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January 16, 2014

**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 December 23, 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  
Kevin McDonald, Chief, Certificate of Need  
Bradford L. Seamon, Chief Administrative Officer, Prince George's County Government  
Neil J. Moore, President & CEO, Dimensions Health Corporation

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Ms. Ruby Potter  
Page 2  
January 16, 2014

Sheldon Stein, President & CEO, Mt. Washington Pediatric Hospital  
John O'Brien, Chief Operating Officer, Dimensions Healthcare System  
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  
Medical System  
Mark Wasserman, Sr. Vice President, External Affairs, University of Maryland Medical  
System  
Sandra H. Benzer, Esquire, Associate Counsel, University of Maryland Medical System  
Andrew L. Solberg, A.L.S. Healthcare Consultant Services  
Richard McAlee, Esquire, Hospital Counsel, MedStar Southern Maryland Hospital  
Center  
Howard L. Sollins, Esq.  
Peter P. Parvis, Esq.

**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 Additional Information Questions Received 12/23/13**

- 1. The response to Question 4 indicates that PGHC currently provides medical oncology services. Please specify the current square footage and treatment spaces that will be replaced by the proposed 5,996 square feet and 14 rooms identified on the table on page 5.**

Inpatient oncology services provided at PGHC are designed to meet the medical and emotional needs of patients and their loved ones. PGHC has medical oncologists on staff who consult on PGHC's oncology patients. Located on E-900, inpatient oncology services at PGHC involve an interdisciplinary team approach, providing specialized care for persons with cancer from oncology physicians, nurses, patient care techs, case managers, pharmacists, social workers, a chaplain, and dietitians. The ninth floor has 15,000 square feet of space. There are 42 beds on this unit, which are used for oncology and non-oncology patients. Our unit encourages "family centered" compassionate cancer care, recognizing the impact of a cancer diagnosis on patients and family members alike. PGHC advances a holistic, individualized approach to the treatment, management and care for persons with cancer including:

- providing cancer treatment with chemotherapy, infusion, and other oncology related therapies;
- certified oncology nurses specially trained to care for cancer patients and their families;
- managing side effects of the disease or treatment;
- providing patient and family teaching; and
- providing emotional and spiritual support of patients, families and significant others

**2. Regarding the response to question 8 involving utilization projections, please provide definitions of each of the "impact factors" used in the Sg2 forecasts in the table on page 16.**

Exhibit 44, included in the November 20, 2013 responses to MHCC staff's second set of completeness questions, is a document created by Sg2 that details Sg2's methodology of its inpatient forecasting model. Specifically, the eight "Impact Factors" are described on pages 10 and 11 of this document and are set forth below for ease of reference:

The Impact of Change demand forecasts are produced using 8 impact factors that are responsible for driving projected growth and declines in utilization. The factors are population, epidemiology, economics, payment and policy, innovation and technology, Systems of CARE, potentially avoidable admissions and 30-day readmissions.

<b>Impact Factor</b>	<b>Definition</b>
<b>Population</b>	Accounts for changes in utilization due to population growth. Sg2 uses demographic data and population growth projections from the Nielsen Company, a leading provider of demographic and census data.
<b>Epidemiology</b>	Quantifies the impact of underlying changes in disease rates over time due to behavioral and sociocultural influences (eg, obesity, smoking), environmental triggers (eg,

**Impact Factor****Definition**

pollutants, sun exposure), and unknown factors that drive rates of certain diseases and conditions such as autism, type I diabetes and select cancers. This impact factor also accounts for the long-term effects of prevention measures (eg, smoking cessation programs, trans-fat bans, cigarette tax).

