IN THE MATTER OF	*	BEFORE THE
	*	
PROPOSED NEW HOSPITAL	*	MARYLAND
	*	
IN PRINCE GEORGE'S COUNTY:	*	HEALTH CARE COMMISSION
	*	
Prince George's Regional Medical Center as a Replacement and Relocation of Prince George's Hospital Center	*	**Matter No. 13-16-2351**

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INTERESTED PARTY DOCTORS COMMUNITY HOSPITAL'S COMMENTS TO THE MODIFIED APPLICATION FOR CERTIFICATE OF NEED FOR PRINCE GEORGE'S REGIONAL MEDICAL CENTER

May 4, 2015

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Counsel for Doctors Community Hospital

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INTERESTED PARTY DOCTORS COMMUNITY HOSPITAL'S COMMENTS TO THE MODIFIED APPLICATION FOR CERTFICATE OF NEED FOR PRINCE GEORGE'S REGIONAL MEDICAL CENTER

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Doctors Community Hospital (hereinafter, "Doctors" or "DCH"), through its undersigned counsel, hereby submits the following comments, pursuant to COMAR 10.24.01.08, in response to the Modified Application for Certificate of Need ("CON") filed by Dimensions Health Corporation d/b/a Prince George's Hospital Center and Mount Washington Pediatric Hospital, Inc. (collectively, "Dimensions" or the "Applicant"), and Mt. Washington Pediatric Hospital, Inc., for the proposed Prince George's Regional Medical Center ("PGRMC") as a replacement and relocation of the existing Prince George's Hospital Center ("PGHC").

I. INTRODUCTION

DCH fully supports the concept of a new replacement hospital in Prince George's County. It believes the new hospital referred to as PGRMC, as proposed, raises significant concerns that need to be addressed and corrected prior to approval. Simply put, the CON application, (the "Application"), lacks relevant and important detail required under Maryland law for approval of a Project of this magnitude, and Applicant has not complied with applicable provisions of the State Health Plan (SHP). DCH takes no position on the parts of the application relating to the pediatric or behavioral medicine services, or to any services to be offered by Mt. Washington Pediatric Hospital at PGRMC.

DCH respectfully requests that PGRMC's approximately $650 million Project be thoughtfully and seriously reviewed, and that the real implications of this project on the relevant population, other medical providers including DCH, and the State of Maryland, be determined **before** approval. As explained below, DCH believes the Project is not currently approvable because: 1) the new hospital's estimates of recapturing Prince George's County patients who currently and historically choose to receive hospital care outside of the county and state are significantly overestimated; 2) the financial projections are fatally flawed and the feasibility of the Project is extremely questionable, (even assuming that the recapture of patients who are happy to

seek their care elsewhere is possible); 3) the Project's proposed increase in medical/surgical/gynecological/addictions (MSGA) beds is not consistent with reality or the Commission's current bed need projections; 4) the impact on DCH is underestimated; and 5) the Application does not consider better and cheaper available alternatives, particularly for ambulatory care.

DCH believes a better replacement project is essential, and therefore urges the Commission to request that the project be modified to reduce PGRMC's proposed capital cost and MSGA inpatient bed and rate regulated ambulatory care capacity. The modified CON Application should assure that PGRMC is cost-effective and financially feasible, and that DCH can continue to be financially viable once it is operational. Specifically, DCH should be held harmless against the negative financial impact from this Project which the Applicant has chosen to place in such close proximity. DCH believes that a less costly and right sized replacement hospital project for PGRMC, that fully explores all of the potential uses of the existing PGHC campus, should be ultimately approved. In the era of population health and the Triple Aim and decreasing reliance on hospital care, existing hospitals should not have to pay the price of another hospital's over expansion.

