	13,834	$21,650,197	$1,565
Prince George's	NICU	3,620	$5,522,008	$1,525
MWPH	PED and Pediatric Step Down	22,045	$23,874,910	$1,083

Source: HSCRC Revenue and Volumes Report for FY 2013, downloaded from its website http://www.hscrc.state.md.us/documents/Hospitals/ReportsFinancial/FinancialData/RevenueVolumeSummary/hscrc-fy-2013.xlsx, accessed 9/24/13

COMAR 10.24.01.08G(3)(d). Viability of the Proposal.

For purposes of evaluating an application under this subsection, the Commission shall consider the availability of financial and non-financial resources, including community support, necessary to implement the project within the time frame set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Please include in your response:

a. Audited Financial Statements for the past two years. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant. The availability of each source of funds listed in Part II, B. Sources of Funds for Project, must be documented.

b. Existing facilities shall provide an analysis of the probable impact of the Project on the costs and charges for services at your facility.

c. A discussion of the probable impact of the Project on the cost and charges for similar services at other facilities in the area.

d. All applicants shall provide a detailed list of proposed patient charges for affected services.

PGHC

The relocation of PGHC has enormous public and community support. **Exhibit 18** includes more than 225 letters of support, including statements of support

from: Lt. Governor Anthony Brown, Senate President Thomas “Mike” Miller, Speaker Michael E. Busch, the entire Prince George’s Delegation of the Maryland House of Delegates, numerous State Senators and Delegates, Prince George’s County Executive Rushern L. Baker III, the Prince George’s County Council, the Charles County Commissioners, Dr. William E. Kirwan (Chancellor of the University System of Maryland), Dr. Wallace D. Loh (President of the University of Maryland), Dr. Jay A. Perman (President of the University of Maryland, Baltimore), Dr. Charlene M. Dukes (President of Prince George’s Community College), numerous health care providers, business and religious leaders, and many others.

Both the State of Maryland and Prince George’s County have approved significant funding for the relocation, showing their support for PGHC’s role in the community and for the project. Funding for the Project Costs is comprised of the following:

- Prince George’s County will contribute $208 million at the time of construction in 2015
- The State of Maryland will provide grants totaling $208 million over five years beginning in 2015
  - $20M a year for 5 years with $108M paid at the end of the 5 years
- A long-term bond issuance of $224M to be paid back over 30 years
  - Annual interest expense of 6.5% on the outstanding balance
  - Interest during construction will be capitalized
  - Principal payments will begin upon the new hospital’s commencement of operations in January 2018
- A short-term bridge loan of $128M will be required due to the timing of the State grants over five years
  - Annual interest expense of 5.0% on the outstanding balance
  - Interest during construction will be capitalized
  - This bridge loan will be repaid upon receipt of $128M of State’s grants during and at the end of 2019 (fifth year)
- A $109.2M line of credit will be obtained to provide 70 days of cash on hand upon commencement of operations in 2018

- Annual interest of 2% interest on the outstanding balance
- Principal repayments will be made over the five years 2018-2022 as cash exceeds 70 days of cash on hand

In addition, Prince George's County is providing the land for the project.

The collaboration of the MOU partners over the past few years is a tremendous show of support for PGHC's role as a regional medical center and for this project.

On August 25, 2013, the *Washington Post* published an editorial entitled "The Hospital Prince George's Deserves" By Editorial Board (See **Exhibit 19**.) The editorial stated:

> OF THE 32,000 Marylanders who leave the state each year to seek medical care elsewhere, about three-quarters are from Prince George's County. One reason is a "pull" factor: the abundance of health-care facilities in the District and Northern Virginia. The other reason is a "push": the paucity of -high-quality health-care options in Prince George's itself . . . .
>
> It's deplorable that residents of a sprawling county on the porch of the nation's capital don't have better health-care options closer to home. Now, after years of false starts, political dysfunction and uncertain funding, Prince Georgians are closer than ever to getting the top-flight regional hospital they deserve.
>
> That's the takeaway from the announcement last week that Dimensions Healthcare System, which oversees county-owned medical facilities, has decided to locate a new, 259-bed regional hospital and medical center just outside the Beltway at the Largo Town Center Metro stop. The $645 million teaching hospital would replace the current, substandard Prince George's Hospital Center, in Cheverly, with a full-service medical center and trauma center operated by the University of Maryland Medical System.
>
> There are several reasons to cheer this development. One is the logic in choosing a 26-acre site for the new hospital with easy access to Metro. It's not clear how many of the 2,000-odd hospital personnel or 60,000 or so annual patients would travel to and from the facility by Metro; still, it's much better to have a rapid transit option than not.
>
> The new hospital may also provide a badly needed trigger for economic development in the area around Largo, which, like so much of the county,

> is heavy on houses and light on office buildings, shops and stores. Beefing up the commercial share of Prince George's tax base would provide a critical lift for the county, which now relies on residential property owners for 70 percent of tax revenue, more than in neighboring jurisdictions.
>
> For years the county and the state have been forced to subsidize Prince George's Hospital Center, which treats large numbers of uninsured and indigent patients, to the tune of $30 million annually. Despite handwringing by elected officials, things were at a standstill until voters elected a new county executive, Rushern L. Baker III (D), in 2010. It was Mr. Baker, with crucial assists from Gov. Martin O'Malley (D) and legislative leaders in Annapolis, who was instrumental in forging a deal that secured county and state funding and in enlisting the support of the Prince George's County Council.
>
> A few hurdles remain. The most critical one may be the issuance of a certificate of need, which is required before any hospital can be built in the state. That is in the hands of the Maryland Health Care Commission, which is certain to hear opposition from neighboring hospital systems that may fear losing patients and profits to the new facility in Prince George's and may try to undermine the deal.
>
> County officials must press hard to overcome those objections. The absence of a top-flight hospital in a locality of 880,000 people — one that provides a variety of specialty care and tertiary services — is a long-running scandal. There have been too many delays. Now, with the selection of a sensible site, the county is in the home stretch."

a. Audited Financial Statements are included in **Exhibit 20**. They can also be found online at www.dimensionshealth.com.

b. The total cost of the project is $764 million of which $615 million are depreciable assets. $224.0 million of the depreciable assets will be funded with proceeds from the issuance of tax exempt bonds. Depreciation and interest expense (i.e., capital costs) related to the project are projected to equal $42.3M in the first full year of operation of the facility.