**Economics**

Considers macroeconomic factors that affect health care utilization—including how changes in unemployment rates affect rates of health insurance coverage and, therefore, health care utilization. The impact of these factors is scaled variably across the continuum of inpatient and outpatient services, based on the level of economic discretion associated with demand. Services for which patients exercise a high level of economic discretion (eg, well-care physician visits, nonemergent joint replacement) are affected more than services for which economic discretion plays little or no role (eg, emergency angioplasty)

**Impact Factor****Definition****Payment and Policy**

Encompasses both macro- and micro-level impacts of third-party payment innovations and health policy impacting service utilization. At the macro level, this series models the impact of insurance coverage expansion via health care reform on demand for health care services. An “economic discretion” factor is applied to reflect the variable impact of new insurance coverage on different services across the continuum. It also models the impact of increased cost sharing, tiered networks, reference pricing and other benefit design changes that introduce more price signals to consumers. At the micro level, this series encompasses significant service line- and disease-specific payment trends that will have the effect of dampening utilization or shifting the site of care.

**Innovation and Technology**

Includes adoption of new technology (eg, proton beam therapy, artificial pancreas and the US Food and Drug Administration’s approval of therapeutics) and clinical innovations (eg, noninvasive ventilator techniques, advances in focal resective epilepsy surgery) that may shift the

Impact Factor	Definition
	<p>site at which care is delivered and/or innovations that affect the utilization of health care services across various care settings.</p>
<p><b>Systems of CARE</b></p>	<p>Accounts for greater efficiency resulting from better care coordination and service integration across various care sites. This impact may reduce inpatient admissions through better use of community-based resources and reduce redundant and unnecessary services in the outpatient setting.</p> <p>Efforts or models that improve clinical alignment and coordination between providers (eg, medical home models, nurse navigators, multidisciplinary care clinics, physician employment)</p> <p>Adoption of standardized guidelines (eg, checklists, clinical pathways) and evidence-based practices that will drive changes in utilization due to decreased complications and reductions in care variation and medical mismanagement)</p> <p>Integration of advanced information technology (IT) capabilities (eg, electronic medical record, computerized physician order entry, clinical decision</p>

**Impact Factor**

**Definition**

support system, patient Web portals and system-wide IT implementation) that improve communication with and among providers to enhance coordination of care delivery)

Adoption and experimentation with new at-risk payment models, such as accountable care organizations and bundled payment initiatives that drive integrated care models and incentivize reductions in costly service utilization

**Potentially Avoidable Admissions (PAAs)**

The PAA factor accounts for a select set of inpatient conditions for which future hospitalization may be prevented as these conditions are better managed and treated in the ambulatory setting. This factor quantifies the impact of initiatives as improved care access, patient education and care coordination ultimately drive down inpatient utilization. The PAA impact factor is applied to Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicator conditions and additional Sg2-defined conditions.

**30-Day Readmissions**

The 30-Day Readmissions factor quantifies the impact of the adoption of initiatives

Impact Factor	Definition
	(e.g., post-acute care coordination efforts) that reduce readmissions to an acute care hospital that occur within 30-days of an index (initial) admission.

More information on Sg2’s inpatient forecasting methodology can be found in the document provided as Exhibit 44.

**3. The response to question 11 includes a table that displays a variety of PCI and cardiac surgery use rates to support your projected use rates for those services. The column headings and data points require some further definition and/or explanation.**

The table referencing PCI and cardiac surgery utilization rates appeared in the market assessment summary portion of Dimensions’ Strategic Cardiovascular Business Plan. The table was prepared by Haber Consulting, which assisted Dimensions in developing the Strategic Cardiovascular Business Plan. The original intent of the table was to demonstrate that several data sources were used to determine use rates. Compiling accurate volume counts and use-rates on a national level is complex, especially for PCI volumes in part because more PCI procedures are increasingly performed on an outpatient basis. The use-rate information, along with Prince George’s County demographic characteristics, were used for discussion purposes to establish realistic assumptions in forecasting future market volume potentials. The information was also used to demonstrate to the key stakeholders involved in strategic planning that Prince George’s County is underserved.

- a) **Explain the column heading: "Claritas 2011 Estimates Prince George's County." We are not aware that Claritas projects medical use rates.**

The column heading: "Claritas 2011 Estimates Prince George's County" represents information obtained from reports generated by Nielsen iEXPRESS software product, which utilizes Claritas demographic data. Claritas is a service of The Nielsen Company and a leading provider of demographic data. Claritas Inc. was acquired by The Nielsen Company.