II. DCH QUALIFICATION AS AN INTERESTED PARTY

Under COMAR 10.24.01.01(B)(20), an interested party includes, "a person who can demonstrate to the reviewer that the person would be adversely affected, in an issue area over which the Commission has jurisdiction, by approval of the proposed project." A person is "adversely affected" if the person, "is authorized to provide the same service as the applicant, in the same planning region used for purposes of determining need under the State Health Plan or in a contiguous planning region if the proposed new facility or service could reasonably provide services to residence in the continuous area." COMAR 10.24.01.01(B)(2).

DCH is authorized to provide the same MSGA services PGRMC seeks to provide in the same county, Prince George's County, in the Southern Maryland planning region. As of July 1, 2014, for FY 2016, DCH was licensed for 182 MSGA beds, with 15 beds dedicated to observation, (although observation patients can occupy beds on the floors, since DCH has an observation ADC of 21 for 2014). Its physical bed capacity is 218 MSG beds, providing an additional 36 MSG beds that could be added with limited to no capital expenditure. In FY 2015, PGHC is licensed for 215 acute care hospital beds, of which 141 were designated as MSGA. (*See* **Exhibit A**, Licensed Acute Care Hospital Beds, FY 2015.) In FY 2022, PGRMC proposes licensure for a total of 216 beds, including 165 MSGA beds. (*See* Responses to Completeness Questions Dated 2/10/2015 to the Modified CON App., at Ex. 50, Table A[1].) The proposed 24 bed MSGA increase is a significant increase in the number of MSGA beds, particularly in light of the fact that Maryland Health Care Commission (MHCC) published projections of MSGA bed need in Prince George's County show a dramatically decreased need for MSGA beds. On March 7, 2014, the Commission updated its MSGA bed need projection and found a minimum gross bed need of only 487 MSGA beds and maximum bed need of 663 MSGA beds in 2022 for Prince George's County. When compared to the 552 licensed MSGA beds in Prince George's County[2], the County currently already has 65 too many MSGA beds according to the minimum need forecast. (*See* discussion in Part III, *infra.*)

Maryland has experienced a significant decrease in hospital inpatient utilization as a result of numerous factors, only partially offset in Prince George's County by population growth and aging. DCH already provides the same MSG services proposed by PGRMC. A substantial increase in MSGA beds within six miles of DCH, which already has available MSGA beds, at a time when the MHCC predicts a decrease in the future need for these beds, is clearly duplicative and will negatively

[1] These Responses will hereinafter be referred to as the "2/10 Resp."
[2] *See* Licensed Acute care beds by hospital and service area published Interim Update (**Exhibit A**). There are 141 fewer licensed acute care beds in the County in 2015 than in 2012.

impact DCH. PGRMC has mapped out a service area that completely overlaps most of the same zip code areas in Prince George's County, (*see* Maps included in **Exhibit B**), already served by DCH and PGHC. The Applicant proposes to "re-capture" future MSGA patients among residents of the shared service area for occupancy in PGRMC's additional 24 MSGA beds that could otherwise obtain those same services in DCH's existing MSGA beds. A more transparent example of duplication of hospital treatment capacity and excess capital costs could not be more evident. PGRMC's plan to offer the same proposed services in the same service area as DCH makes DCH an interested person in this review. The anticipated adverse impact on DCH is discussed more thoroughly below in these Comments.

III. STATE HEALTH PLAN STANDARDS AND REVIEW CRITERIA NOT MET BY APPLICANT

Standard: ***Identification of Bed Need and Addition of Beds. COMAR 10.24.10.04 B(2)***

COMMENT: This four-part standard requires that a proposal to increase capacity of MSGA beds, which is the case here, must be justified in one of four ways. First, the applicant may demonstrate that the proposed bed increase will result in actual bed capacity at an existing hospital that is equal to or less than its current licensed acute care bed capacity. With the present Applicant, this is not the case. As noted above, the 165 MSGA beds proposed at PGRMC is greater than the 141 licensed MSGA beds currently designated at PGHC. Second, a proposed bed increase may be consistent with the State Health Plan's current minimum jurisdictional bed need projection for the jurisdiction in which the hospital is located. This is not the case. The jurisdictional bed need minimum projection is 487 MSG beds in 2022[3], compared to the 2015 total of 552 licensed MSGA beds at the five acute care general hospitals located in Prince George's County. The applicant has the burden to demonstrate need for any beds in excess of the minimum projected. It has failed to do so. Third,

