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November 4, 2013

**VIA EMAIL & HAND DELIVERY**

Ms. Ruby Potter  
Health Facilities Coordination Officer  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Re: CON Application-Prince George's Regional Medical Center  
As a Replacement and Relocation of Prince George's Hospital Center  
Matter No. 13-16-2351

Dear Ms. Potter:

Enclosed are ten copies of the "Responses to Completeness Questions Dated October 21, 2013" with respect to the CON Application of Dimensions Health Corporation d/b/a Prince George's Hospital Center and Mount Washington Pediatric Hospital, Inc. for Relocation of a General Acute Care Hospital and a Special Hospital-Pediatric.

Please sign and return to our waiting messenger the enclosed acknowledgment of receipt. Thank you for your assistance.

Sincerely,



Thomas C. Dame

TCD:blr

Enclosures

cc: Pamela B. Creekmur, Health Officer, Prince George's County  
Dr. Laurence Polsky, Health Officer, Calvert County  
Meenakshi G. Brewster, Health Officer, St. Mary's County  
Dianna E. Abney, Acting Health Officer, Charles County  
Patrick D. Dooley, Chief of Staff, Department of Health & Mental Hygiene  
Paul Parker, Director, Center for Health Care Facilities Planning & Development, MHCC  
Bradford L. Seamon, Chief Administrative Officer, Prince George's County Government  
Neil J. Moore, President & CEO, Dimensions Health Corporation  
Sheldon Stein, President & CEO, Mt. Washington Pediatric Hospital  
John O'Brien, Chief Operating Officer, Dimensions Healthcare System

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Carl Jean-Baptiste, Esquire, Senior Vice President & General Counsel, Dimensions  
Health Corporation

Patricia Tihansky, Strategic Planning & Marketing, Dimensions Health Corporation

John Ashworth, Sr. Vice President, Network Development, University of Maryland  
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Sandra H. Benzer, Esquire, Associate Counsel, University of Maryland Medical System

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Richard McAlee, Esquire, Hospital Counsel, MedStar Southern Maryland Hospital  
Center

**Dimensions Health Corporation d/b/a Prince George's Hospital Center  
Mount Washington Pediatric Hospital, Inc.  
Relocation of a General Acute Care Hospital and a Special Hospital-Pediatric  
Matter No. 13-16-2351  
Responses to Completeness Questions Received 10/21/13**

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**PART I – PROJECT IDENTIFICATION AND GENERAL INFORMATION**

**1. In June of this year, Prince George's Hospital Center ("PGHC") reported to MHCC that it had physical capacity for 367 acute care beds. Why is it now reported that the hospital only has physical capacity for 311 beds (page 3)?**

In calculating the physical bed count for the CON application, PGHC visually counted 311 headwalls in the hospital. As noted, PGHC previously disclosed a physical bed count of 367 beds. In light of the discrepancy, PGHC re-counted the beds on Friday, October 25, 2013. The new count confirmed that there are 311 physical beds in the building (including 15 beds used by MWPH). Also, PGHC determined that the earlier disclosure of 367 beds included 71 bassinets and Labor and Delivery Triage and Labor beds (which are for patients who have not yet been admitted). The reconciliation is as follows:

<b>Total Historic Count</b>	<b>367</b>
<b>K300 Nursery</b>	<b>(23)</b>
<b>K200 Nursery</b>	<b>(12)</b>
<b>K200 NICU</b>	<b>(22)</b>
<b>L&amp;D Triage</b>	<b>(3)</b>
<b>L&amp;D Labor</b>	<b>(11)</b>
<b>SUBTOTAL</b>	<b>296</b>
<b>MWPH Beds</b>	<b>15</b>
<b>Total Inpatient Beds</b>	<b>311</b>

**2. Provide a brief description of the outcome of the first four site zoning and approval process steps listed on page 4. Also report on any other progress or problems arising to date in the required sector plan and zoning map amendment, or the drafting of legislation making the hospital a permitted use at the site.**

The Prince George's County Planning Board of The Maryland-National Capital Park and Planning Commission held a work session on September 19, 2013, which was continued to October 3, 2013, to review comments contained in the hearing record and staff recommendations.

On October 10, 2013, the Planning Board adopted resolution PGCPB No. 13-96, transmitting to the District Council the Adopted Largo Town Center Sector Plan and endorsed Sectional Map Amendment, with the recommendation that the Council approve the proposals with the revisions described in the resolution of adoption.

The District Council held a work session on October 22, 2013, to consider public hearing testimony and the recommendations of the Planning Board as specified in adopted resolution PGCPB No. 13-96, and proposed an amendment to the Adopted Largo Town Center Sector Plan and Endorsed Sectional Map Amendment.

The County Council of Prince George's County, Maryland, sitting as the District Council for that portion of the Maryland-Washington Regional District in Prince George's County, voted to accept the Digest of Testimony presented by the Planning Department. The Council also directed its staff to prepare a Resolution of Approval for the Adopted Largo Town Center Sector Plan and Endorsed Sectional Map Amendment. Final Council approval is expected on November 12, 2013.

The Adopted Largo Town Center Sector Plan and Endorsed Sectional Map Amendment plan recommends a regional medical center at the designated site and provides for flexible height standards to accommodate the RMC's anticipated design.

On Tuesday, October 22, the County Council introduced legislation (CB-99-2013), which, if adopted, would allow the PGRMC to be developed as a permitted hospital use in the M-X-T zone, which is the zone recommended in the adopted Sector Plan for the RMC site. The Council will hold a public hearing on November 19, 2013 and the legislation is eligible for enactment by the Council on the same day.

At this time, the applicants anticipate no problems in acquiring the necessary zoning for the proposed PGRMC.

**3. The site plan (third page of Exhibit 2) refers to 261 beds (Hospital and Behavioral Health) and “future patient units” with 136 beds. Please clarify and reconcile with the table on page 3.**

The chart on page 3 of the application is correct, identifying 231 beds. The site plan Exhibit has been corrected to match the bed count chart and area summary from page 3. The corrected site plan is included as Exhibit 29 to this filing. The reference to 136 beds in the original site plan refers to the capacity of a potential second patient tower, should PGHC ever decide to construct one (not part of this project).

**4. Is there any below-grade space planned for this project?**

The site topography allows for at grade access for the Concourse Level and Level One. The Concourse Level opens to grade on the south and west sides, and Level One opens to grade on the north and east sides. The support areas of materials management, laboratory, and the linear accelerators are cut into the grade, but this floor level equals the grade level at the main entry locations. Refer to the attached Exhibit 30.

The percentage of the Concourse Level that is below grade is relatively small. As the calculation below shows, only 24% of that level is below grade. This section of the building will house the linear accelerators and other oncology treatment areas.

Concourse Level	
Total floor area	124,875
Area underground:	30,100
Calculated to mid-point of floor plate from retaining walls	
Percentage underground	24%

**5. What is the time frame for a decision by Prince George’s County to build and operate a parking garage on the proposed hospital campus? Is the project feasible without this garage? If not, what assurances can be provided that a plan for funding and development of this resource will be implemented?**

Prince George’s County and its partners (Dimensions, UMMS, and RPAI, the private owner of the adjoining parcel) are developing a comprehensive parking strategy for the PGRMC medical campus and the adjoining parcel. The County (through the Prince Georges County Revenue Authority) plans to construct the parking garage and will include the parking garage financing plan in the upcoming FY 2015 Budget (e.g. fiscal year starting July 1, 2014). The construction of the parking garage will coincide with the construction schedule of PGRMC and the medical campus. The County has assured PGHC that the construction for the parking garage will be funded. The County (via Prince Georges County Revenue Authority) will operate the parking facility. PGHC will keep the MHCC staff advised of further developments in the County’s plan to construct the garage.

The current site plan includes 380 surface parking spaces. The parking garage is planned for approximately 1,200 parking spaces, which will be in addition to the stated

surface parking spaces. The parking garage is a necessary component of the medical campus.

**6. Please provide a table that compares the room and equipment capacity of the current PGHC and the proposed Prince George’s Regional Medical Center (“PGRMC”), for the following departments/service lines:**

- A. Cancer Treatment (both medical and radiation oncology)**
- B. Diagnostic Imaging**
- C. Cardiac Catheterization and other Angiography**
- D. Dialysis (acute and chronic)**
- E. Neonatal Intensive Care**
- F. Endoscopy**

The requested information appears in the table below:

DEPARTMENT	EXISTING		PROPOSED	
	DEPARTMENT AREA	EXISTING CAPACITY	DEPARTMENT AREA	PROPOSED CAPACITY
Cancer Treatment – Medical	0	0	5,996	14
Cancer Treatment - Radiation Oncology	0	0	10,440	2
Diagnostic Imaging	17,854		18,702	
Mammography	incl above	1	incl above	2
Radiology	incl above	2	incl above	3
Ultrasound	incl above	4	incl above	2
Fluoroscopy	incl above	2	incl above	1
Angiography	incl above	1	incl above	See Cardiac Cath
Vascular lab	1,713	1	incl above	See Echo / EKG
Echo / EKG / Vasc US	1,363	4	2,944	4
EMG	N/A	0	1,032	2
CT	incl above	2	incl above	1
MRI	Mobile	1	incl above	1
Nuclear Medicine	incl above	2	incl above	2
Bone Density		0		1
Cardiac Catheterization and other Angiography	3,939	4	9,800	4
Dialysis (acute and chronic)	1,166	8	1,740	6
Neonatal Intensive Care	2,272	24	15,100	24
Endoscopy	5,398	3	1,900	2

**7. Provide a brief description of the program and patient population served by the PGHC “Transcare” unit and the “Short Stay Center.” Are these programs/units being replicated in the proposed PGMC?**

**A. The Transcare Unit.**

The purpose of the Transcare unit is to provide care to adult patients scheduled for invasive cardiac diagnostic or interventional procedures performed in the Cardiac Catheterization Laboratory and Transcare Area. The unit provides pre and post procedure care to for both inpatient and outpatient treatment.

**Procedures in Catheterization Laboratory:**

- Cardiac & Peripheral Diagnostic Invasive Procedures
- Cardiac & Peripheral Interventional Procedures
- Electrophysiological Diagnostic & Interventional Procedures
- Device Implantations
- Intra Aortic Balloon Pumps
- Moderate Sedation administration

**Procedures in Transcare Area:**

- Tilt Tables
- Transesophageal Echocardiogram
- Cardioversion

**Pre procedure care for the above procedures:**

- Clinical Nursing Care
- Obtaining history and physical
- Drawing blood
- Nursing admission process
- Intravenous insertion
- Medication dispensing.

**Post procedure for the above procedures:**

- Post procedure recovery
- VS monitoring
- Clinical nursing care
- Medication dispensing

In the proposed facility, the Transcare function will be merged with the PACU, which will be adjacent to both the ORs and the Catheterization Laboratory.

B. The Short Stay Center.

The Short Stay Center (“SSC”) is a surgical ambulatory care unit located on the first floor of the Pavilion. It is comprised of eleven (11) private rooms for preparing patients for surgery and a separate area for pre-admission testing. Hours of operation are 6:00 AM – 6:00 PM, Monday through Friday.

Any patient who is scheduled for outpatient surgery or who will be admitted to the hospital the day of surgery is a candidate for the SSC. The SSC is used for patients of all ages who are having surgery and receiving general, local, or regional anesthesia, and with Intra Venous (IV) sedation.

As a holding area of limited size, the SSC is designed and staffed to care for patients waiting to be taken to an operating room or those undergoing pre-admission testing.

The SSC is not intended, or equipped, to care for acutely ill patients, including patients requiring continuous medication administration, cardiac or invasive monitoring, respiratory support (except for nasal oxygen during an emergency), or any type of intensive monitoring or nursing care that would require one-to-one support. The SSC is not equipped with kitchen facilities, nor is it routinely stocked with medications, except those routinely ordered pre-operatively. Medical direction for patient care in SSC is provided by anesthesiologists and the attending surgeons.

To provide the highest standard of patient care and maintain excellent customer satisfaction through quality care in a timely and caring manner, SSC participates in intra-departmental, surgical services, PI initiatives, and ongoing QI studies.

In the proposed facility, these functions will be performed in the Universal Care Unit.

**8. Provide a brief description of the program and patient population to be served by the PGRMC “Cardio/Neuro Diagnostics” department on the Concourse Floor.**

Cardio/Neuro Diagnostics includes general non-invasive diagnostic modalities for cardiology and neurology, including ECHO, EKG, Stress, EMG and EEG. The department primarily will serve ambulatory outpatients as most inpatient studies will be performed at bedside.

**9. Provide a brief description of how the “Pediatric ED area” will function as both an inpatient unit and an observation unit. How many patients can be accommodated in this proposed unit at any given time? How will it be staffed?**

The PGRMC ED Pediatric unit will be a hybrid ED and inpatient/observation unit (“OU”) that will be used to provide medical evaluation and/or management of children from birth to 14 years of age for health-related conditions requiring close observation and monitoring. The ED component of the unit will include five treatment spaces, while the hybrid unit will include five rooms for observation/short-stay inpatients.

The hybrid OU will be used to provide both short-term diagnostic and management work performed in the typical OU and hospital-level care for scheduled, brief, elective admissions, typically for diagnostic or therapeutic procedures. The most common of these pediatric procedures includes: respiratory conditions, such as asthma, bronchiolitis, and croup; gastroenteritis/dehydration and abdominal pain; and prolonged observation of patients with head or other injuries, potential appendicitis, or toxic ingestions. The OU can also be used for day surgery or ambulatory procedure patients who have a delayed recovery time from sedation or anesthesia or whose postoperative/procedure pain is not well controlled. Further, it can be used for patients who require extended post-surgery/procedure periodic monitoring by physicians,

nursing and other staff, and other reasonable and necessary services to evaluate a patient's condition to determine the need for a possible inpatient admission to PGHC or transfer to a higher level of care.

The inpatient general pediatric unit will be used for children who need in-patient level of care/intervention of stay for exacerbated conditions listed above such as: severe dehydration, viral infections, respiratory illnesses, pediatric ketoacidosis, or need for more recovery and observation time from elective or emergent surgical procedures. There is no need to transport such patients to a specialty center, such as the National Children's Medical Center, saving both the trauma and cost of transport, and enabling the children and their parents to remain closer to their homes.

Optimal management of an OU requires a team approach, with all involved focused on the goal of efficient and safe patient management. To enhance efficiency and decrease OU length of stay and waiting time, a well-organized system to schedule and interpret laboratory, imaging, and other test results is also important. A benefit of OUs is that they may reduce the rate of admissions to inpatient units. Having an OU reduces patient hospitalizations while generating few inappropriate short-stay hospitalizations, in part because a significant number of inpatient admissions among children are relatively short. A growing research base, largely descriptive to date, also suggests that OUs enhance the care of children. It is the position of the Emergency Nurses Association that observation units enhance the quality and safety of patient care and increase cost-effectiveness. Emergency Nurses Association Position Statement on Observation Units / Clinical Decision Units (revised and approved May 2011). Staffing efficiencies can also be gained with this model versus the traditional inpatient model, as

downtime will be minimal with staff having the competencies to function in both the ED and the ED OU/inpatient unit. Consequently, staff will be shared among all three components of the integrated unit.

Because of its location (adjacent to the ED), staffing and management of the ED, OU, and general pediatric unit is typically led by experienced pediatric physicians/pediatric hospitalists; however, nurse practitioners and/or physician assistants may also be used, further reducing costs without compromising the quality of care. All PGHC ED nurses are certified in pediatric advanced life support. There are also members of the ED nursing staff who have specific pediatric skills and experience.

For children facing a medical crisis that could result in hospitalization nothing is more traumatic for emotional and physical well-being than not having parents close by for love and support. The concept of the ED OU/inpatient Unit is built on the goal of keeping children and families together whenever possible and providing an appropriate level of care for pediatric patients in the Prince George's community.

**10. Provide a brief description of the service programs and patient population to be served by the PGRMC "outpatient clinics" in the Ambulatory Care Center.**

The outpatient clinics will provide hospital-based ambulatory care, including orthopedics, OB, general surgery and medicine, and cancer treatment. In addition, the clinic will accommodate specialty clinics in trauma follow-up, cardiology, neurology, gynecology, and other subspecialties to provide access to outpatient services for the community.

## **PART II – PROJECT BUDGET**

**11. Will any equipment or furnishings be salvaged from the existing PGHC for installation and use at the proposed PGRMC? If so, how is this accounted for in the budget estimate?**

The Project Budget assumes that all equipment and furnishing will be replaced. The new hospital is projected to open in 2017; much of the existing equipment will be four years older than it is today. Also, PGHC will need to be fully operational until the day that PGRMC opens, requiring that the furniture and equipment remain on line through the last day of operation of PGHC.