- b) **What year is reported in the "Nat'l Hospital Discharge Summary Report 2010"? Is it a report issued in 2010 for previous year's data, or 2010 data?**

The report represents 2010 data obtained by Haber Consulting. It was published on the CDC website on August 28, 2012 according to original internet search for the data.

- c) **The table also has a column heading for the "AHA 2012 Report (2009 data) Nat'l Rate" which provides different utilization results. Are these reports drawing on differing data sources and/or different reporting periods?**

The 2012 AHA report is reporting 2009 data derived from the National Hospital Discharge Survey summary/National Center for Health Statistics, 2009 and obtained by Haber Consulting. Estimates are based on a sample of inpatient records from short-stay hospitals in the United States.

- d) **CABG rates have been in decline as other treatment methodologies have emerged. Does your planning for the service take this into account?**

Yes, the decline in CABG and PCI utilization rates was considered and discussed extensively with cardiac surgeons, as well as cardiologists. Some believe that the decrease in total procedures may level off due to continued growth in the 45 and older age cohort, especially the 65 and older population. The projected five-year

growth rate in Prince George's County of people aged 65 and older is estimated to increase by 22.9% between 2011 and 2016, which is higher than national and state growth projections of 15.9 % and 17.7%, respectively.

In addition to the aging factor, Prince George's County has a significantly high death rate due to heart disease, *i.e.*, 224.2 per 100,000 people versus a rate of 194.0 for the state of Maryland and 130.2 for Montgomery County, as reported in Table 1 in the University of Maryland School of Public Health's report, *Transforming Health in Prince George's County, Maryland: A Public Health Impact Study, July 2012* (Exhibit 4). By focusing efforts on reducing deaths due to heart disease, it is realistic to assume cardiac procedure volumes will increase.

In sum, Prince George's County is under served, utilization rates are low for cardiac surgery, and volumes are projected to increase as the cardiovascular needs of the community are further addressed.

- 4. Question 14A requested the calculations for Exhibit 27, columns 2, 4, 6, 8. While the pdf file submitted is very informative, it shows the results but not the methodology or assumptions underlying the calculations. Staff would like a written description of the methodology and assumptions, and would like to "walk through it" with you in a meeting so that we can feel confident in having a full understanding of your reasoning and confidence in our ability to describe it in our staff report.**

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

is shifting from one based on its current location in Cheverly, Maryland to a new location in Largo, Maryland.

To determine the Zip Code areas that would be included in the expected 85% service area for the Largo site, PGHC used drive times generated by Spatial Insights from Zip Codes in Prince George's County, and selected surrounding Zip Codes to each hospital in Maryland, the District of Columbia, and Virginia.

The Maryland Zip Codes were then sorted by proximity to PGHC's current location, and PGHC's 2012 discharges were summed until they equaled or exceeded 85% of its total 2012 discharges. This was done for each of the following cohorts individually:

- MSGA (15-64)
- MSGA (65+)
- Obstetrics (OB)
- Pediatrics (PED)
- Psychology (PSY)

For MSGA discharges, this 85% of discharges included the Zip Codes for which PGHC was the first through the ninth closest hospital. These Zip Codes contributed 78.2% of PGHC's 2012 MSGA (15-64) discharges and 84.7% of PGHC's 2012 MSGA (65+) discharges.

Eighty five percent of OB discharges included in the Zip Codes for which PGHC was the first through the fourth closest hospital. These Zip Codes accounted for 91.1% of PGHC's 2012 OB discharges because there are fewer hospitals that provide OB services. In determining the closest hospital for OB, PGHC was compared only to those hospitals offering OB services. These definitions or rankings were then applied to Zip Codes surrounding the future Largo site for PGRMC. Zip Codes for which PGRMC

would be the ninth most proximate hospital or closer for MSGA and the fourth or closer hospital for OB beds were identified. This was determined by ranking the proximity of all hospitals excluding the existing PGHC.