[3] As published at 41 Md. Reg., pp 3567-358 (March 7, 2014), using a base year of 2012 and target year of 2022. The licensed and approved MSGA bed total at the date of the publication was 595 beds. *See* **Exhibit C**.

an applicant must demonstrate that the additional beds are consistent with the maximum bed need for the jurisdiction and meet the burden of demonstrating a need for the additional beds at the applicant hospital using the State's need methodology. It has not demonstrated any need. The final approach outlined in the standard is for the applicant to propose a service area analysis modeled on the jurisdictional bed need projection methodology demonstrating the need. It has not done that either.

PGRMC does not adequately justify the additional twenty-four (24) MSGA beds proposed in its application under any of the standards, from its current 141 MSGA beds to the proposed 165 in the revised Application.

When the original CON Application was filed for the PGRMC project on October 4, 2013, the Commission's MSGA Bed Need forecast for 2018 showed a minimum gross bed need for 671 MSGA beds and a maximum gross need for 787 MSGA beds in Prince George's County in 2018, reflecting older data that could not reflect the decline in utilization that occurred after its publication.

Table A

	2018 Gross Bed Need			2018 Net Bed Need	
Prince George's	Minimum	Maximum	License and Approved Beds	Minimum	Maximum
MSGA	671	787	663[4]	8	124

Source: MHCC—Published in 37 MD. REG. 589-591 (3/26/10), using a base year of 2008 and a target year of 2018, **Exhibit D**.

Subsequently, on March 7, 2014, the Commission updated its MSGA bed need projection and found a minimum gross bed need of 487 MSGA beds and maximum bed need of 663 MSGA beds in 2022, based on a 2012 base year.

Table B

	2022 Gross Bed Need			2022 Net Bed Need	
Prince George's	Minimum	Maximum	License and Approved Beds	Minimum	Maximum
MSGA	487	663	595	-65	+111

Source: MHC—41 MD. REG. 356-358 (3/7/14), **Exhibit C**.

[4] Licensed MSGA beds in Prince George's County in FY 2010.

We note that due to declining utilization, the number of MSGA licensed beds in Prince George's County declined to 552 for FY 2015. The Applicant concluded that the proposed PGRMC project was consistent with Part (c) (ii) because it referenced the older, now-replaced jurisdictional MSGA bed need projections for Prince George's County for 2018, instead of the more recently published MSGA bed need projections for 2022 published on March 7, 2014. (Original CON App. at p. 53.) The Applicant submitted a Modified CON Application on January 16, 2015, nine months after the Commission's updated MSGA bed need projections for 2022 replaced its MSGA bed need projections for 2018, but did not address the fact that the minimum bed need projection for 487 MSGA beds in 2022 clearly is below the FY 2015 count of 552 licensed MSGA beds in Prince George's County hospitals. This is an error since the published notice clearly states that the projections remain in effect until "MHCC publishes updated acute care bed need projections," so the updated projections are applicable.

The MHCC Minimum MSGA Forecasted Net Bed Need between 2018 and 2022 **decreased by 184 beds**; the Maximum Bed Need **decreased by 124 beds**, indicating a growing surplus of MSGA bed capacity[5] among the five acute care general hospitals located in Prince George's County. This "swing" between the 2018 and 2022 MSGA bed need forecasts, (as well as the actual number of licensed MSGA beds in FYs 2010 and 2013), is the result of the reduction in MSGA discharges and patient days reported by the Prince George's County acute care hospitals between those periods, as shown in **Exhibit F**. In other words, the decreasing projections of MSGA beds made by the Commission itself reflect reality.