As construction of the new hospital proceeds, PGHC will re-evaluate the status of the equipment and the ability to operate seamlessly during the transition if selected equipment is relocated to the new facility. If equipment can be moved, PGHC expects that there will be savings within the Project Budget.

**12. What is the market value of the PGHC campus?**

Based upon an appraisal completed on December 13, 2012 by Integra Realty Resources on behalf of Prince George's County Government, the Cheverly hospital campus was appraised at \$12.2 million under a fee simple interest approach. The firm used a sales comparison approach in their valuation.

**13. Please provide documentation of the Prince George's County and Maryland commitments to contribute \$416 million for this proposed project.**

Exhibit 31 includes the County's approved capital improvement program for FY 2014 through FY 2019, which includes the \$208,000,000 commitment to partially fund the proposed regional medical center.

Exhibit 32 includes excerpts of the State's capital budget plan, which shows the State's plan to partially fund the proposed regional medical center in the amount of \$200,000,000. The FY2014 commitment is \$20,000,000, followed by plans to provide grants of \$20,000,000 in fiscal years 2015, 2016, and 2017, and a \$120,000,000 grant in FY2018. The five-year State Capital Budget prepared during the 2013 legislative session currently includes \$200,000,000 for the regional medical center project. The MOU participants will meet with State legislators this fall to ask that an additional \$8,000,000 in funding be placed in the State's Capital Budget to achieve the original capital funding amount agreed to be committed by Prince George's County and the State (\$208,000,000 each). PGHC will keep the MHCC staff advised of its progress in obtaining an additional funding commitment of \$8,000,000 from the State.

**14. Please provide documentation of the ability to obtain the anticipated debt financing.**

Because it is too soon to secure firm debt commitments, documentation is not yet available. However, upon consultation with its financial advisors and parties involved in hospital financing, Dimensions is confident that it will be able to obtain the anticipated debt financing for the following reasons:

- Dimensions has successfully accessed the bond market in the past.
- Dimension has existing relationships with banks for working capital loans.
- Dimensions has conservatively assumed an interest rate of 6.5%, which would be in the higher range of the market for long term bonds and will make them more attractive to investors.
- During 2014, Dimensions' bonds will be assumed by Prince George's County leaving it with positive debt related ratios and an increase in its debt capacity.
- The State and County have committed to fund 56% of the total project costs.

- The long term debt associated with the project equals 44% of the total project costs resulting in significant equity associated with the project, making the debt attractive to bond holders and lenders.
- The short term debt is expected to be repaid within two years of the opening of the new hospital.

**15. What are the expected covenants on the long term bond financing and the other financing?**

The documentation for the financing may contain the following covenants, all of which are typical for healthcare financings:

Covenant Not to Encumber:

A covenant not to encumber or allow any lien or mortgage to remain against any assets, subject to customary exceptions, including but not limited to purchase money liens, liens of any third-party payor for recoupment of amounts paid for patient care, and statutory reverters under Hill-Burton grants.

Liquidity Covenant/Days Cash on Hand:

A covenant to maintain unrestricted and unencumbered liquid assets, tested not more frequently than semi-annually, in an amount not less than a specified number of "Days Cash on Hand", which is generally an amount equal to a proportionate amount of total annual operating expenses for the specified number of days, and is a measure of the number of days a hospital could continue paying its operating expenses from existing unrestricted cash and investments in the absence of any future cash inflow. If the specified liquidity is not maintained, then the hospital promises to hire a consultant to do a study and determine what changes need to be made to achieve the specified liquidity.

Coverage Ratio/Rate Covenant:

A covenant to maintain a certain ratio of net income available for debt service to maximum annual debt service, tested annually as of each fiscal year end, with a corresponding covenant to set rates and other charges as shall be sufficient to produce in each fiscal year a debt service coverage ratio that meets the requirement. If the specified coverage is not maintained, then the hospital promises to hire a consultant to do a study and determine what changes need to be made to achieve the specified debt service coverage. Typically, any calculation of the coverage ratio for any fiscal year that occurs prior to the earlier of (i) the first fiscal year in which any principal amount of long term indebtedness issued to finance capital facilities becomes due and payable and (ii) the first fiscal year in which any interest on such long term indebtedness ceases to be paid from amounts deposited in escrow for the payment of interest on such long term indebtedness, shall not take into account such long term indebtedness in calculating maximum annual debt service.

Debt to Capitalization Ratio:

A covenant to maintain a certain ratio of (a) the aggregate principal amount of all outstanding debt to (b) the sum of (i) the total outstanding principal amount of debt and (ii) the sum of unrestricted net assets and equity accounts.

**16. Please provide a brief description of the assumptions used in estimating the inflation allowance.**

The inflation rate was calculated using the MHCC's Building Cost Index in Healthcare Cost Review, accessed from the MHCC's website. Inflation was calculated from 2013.3 to the estimated midpoint of construction in 2016.3. Because the Index posted on the MHCC website only projects inflation to 2015.4, PGHC had to make an

assumption about the interest rate between 2015.3 and 2016.3. PGHC based its assumption on the inflation growth in previous quarters.

Filing Date	13.3			
Modification Date	16.3			
Step 1	2014.3	%MOVAVG	1.4	1.014A
Step 2	2015.3	%MOVAVG	1.5	1.015B
Step 3	2016.3	%MOVAVG	1.6	1.016C
	A * B * C			1.045677

This resulted in an inflation rate of 4.56%.

**17. Please provide a brief description of the assumptions used in calculating the amount of capitalized construction interest and interest income.**

The projection of \$50.5M in capitalized construction Interest in the Project Budget, Item 1.d(2), is the gross interest expense incurred on the following debt issuances during the construction period July 2014 through December 2017.

- A short-term bridge loan of \$128M to be issued in 2014 to pay for construction cost not funded by State grants which are provided over five years
  - Annual interest expense is calculated at 5.0% of the outstanding balance
  - This bridge loan will be repaid upon receipt of \$128M of State’s grants during and at the end of 2019 (fifth year)
- A long-term bond issuance of \$224M to be paid back over 30 years
  - Annual interest expense is calculated at 6.5% on the outstanding balance
  - Principal payments will begin upon the new hospital’s commencement of operations in January 2018

The projection of \$15.1M in interest income presented as a source of funds in the Project Budget, Item B.4, represents the investment income earned on the bond

proceeds prior to their expenditure. An investment earning rate of 3.0% is applied to the average balance of these funds each year.

**18. Is the purchase of land for the project by Prince George’s County included in the \$208 million commitment of the County to the project?**

No. Any consideration or costs associated with any real estate transactions between the County and RPAI for the 8.4 acre parcel and the 17 acre parcel are not to be included in the \$208 million commitment. The project will bear no cost for land acquisition.

**19. Please explain how the contingency estimate was calculated and explain why it is reasonable for a project of this size and scope.**

The contingency amount was calculated as 8.1% of the subtotal of new construction items plus major and minor moveable equipment. Below, are calculations of the contingency percentages in two relatively recently approved CON applications, one for a new hospital and another for a major hospital replacement. PGHC’s contingency percentage is comparable to both approved levels.

	Mercy Medical Center Replacement			Holy Cross Germantown New Hospital
	<u>New Construction</u>	<u>Renovation</u>	<u>Total</u>	<u>New Construction</u>
(1) Building	\$212,514,959	\$906,125		\$86,809,872
(2) Fixed Equipment	\$8,653,166	\$0		\$3,439,500
(4) Site Preparation	\$14,582,705	\$165,000		\$7,139,623
(5) Professional Fees	\$27,972,286	\$37,500		\$5,975,188
(6) Permits	\$1,200,647			\$1,174,369
Subtotal	\$264,923,763	\$1,108,625	\$266,032,388	\$104,538,552
(1) Major Movable Equipment			\$36,181,815	\$14,636,677
(2) Minor Movable Equipment				\$23,118,707
<b>TOTAL</b>			\$302,214,203	\$142,293,936
(3) Contingency			\$26,715,441 8.8%	\$12,104,857 8.5%

### **PART III - CONSISTENCY WITH REVIEW CRITERIA**

**20. Please provide a more legible visual of the hospital's notice of charity care, attached as Exhibit 8.**

Please see Exhibit 33.

**21. Is PGHC's relatively poor recent performance on the core quality measures (pages 72-76) related to the inadequacy of its physical facilities? If so, please elaborate on this connection. If not, why should MHCC have confidence that performance will improve in a new hospital?**

PGHC's current facility has structural barriers that affect its ability to satisfy quality measures.

For example, there is insufficient space in the NICU to accommodate the needed beds. Consequently the NICU beds are not as far apart as desired, increasing risk of infection. The space limitation is also a problem in the emergency department, inhibiting patient flow and making it difficult to satisfy MHCC quality measures such as "ED to bed."

Aside from expecting improvement in quality care as a result of relieving physical space limitations in the new facility, PGHC has recently implemented measures to improve quality care in the existing facility. Those new measures will be carried over to PGRMC. The institution of the new EMR occurred on June 9, 2013. This development provides new avenues for helping PGHC satisfy Core measures. For example, PGHC is currently instituting parameters via the EMR that allow it to remind its providers to address a particular measure as well as real-time reports on satisfaction of core measures.

The EMR will significantly enhance PGHC's ability to measure performance of its providers relative to core quality measures. The data that results will be used to

evaluate private practicing providers who are on the medical and AHP staff, as well providers employed by or contracted with PGHC and its affiliates. Dimensions is currently putting in place procedures to better link quality metrics from the EMR with professional practice evaluations for all medical and AHP staff. Similarly, Dimensions Healthcare Associates (which is a wholly-owned subsidiary of Dimensions Health Corporation providing physician and AHP provider services) is in the process of restructuring its processes and contracts with providers to link incentives (e.g. payment to providers, continuation of contractual arrangements) with provider-specific performance on core quality measures. Dimensions believes that these new processes will substantially enhance quality of care at its facilities.

Also there is new leadership at Dimensions who have placed an increased emphasis on quality. For example, a Quality Committee of the Dimensions Board was recently created to oversee quality of care throughout Dimensions Healthcare System. This increased emphasis is resulting in more focus on, and resources for, quality improvement. Moreover, PGHC expects that its recent expansion of clinical partnerships with UMMS, and the development of a new regional medical center, will help it recruit and retain more excellent health care professionals, who will help ensure the highest quality care is provided at PGRMC.

**22. Outline the specific steps PGHC took to improve its performance for Pneumococcal Immunization (PPV23) that could help to explain the improvement in performance from 83% in CY 2012 to 91.6% in the first quarter of CY 2013?**

PGHC's nursing staff instituted a performance improvement program on all the floors. The program involved following on all admitted patients to check their

vaccination status. Case Management performed quality checks to capture any missed patients.

**23. The Department of Health and Mental Hygiene’s “Maryland’s All Payer Model,” submitted to the Centers for Medicare and Medicaid Innovation on October 11, 2013, anticipates that, “The CON program would support the success of the Maryland All-Payer Model by considering the goals and objectives of the model in its decisions to approve or deny health care facility projects by requiring health care facilities to demonstrate that their projects are viable without reliance on continually growing service volume.” Given this expectation:**

**A. Can the applicants demonstrate that the proposed project is viable without reliance on continually growing service volume? Page 91 of the application indicates that the project has used an assumption that medical/surgical/gynecological/addictions use rates of the service area population will “stabilize,” i.e., remain at 2015 levels, between 2016 and 2021, which, given adult population growth, will result in growing demand for MSGA beds during this period. The pediatric population is also projected to grow with no change in use rates, leading to growing demand for this service. The same is true for adult acute psychiatric services. How can this analysis be squared with Maryland’s All Payer Model?**

**B. Can the applicants demonstrate that the proposed project’s utilization forecasts are consistent with a future in which demand for hospital admissions by the hospital’s service area population (i.e., the acute hospital use rate of the service area population) is trending down, consistent with the Model’s expectations?**

This project is consistent with the State’s waiver proposal entitled Maryland’s All-Payer Model (“Waiver Proposal”). The assumptions in the methodology project substantial decreases in utilization.

First, it is important to recognize that the proposed Waiver Proposal proposes reductions in “per capita” growth, not necessarily reductions in total volume. The Waiver Proposal states:

This model will require Maryland to limit its annual all-payer per capita total hospital cost growth to 3.58%, the 10-year compound annual growth rate in per capita gross state product. (emphasis added)

The Waiver Proposal does not state that there can be no growth, but, rather, that the growth will be measured on a per capita basis. PGHC projects significant per capita reductions in inpatient volumes, as follows:

Use Rates

PGHC projects an 11.5% decline in use rates (admissions/1,000 population) for MSGA patients (both age 15-64 and 65+) between 2012 and 2021. Utilization rate projections were developed after reviewing 10-year inpatient utilization forecasts from Sg2 and Milliman. PGHC has taken the position that inpatient utilization rate declines will take place in the front end of the project projection period. PGHC also projects a 2% decline in OB use rates (admissions/1,000 women age 15-44) during the same time frame, as shown below.

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	Total
MSGA (15-64) Use Rate	61.34	56.43	54.74	54.46	54.46	54.46	54.46	54.46	54.46	54.46	
MSGA (15-64) Use Rate Δ		-8.0%	-3.0%	-0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-11.5%
MSGA (65+) Use Rate	283.21	260.56	252.74	251.48	251.48	251.48	251.48	251.48	251.48	251.48	
MSGA (65+) Use Rate Δ		-8.0%	-3.0%	-0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-11.5%
OB Use Rate	62.59	61.33	61.33	61.33	61.33	61.33	61.33	61.33	61.33	61.33	
OB Use Rate Δ		-2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-2.0%
PEDS Use Rate	20.16	20.16	20.16	20.16	20.16	20.16	20.16	20.16	20.16	20.16	
PEDS Use Rate Δ		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PSY Use Rate	5.25	5.25	5.25	5.25	5.25	5.25	5.25	5.25	5.25	5.25	
PSY Use Rate Δ		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Average Length of Stay

PGHC also projects substantial decreases in ALOS for MSGA and OB patients who are admitted to PGRMC.

	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	Total
MSGA (15-64) ALOS	5.28	5.40	5.29	5.08	4.88	4.71	4.56	4.47	4.47	4.47	-
MSGA (15-64) ALOS Δ		2.2%	-2.0%	-4.0%	-4.0%	-3.5%	-3.0%	-2.0%	0.0%	0.0%	16.3%
MSGA (65+) ALOS	6.68	6.51	6.25	5.94	5.70	5.50	5.39	5.39	5.39	5.39	-
MSGA (65+) ALOS Δ		-2.5%	-4.0%	-5.0%	-4.0%	-3.5%	-2.0%	0.0%	0.0%	0.0%	21.0%
OB ALOS	2.83	2.78	2.75	2.73	2.71	2.69	2.67	2.65	2.65	2.65	-
OB ALOS Δ		-2.0%	-1.0%	-0.8%	-0.8%	-0.8%	-0.8%	-0.8%	0.0%	0.0%	-6.8%
PEDS ALOS	2.63	2.63	2.63	2.63	2.63	2.63	2.63	2.63	2.63	2.63	-
PEDS ALOS Δ		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PSY ALOS	5.45	5.45	4.80	5.50	5.60	5.70	5.70	5.80	5.80	5.80	-
PSY ALOS Δ		0.0%	-13.5%	14.6%	1.8%	1.8%	0.0%	1.8%	0.0%	0.0%	6.5%

Consistent with the Waiver Proposal, these assumptions result in a substantial decline in MSGA patient days per capita as shown below.

2012	MSGA			OB		PED		PSY		Total
	15-64	65+	Total							
Projected Population	666,304	97,746	764,050	169,791		168,128		724,643		892,770
Admission Rate/1,000	61.34	283.21		62.59		20.16		5.25		
Admissions	40,869	27,683	68,552	10,626		3,390		3,803		
ALOS	5.28	6.68		2.83		2.63		5.45		
Patient Days	215,914	184,968	400,882	30,121		8,927		20,712		460,643
Patient Days per Capita	0.32	1.89	0.52	0.18		0.05		0.03		0.52
Projected Population	679,026	148,524	827,550	161,617		172,495		787,672		960,166
Admission Rate/1,000	54.46	251.48		61.33		20.16		5.25		
Admissions	36,982	37,350	74,332	9,913		3,478		4,133		

2012	MSGA			OB	PED	PSY	Total
	15-64	65+	Total				
ALOS	4.47	5.39		2.65	2.63	5.76	
Patient Days	165,433	201,467	366,900	26,253	9,159	23,808	426,120
Patient Days per Capita	0.24	1.36	0.44	0.16	0.05	0.03	0.44
Percent Change	-24.8%	-28.3%		-8.4%	0.0%	5.7%	-14.0%

While the Waiver Proposal states that projects should be “viable without reliance on continually growing volume,” the applicants do not rely on continually growing volume. The projections provided are through FY 2021, when PGRMC is expected to reach its maturity. There is no assumption that volumes will grow continually after that point in order for the hospital to remain financially viable. The hospital will remain financially viable without growing volumes.