Capital Costs Related to the Project (First Full Year Impact)
($ in millions)

Depreciation	$27.8
Interest	14.5
Total Capital Costs	$42.3
% of Capital to Include in Rates	40%
Capital in Rates	$16.9

Applying PGHC's mark-up of 1.182 to the capital to be included in rates results in an estimate of gross revenue related to the project of $19,995,700 which is expected to equate to a 7.0% increase on the 2017 projected HSCRC rates.

The expected growth in volumes from 2018 to 2021 will contribute to the fixed overhead associated with the new hospital and thereby enable a reduction in unit costs and related HSCRC rates.

c. Please see the response to 10.24.01.08G(3)(f). Impact on Existing Providers.

d. PGHC's Charge Master is attached as **Exhibit 21**.

Exhibit 22 includes statements of assumptions and inflated Table 3.

MWPH

a. Audited Financial Statements are included in **Exhibit 23**.

b. As MWPH is in leased space and is not responsible for any debt, this project will not impact charges. MWPH recognizes that rent will increase, and it is reflected in Table 3.

c. There are no comparable providers in Maryland, except for MWPH in Baltimore. This project will have no impact on MWPH in Baltimore.

d. MWPH's Charge Master is attached as **Exhibit 24**.

MWPH's Table 4 shows that the MWPH unit at PGHC is financially solid when corporate overhead is not allocated to the unit. When corporate overhead is allocated to the unit, MWPH at PGHC shows a financial loss. However, the major point is that the positive net revenue at the PGHC MWPH unit contributes to MWPH's overall financial viability. The corporate overhead that is allocated to the PGHC unit would not be eliminated if the unit was closed. Consequently, the PGHC unit contributes to MWPH's overall bottom line.

Exhibit 25 includes statements of assumptions, an inflated Table 3, and an inflated Table 4.

(INSTRUCTIONS: Table 3, "Revenue and Expenses - Entire Facility **(including the proposed project)" is to be completed by existing facility applicants only. Applicants for new facilities should not complete Table 3. Specify whether data are for calendar year or fiscal year. All projected revenue and expense figures should be presented in current dollars. Medicaid revenues for all years should be calculated on the basis of Medicaid rates and ceilings in effect at the time of submission of this application. Specify sources of non-operating income. State the assumptions used in projecting all revenues and expenses.) Table 4,** "Revenues and Expenses - Proposed Project," **is to be completed by each applicant for the proposed project only, using the same instructions outlined above for Table 3.**

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project) **PGHC**

Excludes HSCRC Annual Update Factors and Expense Inflation

(Dollars are presented in thousands)

	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first fullyear at full utilizaton)						
Fiscal Year	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21
1. Revenue										
a. Inpatient Services	$191,109	$173,139	$190,287	$192,852	$196,952	$201,128	$220,452	$236,744	$247,063	$257,167
b. Outpatient Services	65,240	76,775	71,141	71,652	72,225	72,825	75,926	81,612	84,282	86,893
c. Gross Patient Services Revenues	256,349	249,914	261,428	264,504	269,178	273,953	296,379	318,356	331,345	344,060
d. Allowance of Bad Debt	14,746	16,710	23,322	23,596	24,013	24,439	26,260	27,236	27,476	27,686
e. Contractual Allowances	12,967	6,272	9,303	7,241	7,369	7,499	8,398	8,758	8,669	8,772
f. Charity Care	24,105	21,930	15,940	16,128	16,412	16,704	17,948	18,615	18,779	18,922
g. Net Patient Services Revenue	204,531	205,002	212,864	217,540	221,383	225,311	243,772	263,747	276,421	288,680
h. Other Operating Revenue										
- State Support	10,546	10,672	10,562	10,000	10,000	10,000	6,667	3,333	3,333	-
- County Support	10,546	10,672	10,562	6,518	6,516	6,516	4,925	3,333	3,333	-
- Other Revenue	3,407	5,826	8,198	4,398	4,398	4,398	4,398	4,398	4,398	4,398
i. Net Operating Revenue	229,030	232,172	242,185	238,456	242,297	246,225	259,762	274,812	287,486	293,078
2. Expenses										
a. Salaries, Wages, Benefits, & Prof Fees	127,865	133,564	131,405	132,172	129,347	128,970	127,403	127,902	132,021	136,071
b. Contractual Services	30,095	30,498	32,634	30,289	29,911	29,361	29,721	30,583	31,568	32,537
c. Interest on Current Debt	1,854	1,816	761	430	407	388	194	-	-	-
d. Interest on Project Debt	-	-	-	-	-	-	11,371	21,278	14,601	14,042
e. Current Depreciation	4,305	5,340	8,132	8,690	8,324	7,120	3,560	-	-	-
f. Project Depreciation	-	-	-	-	-	-	14,264	28,983	29,626	29,626
g. Current Amortizaton	1,268	1,268	1,268	1,268	1,268	1,268	634	-	-	-
h. Project Amortiziation	-	-	-	-	-	-	118	237	237	237
i. Supplies	32,844	33,633	35,935	35,378	35,663	36,131	36,351	37,180	38,377	39,554
j. Other Expenses										
- Physician Support	20,734	23,855	26,750	23,906	25,388	25,486	25,005	24,983	24,529	22,375