[5] The number of licensed and approved beds itself understates the number of available beds, since licensed beds will decrease as utilization decreases. The notice itself states that most hospital "report more physical bed capacity than licensed bed capacity." There are potentially hundreds of beds that are available on the basis of reported capacity of beds, although at least some of those are devoted to other uses. *See* **Exhibit E** for the June 2014 report of capacity in Prince George's County.

By 2014, the number of MSGA patient days had declined to 155,399 days, accounting in part for the steep 43 bed drop-off in the number of MSGA beds qualifying for licensure between FY 2014 and FY 2015 in the five Prince George's County hospitals, a drop-off the Commission has already projected will continue through 2022, when the proposed PGRMC is scheduled to provide 53,311 MSGA patient days and achieve full 88.5% MSGA bed occupancy in its 165 beds. Even assuming that such a result might actually occur, which DCH does not believe has been demonstrated, PGRMC's share of the current number of MSGA patient days in Prince George's County hospitals would rise to 34% of the total, as opposed to PGHC's 27% share of its 42,322 MSGA patient days reported for 2014.

In summary, real historic MSGA utilization of the five existing acute care general hospitals in Prince George's County and the revised forecasted bed need, all point to a continuing **decline in inpatient utilization** and the near certainty that the 552 MSGA beds currently licensed in Prince George's County hospitals, including 141 MSGA beds at PGHC, will be more than sufficient to address the projected need through 2022 without increasing the number of MSGA beds at the replacement hospital. Given that the proposed project is for a new hospital, Part (c)(1) of this standard is inapplicable. Because the minimum jurisdictional bed need projection for Prince George's County adopted by the Commission is negative, there is **no need for additional MSGA beds in Prince George's County** at the minimum projection, and the additional 24 MSGA beds proposed for PGRMC cannot be developed or put into operation based on Part (c)(ii) in the absence of a compelling need.

The Applicant has the burden of demonstrating the need for its proposed addition of 24 MSGA beds. DCH doesn't believe that the Applicant has presented sufficient evidence of need by the population to be served for additional MSGA beds in light of the likely continuation of a decline in inpatient utilization. Since all of the patients requiring hospitalization in the County currently

receive it, the fact that 50% of the County residents choose to receive hospital care in hospitals in bordering counties and in D.C. and Virginia does not establish the existence of an unmet need. Further, as will be documented *infra*, the simple fact is that the need for inpatient MSGA beds in the County's hospitals will significantly **decrease** by 2022 as potentially avoidable utilization continues to be reduced. The additional MSGA beds should not be approved, and costs associated with those unnecessary beds should be reduced in the requested redesign.

Standard: ***Cost Effectiveness. (COMAR 10.24.10.04 B(5))***

COMMENT: The existing PGHC is a high charge hospital. Using the HSCRC's inpatient charge data for FY-2014, we calculated the hospital's inpatient charges per case, adjusted for case mix, and ranked the hospitals (excluding specialty and TPR hospitals). PGHC had the sixth highest charge per case in this ranking. (*See* Table C below).

Despite PGHC's high charge per case, the hospital proposed an incremental 7% charge increase upon the implementation of its proposed CON. With this incremental charge increase, PGHC's charge per case (in FY-2014 dollars) would increase from $16,319 to $17,461, making it the third highest cost hospital in the ranking behind only the states two academic medical centers. The original and revised rankings are set forth on Table C. Note the highest are academic medical centers, which PGHC currently is not, and PGRMC will not be.