Redefining the service area for the new location resulted in a reduction in the population. Assuming current market shares for each hospital in each zip code, total discharges also decreased, in correlation with the decrease in population.

### **Changes in population and use rate**

As described in pages 89-91 of the CON Application, Claritas population data were used to project the population by zip code and cohort to 2021. The Claritas population projections ended in 2018, and PGHC applied the 2013-2018 compound average growth rate (“CAGR”) to extend the projections to 2021. PGHC’s use rate assumptions over the period are also described in the Application (pages 89-91). Overall, the projections assume population growth (except in the OB cohort) and use rate decline from 2012 to 2021.

### **Change in market share due to relocation**

For each of the Zip Codes in PGRMC’s projected service area, the expected market share at PGRMC was based on PGHC’s average market share for Zip Codes of a comparable proximity. For example, using 2012 data, PGHC calculated the average market share for all of the Zip Codes where PGHC was the closest hospital. PGHC then applied this average market share to all Zip Codes where PGRMC would be the closest hospital. To illustrate this, in 2012, PGHC had an average market share of 22.1% of MSGA (15-64) discharges in Zip Codes where it ranked as the closest hospital. In the old location, PGHC ranked as the third closest hospital to Zip Code

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

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

In adjusting PGRMC's market share for relocation, PGHC assumed that total discharges in the market would remain the same. Thus, the impact of the change in market share due to relocation was absorbed by other hospitals treating that population. The magnitude of the impact to each hospital was determined by their pro-rata share of the market, when compared to other hospitals.

In summary, PGHC took the approach used by MHCC Staff in determining volume and market share implications of relocating a hospital in the Washington Adventist Hospital Proposed Decision.

### **Recapture impact**

With a baseline of projected PGRMC discharges established for the PGRMC service area, PGHC then considered the initiatives and growth areas anticipated for the new hospital, as described in pages 91-94 of the CON Application. As shown in Table 13 on pages 92-93 of the CON Application, recapture assumptions (market share and volumes) were determined at the service line level. PGHC arrived at assumptions

based on initiatives and growth areas, as well as consideration of PGHC's prior service line market share performance before PGHC experienced financial hardship.

PGHC determined the number of discharges that it likely will recapture from the DC/VA marketplace as well as within Maryland. Similar to the relocation methodology described above, recaptured discharges were added to PGRMC projected 2021 discharges by cohort and by Zip Code. Each Zip Code's proportion of total discharges within a cohort determined the number of recaptured discharges attributable to that Zip Code. Within that Zip Code, the magnitude of the impact to each hospital was determined by their pro-rata share of the market, when compared to other hospitals.

- 5. The format as submitted of the Physical Bed Chart, Exhibit 28, makes it difficult to identify the room and bed inventory by service. Please complete the attached Physical Bed Inventory form adding additional rows, if necessary to include all inpatient beds.**

See attached Exhibit 50.

- 6. MHCC staff has had limited time to compile space and cost comparables for new hospital construction, but that limited research suggests that the proposed shows almost 50% more square feet/bed than is occurring in comparable new construction. That in turn drives construction cost and project cost per bed above benchmarks as well. Please explain and justify the reasons for this apparent excess space.**

HOK maintains area summaries for recently built projects, both community and academically affiliated hospitals. For these recent HOK-designed projects, the area per bed shows a range from 2,145-3,619 SF / bed, with the average of these being 2,638 SF / bed, as shown in the following table.