- Uitlities	2,713	1,184	2,610	2,584	2,545	2,511	2,527	2,584	2,668	2,749
k. Total Operating Expenses	221,678	231,158	239,495	234,718	232,853	231,237	251,148	273,730	273,626	277,190
3. Income										
a. Income from Operations	7,352	1,014	2,690	3,738	9,444	14,988	8,613	1,082	13,860	15,888
b. Non-Operating Income										
- Investment Income	17	12	86	86	86	86	86	86	86	86
- State Grant Capital Support	-	-	-	7,500	-	-	-	-	-	-
c. Subtotal	7,369	1,026	2,776	11,324	9,530	15,074	8,699	1,168	13,946	15,974
d. Income Taxes	-	-	-	-	-	-	-	-	-	-
e. Net Income (Loss)	$ 7,369	$ 1,026	$ 2,776	$ 11,324	$ 9,530	$ 15,074	$ 8,699	$ 1,168	$ 13,946	$ 15,974
4. Patient Mix										
A. Percent of Total Revenue										
1. Medicare	27.4%	27.4%	27.4%	27.4%	27.4%	27.4%	27.6%	27.9%	28.3%	28.7%
2. Medicaid	33.5%	33.5%	33.5%	33.5%	33.5%	33.5%	33.1%	32.1%	31.2%	30.2%
3. Blue Cross	10.5%	10.5%	10.5%	10.5%	10.5%	10.5%	10.3%	10.0%	9.7%	9.4%
4. Commercial Insurance	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	12.0%	13.4%	14.8%	16.2%
5. Self Pay	10.7%	10.7%	10.7%	10.7%	10.7%	10.7%	10.6%	10.3%	10.0%	9.7%
6. Other	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.2%	6.0%	5.8%
7. Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
B. Percent of Patient Days										
1. Medicare	34.1%	34.5%	34.5%	34.5%	34.5%	34.1%	34.8%	35.1%	35.3%	35.6%
2. Medicaid	34.1%	34.6%	34.6%	34.6%	34.6%	34.1%	30.1%	28.6%	27.1%	25.8%
3. Blue Cross	8.6%	8.2%	8.2%	8.2%	8.2%	8.6%	7.6%	7.2%	6.9%	6.5%
4. Commercial Insurance	12.8%	12.9%	12.9%	12.9%	12.9%	12.8%	18.3%	20.4%	22.4%	24.3%
5. Self Pay	9.5%	8.9%	8.9%	8.9%	8.9%	9.5%	8.4%	8.0%	7.6%	7.2%
6. Other	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.8%	0.7%	0.7%	0.6%
7. Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

(INSTRUCTION: ALL APPLICANTS OPERATING EXISTING FACILITIES MUST SUBMIT THEIR MOST RECENT AUDITED FINANCIAL STATEMENTS)

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project) – MWPH

	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)						
Fiscal Year	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21
1. Revenue										
a. Inpatient Services	$39,036	$42,757	$48,070	$49,063	$49,760	$50,410	$51,054	$51,765	$52,427	$53,019
b. Outpatient Services	12,180	12,723	13,822	14,237	14,664	15,104	15,817	16,320	16,809	17,313
c. Gross Patient Services Revenues	51,216	55,479	61,892	63,299	64,423	65,514	66,871	68,084	69,236	70,333
d. Allowance for Bad debt	496	533	589	633	644	655	669	681	692	703
e. Contractual Allowance	3,124	3,360	4,002	4,107	4,251	4,359	4,490	4,490	4,490	4,490
f. Charity Care	55	67	73	75	76	78	81	82	84	85
g. Net Patient Services Revenue	47,541	51,519	57,227	58,484	59,452	60,422	61,632	62,831	63,970	65,054
h. Other Operating Revenues (Specify)	714	2,912	750	765	780	796	812	828	845	862
i. Net Operating Revenues	48,255	54,431	57,977	59,249	60,232	61,218	62,444	63,659	64,815	65,916

Table 3 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)						
Fiscal Year	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21
2. Expenses										
a. Salaries, Wages. And Professional Fees, (including fringe benefits)	$32,856	$34,069	$39,117	$40,965	$41,439	$41,819	$42,365	$42,745	$43,161	$43,574
b. Contractual Services	4,792	5,417	5,596	5,860	5,928	5,982	6,061	6,115	6,175	6,234
c. Interest on Current Debt	62	83	151	151	151	151	151	151	151	151

d. Interest on Project Debt										
e. Current Depreciation	1,777	2,025	2,381	2,472	2,666	2,816	2,898	2,985	3,074	3,167
f. Project Depreciation										
g. Current Amortization										
h. Project Amortization										
i. Supplies	4,683	5,136	5,748	6,020	6,089	6,145	6,225	6,281	6,342	6,403
j. Other Expenses (Specify)	2,024	1,896	2,322	2,432	2,460	2,482	2,515	2,537	2,562	2,587
k. Total Operating Expenses	46,194	48,626	55,315	57,900	58,733	59,395	60,214	60,814	61,465	62,115
3. Income										
a. Income from Operation	2,061	5,805	2,662	1,349	1,499	1,822	2,230	2,845	3,349	3,801
b. Non-Operating Income	(111)	1,813	1,082	1,187	1,164	1,160	1,194	1,224	1,254	1,286
c. Subtotal	1,950	7,618	3,744	2,536	2,663	2,982	3,424	4,069	4,604	5,087
d. Income Taxes			-							
e. Net Income (Loss)	$1,950	$7,618	$3,744	$2,536	$2,663	$2,982	$3,424	$4,069	$4,604	$5,087

Table 3 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)						
Fiscal Year	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21
4. Patient Mix: A. Percent of Total Revenue										
1) Medicare	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%
2) Medicaid	70.3%	71.3%	70.8%	70.8%	70.8%	70.8%	70.8%	70.8%	70.8%	70.8%
3) Blue Cross	16.9%	12.7%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%
4) Commercial Insurance	5.9%	7.3%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%
5) Self Pay	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
6) Other (Managed care)	6.5%	8.2%	7.4%	7.4%	7.4%	7.4%	7.4%	7.4%	7.4%	7.4%

7) Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
B. Percent of Patient Days\Visits\Procedures (as applicable)										
1) Medicare	0.1%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
2) Medicaid	77.1%	79.6%	78.3%	79.0%	78.7%	78.8%	78.8%	78.8%	78.8%	78.8%
3) Blue Cross	12.5%	9.0%	10.7%	9.9%	10.3%	10.1%	10.2%	10.1%	10.2%	10.2%
4) Commercial Insurance	4.9%	4.6%	4.8%	4.7%	4.7%	4.7%	4.7%	4.7%	4.7%	4.7%
5) Self Pay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
6) Other (Managed care)	5.5%	6.6%	6.0%	6.3%	6.2%	6.2%	6.2%	6.2%	6.2%	6.2%
7) Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

(INSTRUCTION: Each applicant should complete this table for the proposed project only)

Note: PGHC is not providing Table 4 based on conversations with CON Staff on other projects. PGHC recognizes that CON Staff has the right to request PGHC to complete Table 4.