TABLE C : **Hospital Charges per Case Adjusted for Case Mix: FY-2014**

Hospital	FY 2014	Ranking	FY 2014 plus PG CON	Ranking
JOHNS HOPKINS HOSPITAL	$ 20,916	1	$ 20,916	1
U OF MD HOSPITAL	$ 20,789	2	$ 20,789	2
BON SECOURS HOSPITAL	$ 16,800	3	$ 16,800	4
MARYLAND GENERAL HOSPITAL	$ 16,701	4	$ 16,701	5
JOHNS HOPKINS BAYVIEW MED. CTR.	$ 16,679	5	$ 16,679	6
PRINCE GEORGES HOSP. CTR.	$ 16,319	6	$ 17,461	3
HARBOR HOSPITAL CENTER	$ 15,535	7	$ 15,535	7
DOCTORS COMMUNITY HOSPITAL	$ 13,364	15	$ 13,364	15
HOLY CROSS HOSPITAL	$ 12,126	23	$ 12,126	23

The statistics on Table C have the following implications, which are presented as examples of the results. In FY-2014, PGHC's adjusted charge per case of $16,319 is 22.1% above Doctors adjusted charge per case ($13,364) and 34.6% above that of Holy Cross. These percentage differences in the hospitals' adjusted charge per case increase to 30.7% and 44.0% subsequent to the incremental charge increase associated with the PGRMC CON. This means that Medicare, Kaiser, CareFirst, Medicaid, and Medicare would be expected to pay 44.0% more at PGRMC upon the implementation of the CON than those payers would pay for the same service at Holy Cross. Given the new model's requirement to reduce Maryland's cost and utilization on a per capita basis, this Project goes in the wrong direction. An entirely new from the ground up hospital should reduce charges to payers, and that is true even without hundreds of millions of free taxpayer capital. This Project does the opposite.

The All Payer Model Demonstration and its Successor will have Per Capita Waiver Tests that will increase price competition between Hospitals in Maryland. The existing and expanding influences on hospital prices and value-based purchases include the following:

1. Kaiser's selection of low cost/ high value hospitals in its hospital network.
2. CareFirst's PCMH program which provides its PCP groups (Medical Panels) with incentives to refer patients for hospital service based on price and value.
3. Medicaid's anticipated formulation of a per capita demonstration covering dual eligibles which will promote referrals to low cost/ high value hospitals.
4. Medicare Managed Care Organizations including MA plans, ACOs, and selected demonstrations that will channel patients to low cost/ high value hospitals in order to reduce the total cost of care.
5. Hospital Sponsored Physician Alignment programs operating as population-based initiatives.

In the future, increases in a hospitals' market share will require competitive rates and perceived value in the hospital's services. The fact that this Project provides neither, calls Applicant's forecasts into question.

Standard ***Burden of Proof Regarding Need. (COMAR 10.24.10.04B(6))***

COMMENT: The Applicant has not established demonstrable need in its Modified CON Application. The PGRMC CON requires a substantial increase in the Hospital's Case Load in FY-2022, but Maryland hospitals are likely to experience a substantial decline in their inpatient case load by FY-2022. In FY-2013, PGHC had 10,399 inpatient discharges (excluding newborns). Upon the full operation of the new hospital in FY 2022, PGRMC projects that it will have "recaptured" 3,282 cases of inpatient services to Prince George's County residents currently provided by other Maryland, DC, or Virginia hospitals:

TABLE D

Recaptured Discharges: PG CON FY-2022

Maryland Hospitals	1,072
DC/Virginia	2,210
Total	3,282

Source: Modified CON Application, p.224.

These recaptured discharges will, for the most part, be insured by Kaiser, CareFirst, Medicaid, or Medicare. 642 (60%) of the 1,072 recaptured discharges from Maryland hospitals are projected to come from four available and accessible Maryland hospitals (Washington Adventist Hospital, Doctors, Southern Maryland Hospital Center, and Holy Cross), all four of which are "existing catchment area" hospitals designated by Prince George County FIRE/EMS for ambulance transport of Prince George's County residents). (Modified CON Application, p. 149; *see* **Exhibit G** for Catchment Area Maps). The 3,282 "recaptured discharges" represent a 32% increase in PG's FY-2013 cases (10,399). [.32 = 3,282/10,399]. Even with the aging of the population and areas of overall population growth Maryland Hospitals are likely to experience a substantial decline in their inpatient case load by FY-2022 in comparison to their caseloads in FY 2013. Moreover,

"recapturing" patients currently well served by existing facilities does not in any way show a need for increasing MSGA beds in this relocated PGRMC.