**24. While the applicants state that Standard .04B(3) is not applicable on the basis that the project does not involve development of a new pediatric service, the proposed one bed pediatric unit is clearly inconsistent with the intent of this standard. Why is it necessary for the proposed PGRMC to have any pediatric beds? Why shouldn't pediatric patients be handled, as necessary, in the emergency department, observed if necessary, and, if found to need admission to a hospital, transferred to a hospital with an organized inpatient unit, given the very small number of patients involved?**

It is part of PGHC’s mission to provide basic pediatric services to families within its service area. The planned concept of care for the regional medical center achieves the goal of keeping children and families together whenever possible and providing an appropriate level of care for pediatric patients.

Most hospitals are facing decreased census of pediatric inpatients, while determining what type of care model is appropriate in meeting basic needs of pediatric patients and their families. Of the 33 hospitals in Maryland with licensed pediatric beds, eleven are licensed for four beds or fewer. Five of these 33 hospitals have only one or

two licensed beds. Despite the declining pediatric census, families expect to have basic pediatric services at their community hospitals, with specialized services being offered at larger hospital centers.

To meet community need, the proposed PGRMC has a designed care approach that maximizes the use of pediatric-trained staff who can provide emergency pediatric care, pediatric observation care, and limited inpatient pediatric care, thereby reducing the need to transfer patients further away from their families and residences. The proposed Pediatric ED Unit adjacent to a hybrid inpatient/observation unit will provide medical evaluation and/or management of children ages 0-14 years. It is a care model approach designed to meet basic community need in a cost-effective manner. Further description of this care model can be found in the response to question 9 above.

**25. How is the request for a rate increase (page 99) consistent with the Maryland All-Payer model?**

The current Maryland HSCRC policies and regulations include a methodology for capital rate increases. The CON projection for PGCRMC includes a provision for a capital rate increase consistent with this formula. The request reflects an increase of 7% in rates, calculated as 40% of incremental depreciation and interest on the new construction.

**26. How will higher rates for the proposed PGRMC affect the competitiveness of this new hospital in the market, given the relatively high rates already authorized for PGHC?**

Under the current HSCRC regulations, rates are generally at their highest level upon the opening of a new facility. PGHC is projecting significant volume growth, which

will significantly offset any capital rate increase over the first few years of operations based upon current variable cost factor assumptions.

In the future, price competitiveness likely will be reviewed in a much different and global manner. PGRMC will focus on reducing utilization, managing cost per capita of care, and managing population health. PGRMC will recruit primary care physicians, improve access to care and treating patients in the appropriate setting to align its service offerings consistent with the new Waiver requirements.

**27. With respect to the analysis of hospital construction cost:**

**A. Explain the need for the deep foundation, pilings and hillside foundation and how each adjustment was calculated;**

**B. Report the total cost estimate for bringing utilities to the building, broken down by the cost estimate for bringing the utilities from the property line to the building and the cost estimate for bringing the utilities to the property line. Do not include jurisdictional hook-up fees; and**

**C. Explain how the adjustment for the concrete frame construction was calculated.**

A. Soils in the region of the proposed project have a bearing capacity such that shallow foundation systems like spread footings are not practical for large building loads in the range of what is expected for PGRMC. Deep foundations, such as driven or drilled piles or drilled caissons, carry the building weight on deeper soil layers, which are better suited to support these loads reliably. Given the sloping nature of the site, the foundation system will bear at varying elevations and will incorporate a basement retaining wall on one side of the building. This type of hillside foundation system presents the unique structural challenge of resisting unbalanced earth pressures which are addressed in the structural design.

- B. The \$5,600,000 shown in Chart 1 and in the MVS analysis as a utility cost represents the cost for the utility company to bring utilities to the property line. The cost of bringing the utilities from the property line to the building is another \$3,000,000. They are both included in the site preparation costs.
- C. PGHC based the premium on discussions with a contractor. The premium was estimated to be between \$3 and \$4/square foot (not counting the first floor, which is already on a concrete slab). The premium that UMMS used is \$3.10/square foot, based on the following calculation

SF	565,022
Premium	\$1,750,000
	\$3.10

A concrete frame structure in a healthcare facility provides several advantages over steel frame construction from a lifecycle facility operations perspective. The concrete system can more readily meet vibration and live load requirements associated with medical equipment, fireproofing is not required improving infection and dust control performance, and the monolithic frame and wall system can eliminate the need for braced frames increasing future flexibility.

**28. Explain why each of the objectives ranked in the scoring matrix on page 137 appears to have the same value in this decision-making process. Are the objectives essentially given the same weight or were some objectives more important than others? If the latter, how does this analysis incorporate those different levels of importance for each objective?**

As PGHC considered the alternatives, it found that the various stakeholders in the selection process would accord different weight to the objectives. Nonetheless, it determined that the objectives were roughly of equal importance and, therefore,

“weighting” any of them was not warranted. Moreover, based upon the uniform high scores of the selected alternative, giving more weight to one or more of the objectives would not have altered the outcome. Once the alternatives were narrowed to the two configurations of parcels of land at the Largo site, the final selection was made based upon assessment of cost, accessibility, and ease of land development.

**29. Please discuss Laurel Regional Hospital in the context of the costs and effectiveness of alternatives. Was consolidation of the two Dimensions’ hospitals in Prince George’s County considered as an option when replacing and relocating PGHC? If so, why was this option rejected, given the declining demand for inpatient service at LRH in recent years (an average daily census of less than 60 total acute care patients in FYE March 31, 2013)? If not, why not?**

Dimensions consistently has sought ways of coordinating services between PGHC and Laurel Regional Hospital (“LRH”). During the planning process for this project, Dimensions considered ways the two sites could be best used in an effective way.

LRH is the sole provider for northern Prince George’s County. It attracts and sustains a provider community of adequate size for that population center and for the underserved ZIP codes nearby. The average hospital acute inpatient census in recent months has been 58. One example of Dimensions’ cost effective coordination of the use of both the PGHC and LRH sites is the relocation in 2011 of the Gladys Spellman chronic care unit from PGHC to the LRH campus. The chronic care unit housed there currently adds an additional 18 patients to the facility’s census. The chronic care facility efficiently shares many of the resources available in the acute care hospital.

LRH’s emergency department serves more than 3,000 patients each month. It supports and provides other quality services including sophisticated wound care with hypobaric therapy.

LRH houses the only CARF accredited rehabilitation center between Baltimore and Washington, DC. In the 1990s, Dimensions moved 12 obstetrical beds from PGHC to LRH to better serve the growing needs of the community. The hospital benefits from greater purchasing power and scale from many support services that have been centralized in the system, including financial services, human resources, professional staff credentialing services, all insurance coverages, employee benefits, purchasing and materials management. LRH is consistently in the lower half of average costs for its peer group.

For most reporting periods over the past two years, LRH has been ranked in the top 25% of Maryland hospitals for the lowest Hospital Acquired Conditions (HACs).

Dimensions considered relocating certain services to LRH, such as consolidating all of PGHC's and LRH's behavioral health units at LRH, when it was planning the current PGHC relocation. However, because the services are important to support the trauma center at PGHC, the unique nature of PGHC's behavioral health unit (and its relationship with the police department), and the need for new construction at LRH to accommodate new services (as LRH has no vacant space to accommodate it), Dimensions determined not to relocate services.

Through the Capital Budget, the Governor and the General Assembly have scrutinized the role and mission of LRH. The Capital Budget appropriates \$15 million to upgrade LRH's ORs and to increase the number of private rooms available to better meet community needs. These projects are now under way. These improvements and range of services have been implemented by the Dimensions Board of Directors, which reviewed the need for LRH and affirmed that it continues to serve a vital mission in an

otherwise underserved part of Prince George's County. It was retained as a vital component of Dimensions and the Prince George's County health system (Dimensions 2015, Strategic Plan adopted November 2011), with a goal to refine the distinct service mission for the Laurel community (Goal 3.5).

Over the past 15 years, there have been a number of studies performed to address the financial difficulties of the Dimensions Health Care System. Although LRH has been a part of this struggle for financial viability, none of the cost saving reports found that health status in the Laurel community would improve if LRH closed. Dimensions determined that the adverse impact on access to care in the northern part of the County associated with closing LRH would outweigh any benefit to the finances of the system. The paramount challenge in the County has been, and continues to be, expanding the health sector infrastructure necessary to attract and sustain inpatient and outpatient resources to improve some of the worst health status measures in the State.

Finally, the plan to improve the Prince George's County health system described in the MOU of July 2011, commits the State, County, Dimensions, UMMS, and the University System of Maryland to develop ways to enhance the capabilities of LRH as necessary to achieve the full benefits of the collaboration. This is described in sections C.1.a and D.1.b. of the MOU (Exhibit 3).

**30. Please discuss cardiac surgery and PCI in the context of the cost and effectiveness of alternatives. Was elimination of the moribund cardiac surgery program at PGHC considered as an option when replacing and relocating this hospital? If so, why was this option rejected, given the declining demand for this service in recent years and its collapse as a viable service at PGHC? If not, why not?**

Dimensions is committed to maintaining and revitalizing its cardiac surgery capabilities at PGHC and at the new PGRMC.

Among other reasons, cardiac surgery is recognized as a critical element for busy trauma programs such as PGHC. PGHC is designated as a Level II Regional Trauma Center. PGHC is also designated as a Cardiac Intervention Center with a cardiac surgery program. In fact, five of the six Level II, Level I, and PARC designated trauma hospitals have cardiac surgery programs. The only Level II trauma center in the State without cardiac surgery onsite is Johns Hopkins Bayview Medical Center, which is closely affiliated with Johns Hopkins Hospital (which has cardiac surgery capacity) and located in a jurisdiction of four nearby hospitals with cardiac surgery programs, each of which has some level of trauma care designation.

PGHC is the second busiest trauma center in the State and serves as a vital link to Maryland's trauma system. The regulations governing Maryland Institute of Emergency Medical Services Systems (MIEMSS) identify cardiac surgery as a desired service for Level II Trauma Centers. COMAR 30.08.05.09. Therefore, it is imperative that PGHC have a broad array of hospital services that can support a trauma program. Because of the complexity and severity of the condition of some of the patients received by PGHC, it is important for PGHC to have a strong cardio-vascular-thoracic surgery program. Therefore a cardiac and vascular surgery program is crucial in the viability of recruiting and retaining specialty trained physicians needed for the trauma program.

Dimensions conducted an analysis of the cardiovascular service line for its facilities to determine plans for the service line in the best interest of the health system. External consultants were used in the planning process, including Haber Consulting, LLC, a cardiovascular program development consultant, as well as KPMG LLP. UMMS, the University of Maryland School of Medicine, as well as community physicians also

participated in the planning process. Based upon the planning process and the market and operational assessments summarized below, Dimensions concluded to proceed with the revitalization of its cardiovascular program, including cardiac surgery.

From the planning process, Dimensions developed a Strategic Cardiovascular Business Plan to revitalize the entire cardiovascular service line, with a specific focus on cardiac surgery. The plan establishes strategies for Dimensions, PGHC, LRH, and Bowie Health Center, for a five year period, 2013 – 2017. The plan was approved in January 2013 by the Dimensions' Board of Directors.

The plan is based on the findings from the following studies completed during the planning process:

- Cardiovascular Business Plan's Market Assessment.

The market assessment determined that despite decreasing trends in cardiac surgery cases and increases in cardiac surgery programs, there will continue to be a viable need and demand in Prince George's County in the years ahead. Key demographic and market characteristics that support a viable opportunity for PGHC include:

- Prince George's County has a higher cardiovascular morbidity and mortality rate, as well as a shortage of approximately 66 primary care physicians. By improving access to care, more cardiovascular disease will be detected and interventional care (PCI and cardiac surgery) will be needed.
- The utilization of PCI and cardiac surgery among Prince George's residents is lower than national utilization rates. The lower utilization rates can be attributed to limited access to care based on the shortage of providers in the county.
- The 45 years of age and older population is expected to grow approximately 8% between 2011 and 2016, comparable to State and national rates. The 65 and over is expected to increase significantly by 22.9%, which is higher than the estimated growth rate of 17.7% for Maryland residents. These aging factors indicate an increase in cardiac surgery volume potential.
- Approximately 554 cardiac surgery cases were performed on Prince George's residents in 2010; 52% were performed in D.C. hospitals. By implementing appropriate strategies to rebuild confidence among

cardiologists and the community, PGHC has the opportunity to recapture a portion of cases out-migrating to D.C. hospitals.

- Cardiovascular Business Plan's Operational Assessment of Prince George's Hospital Center.

The operational assessment was conducted with participation from University of Maryland Medical Center ("UMMC") clinical administrators for cardiac surgery and cardiac nursing. The assessment concluded that PGHC has the majority of key infrastructure pieces and cardiology physician support necessary for a viable cardiac surgery program if improvements / enhancements are made in a timely manner.

The assessment found that specialized operating room staff are cross trained to assist with cardiac, vascular, and thoracic. Post care cardiovascular nursing staff and physician extenders are needed regardless of cardiac surgery for cardiology patients, vascular patients and thoracic. Therefore, there are economies of scale related to providing vascular, thoracic and cardiac surgery.

The assessment also determined that PCI services would continue to decrease if improvements were not made to re-establish confidence in the cardiac surgery program, as well as PGHC's overall cardiovascular program. The majority of PGHC's active cardiologists (approximately 40 are on the medical staff) are either solo practitioners or in small group practices. As such, they do not have the time to cover multiple hospitals and their offices in an efficient manner. As a result, they tend to refer elective PCI and cardiac surgery cases to the same hospital so they can efficiently follow-up on their patients. Approximately 80-90% of PGHC's cardiovascular procedures are urgent or emergent. A more desirable mix is 60% urgent/emergent and 40% elective.

PGHC has approximately 10-12 loyal cardiologists who have stated that a cardiac surgery program is needed in the community. They believe there is adequate volume potential, and support to revitalize the cardiac surgery program with University of Maryland cardiac surgeons. In addition, they have a strong loyalty to the Prince George's community and want a high quality, state of the art program at PGHC.

Based on the Market Assessment and Operational Assessment findings, Dimensions rejected the option to discontinue the cardiac surgery program when the hospital is relocated. Dimensions strongly believes there will be an ongoing need in the community with adequate physician support to justify retaining the cardiac surgery program.

The Business Plan was used to determine that it is financially feasible for Dimensions to reinvest capital in the cardiac surgery program, as well as initiatives to enhance the entire cardiovascular program.

Dimensions and PGHC have accomplished the majority of Phase I program enhancement initiatives in the Business Plan. A summary of progress made is summarized below:

#### 1. Cardiovascular Program Leadership Enhancement

- A contract with the cardiac surgery practice of the clinical affiliate of the University of Maryland School of Medicine (“UM”) was recently entered to provide 1.2 FTE cardiac surgeon services at PGHC for administrative and clinical services. Under this contract, the UM Cardiac Division Chief functions as the Senior Administrative Medical Director of Cardiac Services at PGHC. In addition, UM is going to provide a full-time cardiac surgeon to function as Chief of Cardiac Surgery at PGHC. A well-respected and established cardiac surgeon was recently recruited specifically for PGHC. Currently, UM and UMMC are working with the PGHC team on training and modifying clinical protocols/processes to complete a “Readiness Plan” for the surgery team to begin doing cases in March 2014.
- PGHC hired a new Chief of Critical Care with extensive cardiac surgery experience to enhance post-surgical care. An additional intensivist is being recruited to help medically manage the coronary care unit, step-down, and telemetry unit patients.
- PGHC engaged a Cardiovascular Service Line Administrator to facilitate program enhancement initiatives.
- PGHC hired a new Vice President of Perioperative Services with cardiac surgery specific experience to enhance day-to-day management of the surgery department.
- PGHC created a CV service line team with meetings every two weeks to improve operational processes and enhance patient care.
- The cardiac nurse practitioner and physician assistants are being trained to function as a team to cover specific needs of the cardiac surgery sub-service line as well as cardiology. In addition, PGHC is recruiting an additional nurse practitioner or CV physician assistant to enhance 24/7 coverage.
- An experienced cardiovascular surgery physician assistant is being recruited for the operating room and to assist with post-surgical patient care.

- PGHC is in the process of recruiting a CV clinical nurse specialist to focus on process improvement with nursing staff and physicians to enhance patient care.
- Other key clinical leadership changes at PGHC that will indirectly enhance the future success of the cardiac surgery program include:
  - A new Chief Nursing Officer;
  - A new Chief of Emergency Services, PGHC, LRH, and BHC (UM affiliated);
  - A new Chief of Trauma; and
  - A new Chief of Anesthesiology

## 2. Collaboration with University of Maryland Medical Center (UMMC)

- UMMC has assisted PGHC in developing a training program for cardiac nurses, cardiac nurse practitioners, physician assistants and the cardiovascular surgery operating room team. The training program includes the PGHC CV surgery team “shadowing “ at UMMC, the UMMC team observing PGHC’s team, sharing clinical protocols, staff competencies, and other valuable information with PGHC.
- PGHC is in the process of establishing a contract with UMMC for cardiac surgery perfusion services.
- An additional contract is also being established for the UMMC cardiac surgery team to assist with the first 30 cases performed by the UM cardiac surgeon at PGHC.