	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20____	20____
1. Revenues				
a. Inpatient Services				
b. Outpatient Services				
c. Gross Patient Service Revenue				
d. Allowance for Bad Debt				
e. Contractual Allowance				
f. Charity Care				
g. Net Patient Care Service Revenues				
h. Other Operating Revenues (Specify)				
i. Net Operating Revenue				
2. Expenses				
a. Salaries, Wages and Professional Fees (including fringe benefits)				
b. Contracted Services				
c. Interest on Current Debt				
d. Interest on Project Debt				
e. Current Depreciation				
f. Project Depreciation				
g. Current Amortization				
h. Project Amortization				
i. Supplies				

j. Other Expenses (Specify)				
k. Total Operating Expenses				

Table 4 cont.	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20____	20____
3. Income				
a. Income from Operation				
b. Non-Operating Income				
c. Subtotal				
d. Income Taxes				
e. Net Income (Loss)				
4. Patient Mix: **A. Percent of Total Revenue**				
1) Medicare				
2) Medicaid				
3) Blue Cross				
4) Commercial Insurance				
5) Self-Pay				
6) Other (Specify)				
7) TOTAL	100%	100%	100%	100%
B. Percent of Patient Days\Visits\Procedures (as applicable)				
1) Medicare				
2) Medicaid				
3) Blue Cross				
4) Commercial Insurance				
5) Self-Pay				
6) Other (Specify)				
7) TOTAL	100%	100%	100%	100%

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT – MWPH at PGHC

	Two Most Recent Actual Years		Current Year Projected					Projected Years (ending with first year at full utilization)		
Fiscal Year	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21
1. Revenue										
a. Inpatient Services	$3,187	$4,644	$4,640	$4,975	$5,065	$5,113	$5,204	$5,295	$5,344	$5,437
b. Outpatient Services	$1,234	$1,202	$1,786	$1,786	$1,786	$1,786	$1,953	$2,788	$3,122	$3,122
c. Gross Patient Services Revenues	4,421	5,846	6,426	6,761	6,851	6,899	7,157	8,083	8,466	8,559
d. Allowance for Bad debt	44	58	64	68	69	69	72	81	85	86
e. Contractual Allowance	290	384	418	439	445	448	465	525	550	556
f. Charity Care	5	7	8	8	8	8	9	10	10	10
g. Net Patient Services Revenue	4,082	5,396	5,937	6,246	6,329	6,373	6,611	7,467	7,821	7,907
h. Other Operating Revenues (Specify)	55	106	168	168	168	168	168	168	168	168
i. Net Operating Revenues	4,137	5,502	6,105	6,414	6,497	6,541	6,779	7,635	7,989	8,075

Table 3 cont.	Two Most Recent Actual Years		Current Year Projected					Projected Years (ending with first year at full utilization)		
Fiscal Year	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21
2. Expenses										
a. Salaries, Wages. And Professional Fees, (including fringe benefits)	$3,282	$3,529	$3,598	$3,630	$3,662	$3,693	$3,911	$4,128	$4,160	$4,191
b. Contractual Services	93	149	333	351	355	358	397	460	483	488
c. Interest on Current Debt										
d. Interest on Project Debt										
e. Current Depreciation										
f. Project Depreciation										
g. Current Amortization										
h. Project Amortization										
i. Supplies	891	963	983	1,035	1,049	1,056	1,172	1,358	1,426	1,442
j. Other Expenses (Specify)	104	123	120	126	128	129	267	310	325	329

k. Total Operating Expenses	4,369	4,765	5,034	5,142	5,194	5,237	5,746	6,255	6,394	6,450
3. Income										
a. Income from Operation	(232)	737	1,071	1,272	1,303	1,305	1,033	1,380	1,595	1,624
b. Non-Operating Income										
c. Subtotal	(232)	737	1,071	1,272	1,303	1,305	1,033	1,380	1,595	1,624
d. Income Taxes										
e. Net Income (Loss)	-$232	$737	$1,071	$1,272	$1,303	$1,305	$1,033	$1,380	$1,595	$1,624

Estimated Overhead Expenses	5,527	6,027	6,368	6,504	6,570	6,624	7,269	7,913	8,088	8,160
Income from Operations w/Overhead	(1,390)	(525)	(263)	(90)	(73)	(83)	(490)	(278)	(99)	(85)
Net Income with Overhead	(1,390)	(525)	(263)	(90)	(73)	(83)	(490)	(278)	(99)	(85)

Table 3 cont.	Two Most Recent Actual Years		Current Year Projected					Projected Years (ending with first year at full utilization)		
Fiscal Year	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21
4. Patient Mix:										
A. Percent of Total Revenue										
1) Medicare	0.5%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
2) Medicaid	79.2%	80.6%	79.9%	79.9%	79.9%	79.9%	79.9%	79.9%	79.9%	79.9%
3) Blue Cross	12.2%	10.0%	11.1%	11.1%	11.1%	11.1%	11.1%	11.1%	11.1%	11.1%
4) Commercial Insurance	3.1%	4.3%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%
5) Self Pay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
6) Other (Managed care)	5.1%	4.8%	4.9%	4.9%	4.9%	4.9%	4.9%	4.9%	4.9%	4.9%
7) Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
B. Percent of Patient Days\Visits\Procedures (as applicable)										
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2) Medicaid	77.0%	82.6%	79.8%	81.2%	80.5%	80.8%	80.7%	80.7%	80.7%	80.7%
3) Blue Cross	12.8%	8.5%	10.7%	9.6%	10.1%	9.8%	9.9%	9.9%	9.9%	9.9%
4) Commercial Insurance	3.7%	3.5%	3.6%	3.6%	3.6%	3.6%	3.6%	3.6%	3.6%	3.6%
5) Self Pay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
6) Other (Managed care)	6.5%	5.4%	5.9%	5.7%	5.8%	5.8%	5.8%	5.8%	5.8%	5.8%
7) Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

COMAR 10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.

To meet this subsection, an applicant shall demonstrate compliance with all conditions applied to previous Certificates of Need granted to the applicant.

List all prior Certificates of Need that have been issued to the project applicant by the Commission since 1990, and their status.

PGHC

PGHC has received approval for one CON project since 1990:

- In 1996, PGHC received a CON (Docket #96-16-1901) for the establishment of an 18 bed Neonatal Intensive Care Unit (NICU). Project was completed and service opened. PGHC completed work for the CON and has complied with all conditions.

MWPH

MWPH has received approval for two CON projects since 1990:

- On February 18, 1994, MWPH was issued an Emergency CON (Docket #94-24-1741) to move 27 specialty pediatric beds from Lutheran Hospital to Montebello Rehabilitation Hospital due to a facility emergency. As a condition to granting the Emergency CON, MWPH was to complete a Certificate of Need application on or before March 18, 1994. MWPH submitted a timely application to relocate the 27 specialty pediatric beds to Harbor Hospital Center. MWPH withdrew that application before decision due to decreasing occupancy. Thus, the conditions of the emergency CON were satisfied.