FACILITY	LOCATION	BEDS	DGSF	DGSF / BED	BGSF	BGSF / BED
<b>Community Hospitals:</b>						
Progress West	O'Fallon, MO	72	122,595	1,703	154,425	2,145
Deaconess Gateway-Evansville	Evansville, IN	116	253,391	2,184	382,646	3,299
Methodist Stone Oak	Houston, TX	147	242,786	1,652	327,343	2,227
Saint Joseph Regional (Replacement)	Mishawaka, IN	253	489,054	1,933	656,122	2,593
Columbia St Mary's Lake Drive (Replacement)	Milwaukee, WI	268	480,560	1,793	702,725	2,622
<b>Academically Affiliated:</b>						
Princeton (UMCP)	Princeton, MA	237			523,010	2,207
Baylor Hospital (Replacement)	Houston, TX	244	644,621	2,642	883,131	3,619
Wishard Hospital (Replacement)	Indianapolis, IN	329	629,887	1,915	881,842	2,680
LAC+ USC Medical Center (Replacement)	Los Angeles, CA	598	1,114,825	1,864	1,407,232	2,353
Average						2,638
Shore Health (Proposed)	Maryland	126	227,917	1,809	300,678	2,386
Prince George's Hospital Center (Proposed)		231	422,602	1,829	603,444	2,612

Sources: HOK, Shore Health CON application

The current proposal for the hospital space only, exclusive of the Ambulatory Care Center and C.U.P. buildings is 603,444 SF / 231 beds = 2,612 SF / bed.

## **Facility Design**

The collaboration between Prince George's Regional Medical Center, University of Maryland School of Medicine, and the University of Maryland Medical System creates facility needs above those of a general community hospital. The presence of students and residents requires a different use of space. Some potential differences with academic - associated regional medical centers include:

- Key Room size increases – treatment of higher acuity patients, medical procedures utilizing cutting edge technology, educational components;
- More people on site – increased size of clinical support spaces; and
- Research – integrated research space needed on unit.

Also, there is more ambulatory space designed within the proposed facility, designed for more emphasis on ambulatory / observation / clinic care, as hospitals of the future must be designed for clinical practice management changes as the industry moves toward population health management practices.

The proposed design of mechanical space takes into consideration the best approach to project construction that considers a spectrum of potential future needs of ambulatory care, inpatient care, and health education facility growth without negatively impacting current hospital operations.

**Existing Facility**

For comparison, the existing Hospital Building (not including the parking garage, the CUP or the Spellman Building) is 579,057 SF / 311 beds = 1,862 SF / bed

HOK identified in the facility analysis that the use of semi-private rooms in the existing facility is not a current standard for patient safety or satisfaction, and there are numerous other areas that are well below current industry benchmarks for area per key room. The process of “right-sizing” a facility to meet current industry standards necessitates an increase in area / bed calculations. As shown in the chart below, making an adjustment solely to change the patient rooms from semi private to private would have an impact of 71,000 BGSF and would increase the calculation for the existing building from 1,862 to 2,093 SF / room.

	Inpatient Beds	Facility Square Footage	Sq. Footage per Patient Room
Prince George’s Hospital Center (Existing)	311	579,057	1,862
Prince George’s Hospital Center (Exist/Adjust)	311	650,957	2,093

Many of the problems identified in the facility analysis report, including the unusually configured and small structural bays and floor to floor heights, would contribute to a continued inefficient use of space in the existing facility, even if the

facility were upgraded in place. If the current facility were upgraded for all other areas outside of the patient units, these inefficiencies would produce a compromised design where the overall area of the building would be greater than the area of the proposed project.

Exhibits

50. Physical Bed Chart

## Exhibit 50 Physical Bed Chart

Location (Floor/Wing)	Existing Physical Capacity							Proposed Physical Bed Capacity							Notes
	Hospital Service	Room Count				Bed Count	Licensed	Hospital Service	Location (Floor/Wing)	Room Count			Bed Count		
		Total Rooms	Three Bed Rms	Semi- Private	Private	Physical Capacity	Beds Jul-13			Total Rooms	Semi- Private	Private	Physical Capacity		
<b>INPATIENT</b>															
E900 Oncology	General M/S	26		16	10	42		General M/S	N/A	0	0	0	0		
E800 Trauma	General M/S	26		17	9	43		General M/S	N/A	0	0	0	0		
E700 Gen Med/Surg	General M/S	26		16	10	42		General M/S	N/A	0	0	0	0		
E500 PCRU Ext.	General M/S	10		7	3	17		General M/S	9	34	0	34	34		
K400 PCRU	General M/S	15		11	4	26		General M/S	8	33	0	33	33		
	General M/S	0				0		General M/S	7	33	0	33	33		
	General M/S	0				0		General M/S	6	33	0	33	33		
<b>Sub-total</b>	<b>General MSGA</b>	103	0	67	36	170		<b>General MSGA</b>		133	0	133	133		
K400	CCU	10			10	10		CCU		0	0	0	0		
Pavilion 1 Surgery	ICU	24			24	24		ICU		32	0	32	32		
						0							0		
<b>Sub-total</b>	<b>CCU/ICU</b>	34	0	0	34	34		<b>CCU/ICU</b>		32	0	32	32		
<b>TOTAL</b>	<b>MSGA</b>	137	0	67	70	204	142	<b>Total MSGA</b>		165	0	165	165		
K300/K200	Obstetrics	42			42	42	36	Obstetrics		22	0	22	22		
E600	Pediatric	6		6		12	8	Pediatric		1	0	1	1		