## 3. Capital Investment in cardiac surgery

The estimated total capital requirements to enhance the program, as identified in the Business and Operational Enhancement Plan, is \$1.3 million dollars. To date, approximately \$800,000 in capital improvements have been made, as outlined below:

- Replacement heart and lung machines (2)
- Replacement intra aorta balloon pumps (2)
- Replacement TEE probe and ultrasound unit
- Replacement OR table (2)
- Replacement OR lighting
- Replacement defibrillator
- Fluid warmer / blanket (4)
- Replacement cell saver machines (4)
- ECMO and microplegia equipment
- Replacement Slush machine (2)
- STS software

4. Increase in cardiac nurse to patient staffing ratios

In an effort to enhance referring physician confidence and patient care, PGHC has increased nursing ratios on the cardiac telemetry unit. Specifically, a step-down nursing ratio of 1:3 was established for cardiac surgery patients post intensive care unit stay.

**31. Regarding COMAR 10.24.10.04B(11), Efficiency, as it relates to Policy 3.2 listed in COMAR 10.24.10.03, please address how this project considers smart and sustainable growth policies and green design principles.**

Please see Exhibit 34, which includes a discussion of smart and sustainable growth features of this project.

**32. Regarding COMAR 10.24.12.04(6), Physical Plant Design and New Technology, please provide additional analysis of patient safety features for the proposed obstetric unit, especially to the degree that these features are improvements over the existing obstetric facilities.**

Safety features will improve in the new facility because the new facility will have the proper number of triage rooms to avoid patients from being placed in any available rooms without the proper care supervision or use of room. The triage bays in the new facility will be appropriately sized and provided with adequate nursing support and visibility. The unit will also include new, dedicated recovery space for the two operating rooms in the suite. In the existing facility, recovering patients use available labor and delivery rooms for recovery. Also, the obstetric unit will include private labor and delivery rooms with an appropriate balance of patient privacy and clinician visibility. In addition, an alarm system will be incorporated to maintain security on the unit.

**33. Regarding COMAR 10.24.07 AP 6, please provide documentation of the hospital's separate written quality assurance programs, program evaluations, and treatment protocols for patients with secondary diagnosis of substance abuse and for geriatric patients.**

PGHC is currently licensed for 28 adult psychiatric beds. PGHC does not provide inpatient psychiatric care for children and adolescents. Likewise, PGHC does not have a distinct substance abuse program nor does it have a distinct gero-psychiatric program. Relatively few acute psychiatric patients with a secondary diagnosis of substance abuse are referred to PGHC, perhaps, because referring facilities know that PGHC does not have a distinct program. On occasion, such a patient is admitted to the psychiatric unit, based upon a clinical assessment / medical clearance for admission. Likewise, geriatric patients (patients age 65-over), may be admitted to the psychiatric unit based upon a clinician's individual assessment. Patients not appropriate for the inpatient unit based upon the clinician's assessment are, and will be, referred to another facility that has the appropriate program for those patients.

The general adult psychiatric unit's Scope of Service document is included as Exhibit 35. This document includes a generalized service scope of the inpatient psychiatric unit, staffing positions / qualifications, general admission criteria, and some information on some quality initiatives.

**34. Regarding COMAR 10.24.11.05B(6), please provide additional analysis of patient safety features of the proposed surgical facilities that enhance and improve patient safety, especially to the degree that these features are improvements over the existing surgical facilities.**

The operating rooms will be larger than the current rooms, and each will be equipped with video equipment (and boom technology throughout the suite), which provides safe conditions and standardization. In the new design, monitoring equipment

will be located within the OR for proper access and visibility by both the RN and anesthesiologist. The surgical suite will provide the correct ratio and location of prep and recovery areas to improve patient flow and the appropriate level of nursing care.

**35. Please provide alternative projections of revenues and expenses for the proposed project that are consistent with a variable cost factor that provides the hospital with 50 percent of revenue for incremental increases in volume above the budgeted amount in the hospital's base for the year, consistent with the Maryland All-Payer Model proposal. Provide this alternative projection in both current year dollars and with inflation assumptions for both revenue and expenses.**

Please see attached Exhibits 36 and 37 for the alternative projections of revenue and expense with 50 percent variable cost factor for both the current year dollars and with inflation. PGRMC's previously provided projections, using 85 percent variable cost factor, are consistent with the current methodology used in the Maryland All-Payer model. PGRMC is projecting to recapture a significant amount of volume and would be greatly impacted by the change from 85 percent to 50 percent variable cost factor.

PGRMC believes presenting projections with an adjustment only for the variable cost factor is misleading in the financial projections and does not conform to the current methodologies implemented by the HSCRC. If the HSCRC decided to change to the 50 percent variable cost factor, it would have implications on other assumptions, including but not limited to, increasing rates through the update factor above inflation.

**36. Provide a service area population-based analysis of the need for surgical capacity at the proposed PGRMC.**

Because PGHC is proposing to relocate, it is not possible to do a direct population based analysis of surgical cases, as PGHC does not have data on all of the surgical cases performed on residents in the new service area in order to calculate

surgical use rates. Furthermore, identifying cases that should be counted in the use rates based on HSCRC data (which would be necessary to identify all cases at all hospitals by Zip Code of residence) is a difficult undertaking because these data do not distinguish whether inpatients with an OR charge were treated in an OR or in a procedure room.

For outpatients, the use of the data is even more problematic, as the HSCRC outpatient database is unreliable due to the way that hospitals code the data for outpatients. Consultants assisting PGHC have extensively used both the HSCRC inpatient and outpatient databases. In their experience, the number of OR cases identified in these databases do not match the number of OR cases reported by the hospitals themselves (which is more accurate).

However, the need projection methodology included in the CON application is population-based for the following reasons:

1. The number of Non-Cardiac or Trauma OR Cases in 2012 was divided by the number admissions at PGHC in 2012 to obtain a ratio of surgical cases per admission.
2. This ratio was multiplied by the projected number of projected MSGA admissions at PGRMC in 2021, which was population-based on the new service area population using the MHCC methodology in the WAH relocation CON application review (adjusted for recapture of market share in specific service lines).

Consequently, PGHC maintains that the OR need projection in the CON application is already population based and cannot be made more reliable through an alternate population-based need analysis methodology.

**37. Please explain the bed occupancy rate projections included in Table 1 that exceed 100%.**

Please see Exhibit 38 for a corrected version of Table 1, which includes a correction made to patient days and the allocation of patient days between MSG, ICU and CCU.

**38. Do the assumptions at Exhibit 22 cover both the PGRMC and MWPH pro forma schedules of revenues and expenses or just PGRMC? If the latter, please provide a comprehensive set of assumptions for MWPH.**

Volume and revenue assumptions in Exhibit 22 are for PGRMC only. Volume and revenue assumptions for MWPH were included in Exhibit 25. Additional MWPH assumptions are below:

1. Contractual allowances, charity care and bad debt are assumed to continue at a consistent percentage of revenue for the foreseeable future.
2. Other revenue including NIH funding for MWPH physicians at PGHC is assumed to continue at consistent level.

**39. Please clarify the revenue deduction assumptions listed in Exhibit 22. What do the declines for contractual allowances, charity care, allowance for bad debt, and UCC pool payment correspond to in Table 3?**

See the table below for the estimated impact of the revenue deduction assumptions. The decrease in the revenue deduction assumptions is driven by revenue cycle improvements and a change in payer mix as a result of the recaptured volumes.

	<u>Exhibit 22</u> <u>% Reduction</u>	<u>Table 3</u> <u>\$ Reduction</u>
Contractual Allowances	1.4%	4,818
Charity Care	0.6%	2,065
Allowance for Bad Debt	0.9%	3,097
UCC Pool Payment	0.4%	1,377

**40. Supplement the assumptions at Exhibit 22 with a detailed discussion of how the changes likely to occur through implementation of the Affordable Care Act (i.e., more persons eligible for Medicaid and more persons with private insurance) influenced the payor mix projections in Table 3 for PGRMC and in Table 3 for MWPH at PGRMC.**

#### PGHC

The full implementation of the Affordable Care Act (ACA) will have a positive impact on access and coverage, resulting in a decline in hospitals' uncompensated care (UCC). However, under the HSCRC system and its UCC pool methodology, the impact on individual hospital finances and margins should be minimal. As such, the CON projections do not reflect any change to the current payment and allowance levels for the ACA.

#### MWPH

Changes due to the implementation of the Affordable Care Act ("ACA") did not influence the payer mix projections in Table 3 for MWPH, because the new law is not expected to affect most MWPH patients.

MWPH typically sees very few patients who self-pay, which is the group most affected by the implementation of the ACA. Currently 71% of patients at MWPH have Medicaid or a Medicaid MCO. Most children covered by Medicaid will continue to receive this coverage regardless of the implementation of the ACA. Private insurance patients will generally keep their coverage, or will purchase new private coverage on an exchange. For these reasons MWPH anticipates a stable payer mix for the foreseeable future.

**41. What is included and will be included in other operating revenues (line 1h) and why is it projected to remain at the same level for years FY 2015 to 2021?**

See below for detail of other operating revenue in FY 2015 – FY 2021. There is no projected change to other operating revenue since the projection is in current year dollars and there is no projected change in contracts or grants.

	<b>Amount</b>
Parking Revenue	\$ 351
Rental Income	400
Trauma Fees	567
Cafeteria	585
Grants	1,427
Other	1,068
FY 2015 Other Operating Revenue	<u>\$ 4,398</u>

**42. What is included and will be included in other expenses for Table 3 for MWPH at PGRMC.**

Other Expenses are as follows:

Total MWPH at Rogers and PG	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21	Notes
<b>Other Expense from Table 3</b>	2,024	1,896	2,322	2,432	2,460	2,482	2,515	2,537	2,562	2,587	
Utilities	732	764	775	812	821	829	839	847	855	863	
Other expense	954	1,149	974	1,020	1,032	1,041	1,055	1,064	1,075	1,085	Includes licenses, dues, travel, printing, biomedical repair, patient assistance, etc.
Rent	71	82	87	91	92	93	94	95	96	97	
Insurance	<u>267</u>	<u>(99)</u>	<u>486</u>	<u>509</u>	<u>515</u>	<u>520</u>	<u>526</u>	<u>531</u>	<u>536</u>	<u>541</u>	
Total	2,024	1,896	2,322	2,432	2,460	2,482	2,515	2,537	2,562	2,587	

<b>Total MWPB at Rogers and PG</b>	<b>FY12</b>	<b>FY13</b>	<b>FY14</b>	<b>FY15</b>	<b>FY16</b>	<b>FY17</b>	<b>FY18</b>	<b>FY19</b>	<b>FY20</b>	<b>FY21</b>	<b>Notes</b>
<b>MWPB at PG</b>											
<b>Other Expense from Table 4</b>	104	123	120	126	128	129	267	310	325	329	
Other Expense	33	41	33	35	35	35	39	46	48	49	Includes patient parking, transportation, biomedical repair, etc.
Rent	<u>71</u>	<u>82</u>	<u>87</u>	<u>92</u>	<u>93</u>	<u>93</u>	<u>228</u>	<u>264</u>	<u>277</u>	<u>280</u>	
Total	104	123	120	126	128	129	267	310	325	329	

**43. Explain how current depreciation and amortization were calculated, and how project depreciation and amortization were calculated.**

Current depreciation and amortization reflects PGHC's 2014 budget which includes the following:

- Projected depreciation and amortization on existing assets as of June 30, 2013
- Projected depreciation on routine capital expenditures in 2014 totaling \$14.2M with useful lives ranging from three to ten years

Projected depreciation and amortization for PGHC at its current location from 2015 through December 2017 are based on the following:

- Projected depreciation and amortization on existing assets as of June 30, 2013
- Projected depreciation on routine capital expenditures in 2014 totaling \$14.2M with useful lives ranging from three to ten years
- Projected depreciation on routine capital expenditures in 2015 through December 2017 totaling \$20.5M with an average useful life of seven years

Projected depreciation and amortization for PGRMC at its new location from January 2018 through 2021 are based on the following:

- Projected depreciation and amortization on the new hospital construction and other related capital costs with component useful lives ranging from ten to thirty-five years
- Projected depreciation on routine capital expenditures from January 2018 through 2021 totaling \$42.5M with an average useful life of seven years

**44. What is the basis for the increase in bad debt as a percent of gross patient revenues from 5.8% in 2012 to 6.7% in 2013 to more than 8% for the projected years? Shouldn't implementation of the Affordable Care Act reduce bad debt levels?**

The increase in bad debt from 5.8% in 2012 to 8.9% in 2014 is caused by a reduction in the amount of patients completing payment of their co-payments and deductibles as well as non-covered charges in recent trends. The assumption of 8.9% in 2014 is expected to continue each year until 2018 when it will decline slightly to 8.0% by 2021 as the relocation of the hospital and recapture of market share will change the payor mix to reflect more Medicare and commercial patients.

While the ACA will have a positive impact on access and coverage, it is not expected to impact the negative trending of the patient responsibility portion of the hospital charge. Under the current HSCRC system and its UCC pool methodology, the impact of changes in bad debt on individual hospital finances and margins should be minimal. As such, the CON projections do not reflect any change to the current bad debt levels for the ACA.

**45. What is the basis for the projection of contractual allowance? As a percent of gross patient revenue, it goes from an actual of 5.1% in 2012 and 2.5% in 2013 to a projected 3.6% in 2014 and a projected range of 2.5 to 2.8% through the projection period? Please explain.**

The contractual allowance of 2.5% in 2013 was less than 2012 due to a reversal of an accrual for possible Recovery Audit Contractor (RAC) adjustments. The 2014 contractual allowance of 3.6% includes a reduction in length of stay and related charges

that were previously denied and resulted in additional contractual allowances. This improvement carries forward into 2015 with a resulting contractual allowance of 2.8% which continues each year until 2018 when it will decline to 2.5% by 2021 as the relocation of the hospital and recapture of market share will change the payor mix to reflect more Medicare and commercial patients.

**46. Please provide a detailed discussion of Exhibit 27, explaining what each column represents and outlining the assumptions and calculations used in each step of the impact analysis shown.**

Exhibit 27 displays the results of the methodology described on pages 77-98 of the CON Application.

- The first column (“FY12 PGHC Service Area Discharges”) shows each hospital’s FY2012 discharges in the current PGHC service area defined on pages 24-25 and shown in Table 6.
- The second column (“Change to Largo Service Area”) shows the number of discharges by hospital that change as a result of redefining the service area for PGRMC (pages 51-52, 85-88, and Tables 7 & 11).
- The third column (“FY12 Largo Service Area Discharges”) shows the resulting discharges after column 2 is applied.
- The fourth column (“Population/Use Rate Adjustment”) applies use rate and population assumptions stated on pages 89-90 and shows the resulting change in discharges from FY2012 – FY2021.
- The fifth column (“FY21 Largo Service Area Discharges”) shows the resulting FY2021 discharges by hospital, reflective of a redefined service area, changes in use rate, and population growth.
- The sixth column (“Relocation/Methodology Adjustment”) applies the new market shares projected by the methodology associated with relocating the hospital to Largo, MD (described on pages 88-89) and shows the resulting change in projected FY2021 discharges. As this column reflects a change in the service area discharges between hospitals, the total column changes net to zero.
- The seventh column (“FY21 Largo Service Area Discharges (post-relocation)”) shows the resulting FY2021 discharges by hospital, reflective of a redefined

service area, changes in use rate, population growth, and relocation of the hospital.

- The eighth column (“Additional Recapture Adjustment”) applies the market recapture assumptions (pages 91-94 and Table 13), driven by identified growth opportunities, recruitment plans, and new program implementations. As this column reflects a change in the service area discharges between hospitals, the total column changes net to zero.
- The ninth column (“FY21 Largo Service Area Discharges (post-relocation, post-recapture)”) shows the resulting FY2021 discharges by hospital, reflective of a redefined service area, changes in use rate, population growth, relocation of the hospital, and market recapture assumptions.
- The tenth column (“Total Adjustment”) shows the total change attributable to relocation (column 6) and recapture assumptions (column 8). As this column reflects a change in the service area discharges between hospitals, the total column changes net to zero.

**47. Please revise Table 5 for PGRMC to account for contract staff.**

Attached as Exhibit 39 is a corrected Table 5 to reflect 46.2 FTEs and \$6.0M of contractual staff costs that are included in the total \$136.1M of Salaries, Wages, Benefits, & Prof Fees that are presented in Table 3.