- On October 8, 1996, MWPH was issued a CON (Docket #96-24-1966) to move 15 specialty pediatric beds to Prince George's Hospital Center facility. Project was completed. MWPH completed work for this CON and has complied with all conditions.

Copies of the applicable CON Orders are attached as **Exhibit 26.**

COMAR 10.24.01.08G(3)(f). Impact on Existing Providers.

For evaluation under this subsection, an applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the

impact on geographic and demographic access to services, on occupancy when there is a risk that this will increase costs to the health care delivery system, and on costs and charges of other providers.

Indicate the positive impact on the health care system of the Project, and why the Project does not duplicate existing health care resources. Describe any special attributes of the project that will demonstrate why the project will have a positive impact on the existing health care system.

Complete Table 5

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1. **An assessment of the sources available for recruiting additional personnel;**

2. **Recruitment and retention plan for those personnel believed to be in short supply;**

   For existing facilities, a report on average vacancy rate and turnover rates for affected positions,

PGHC

PGHC has projected the impact on other facilities by using the methodology used by the MHCC in Commissioner Barbara McLean's proposed decision on the CON application for the relocation of Washington Adventist Hospital (Docket No. 09-15-2295) (see Proposed Decision, Pp. 157-162). In addition, PGHC has reflected some additional recapture of market share that it has lost over the past decade in service lines that were affected by the loss of a physician, upcoming PGHC recruitment initiatives, and other reasons, as described previously. Also, as described previously, one of the goals of this project is to reduce the number of patients who are traveling outside of the state of Maryland to receive care. The result of these projections is reduction in utilization at most other hospitals in Washington, DC, Maryland, and Virginia. Table 33 shows a summary of the impact of these projections on other hospitals. **Exhibit 27** shows the

impact of each factor, such as population changes, impact of the move to Largo using the MHCC methodology, and recapture of market share.

Table 33
Impact on Other Hospitals
2021

Estimated Impact on Maryland Hospital Discharges FY2021			Estimated Impact on Non-Maryland Hospital Discharges FY2021	
Hospital	Change in Discharges	2012 Discharges	Hospital	Change in Discharges
Southern Maryland Hospital Center	(615)	16,866	Washington Hospital Center	(811)
Anne Arundel Medical Center	(394)	33,394	Georgetown University Hospital	(272)
Doctor's Community Hospital	(83)	12,052	George Washington University Hospital	(189)
Johns Hopkins Hospital	(70)	48,206	Providence Hospital	(84)
Holy Cross Hospital	(56)	36,251	Children's National Medical Center	(77)
University of Maryland Medical Center	(50)	28,259	Other DC Hospitals	(179)
Fort Washington Medical Center	(40)	2,185	Total DC Hospitals	(1,611)
Howard County General Hospital	(17)	19,000		
Laurel Regional Hospital	(17)	6,627	Inova Alexandria Hospital	(44)
Suburban Hospital	(10)	14,172	Inova Fairfax Hospital	(41)
Shady Grove Hospital	(4)	26,020	Virginia Hospital Center - Arlington	(38)
Montgomery General Hospital	11	13,162	Inova Mount Vernon Hospital	(29)
Washington Adventist Hospital	146	14,744	Inova Fair Oaks Hospital	(6)
Other MD Hospitals	(114)		Other VA Hospitals	(20)
Total Maryland Recapture	(1,314)		Total VA Hospitals	(178)
			Total Non-Maryland Recapture	(1,789)

As the inpatient utilization of Maryland hospitals is reduced, the inpatient revenue at these hospitals will be proportionately reduced. This reduction in revenue in each year, though, will be offset by a 15% increase in the following year in the form of a prospective volume adjustment. This impact on revenue would not be applicable to TPR hospitals which operate on a fixed revenue base. There are no TPR hospitals, though, in PGHC's service area that would be impacted by PGHC's relocation and recapture of market share.

Any reduction in volumes and related revenue at Maryland hospitals is expected to be partially offset by a reduction in variable expenses. Applying an assumption of 60% variability of expenses with changes in volumes suggests that for every 1%

reduction in volumes, it is expected that the affected Maryland hospitals will be able to reduce their variable expenses by 0.6%.

The proposed project will have no negative effects on other providers and will have positive effects on the health care system as a whole.

- The project will address and resolve considerable deficiencies in the current site. (See Project Description)

- PGHC believes that the project will assist PGHC in recruiting and retaining physicians, which is a challenge in its service area.

- The existing PGHC has 73 semi-private rooms. (See **Exhibit 28**, Physical Bed Chart) The new PGHC will have all private rooms. Higher occupancy rates than are achievable with semi-private rooms. Private rooms also enhance patient satisfaction and family involvement, reduce the risk of infection, and reduce the need for transfers due to patient incompatibility.

  Copies of letters of support for the proposed project are included as Exh. 18.

  PGHC utilizes various recruitment strategies as listed:

  1. Succession planning – promote from within.
  2. Workforce development – this is part of the HR Strategic Plan.
  3. Offer various scheduling options through Supplemental Staffing (Relief, Per Diem, Short Term Assignment, and Float pool).
  4. Relocation assistance.
  5. Tuition Reimbursement.
  6. Shared Governance (chaired by staff nurse; nurses participate in unit & hospital committees).
  7. Professional Advancement Program – Provides professional opportunities for nurses who demonstrated advance nursing knowledge.
  8. Career Fairs – An alumnus sometimes attends a career fair with recruiters when possible.
  9. Critical Care/Graduate University -4-9 month Residency program for New RN Graduates to be implemented.
  10. Meet monthly with nursing leadership to review vacancy, turnover, new initiatives and strategies to fill future needs.
  11. Awareness of generational needs – College graduates thrive on quick delivery and constant feedback while some seasoned workers prefer face-to-face interaction and phone calls instead of text.
  12. Internships.
  13. PGHC uses fewer print ads-it uses specialty websites (i.e. nurse.com).