## Exhibit 50 Physical Bed Chart

Location (Floor/Wing)	Existing Physical Capacity							Proposed Physical Bed Capacity							Notes
	Hospital Service	Room Count				Bed Count	Licensed	Hospital Service	Location (Floor/Wing)	Room Count			Bed Count		
		Total Rooms	Three Bed Rms	Semi- Private	Private	Physical Capacity	Beds Jul-13			Total Rooms	Semi- Private	Private	Physical Capacity		
E400	Psychiatric	22		16	6	38	28	Psychiatric		28	0	28	28		
<b>TOTAL ACUTE</b>		207	0	89	118	296	214	<b>TOTAL ACUTE</b>		216	0	216	216		
<b>MWPH</b>		50			15	15	15	<b>MWPH</b>		15		15	15		
<b>TOTAL INPATIENT</b>		222	0	89	133	311	229	<b>TOTAL INPATIENT</b>		231	0	231	231		

Note: Physical capacity is the total number of beds that could be accommodated without significant renovations. A room with two headwalls and two sets of gasses is a semi-private room, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough, from a square footage perspective, to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain a single headwall, but are used to accommodate more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms is semi-private, and the bed capacity is as applicable.

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Response to December 23, 2013 Completeness Questions and its exhibits are true and correct to the best of my knowledge, information, and belief.

January 16, 2014

Date



Dolores Marshall, MBA, BSN  
Vice President/Chief Nursing Officer  
Dimensions Health Corporation

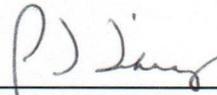
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January 16, 2014

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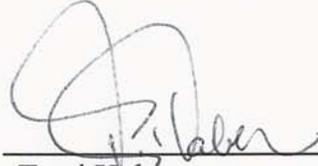
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Patricia T. Tihansky  
Director of Strategic Planning  
Dimensions Health Corporation

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January 16, 2014

Date



Terri Haber  
Cardiovascular Program Development  
Consultant  
Haber Consulting, LLC

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January 16, 2014

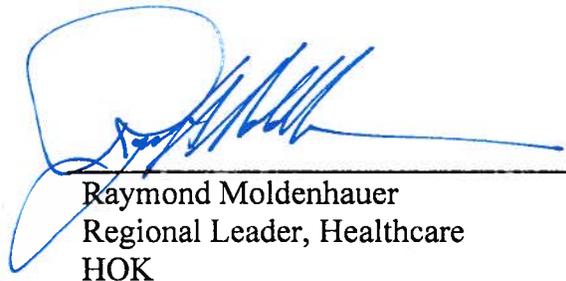
Date

  
Jeffrey Johnson  
Consultant

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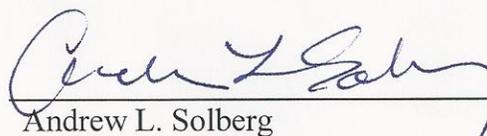


Raymond Moldenhauer  
Regional Leader, Healthcare  
HOK

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January 16, 2014

\_\_\_\_\_  
Date



\_\_\_\_\_  
Andrew L. Solberg

A.L.S. Healthcare Consultant Services