**48. Contract staff expenditures for 2021 shown in the Table 3 for MWPH at PGRMC do not appear to be consistent with the contract staff expenditures shown in Table 5 for MWPH at PGRMC. Please clarify.**

Contract staff in Table 5 refers only to the Respiratory Therapy staff used under contract with PGHC. Contract staff in Table 3 includes all contractual services, including Lab, Radiology, Sleep Studies, etc. MWPH typically does not count these in FTEs because they are contracts for services.

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Response to October 21, 2013 Completeness Questions and its exhibits are true and correct to the best of my knowledge, information, and belief.

10/31/2013

Date

K. Singh Taneja

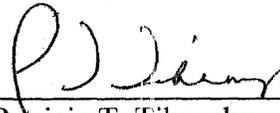
K. Singh Taneja  
Chief Operating Officer  
Prince George's Hospital Center

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Response to October 21, 2013 Completeness Questions and its exhibits are true and correct to the best of my knowledge, information, and belief.

11/1/2013

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Date

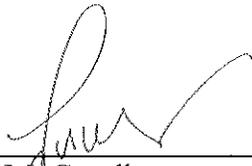


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Patricia T. Tihansky  
Director of Strategic Planning  
Dimensions Health Corporation

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Response to October 21, 2013 Completeness Questions and its exhibits are true and correct to the best of my knowledge, information, and belief.

10/31/13  
Date



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Lisa M. Goodlett  
Chief Financial Officer  
Dimensions Health Corporation

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Response to October 21, 2013 Completeness Questions and its exhibits are true and correct to the best of my knowledge, information, and belief.

10/31/13

Date

Mary Miller

Mary Miller  
Vice President, Finance and Business  
Development  
Mt. Washington Pediatric Hospital

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Response to October 21, 2013 Completeness Questions and its exhibits are true and correct to the best of my knowledge, information, and belief.

10/31/13

Date

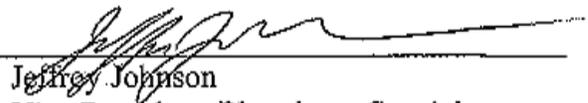


Andrew L. Solberg  
A.L.S. Healthcare Consultant Services

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Response to October 21, 2013 Completeness Questions and its exhibits are true and correct to the best of my knowledge, information, and belief.

11 / 4 / 13

Date



Jeffrey Johnson  
Vice President, Planning—Special  
Projects  
University of Maryland Medical System

## EXHIBITS

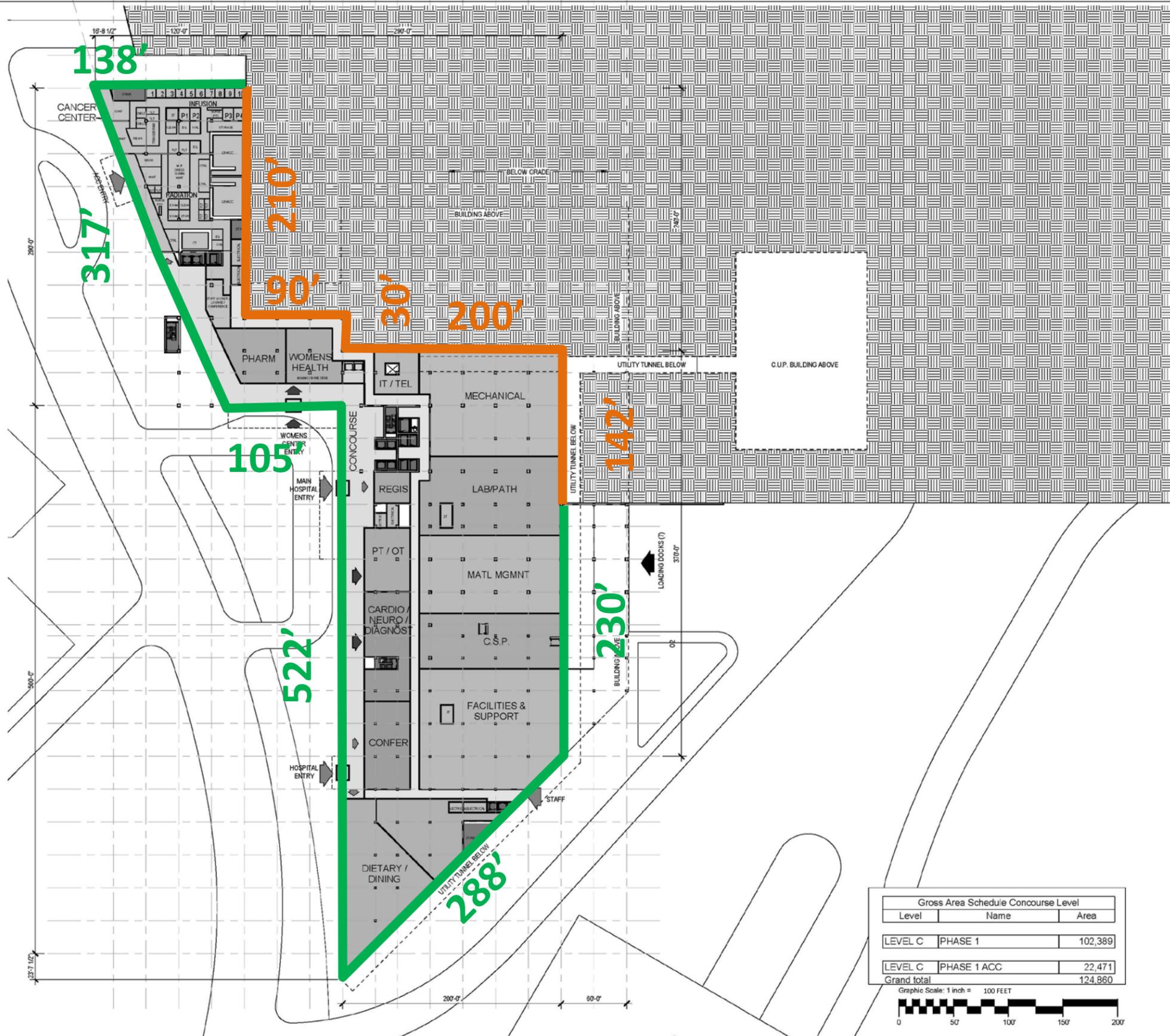
29. Updated site plan with corrected bed count chart and area summary
30. Site plan depicting at-grade and below-grade levels
31. Prince George's County approved capital improvement program
32. Maryland capital budget plan FY2014-FY2019
33. Photograph of Hospital's notice of charity care
34. Description of smart and sustainable growth features of the project
35. Scope of Services for Adult Psychiatric Unit
36. Revenue and expense projection at 50 percent variable cost factor for both the current year dollars
37. Revenue and expense projection at 50 percent variable cost factor for both the current year dollars with inflation
38. Corrected Table 1
39. Corrected Table 5

# **EXHIBIT 29**



1. Hospital: 603,444 SF  
231 Beds, Including  
28 Bed Behavioral Health
2. Ambulatory / Cancer  
Center:  
68,255 SF
3. Potential Additional  
Administration:  
21,000 SF
4. Surface Parking: 835
5. Parking Deck: 720 spaces  
5 Levels
6. Central Utility Plant  
40,000 SF
7. Future Patient units  
Up to 4 x 34 beds  
136 beds total

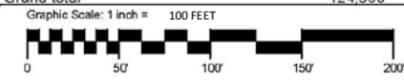
# **EXHIBIT 30**

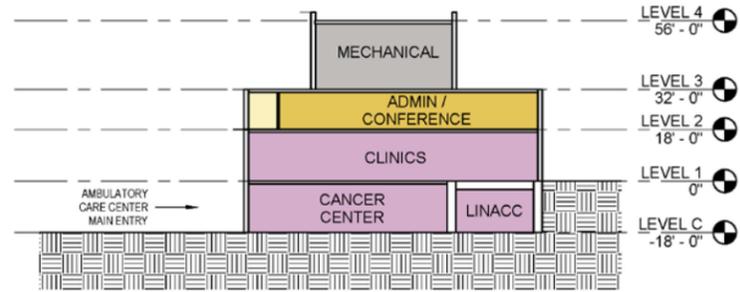
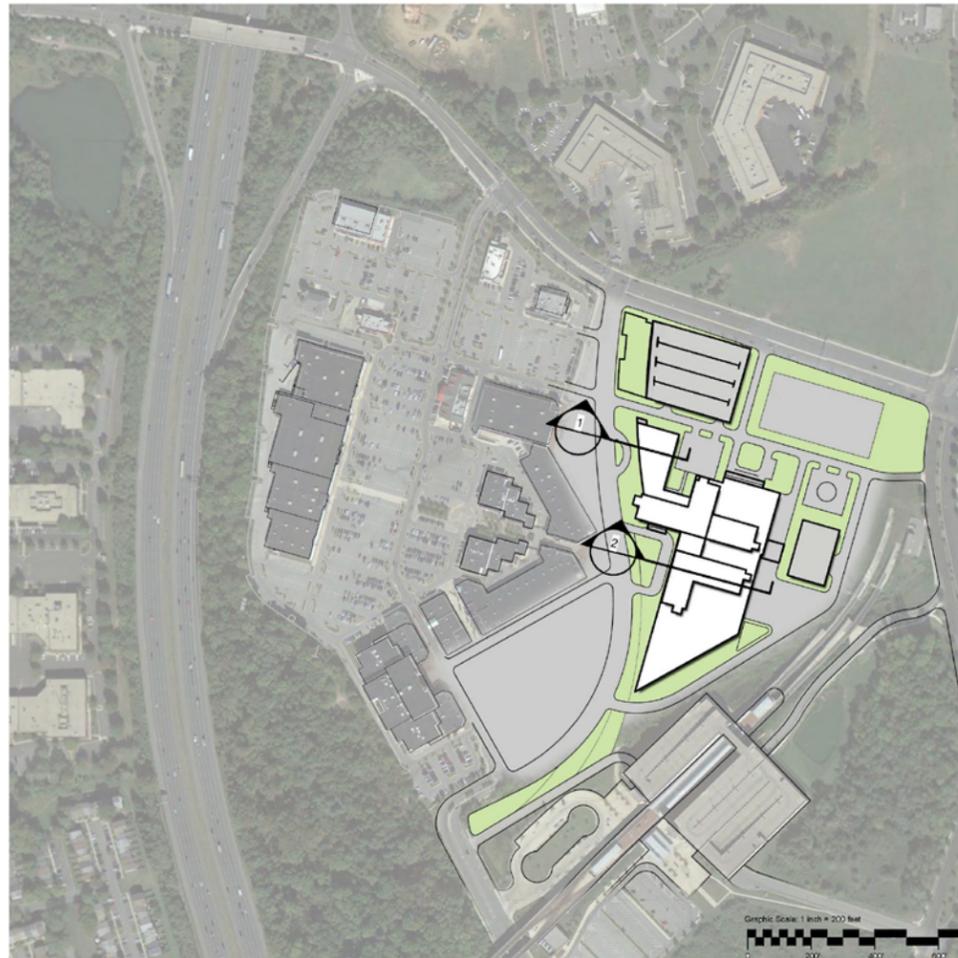


UNDERGROUND (FEET)	
	210
	90
	30
	200
	142
TOTAL	672
	30%

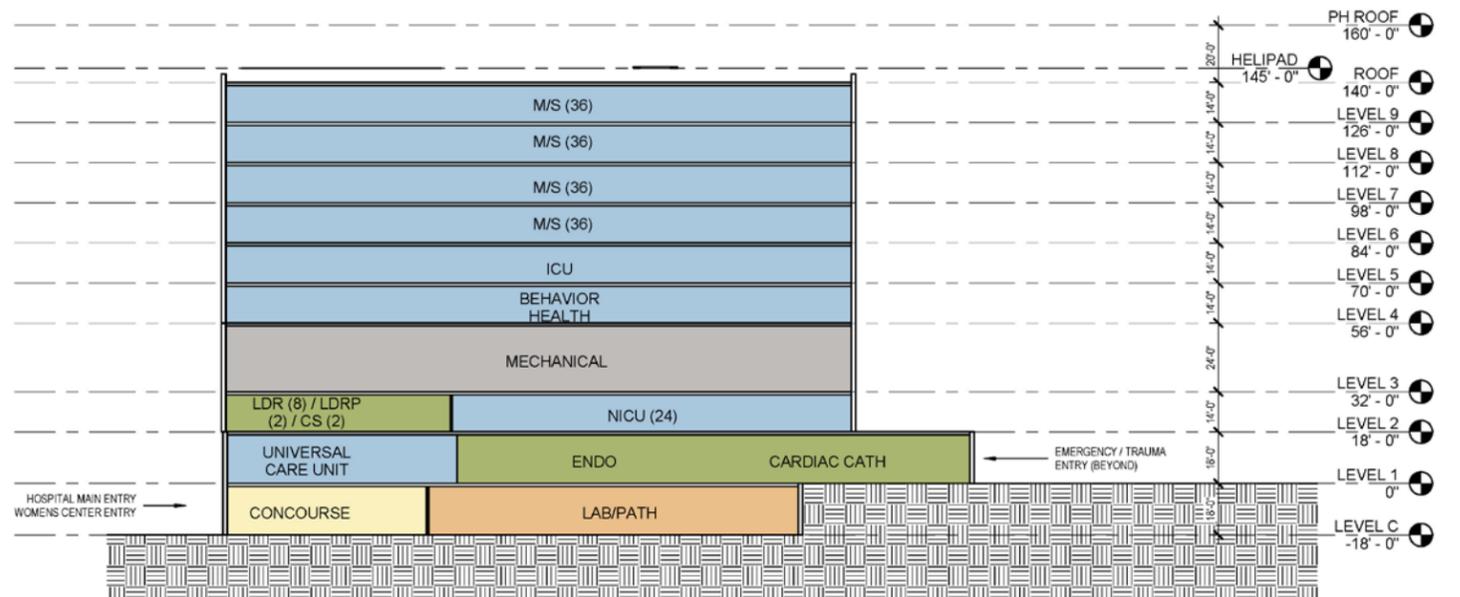
OPEN TO GRADE (FEET)	
	230
	288
	522
	105
	317
	138
TOTAL	1600
	70%

Gross Area Schedule Concourse Level		
Level	Name	Area
LEVEL C	PHASE 1	102,389
LEVEL C	PHASE 1 ACC	22,471
Grand total		124,860





**2** BUILDING SECTION - EAST-WEST - ACC  
1/32" = 1'-0"



**1** BUILDING SECTION - EAST-WEST - HOSPITAL  
1/32" = 1'-0"

# **EXHIBIT 31**

**THE PRINCE GEORGE'S COUNTY FY 2014-2019 APPROVED CAPITAL IMPROVEMENT PROGRAM**

<b>CIP ID NO.</b>	<b>PROJECT NAME</b>	<b>AGENCY</b>
M1809713	REGIONAL MEDICAL CENTER	HOSPITALS

<b>OPERATING IMPACT (000,S)</b>	
DEBT SERVICE	0
MAINTENANCE COSTS	0
OPERATING COSTS	0
TOTAL	0
COST SAVINGS	0

<b>COUNCIL DIST PLANNING AREA ADDRESS</b>	<b>LOCATION AND CLASSIFICATION</b>	<b>STATUS CLASS FUNCTION</b>	<b>Original New Construction Health Service Facilities</b>
Not Applicable Not Applicable Location Not Determined			

<b>APPROPRIATION DATA (000,S)</b>	
YEAR FIRST IN CIP	FY 2014
YEAR FIRST IN CAPITAL BUDGET	FY 2014
CURRENT AUTH THRU	FY 14 208000
CUMULATIVE APPROP. THRU	FY 14 208000
<b>APPROPRIATION REQUESTED</b>	<b>0</b>
BONDS SOLD	0
OTHER FUNDS	0
TOTAL FUNDS RECEIVED	0
EXPENDITURES & ENCUMBRANCES	0
UNENCUMBERED BALANCE	0

<b>EXPENDITURE SCHEDULE (000,S)</b>										
TOTAL	THRU FY 12	EST. FY 13	TOTAL 6 YRS	BUD YR FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	BEYOND 6 YRS
PLANS	3000	0	3000	3000	0	0	0	0	0	0
LAND	2000	0	2000	2000	0	0	0	0	0	0
CONST	201500	0	201500	201500	0	0	0	0	0	0
EQUIP	1000	0	1000	1000	0	0	0	0	0	0
OTHER	500	0	500	500	0	0	0	0	0	0
<b>TOTAL</b>	<b>208000</b>	<b>0</b>	<b>208000</b>	<b>208000</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

<b>PROJECT STATUS</b>	
LAND STATUS	Location Not Determined
PROJECT STATUS	Design Not Begun
PERCENT COMPLETED	0
ESTIMATED COMPLETION DATE	07/2018