14. Long term relationships with nursing schools and other universities (PGHC is a clinical site).
15. Usage of behavioral interviewing, professional development assessments, assess Magnet qualities and cultural fit, provide benefit summary as part of Total Rewards - the goal is to create positive and memorable impressions.
16. PGHC will institute an applicant assessment tool in FY13 that will be used to determine which candidate is truly the best "fit" for the posted position. This method is intended to "weed" out those persons who may not be optimum performers and assist recruiters in presenting the top 3-4 scoring candidates to the hiring manager. This approach will result in better hiring decisions, high performing employees, sustained retention and a noticeable reduction in time to fill.
17. PGHC rarely offers sign-on bonus or utilize recruitment agencies for staff position, but does consider them for difficult to fill positions. In addition to the current approaches, PGHC is strengthening social networking (Faceboook, LinkedIn) and increasing employee referrals.

Currently, PGHC is evaluating its overall talent management systems strategy with the intent of upgrading and/or adopting more effective and efficient HCM systems. This will improve return on investment, data integrity, accuracy, and improve access to reliable employee information online.

The Vacancy and Turnover Rate for RNs at PGHC for the past two years are as follows:

FY	Vacancy	Turnover
FY12	7.0%	10.6%
FY13	7.1%	11.9%

MWPH

As discussed previously, the MWPH unit at PGHC is a statewide resource. MWPH's patients live in all regions of Maryland. MWPG at PGHC provides a more geographically proximate alternative for patients' families than being admitted to MWPH in Baltimore City. MWPH at PGHC improves access for many of these families.

MWPH has provided the following staff and services, and will continue to provide these services in the new facility:

A nurse manager oversees the operation at PGHC and serves as the communication and facilitating link between MWPH's operation at PGHC and MWPH in Baltimore, as well as with the administrative team of PGHC. This individual ensures the quality of services delivered to the patients, adherence to the policies and procedures of both institutions and appropriate cost effective use of all resources.

MWPH nurse liaisons identify patients who will benefit from MWPH's services and assist in the referral/transfer process to the unit. These are not specific to PG site; all the liaisons work for both sites.

MWPH provides 24 hour seven day per week coverage of physicians and all nurses (at the appropriate mix of licensed to non-licensed professionals). Such staff will include Registered Nurses and Nurse Technicians as needed. All nursing staff have current Maryland nursing licenses. Nurses are selected by MWPH in accordance with the standards that have been established to provide current pediatric and neonatal skills which are specialized for the care of MWPH's type of patient.

A Social Worker/Care Manager coordinates the internal care to be provided at the PGHC location, and facilitates the discharge process, utilization review process, and integration of home/community care needs of the patient. This position is critical to this operation in assuring that all services are delivered at the appropriate time and quality. Social work staff are licensed in the state of Maryland, serving this unit by also providing for the family interventions and discharge coordination. Experience has shown that these patients and families require a great deal of time and energy in meeting their

social and community resource needs. MWPH social workers/care managers have developed an enormous network of contacts and resources that will assist their families once discharged from the institution.

Pediatric expertise in the areas of physical therapy, occupational therapy and speech and language pathology are provided as needed. These services will be available five days per week, Monday through Friday. These staff are selected and oriented to assure that all staff possess the necessary pediatric skills of developmental assessment and treatment planning. All of these employees possess current practice licenses in the state of Maryland.

Child Life services are provided to meet and address patients' social/emotional, play, developmental and leisure needs in the hospital setting.

Respiratory therapy services are currently provided through a contractual arrangement with Prince Georges County Hospital Center.

An MWPH dietician completes a full nutrition assessment on all admissions. Weekly follow-up is provided as needed.

Clerical support is provided for patient registration, patient intake, insurance verification, correspondence, meeting minutes, phone calls and scheduling.

MWPH employs board certified pediatricians to be on site 24/7 in order to provide direct medical care to these patients and supervise the clinical operation of the other services. A pediatric nurse practitioner will also provide medical care. MWPH physician program subspecialists, either staff or consultants, will be on site at PGHC as needed.

MWPH contracts with PGHC to provide services including: housekeeping, laundry, food, maintenance, heat/utilities, and trash removal. PGHC also provides

dietary consultations (per consult), radiology (per test basis), laboratory (per test basis) and supplies (per charge basis) on a contractual basis.

MWPH is considered an attractive employer, and advertisements in the Baltimore-Washington metropolitan area, along with open houses, will be offered to recruit additional personnel. Significantly, MWPH has training agreements with a number of professional schools in the metropolitan area. These programs are excellent sources of personnel. In addition, Staff at MWPH in Baltimore are offered the opportunity to transfer to MWPH at PGHC.

MWPH has not experienced difficulty in recruiting quality personnel in the past and does not anticipate a problem in the future.

The Vacancy and turnover rates at MWPH at PGHC are as follows:

RN Turnover = 10.2%
Vacancy = 6.8%

TABLE 5: MANPOWER INFORMATION - PGHC:

(INSTRUCTION: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project.)

(INSTRUCTION: FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours.)

Expense Centers	2014 FTEs	Change in FTEs	Avg Salary per FTE	2021 Total Cost
Executive Office/Administration				
120854000 PHYSICIAN ASSISTANTS	19.50	(2.12)	$100,933	$1,754,476
120901000 EXECUTIVE OFFICES	6.00	(0.65)	118,125	631,797
120910000 COMMUNICATIONS	11.20	(1.22)	34,279	342,234
Total - Executive Office/Administration	36.70	(3.99)	$83,402	$2,728,508
Corporate Allocations/Overhead - Direct & Indirect	15.80	(1.72)	$202,517	$2,852,337
Planning/Public Affairs				
120921000 MARKETING & PUBLIC REL	2.49	(0.27)	$68,034	$151,294
Total - Planning/Public Affairs	2.49	(0.27)	$68,034	$151,294
Fiscal Services				
120902000 PT FINANCIAL SVCS	38.66	(4.20)	$45,675	$1,574,048
120902100 MEDICAID ELIGIBILITY	1.80	(0.20)	40,138	64,403
120903000 REGISTRATION	27.30	(2.96)	37,245	906,396
120908000 MIS	-			176,554
120970000 HEALTH INFO MGT(MED RECOR	30.21	(3.28)	53,719	1,446,688
Total - Fiscal Services	97.97	(10.64)	$47,726	$4,168,088
Human Resources				
120916000 HUMAN RESOURCES	14.60	(1.59)	$85,635	$1,114,521
120919000 EMPLOYEE HEALTH	2.50	(0.27)	74,672	166,410
Total - Human Resources	17.10	(1.86)	$84,033	$1,280,930
Medical Affairs				
120855000 INTERNAL MEDICINE	45.00	(4.89)	$53,645	$2,151,914
120856000 MEDICAL AFFAIRS OFFICE	5.30	(0.58)	60,110	283,988