<b>FUNDING SCHEDULE (000,S)</b>			
OTHER	TOTAL	FY 14	FY 15
0	208000	208000	0
0	208000	208000	0
<b>TOTAL</b>	<b>208000</b>	<b>208000</b>	<b>0</b>

**MAP**

**DESCRIPTION AND JUSTIFICATION**

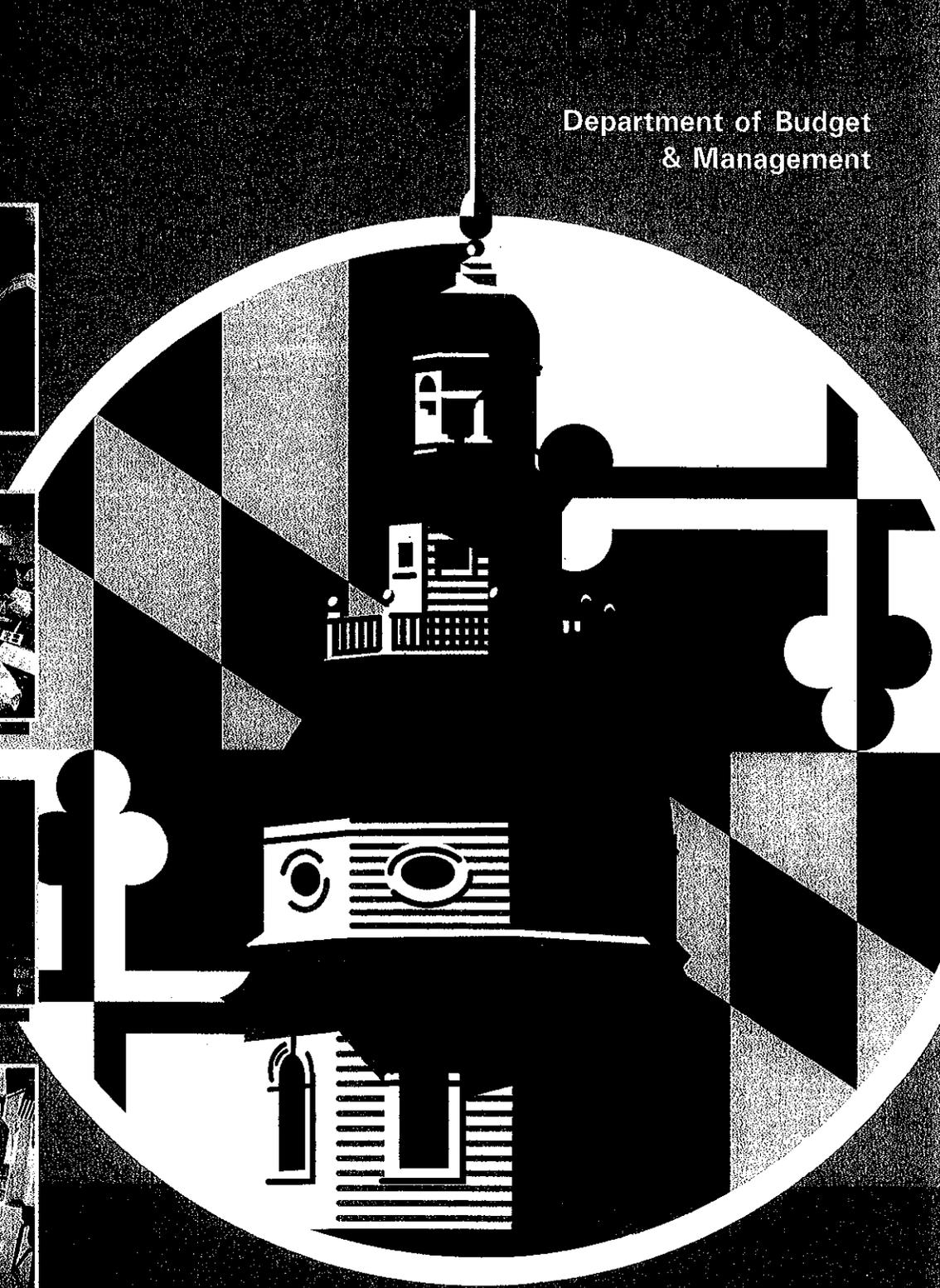
**DESCRIPTION:** This project is to construct a new Regional Medical Center (RMC) and make improvements to existing health facilities in the Prince George's Hospital System. Funding is provided based on a memorandum of understanding entered into by the State, Prince George's County, and Dimensions Healthcare in 2008, and updated in 2011 to include the University of Maryland Medical System and the University System of Maryland. The agreement included a commitment to construct the RMC, with the State, County and Dimensions or another private entity each providing approximately \$200 million toward the project cost. "Other" funding will come from appropriation backed financing likely to include public/private partnership and the State's commitment as shown in its budget with \$20M for each FY14-17 and \$120M in FY18.

**JUSTIFICATION:** The new Regional Medical Center will be a state-of-the-art facility, which is being constructed as a part of a strategy to transform the County's healthcare system into an efficient, effective and financially viable healthcare delivery system which will improve the health of residents of Prince George's County and the Southern Maryland region.

# **EXHIBIT 32**

# MARYLAND

Department of Budget  
& Management



Martin O'Malley, Governor    Anthony G. Brown, Lt. Governor  
T. Eloise Foster, Secretary

**MISCELLANEOUS**

**PRINCE GEORGE'S HOSPITAL SYSTEM**

Budget Code: **ZA00**

**Prince George's Hospital System (Prince George's)**

**FY 2014 Total \$30,000**

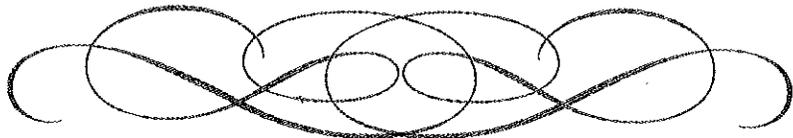
Construct a new Regional Medical Center (RMC) and make improvements to existing health facilities in the Prince George's Hospital System (PGHS). Funding is provided based on a Memorandum of Understanding (MOU) entered into by the State, Prince George's County, and Dimensions Healthcare in 2008, and updated in 2011 to include the University of Maryland Medical System and the University System of Maryland. The agreement included a commitment to construct the RMC, with the State, County, and Dimensions or another private entity each providing approximately \$200 million toward the project cost. In addition, the State committed \$24 million in funding over three years for the improvement of existing health facilities in the hospital system. The FY 2014 budget includes funding to acquire a site and design the RMC, and to make capital improvements to Laurel Regional Hospital agreed to by the State and County.

<u>Source</u>	<u>FY 2014</u>	<u>FY 2015</u>	<u>FY 2016</u>	<u>FY 2017</u>	<u>FY 2018</u>	<u>TOTAL</u>
GO Bonds	30,000	20,000	20,000	20,000	120,000	210,000
<b>TOTAL</b>	<b>30,000</b>	<b>20,000</b>	<b>20,000</b>	<b>20,000</b>	<b>120,000</b>	<b>210,000</b>

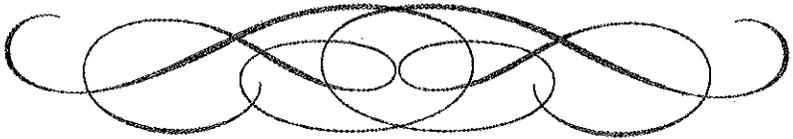
**Subtotals for Prince George's Hospital System**

<u>Source</u>	<u>FY 2014</u>	<u>FY 2015</u>	<u>FY 2016</u>	<u>FY 2017</u>	<u>FY 2018</u>	<u>TOTAL</u>
GO Bonds	30,000	20,000	20,000	20,000	120,000	210,000
<b>TOTAL</b>	<b>30,000</b>	<b>20,000</b>	<b>20,000</b>	<b>20,000</b>	<b>120,000</b>	<b>210,000</b>

A



Report on the Fiscal 2014  
State Operating Budget (HB 100)  
and the State Capital Budget (HB 101)  
and Related Recommendations



by the Chairmen of the  
Senate Budget and Taxation Committee and  
House Appropriations Committee



Joint Chairmen's Report  
Annapolis, Maryland  
2013 Session

# **EXHIBIT 33**

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## NOTICE

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### MEDICAL CARE FOR THOSE WHO CANNOT AFFORD TO PAY

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This health care facility is required to give a reasonable amount of its services free or at a reduced charge to eligible persons who cannot afford to pay for medical care.

If you are not able to pay for all or part of the care you need, please contact the Admissions or Business Office of this facility and ask about the availability of and the eligibility requirements for such care.

If you feel you have been improperly denied free or reduced-charge care, call Toll Free 1-800-638-0742 (Maryland residents call 1-800-492-0359) for assistance.



U.S. Department of Health and Human Services  
Public Health Service

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## AVISO

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### ATENCIÓN MÉDICA PARA AQUELLOS QUE NO LA PUEDEN PAGAR

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Esta institución de salud tiene que dar una cantidad razonable de sus servicios gratuitamente o a precio reducido a personas que no pueden pagar atención médica.

Si usted no puede pagar todo o parte de la atención médica que necesita, por favor comuníquese con la Oficina de Admisiones o la Oficina de Contabilidad de esta institución de salud y pregunte acerca de este tipo de atención médica.

Si usted cree que se le ha negado indebidamente atención médica gratuita o a precio reducido, llame por teléfono sin cargos al número 1-800-638-0742 (si es residente de Maryland, llame al 1-800-492-0359) para ayuda.



Departamento de Salud y Servicios Humanos de  
los Estados Unidos, Servicio de Salud Pública

# **EXHIBIT 34**

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## SUSTAINABILITY NARRATIVE

### 1. INTRODUCTION

The design and systems incorporated into the hospital enable sustainable operation of the facility by reducing resources consumed, waste generated, emissions generated, and reducing the financial burden on facility operators while improving occupant and public health.

Many sustainable features provide subtle benefits to the hospital such as selected robust, easily cleaned materials which last longer and reduce risk of infection. Other features such as energy efficiency have direct, measurable impacts on utility bills. The project should embrace a holistic design that may not always have a measurable impact, but improves the physical, mental, and financial health and wellbeing of building owners, staff, patients and the surrounding community.

### 2. CODES & STANDARDS

- A. International Energy Conservation Code (IECC) 2012
  - a. The state of Maryland has recently adopted IECC 2012 as a means of reducing the energy consumption associated with buildings. The American Society of Heat, Refrigeration, and Air-Conditioning Engineers (ASHRAE) Standard 90.1-2010 Energy Standard for Buildings Except Low-Rise Residential Buildings is equivalent to IECC 2012.
  - b. Meeting IECC 2012 is a significantly greater challenge than prior codes had been; this will require the design team to consider more aggressive energy efficiency approaches, some of which may be new to the building owners and operators and may carry a first cost premium. The design team will thoroughly research and analyze each energy savings option considered and will include the first cost and maintenance complexity as significant factors before incorporating an energy conservation measure into the design.
- B. Water Standards
  - a. Few jurisdictions have significant guidance for water consumption as water availability is a relatively new problem in many locations. The majority of the water consumption requirements will be driven LEED as discussed in section 3.C.a and good design practices as discussed in section 5.
  - b. There are significant stormwater requirements that include:
    - i. Reduce limit of disturbance by at least 50%.
    - ii. Implement environmental site design (ESD) -- e.g. small scale stormwater management practices, nonstructural techniques, site planning that mimics natural hydrologic runoff -- to the maximum extent practicable to provide water quality treatment for at least 50% of the existing impervious area within the limit of disturbance, OR use a combination of the both for at least 50% of the site impervious area within the limit of disturbance.
    - iii. Infiltrate 100% of the annual average predevelopment groundwater recharge volume if soil's infiltration is 1.02 inches per hour or greater.
    - iv. Reduce impervious area within the limits of disturbance by 100% in accordance with the state design manual.
    - v. Implement ESD to the maximum extent practicable to provide water quality treatment for 100% of the existing impervious area within the limits of

- 
- disturbance OR use a combination of the D and E to meet 100% of the existing impervious area within the limits of disturbance
  - vi. Density bonuses (increased FAR, reduced parking, priority permitting) available if requirements are exceeded by 25%.
  - vii. ESD must be distributed.
  - viii. Alternative and off-site ESD possible when site cannot otherwise meet the stormwater standards.
- C. Emissions Standards
- a. As of July 31, 2013 The U.S. EPA has designated Prince George's County, Maryland as Nonattainment for 3 NAAQS (National Ambient Air Quality Standards) Pollutants. NAAQS covers Carbon Monoxide, Lead, Nitrogen Dioxide, Ozone, Particulate Matter, and Sulfur Dioxide. Specifically Ozone (8-hour Ozone 1997,2008) and Particulate Matter (PM-2.5-1997) are currently of concern for Prince George's County.
  - b. Sources of combustions such as emergency generators, boilers, and cogeneration systems may be subject to additional emissions requirements and after treatment to meet local requirements to remove ozone and filter particulates.
  - c. LEED introduces the California South Coast Air Quality Management District standards for all sources of combustion under EAc7. Many larger pieces of equipment may not be able to meet this standard without the addition of after treatment equipment.

### 3. CERTIFICATIONS

- A. Sustainability strategies will be implemented that support the goal of achieving LEED 2009 for Healthcare certification, with the certification level to be evaluated during the next design phase. .
- B. LEED 2009 for Healthcare is broken into six categories which cover: Sustainable Sites, Water Efficiency, Energy & Atmosphere, Materials & Resources, Indoor Environmental Quality, and Innovation in Design. A total of 110 points are available to LEED projects, however not all will be applicable or available to each project.
- C. LEED HC incorporates 13 prerequisites that are required for all certified projects. Many of these are best practice and/or are required by local codes. Some set minimum performance thresholds in key areas. The following prerequisites require special attention as they may not be standard practice for all locations and facilities. They are not required to be pursued except to achieve the highest levels of certification.
  - a. Water Efficiency: LEED 2009 for Healthcare requires that the hospital save 20% water consumption from domestic fixtures and processes as compared to the Energy Policy Act 1992 and 2005. This prerequisite is typically easy to achieve when appropriate plumbing fixtures are specified. Because domestic plumbing fixtures can represent less than half of the overall water consumption of a hospital, additional LEED credits are recommended to reduce water consumption associated with irrigation, building/medical equipment, food service and cooling towers.
  - b. Energy Efficiency: A minimum energy cost savings of 10% beyond ASHRAE 90.1-2007 is required for LEED certification as part of the energy efficiency prerequisite. The local code is IECC 2012 is often about 10-15% more stringent than ASHRAE 90.1-2007. Meeting energy code should enable the project to meet its minimum energy requirements under LEED. See section 2.A.b.
  - c. Fundamental Commissioning: Fundamental commissioning during and after construction is a LEED HC prerequisite. Additional credits are offered for enhanced commissioning and building envelope commissioning.
  - d. Building Recycling: Hospitals are required to incorporate recycling programs into

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- building operations for standard recyclable materials, including but not limited to paper, cardboard, glass, plastics, metals, batteries, and mercury containing devices. Appropriate collection and storage locations are required to be incorporated into the design.
- e. Ventilation: Hospitals are required to meet ASHRAE Standard 170. Spaces not covered in ASHRAE 170, such as offices, are required to meet ASHRAE 62.1.
- D. There are multiple design paths that support achieving LEED certification for any given project. Many credits are simple to achieve and are considered standard practice in many facilities. However, based on project experience the following areas may provide challenges to the design team and will need to be carefully considered:
- a. SSc9.2: Connection to the Natural World - Direct Exterior Access
  - b. WEc3: Water Use Reduction (highest reduction thresholds)
  - c. EAc1: Energy Performance (highest performance thresholds)
  - d. EAc2: On-Site Renewable Energy
  - e. EAc5: Measurement & Verification
  - f. EAc7: Community Containment Prevention – Airborne Release
  - g. IEQc2.2: Acoustic Environment
  - h. IEQc5: Indoor Chemical and Pollutant Source Control
  - i. IEQc6.1,2: Controllability of Systems – Lighting, Thermal Comfort
  - j. IEQc8.1,2: Daylight and Views
- E. There are additional certifications and initiatives that the hospital may pursue such as:
- a. EnergyStar – Based on 1 year of measured energy performance as compared to peer hospital buildings. Score better than 75 out of 100 points to achieve EnergyStar certification.
  - b. Healthier Hospital Initiative – A series of challenges that focus on: Leaderships, Food, Energy, Waste, Chemicals, and Purchasing. HHI is a peer-to-peer, membership-based organization.
  - c. Green Guide for Healthcare New Construction (GGHC NC) – GGHC was a nonprofit organization that developed free tools for healthcare design and operations. GGHC NC formed the basis for LEED HC, but it includes several relevant sustainability strategies and opportunities that were not incorporated into LEED HC. GGHC is a free tool and does not offer a third party certification.
  - d. Green Guide for Healthcare Operations (GGHC Operations) – This guidance document provides good recommendations for greening the operations of healthcare facilities. Although many measures are not directly relevant for new construction projects, it is beneficial to evaluate operations measures to properly plan for them during the design process. LEED for Existing Buildings Operations and Maintenance can provide a third party certification for operational measures, but it is not specific to healthcare.
  - e. Sustainable Roadmap for Hospitals – This initiative was set up by ASHE, the AMA, and other industry organizations to provide free peer-to-peer implementation tools and justification metrics for sustainability measures.