120975000 CASE MANAGEMENT	25.40	(2.76)	82,273	1,862,861
Total - Medical Affairs	75.70	(8.22)	$63,704	$4,298,764
Quality Affairs				
120603000 INFECTION CONTROL	3.00	(0.33)	$102,298	$273,617
120852000 CLINICAL DOCUMENTATION	5.00	(0.54)	85,197	379,732
120857000 RISK MANAGEMENT	2.00	(0.22)	88,026	156,938
120859000 QUALITY IMPROVEMENT	9.30	(1.01)	80,274	665,696
Total - Quality Affairs	19.30	(2.10)	$85,776	$1,475,983
Nursing				
120600000 NURSING ADMINISTRATION	8.80	0.49	$64,625	$600,341
120600200 INPATIENT OPERATIONS	25.00	1.39	105,233	2,777,187
120601000 ON CALL FLOAT POOL	22.60	1.26	35,004	835,092
120601200 NURSING INTERNSHIP/GRADS	2.00	0.11	57,288	120,947
120602000 HOSPITAL EDUCATION	8.60	0.48	77,451	703,137
120603500 PATIENT TRANSPORT	14.40	0.80	30,113	457,755
120611000 NURSING E 900 (MS-TELE/ON	41.19	2.29	68,956	2,998,460
120612000 NURSING E 700 (MS-TELE)	39.30	2.19	71,656	2,972,623
120612500 NURSING E-800 (MS-ORTHO/T	44.71	2.49	69,823	3,295,784
120624000 NURSING K400 - PCRU	87.29	4.86	63,429	5,844,980
120640000 NURSING E 600 PEDIATRICS	10.20	0.57	81,422	876,714
120651000 NURSING K 200 - ANTE/POST	45.90	(3.50)	78,261	3,318,076
120660000 NURSING - CCU	20.50	1.14	81,795	1,770,226
120663000 NURSING - ICU/CCC	86.50	4.81	74,970	6,845,434
120666000 NURSING - PSYCH	33.70	1.87	71,863	2,556,520
120672000 NURSING - NICU	35.00	(2.67)	88,220	2,852,463
120701000 OPERATING ROOM	51.70	2.88	68,222	3,723,629
120702000 PERFUSION SERVICES	2.00	0.11	129,058	272,474
120704000 POST ANESTHESIA CARE UNIT	18.00	1.00	86,040	1,634,883
120706000 SAME DAY SURGERY	8.10	0.45	73,566	629,036
120707000 TRANSCARE	4.40	0.24	88,635	411,837
120708000 LABOR AND DELIVERY	41.40	(3.16)	81,158	3,103,552
120718000 CENTRAL STERILE PROCESSIN	12.90	0.72	38,207	520,289
120724000 ANESTHESIOLOGY	4.00	0.22	48,225	203,630
120725000 HEMODIALYSIS	8.80	0.49	78,076	725,363
120744000 CARDIOLOGY	8.20	0.46	79,248	685,983

120746000 CARDIAC CATH LAB	10.60	0.59	90,247	1,009,745
120763100 CARDIAC REHAB	2.20	0.12	83,442	193,785
120770000 PSYCH-PARTIAL HOSPITALIZA	3.50	0.19	70,833	261,705
120771100 SMOKING CESSATION	1.20	0.07	50,825	64,384
120772000 EMERGENCY PSYCH SERVICE-E	15.50	0.86	77,380	1,266,118
120778500 EMERGENCY-LABOR & DELIVERY	4.20	(0.32)	72,999	283,197
120781000 PERINATAL DIAGNOSTIC CTR	4.20	0.23	68,985	305,857
120783200 SPECIAL PROCEDURES	5.30	0.29	70,542	394,671
120789000 INFUSION CENTER	1.50	0.08	54,750	86,694
120844000 CARDIAC SERVICES	1.00	0.06	94,238	99,479
120918000 NURSING SUPPORT PROGRAM	1.70	0.09	96,122	172,497
120926000 CUSTOMER SERVICE	1.00	0.06	63,481	67,012
Total - Nursing	737.11	24.31	$72,156	$54,941,560
Ambulatory Care & Ancillary Services				
120710000 PHARMACY	36.00	2.00	$84,516	$3,212,243
120719000 PATHOLOGY ADMINISTRATION	52.00	2.89	64,776	3,555,737
120722000 ANGIOGRAPHY	3.50	0.19	70,478	260,396
120728000 RADIOLOGY	32.00	1.78	61,571	2,079,994
120729000 ULTRASOUND	6.20	0.34	71,450	467,638
120730000 CAT SCAN	7.00	0.39	78,414	579,436
120731000 VASCULAR LAB	3.40	0.19	91,978	330,122
120732000 NUCLEAR MEDICINE	3.40	0.19	105,224	377,667
120745000 PULMONARY FUNCTION	1.10	0.06	85,277	99,023
120748000 ELECTROENCEPHALOGRAPHY	1.00	0.06	84,842	89,561
120752000 RESPIRATORY THERAPY	29.00	1.61	82,270	2,518,158
120760000 PHYSICAL MEDICINE	11.00	0.61	65,034	755,171
120761000 OCCUPATIONAL THERAPY	3.70	0.21	84,547	330,227
120762000 SPEECH THERAPY	2.70	0.15	94,427	269,138
Total - Ambulatory Care & Ancillary Services	192.00	10.68	$73,635	$14,924,512
Emergency Services				
120769000 SEXUAL ASSAULT CENTER	8.30	0.46	$66,073	$578,983
120774000 EMERGENCY SERVICES	92.30	5.13	87,795	8,553,969
120835000 TRAUMA	5.20	0.29	60,798	333,739
Total - Emergency Services	105.80	5.89	$84,764	$9,466,692
New Departments				

Cardiac		35.00	$126,115	$4,414,042
Cancer		13.00	69,696	906,048
Total - New Departments		48.00	$110,835	$5,320,090
Support Services				
120930000 FOOD SERVICES	56.30	(6.11)	$40,715	$2,043,289
120940000 ENVIRONMENTAL SERVICES	86.21	(9.36)	33,775	2,595,601
120963000 CLINICAL ENGINEERING	8.00	(0.87)	87,712	625,506
120964000 MAINTENANCE	23.40	(2.54)	57,855	1,206,820
Total - Support Services	173.91	(18.88)	$41,743	$6,471,215
Materials Management				
120912000 MATERIALS MANAGEMENT	17.30	(1.88)	$50,368	$776,758
Total - Materials Management	17.30	(1.88)	$50,368	$776,758
Total Salaries	**1,491.19**	**39.34**	**$71,124**	**$108,856,731**
Benefits @ 25%				$27,214,183
Total Salaries and Benefits				**$136,070,913**

(INSTRUCTION: Indicate method of calculating benefits percentage):

The benefits percentage is 25% of total salaries, is based upon the historical experience of total benefits to total salaries.