## 4. ENERGY

- A. Systems & Strategies
  - a. The basis of design will include many common energy savings features such as high performance chiller and boiler plants, VAV air handling systems, heat shift heat pump system, sophisticated HVAC and lighting control schemes, heat recovery where appropriate, and other solutions that have proven life cycle cost effective in healthcare

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facilities. Life cycle cost analysis will be conducted during schematic design to confirm these assumptions.

- b. Additional sustainable strategies such as combined heat and power (CHP), dedicated outside air system coupled with active chilled beams, renewable energy etc. will be evaluated as design progresses. Preliminary CHP analyses have already been completed, and are included in the engineering narrative.
- c. Process loads (imaging, sterilizers, kitchen equipment, etc.) will be incorporated into the sustainable engineering strategies to reduce energy and water consumption related to these systems and to create energy and water efficiency synergies that support the facility's goals.

**B. Energy Modeling**

- a. The design team will provide early exploratory energy modeling starting in the Programming and Concept phases of the project with the intent of testing goals, gauging ideas, and filtering some of the ideas. Standard and custom modeling tools will allow for a smooth transition into the Schematic Design phase and a greater level of design detail.
- b. The modeling is intended to support a variety of needs: design goals, code compliance, LEED documentation, utility incentive opportunities and/or water use impacts. The data can also be used to support economic analysis efforts which may include payback analysis, life cycle cost analysis, and/or Value Engineering efforts.
- c. The models will be updated as the project progresses into later phases and can be used in the construction submittal stage to evaluate the value of potential final system alternatives if deemed of value.

**C. Energy Savings Target**

- a. The U.S. Department of Energy's Commercial Building Energy Consumption Survey (CBECS) 2003 determined that the average energy use intensity of inpatient healthcare facilities for the mid-Atlantic region of the U.S. is 220kBtu/SF-Year.
- b. A new hospital meeting energy code should have an EUI of between 175 to 200 kBtu/SF-Year for this region with a goal of 150 kBtu/SF-Year. The target will be revisited during schematic design and confirmed with energy models as the design progresses.

## **5. WATER**

- A. The design team will provide an estimate of both water used on the site and water available on the site. This includes gross quantities of site, mechanical and building water needs, each of which are characterized by different water quality requirements. This will inform strategies that support project goals, compliance with stormwater and water reuse/recycling standards, and cost effective reduction of potable water use. Water use will be minimized through design of the plant and building mechanical systems, site landscape design, and fixture and equipment selection. Opportunities for minimizing the project's potable water use, such as rain or gray water reuse, will be studied. These concepts will be supported by gross estimates of water volumes that correlate sources and uses with an assessment of relative costs. These will be initially vetted with the owner and the most viable of the strategies will be developed and evaluated with greater detail as the design progresses.
- B. Energy is a significant portion of the cost of water, both at the utility level and at the site and building scale. Similarly, significant volumes of water are used to support the functioning of building mechanical systems and building process loads. The design team will employ life cycle cost analysis to track the water cost-versus energy cost tradeoffs of design decisions and use this data to support design decision making. Note that this site's water utilities

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- (including stormwater) are relatively expensive. Water utility costs have risen an average of 7% per annum for the previous 8 years in part because of a consent decree that compels system improvements. It is reasonable to expect similar annual increases through the direction of the consent decree schedule (to 2016) and beyond.
- C. Based on a past project experience and the local water utility rates, a design-modeled (mechanical systems, site water, fixtures and furnishings, lawn) plant/building water savings target of 50% potable is recommended. The target will be revisited during schematic design and confirmed with energy and water models as the design progresses. The design team will describe its water related design work with the following metrics:
- a. Design baseline (assumed volume of potable water)
  - b. Designed water volumes (potable and reused/recycled water)
  - c. Potable water volumes
  - d. Reused/recycled water volumes
  - e. Design baseline annual water utility costs (water, sewer, stormwater)
  - f. Designed water annual utility costs (water, sewer, stormwater)

## 6. INDOOR ENVIRONMENTAL QUALITY

- A. A major factor in sustainability is enabling a productive and healthy working environment, and in the case of hospitals an environment that supports healing. Indoor environmental quality includes: views and daylight, air quality, acoustic quality, and thermal comfort.
- B. Daylight & Views
- a. Access to natural light and views helps establish circadian rhythm and creates a calm environment that encourages healing and productivity. This can be especially important in hospitals where staff often works night shifts, which can have detrimental impacts on performance.
  - b. Interior and exterior shading will be investigated to minimize glare while maximizing quality daylight. The target value for glare (maximum daylight autonomy) should be less than 5%, and the target value for daylight (continuous daylight autonomy) shall be 50%. Of particular concern will be the location of the patient's head as compared to the window and direct sun to eliminate glare. Glare on patients faces will cause discomfort and will result either in a nurse call or closing of shades and activation of artificial lighting. Motorized blinds with controls at the patient beds are recommended to provide additional comfort and control when glare and/or high light levels are problematic.
- C. Indoor Air quality
- a. Both ASHRAE Standard 170 Ventilation of Health Care Facilities and ASHRAE Standard 62.1 Ventilation for Acceptable Indoor Air Quality set air flow and filtration requirements for the hospital.
  - b. Key components to maintaining air quality are internal pollutants generated by off-gassing furniture and materials.
- D. Acoustics
- a. Architectural and MEP systems shall be designed to minimize noise and maintain privacy. This is especially important in a hospital where confidential medical information is frequently conveyed.
  - b. Exterior noise shall be managed as practicable. Major sources of noise include: The Capitol Beltway, Largo Town Center Metro Station, Air Traffic for nearby airports, medical transport helicopters, and mechanicals systems (cooling towers & generators).
- E. Thermal Comfort
- a. Thermal comfort guidelines are established by ASHRAE Standard 55 Thermal

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- Environmental Conditions for Human Occupancy.
- F. User (Staff & Patient) Controls
    - a. The user's ability to adjust their environment and light levels is great satisfier. The level of controllability of systems including lighting and thermal comfort will be discussed early in schematic design.

## 7. ECONOMICS & OPERATIONS

- A. Life cycle cost analyses will be conducted for all major systems and strategies analyses. Factors that help to determine total cost of ownership include: first cost, incentives, utility cost (energy & water), maintenance costs, and expected equipment life.
- B. A target payback time or ROI will be set early in schematic design to be used as a performance metric. Initial investigations into both energy and water utility rates indicate effective paybacks for multiple energy and water savings strategies. Utility rates will need to be confirmed with UMMS, and include:
  - a. Electricity = \$0.134/kWh : Pepco GS-3A Electric Rate Schedule
  - b. Natural Gas = \$10.15/MMBtu : US DOE, EIA Maryland Average Rate
  - c. Water = \$6.76/kgal : Washington Suburban Sanitary Commission
  - d. Sewer = \$10.29/kgal : Washington Suburban Sanitary Commission
- C. Both energy and water measurement and verification will be pursued to meet both LEED and UMMS requirements to maintain long term efficient performance of MEP and process systems such as sterilizers, food service, laundry and imaging.
- D. Incentives:
  - a. Pepco pays incentives for electricity and water savings
    - i. Electricity Incentive = \$0.16/kWh
    - ii. Water Incentive = \$0.624/kgal
  - b. Maryland Department of Environmental Resources
    - i. Incentives are currently being determined under the Clean Water Act Fee regulation.
  - c. Additional incentives will be determined as the design progresses.

**END OF NARRATIVE**

# **EXHIBIT 35**

**Prince George's Hospital Center**  
**SCOPE OF SERVICE**

**Department/Unit:** E400 - Inpatient Psychiatric Unit

<p><b>Scope of Service:</b></p>	<ul style="list-style-type: none"> <li>▪ Located on the 4<sup>th</sup> floor of the Hospital in the E wing.</li> <li>▪ Hours of Operation: twenty-four hours a day, seven days a week.</li> <li>▪ Services of the department include: Locked inpatient unit serving voluntary and involuntary patients.             <ul style="list-style-type: none"> <li>✦ Acute psychiatric treatment</li> <li>✦ Chronic psychiatric management</li> <li>✦ Diagnostic evaluation</li> <li>✦ Therapeutic treatment including art therapy and crafts</li> <li>✦ Smoking Cessation Groups</li> <li>✦ Counseling including anger management, social issues, and family meetings</li> <li>✦ Exercise and recreation</li> <li>✦ Patient and family education</li> <li>✦ Library with reference material</li> <li>✦ Referral to the partial hospitalization program or outpatient behavioral health services and programs in the community</li> </ul> </li> </ul>
<p><b>Criteria for Entry/Admission to Service:</b></p>	<ul style="list-style-type: none"> <li>▪ Patients must have an acute or chronic mental health condition that cannot be treated in a less restrictive environment. The criteria are:             <ul style="list-style-type: none"> <li>✦ At least 18 years old</li> <li>✦ Mental disorder with DSM-IV primary multi-axial diagnosis.</li> <li>✦ Documentation that indicates a less intensive treatment or outpatient treatment is not appropriate or has failed.</li> <li>✦ Patient has made direct threats of harm to themselves or others requiring suicide precautions and/or observation.</li> </ul> </li> <li>▪ Patients may be admitted through the Assessment and Stabilization Center (ASC) or by direct admission from the community or within the Hospital.</li> <li>▪ Patients may voluntarily admit themselves for treatment.</li> <li>▪ Patients may be involuntarily admitted for treatment when certified by two (2) physicians.</li> </ul>
<p><b>Staffing:</b></p>	<ul style="list-style-type: none"> <li>▪ Staffing consists of:             <ul style="list-style-type: none"> <li>✦ Director, Behavioral Health Services = 1.0 FTE</li> <li>✦ Manager, Inpatient Psychiatry (E-400) = 1.0 FTE</li> <li>✦ Assistant Department Manager = 2.0 FTE</li> <li>✦ Registered Nurse = 12.8 FTE</li> <li>✦ Technician = 8.0 FTE</li> </ul> </li> </ul>

**Prince George's Hospital Center  
SCOPE OF SERVICE**

**Department/Unit:** E400 - Inpatient Psychiatric Unit

<p><b>Staffing (Cont'd)</b></p>	<ul style="list-style-type: none"> <li>✦ Art Therapist = 1.0 FTE</li> <li>✦ Addictions Counselor = 0.5 FTE</li> <li>✦ Lead Total Care Manager/Social Worker = 1.0</li> <li>✦ Total Care Manager/Social Worker = 2.5 FTE</li> <li>✦ Clerical Specialist = 2.5 FTE</li> <li>✦ Smoking Cessation Counselor</li> </ul>
<p><b>Qualification of Staff:</b></p>	<ul style="list-style-type: none"> <li>▪ Director: A Registered Nurse with a current State of Maryland license, MS degree, with psychiatric nursing experience, and must successfully complete an extended departmental orientation that focuses on daily patient care operations. Must have Basic Life Support (BLS) certification.</li> <li>▪ Department Manager: Must be a Registered Nurse with a current State of Maryland license, MS or BS degree, with psychiatric nursing experience, and must successfully complete an extended departmental orientation that focuses on daily patient care operations. Must have Basic Life Support (BLS) certification.</li> <li>▪ Assistant Department Manager: Must be a Registered Nurse with a current State of Maryland license, BS or AS degree, with psychiatric nursing experience, and must successfully complete an extended departmental orientation that focuses on daily patient care operations. Must have Basic Life Support (BLS) certification.</li> <li>▪ Registered Nurse: Must have a current State of Maryland license and psychiatric nursing experience or successfully complete an extended departmental orientation that focuses on daily patient care operations. Must have Basic Life Support (BLS) certification.</li> <li>▪ Patient Care Technician: Must be certified as a PCT in the State of Maryland and have psychiatric nursing experience or successfully complete an extended departmental orientation that focuses on daily patient care operations. Must have Basic Life Support (BLS) certification.</li> <li>▪ Art Therapist: Must have a MA degree in Art Therapy and requisite knowledge and experience in the particular form of therapy provided. Encouraged to obtain LPC.</li> <li>▪ Counselor: Must have a BS or BA degree in Psychology or related field and have psychiatric</li> </ul>

**Prince George's Hospital Center**  
**SCOPE OF SERVICE**

**Department/Unit:** E400 - Inpatient Psychiatric Unit

<p><b>Qualification of Staff(Cont'd)</b></p>	<p>counseling experience or successfully complete an extended departmental orientation that focuses on daily patient care operations. Encouraged to obtain certification in crisis counseling or comparative proficiency.</p> <ul style="list-style-type: none"> <li>▪ Lead Social Worker: Must have a LCSW-C with experience in psychotherapy and group education, and must successfully complete an extended departmental orientation that focuses on daily patient care operations.</li> <li>▪ Social Worker: Must have a LGSW and/or LCSW-C with experience in psychotherapy and group education, and must successfully complete an extended departmental orientation that focuses on daily patient care operations. Encouraged to obtain LCSW-C.</li> <li>▪ Addictions Counselor: Must have a MS degree, State of Maryland license, and must have psychiatric counseling experience or successfully complete an extended departmental orientation that focuses on daily patient care operations.</li> <li>▪ Clerical Specialist: Must have requisite knowledge and experience to provide administrative support.</li> </ul>
<p><b>Description of Communication/Collaboration/Functional Relationship with Other Departments and Services</b></p>	<ul style="list-style-type: none"> <li>▪ Work collaboratively with the Assessment and Stabilization Center, Partial Hospitalization Program, hospital inpatient units, and Community Providers.</li> <li>▪ Participate in hospital-wide committees including Infection Control, Safety Committee, Leadership Forum, Performance Improvement, Customer Service and others as indicated and appropriate.</li> <li>▪ Interact with the state and county agencies to facilitate proper placement and treatment of mental health patients.</li> <li>▪ Participate in the Prince George's County Advisory Committee.</li> <li>▪ Attend DHMH mental health authority meetings.</li> </ul>
<p><b>Goals of Department/Service</b></p>	<ul style="list-style-type: none"> <li>▪ Maintain safe, therapeutic environment to provide quality care to mental health patients.</li> <li>▪ Ensure compliance with protocol for transfer to Inpatient Psychiatric Unit (E-400).</li> <li>▪ Develop consistent format for treatment teams to ensure efficient operation and reduce patient length of stay.</li> <li>▪ Improve patient satisfaction.</li> </ul>

**Prince George's Hospital Center**  
**SCOPE OF SERVICE**

**Department/Unit:**      E400 - Inpatient Psychiatric Unit

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<b>Goals of Department/Service (Cont'd)</b>	<ul style="list-style-type: none"><li>▪ Enhance formal staff recognition.</li><li>▪ Refine the use of visual communication system.</li><li>▪ Implement self study program for staff.</li><li>▪ Expand alliance with community providers of mental health services.</li></ul>
<b>Plan for Quality Improvement</b>	<ul style="list-style-type: none"><li>▪ Participate in departmental and hospital wide PI projects such as restraint monitoring, pain assessment, falls, chart reviews and other applicable PI activities.</li><li>▪ Concurrent review of medical record documentation.</li><li>▪ Cross-train ASC, E-400, and PHP staff to ensure staff is knowledgeable to float as needed to ensure adequate staffing.</li><li>▪ Establish routine meetings with all Behavioral Health Services departments to promote team concept.</li></ul>

**Exhibit 36**  
**Table 3**  
**50% Variable Cost Factor without Inflation**

**TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project)**  
**Excludes HSCRC Annual Update Factors and Expense Inflation**  
**(Dollars are presented in thousands)**

Fiscal Year	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first full-year at full utilization)						
	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21
<b>1. Revenue</b>										
a. Inpatient Services	\$191,109	\$173,139	\$190,287	\$189,043	\$193,143	\$197,319	\$216,664	\$231,476	\$238,361	\$244,570
b. Outpatient Services	65,240	76,775	71,141	71,402	71,975	72,575	75,694	80,968	82,648	84,144
c. Gross Patient Services Revenues	256,349	249,914	261,428	260,444	265,118	269,893	292,358	312,444	321,009	328,714
d. Allowance of Bad Debt	14,746	16,710	23,322	23,234	23,651	24,077	25,904	26,734	26,626	26,462
e. Contractual Allowances	12,967	6,272	9,303	7,130	7,258	7,388	8,285	8,599	8,404	8,388
f. Charity Care	24,105	21,930	15,940	15,880	16,165	16,456	17,705	18,272	18,198	18,086
g. Net Patient Services Revenue	204,531	205,002	212,864	214,201	218,044	221,972	240,464	258,838	267,780	275,779
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	235,117	238,958	242,886	256,453	269,903	278,845	280,177
<b>2. Expenses</b>										
a. Salaries, Wages, and Benefits	127,865	133,564	131,405	132,593	129,755	129,367	127,729	128,168	132,292	136,347
b. Contractual Services	30,095	30,498	32,634	30,386	30,006	29,453	29,799	30,649	31,635	32,605
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 Amortization	1,268	1,268	1,268	1,268	1,268	1,268	634	-	-	-
h. Project Amortization	-	-	-	-	-	-	118	237	237	237
i. Supplies	32,844	33,633	35,935	35,487	35,770	36,235	36,437	37,251	38,449	39,628
j. Other Expenses										
- Physician Support	20,734	23,855	26,750	23,906	25,388	25,486	25,002	24,981	24,529	22,375
- Utilities	2,713	1,184	2,610	2,593	2,553	2,519	2,534	2,590	2,673	2,755
k. Total Operating Expenses	221,678	231,158	239,495	235,354	233,471	231,838	251,643	274,137	274,042	277,616
<b>3. Income</b>										
a. Income from Operations	7,352	1,014	2,690	(237)	5,487	11,048	4,810	(4,234)	4,803	2,561
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	7,349	5,573	11,134	4,896	(4,148)	4,889	2,647
d. Income Taxes	-	-	-	-	-	-	-	-	-	-
e. Net Income (Loss)	\$7,369	\$1,026	\$2,776	\$7,349	\$5,573	\$11,134	\$4,896	-\$4,148	\$4,889	\$2,647



**Exhibit 37**  
**Table 3**  
**50% Variable Cost Factor with Inflation**

**TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project)**  
**Includes HSCRC Annual Update Factors and Expense Inflation**  
**(Dollars are presented in thousands)**

Fiscal Year	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first full-year at full utilization)						
	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21
<b>1. Revenue</b>										
a. Inpatient Services	\$191,109	\$173,139	\$190,287	\$191,799	\$198,615	\$205,548	\$226,497	\$251,081	\$264,655	\$277,983
b. Outpatient Services	65,240	76,775	71,141	72,281	73,741	75,241	79,126	86,604	90,273	93,867
c. Gross Patient Services Revenues	256,349	249,914	261,428	264,080	272,356	280,789	305,624	337,685	354,927	371,850
d. Allowance of Bad Debt	14,746	16,710	23,322	23,559	24,297	25,049	27,079	28,889	29,431	29,921
e. Contractual Allowances	12,967	6,272	9,303	7,229	7,456	7,687	8,657	9,283	9,280	9,474
f. Charity Care	24,105	21,930	15,940	16,102	16,606	17,120	18,508	19,745	20,115	20,450
g. Net Patient Services Revenue	204,531	205,002	212,864	217,191	223,997	230,933	251,380	279,767	296,102	312,005
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	4,432	4,465	4,500	4,561	4,622	4,658	4,694
i. Net Operating Revenue	229,030	232,172	242,185	238,140	244,979	251,949	267,532	291,056	307,427	316,699
<b>2. Expenses</b>										
a. Salaries, Wages, and Benefits	127,865	133,564	131,405	135,752	136,096	138,768	139,062	143,946	152,295	160,892
b. Contractual Services	30,095	30,498	32,634	31,120	31,473	31,657	32,533	34,529	36,532	38,594
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 Amortization	1,268	1,268	1,268	1,268	1,268	1,268	634	-	-	-
h. Project Amortization	-	-	-	-	-	-	118	237	237	237
i. Supplies	32,844	33,633	35,935	36,310	37,391	38,657	39,500	41,690	44,108	46,598
j. Other Expenses										
- Physician Support	20,734	23,855	26,750	25,287	28,213	29,822	30,521	32,353	33,573	33,171
- Utilities	2,713	1,184	2,610	2,656	2,681	2,711	2,770	2,923	3,093	3,267
k. Total Operating Expenses	221,678	231,158	239,495	241,514	245,852	250,391	274,527	305,939	314,065	326,427
<b>3. Income</b>										
a. Income from Operations	7,352	1,014	2,690	(3,374)	(873)	1,558	(6,995)	(14,882)	(6,638)	(9,728)
b. Non-Operating Income										
- Investment Income	17	12	86	87	88	89	91	93	94	95
- State Grant Capital Support	-	-	-	7,500	-	-	-	-	-	-
c. Subtotal	7,369	1,026	2,776	4,213	(785)	1,647	(6,904)	(14,790)	(6,545)	(9,633)
d. Income Taxes	-	-	-	-	-	-	-	-	-	-
e. Net Income (Loss)	\$7,369	\$1,026	\$2,776	\$4,213	-\$785	\$1,647	-\$6,904	-\$14,790	-\$6,545	-\$9,633



**Exhibit 38**

**Corrected Table 1**



	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first full-year at full utilization)						
g. Rehabilitation										
h. Chronic										
i. Other										
i. Total	242	224	214	214	214	214	215	216	216	216

<b>6. Outpatient Visits</b>										
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
Other – Observation										
c. 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

**Exhibit 39**

**Corrected Table 5**

Expense Centers	2014 FTEs	Change in FTEs	Avg Salary per FTE	Employee / Contractual	2021 Total Cost
Executive Office/Administration					
120854000 PHYSICIAN ASSISTANTS	19.50	( 2.12)	\$ 100,933	Employee	\$ 1,754,476
120901000 EXECUTIVE OFFICES	6.00	( 0.65)	118,125	Employee	631,797
120910000 COMMUNICATIONS	11.20	( 1.22)	34,279	Employee	342,234
Total - Executive Office/Administration	<u>36.70</u>	<u>( 3.99)</u>	<u>83,402</u>		<u>2,728,508</u>
Corporate Allocations/Overhead - Direct & Indirect	15.80	( 1.72)	202,517	Employee	2,852,337
Planning/Public Affairs					
120921000 MARKETING & PUBLIC REL	2.49	( 0.27)	68,034	Employee	151,294
Total - Planning/Public Affairs	<u>2.49</u>	<u>( 0.27)</u>	<u>68,034</u>		<u>151,294</u>
Fiscal Services					
120902000 PT FINANCIAL SVCS	38.66	( 4.20)	45,675	Employee	1,574,048
120902100 MEDICAID ELIGIBILITY	1.80	( 0.20)	40,138	Employee	64,403
120903000 REGISTRATION	27.30	( 2.96)	37,245	Employee	906,396
120908000 MIS	-			Employee	176,554
120970000 HEALTH INFO MGT(MED RECOR	30.21	( 3.28)	53,719	Employee	1,446,688
Total - Fiscal Services	<u>97.97</u>	<u>( 10.64)</u>	<u>47,726</u>		<u>4,168,088</u>
Human Resources					
120916000 HUMAN RESOURCES	14.60	( 1.59)	85,635	Employee	1,114,521
120919000 EMPLOYEE HEALTH	2.50	( 0.27)	74,672	Employee	166,410
Total - Human Resources	<u>17.10</u>	<u>( 1.86)</u>	<u>84,033</u>		<u>1,280,930</u>
Medical Affairs					
120855000 INTERNAL MEDICINE	45.00	( 4.89)	53,645	Employee	2,151,914
120856000 MEDICAL AFFAIRS OFFICE	5.30	( 0.58)	60,110	Employee	283,988
120975000 CASE MANAGEMENT	23.90	( 2.60)	79,604	Employee	1,695,988
120975000 CASE MANAGEMENT	1.50	( 0.16)	124,800	Contractual	166,873
Total - Medical Affairs	<u>75.70</u>	<u>( 8.22)</u>	<u>63,704</u>		<u>4,298,764</u>

Expense Centers	2014 FTEs	Change in FTEs	Avg Salary per FTE	Employee / Contractual	2021 Total Cost
Quality Affairs					
120603000 INFECTION CONTROL	3.00	( 0.33)	102,298	Employee	273,617
120852000 CLINICAL DOCUMENTATION	5.00	( 0.54)	85,197	Employee	379,732
120857000 RISK MANAGEMENT	2.00	( 0.22)	88,026	Employee	156,938
120859000 QUALITY IMPROVEMENT	9.30	( 1.01)	80,274	Employee	665,696
Total - Quality Affairs	19.30	( 2.10)	85,776		1,475,983
Nursing					
120600000 NURSING ADMINISTRATION	8.80	0.49	64,625	Employee	600,341
120600200 INPATIENT OPERATIONS	25.00	1.39	105,233	Employee	2,777,187
120601000 ON CALL FLOAT POOL	22.60	1.26	35,004	Employee	835,092
120601200 NURSING INTERNSHIP/GRADS	2.00	0.11	57,288	Employee	120,947
120602000 HOSPITAL EDUCATION	8.60	0.48	77,451	Employee	703,137
120603500 PATIENT TRANSPORT	14.40	0.80	30,113	Employee	457,755
120611000 NURSING E 900 (MS-TELE/ON	40.89	2.27	68,547	Employee	2,958,937
120611000 NURSING E 900 (MS-TELE/ON	0.30	0.02	124,800	Contractual	39,523
120612000 NURSING E 700 (MS-TELE)	37.50	2.09	69,105	Employee	2,735,487
120612000 NURSING E 700 (MS-TELE)	1.80	0.10	124,800	Contractual	237,137
120612500 NURSING E-800 (MS-ORTHO/T	43.21	2.40	67,915	Employee	3,098,171
120612500 NURSING E-800 (MS-ORTHO/T	1.50	0.08	124,800	Contractual	197,614
120624000 NURSING K400 - PCRU	85.09	4.73	61,843	Employee	5,555,146
120624000 NURSING K400 - PCRU	2.20	0.12	124,800	Contractual	289,834
120640000 NURSING E 600 PEDIATRICS	10.20	0.57	81,422	Employee	876,714
120651000 NURSING K 200 - ANTE/POST	44.10	( 3.37)	76,362	Employee	3,110,579
120651000 NURSING K 200 - ANTE/POST	1.80	( 0.14)	124,800	Contractual	207,497
120660000 NURSING - CCU	18.10	1.01	76,093	Employee	1,454,044
120660000 NURSING - CCU	2.40	0.13	124,800	Contractual	316,182
120663000 NURSING - ICU/CCC	82.90	4.61	72,806	Employee	6,371,161
120663000 NURSING - ICU/CCC	3.60	0.20	124,800	Contractual	474,273
120666000 NURSING - PSYCH	30.20	1.68	65,728	Employee	2,095,421
120666000 NURSING - PSYCH	3.50	0.19	124,800	Contractual	461,099
120672000 NURSING - NICU	33.00	( 2.52)	86,003	Employee	2,621,911
120672000 NURSING - NICU	2.00	( 0.15)	124,800	Contractual	230,552
120701000 OPERATING ROOM	51.70	2.88	68,222	Employee	3,723,629

Expense Centers	2014 FTEs	Change in FTEs	Avg Salary per FTE	Employee / Contractual	2021 Total Cost
120702000 PERFUSION SERVICES	2.00	0.11	129,058	Employee	272,474
120704000 POST ANESTHESIA CARE UNIT	17.00	0.95	83,760	Employee	1,503,141
120704000 POST ANESTHESIA CARE UNIT	1.00	0.06	124,800	Contractual	131,743
120706000 SAME DAY SURGERY	8.10	0.45	73,566	Employee	629,036
120707000 TRANSCARE	4.40	0.24	88,635	Employee	411,837
120708000 LABOR AND DELIVERY	40.50	( 3.09)	80,189	Employee	2,999,803
120708000 LABOR AND DELIVERY	0.90	( 0.07)	124,800	Contractual	103,748
120718000 CENTRAL STERILE PROCESSIN	12.90	0.72	38,207	Employee	520,289
120724000 ANESTHESIOLOGY	4.00	0.22	48,225	Employee	203,630
120725000 HEMODIALYSIS	8.80	0.49	78,076	Employee	725,363
120744000 CARDIOLOGY	8.20	0.46	79,248	Employee	685,983
120746000 CARDIAC CATH LAB	10.50	0.58	89,917	Employee	996,570
120746000 CARDIAC CATH LAB	0.10	0.01	124,800	Contractual	13,174
120763100 CARDIAC REHAB	2.20	0.12	83,442	Employee	193,785
120770000 PSYCH-PARTIAL HOSPITALIZA	3.50	0.19	70,833	Employee	261,705
120771100 SMOKING CESSATION	1.20	0.07	50,825	Employee	64,384
120772000 EMERGENCY PSYCH SERVICE-E	15.50	0.86	77,380	Employee	1,266,118
120778500 EMERGENCY-LABOR & DELIVERY	4.20	( 0.32)	72,999	Employee	283,197
120781000 PERINATAL DIAGNOSTIC CTR	4.20	0.23	68,985	Employee	305,857
120783200 SPECIAL PROCEDURES	5.10	0.28	68,414	Employee	368,323
120783200 SPECIAL PROCEDURES	0.20	0.01	124,800	Contractual	26,349
120789000 INFUSION CENTER	1.50	0.08	54,750	Employee	86,694
120844000 CARDIAC SERVICES	1.00	0.06	94,238	Employee	99,479
120918000 NURSING SUPPORT PROGRAM	1.70	0.09	96,122	Employee	172,497
120926000 CUSTOMER SERVICE	1.00	0.06	63,481	Employee	67,012
<b>Total - Nursing</b>	<b>737.11</b>	<b>24.31</b>	<b>72,156</b>		<b>54,941,560</b>
<b>Ambulatory Care &amp; Ancillary Services</b>					
120710000 PHARMACY	36.00	2.00	84,516	Employee	3,212,243
120719000 PATHOLOGY ADMINISTRATION	51.00	2.84	63,232	Employee	3,404,233
120719000 PATHOLOGY ADMINISTRATION	1.00	0.06	143,520	Contractual	151,504
120722000 ANGIOGRAPHY	3.50	0.19	70,478	Employee	260,396
120728000 RADIOLOGY	32.00	1.78	61,571	Employee	2,079,994
120729000 ULTRASOUND	6.20	0.34	71,450	Employee	467,638
120730000 CAT SCAN	7.00	0.39	78,414	Employee	579,436

Expense Centers	2014 FTEs	Change in FTEs	Avg Salary per FTE	Employee / Contractual	2021 Total Cost
120731000 VASCULAR LAB	3.40	0.19	91,978	Employee	330,122
120732000 NUCLEAR					
MEDICINE	3.40	0.19	105,224	Employee	377,667
120745000 PULMONARY					
FUNCTION	1.10	0.06	85,277	Employee	99,023
120748000					
ELECTROENCEPHALOGRAPHY	1.00	0.06	84,842	Employee	89,561
120752000 RESPIRATORY					
THERAPY	29.00	1.61	82,270	Employee	2,518,158
120760000 PHYSICAL					
MEDICINE	11.00	0.61	65,034	Employee	755,171
120761000					
OCCUPATIONAL THERAPY	3.70	0.21	84,547	Employee	330,227
120762000 SPEECH					
THERAPY	2.20	0.12	85,160	Employee	197,777
120762000 SPEECH					
THERAPY	0.50	0.03	135,200	Contractual	71,361
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	Employee	578,983
120774000 EMERGENCY					
SERVICES	70.40	3.92	73,047	Employee	5,428,377
120774000 EMERGENCY					
SERVICES	21.90	1.22	135,200	Contractual	3,125,593
120835000 TRAUMA	5.20	0.29	60,798	Employee	333,739
Total - Emergency Services	105.80	5.89	84,764		9,466,692
New Departments					
Cardiac		35.00	126,115	Employee	4,414,042
Cancer		13.00	69,696	Employee	906,048
Total - New Departments		48.00	110,835		5,320,090
Support Services					
120930000 FOOD					
SERVICES	56.30	( 6.11)	40,715	Employee	2,043,289
120940000					
ENVIRONMENTAL SERVICES	86.21	( 9.36)	33,775	Employee	2,595,601
120963000 CLINICAL					
ENGINEERING	8.00	( 0.87)	87,712	Employee	625,506
120964000 MAINTENANCE	23.40	( 2.54)	57,855	Employee	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	Employee	776,758
Total - Materials Management	17.30	( 1.88)	50,368		776,758

<b>Expense Centers</b>	<b>2014 FTEs</b>	<b>Change in FTEs</b>	<b>Avg Salary per FTE</b>	<b>Employee / Contractual</b>	<b>2021 Total Cost</b>
<b>Total Salaries</b>	<b><u>1,491.19</u></b>	<b><u>39.34</u></b>	<b><u>\$ 71,124</u></b>		<b><u>\$ 108,856,731</u></b>
Benefits @ 25%					27,214,183
<b>Total Salaries and Benefits</b>					<b><u>\$ 136,070,913</u></b>