TABLE 5: MANPOWER INFORMATION – MWPH at PGHC

Position Title	Current No. FTEs	2021 FTEs	Changes in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL Total
Administration						
Site Manager	1.0	1	0	$92,077	Employee	$92,077
Unit Clerk	1.0	1	0	$33,818	Employee	$33,818
Outpatient clerical	1.1	1.1	0	$39,674	Employee	$43,641
Direct Care						
RN	13.4	14.7	1.3	$81,957	Employee	$1,201,779
CNAs	0.1	0.1	-	$34,646	Employee	$3,465
PT	0.8	1.6	0.8	$71,583	Employee	$114,532
OT	0.8	1.6	0.8	$81,554	Employee	$130,487
SP	1.0	2.0	1.0	$86,646	Employee	$173,292
Psych	1.0	2.0	1.0	$90,380	Employee	$180,760
Respiratory Therapy	0.9	1.1	0.2	$97,248	Contractual	$104,080
Medicine	6.6	6.9	0.3	$160,359	Employee	$1,108,802
Outpatient RN	1.0	1.0	-	$70,437	Employee	$70,437
Outpatient PCA	0.6	0.6	-	$33,733	Employee	$21,252
Support						
Social Work	0.9	1.1	0.2	$64,666	Employee	$70,462
Child Life	0.5	0.6	0.1	$38,231	Employee	$22,397
Dietary	0.2	0.2	0.0	$84,864	Employee	$19,886
TOTAL SALARIES						$3,391,168
TOTAL BENEFITS						$800,316
TOTAL SALARIES, WAGES AND PROFESSIONAL FEES (INCLUIDNG FRINGE BENEFITS)						$4,191,484

The benefits percentage, currently 23.6% of total salaries, is based upon the historical experience of total benefits to total salaries.

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

1. List names and addresses of all owners and individuals responsible for the proposed project and its implementation.

Sheldon Stein
President & CEO
Mt. Washington Pediatric Hospital
1708 West Rogers Avenue
Baltimore, MD 21209-4596

2. Are the applicant, owners, or the responsible persons listed above now involved, or have they ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of these facilities, including facility name, address, and dates of involvement.

Please list all of the facilities at which Mr. Stein has had management responsibility, listing their facility name, address, and dates of involvement

University Hospital – University of Colorado Health Science Center
April 1984 to February 1995

3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to number 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owners or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

No

4. Are any facilities with which the applicant is involved, or have any facilities with which the applicant has in the past been involved (listed in response to Question 2, above) ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to actions to suspend the licensure or certification at the applicant's facility or facilities listed in response to Question 2? If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable governmental authority.

No

5. Have the applicant, owners or responsible individuals listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).

No

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

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

September 25, 2013
Date

Sheldon Stein
President & CEO

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

1. List names and addresses of all owners and individuals responsible for the proposed project and its implementation.

Neil J. Moore, President and CEO
John A. O'Brien, COO

Dimensions Healthcare System
3001 Hospital Drive
Cheverly, MD 20785

2. Are the applicant, owners, or the responsible persons listed above now involved, or have they ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of these facilities, including facility name, address, and dates of involvement.

Neil J. Moore facilities:

Dimensions Healthcare System, President & CEO 2011-present
Dimensions Healthcare System, Chief Financial Officer 2005-2011
New York Health & Hospitals Corp:
Harlem Hospital Health Network, CFO 2003-2005
Woodhull Hospital Health Network, Deputy CFO 1999-2003
Dr. McKinney Skilled Nursing Facility, COO / CFO 1998-1999
Kings County Hospital, Interim Dep CFO 1996-1997
Kings County Hospital, various positions in HR and Network Management 1989-1996

John A. O'Brien facilities:

Prince George's Hospital Center, President 2005-present
Harper Hospital, Detroit Medical Center, Executive Vice President 1994-99
Hamot Medical Center (Erie PA), Executive Vice President 1989-1993
University Health Network (Univ. of Pittsburgh), President 1985-1989
Presbyterian University Hospital (Pittsburgh), Senior Vice President for Planning 1979-1985

3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to number 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owners or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

No

4. Are any facilities with which the applicant is involved, or have any facilities with which the applicant has in the past been involved (listed in response to Question 2, above) ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to actions to suspend the licensure or certification at the applicant's facility or facilities listed in response to Question 2? If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable governmental authority.

No

5. Have the applicant, owners or responsible individuals listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).

No

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

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

10/1/2013
Date

Neil J. Moore
President & CEO
Dimensions Healthcare System

10/1/2013
Date

John A. O'Brien
COO
Dimensions Healthcare System

AFFIRMATIONS

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

Oct. 1, 2013
Date

K. Singh Taneja
Chief Operating Officer
Prince George's Hospital Center

#481235
013346-0001

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

10/3/2013
Date

Patricia T. Tihansky
Director of Strategic Planning
Dimensions Health Corporation

Dimensions Healthcare System

Lisa M. Goodlett, CPA
SVP and Chief Financial Officer

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

10/3/13
Date

Lisa M. Goodlett
Chief Financial Officer
Dimensions Health Corporation

3001 Hospital Drive, Executive Office, Cheverly, Maryland 20785
TEL 301-618-2109 FAX 301-618-2883

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

9/25/13
Date

Mary Miller
Vice President, Finance and Business Development
Mt. Washington Pediatric Hospital

#480787
013346-0001

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

10/1/2013
Date

Andrew L. Solberg
A.L.S. Healthcare Consultant Services

#481240
013346-0001

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

10/1/2013
Date

Jeffrey Johnson
Vice President, Planning—Special Projects
University of Maryland Medical System

#481237
013346-0001