Standard: ***Rate Reduction Agreement. (COMAR 10.24.10.04 B(10))***

COMMENT: The existing PGHC is a high charge hospital under the most recent (2011) ROC analysis. It ranked 8.76% above Peer Group 4. (*See* **Exhibit H**). Although the HSCRC has not released a current ROC, PGHC is by any definition a high charge hospital. It has not met the requirements of this standard: that it enter into an agreement with the HSCRC to reduce costs prior to approval. HSCRC action is required for this Project.

Standard: ***Financial Feasibility. (COMAR 10.24.10.04 B(13))***

COMMENT: The Applicant has not met its burden of proving that the proposed hospital is financially feasible. DCH has many questions regarding the projections and assumptions as shown in the CON application, and has raised these questions elsewhere in these Comments. The most critical questions, however, must be addressed by the HSCRC, as these are policy/methodology issues, and HSCRC input on these critical issues is essential.

The first question is whether the HSCRC will grant the assumed revenue increase related to capital that exceeds $21 million, especially since current charges at PGHC are very high in relation to its peer group and in relation to its competitors. The second question is whether the HSCRC will "allow" the approved global budget revenue (GBR) revenue at PGRMC to increase to **concurrently** recognize a Market Shift Adjustment (MSA). The MSA policy has not yet been finalized, but all proposed policies include recognition of the MSA starting in the seventh month of the year following the year of the actual market shift and continuing to the sixth month of the second following year (a six month lag). **These two issues alone account for a $25+ million a year impact on net income and cash flows for FYs 2020, 2021 and 2022.** The Applicant's projections only show $1.6 million in net income in 2022. The uncertainty of the treatment of GBR

increases alone calls the financial feasibility of the Project into severe question. For the financial projections as shown in the CON application to be "considered" as possibly presenting positive feasibility, and assuming all other revenue and expense and cash flows assumptions are somehow considered acceptable (something we very much doubt, as discussed herein), these two very significant policy issues must be answered by HSCRC before the Project can be even properly considered.

Discussion of Additional Issues

The Application filed by Dimensions regarding the proposed PGRMC includes four tables regarding historical and projected revenue and expenses for the entire facility. These tables are supported by the applicant via assumptions described in attachments to the tables. There are two scenarios. One scenario addressed by Applicant assumes that the revenue associated with the projected HSCRC to-be-approved market shift adjustment for the projected volume increases for fiscal years 2020, 2021 and 2022 would be added to the HSCRC approved Global Budgeted Revenue (GBR) and charged by PGRMC during the year of the shifting market share. This is not the current approach described in the emerging HSCRC policy. The second scenario assumes such additional HSCRC approved GBR would be added for the year after the year of the projected market shift. This is also inconsistent with the currently emerging HSCRC proposal, which calls for any approved MSA to be included in the following years with a six month lag (for example, a FY 2016 HSCRC approved MSA would be included in the GBR effective January 1, 2017). Each of these scenarios is then presented in un-inflated dollars as well as in inflated dollars.

The primary purpose of the referenced tables is to support the assertion by the Applicant that the proposed project is financially feasible. Financial feasibility determinations should consider several factors including the proposed project's ability to generate on an ongoing basis net income

and positive cash flow as well as to have and be able to generate or borrow adequate cash and other needed resources to meet the obligations of the entity and the proposed and future projects.

Discussion of Market Shift Adjustments

Since the inflated projections present the most realistic measure of financial feasibility, comments regarding financial feasibility have been associated with the inflated scenarios. Unless otherwise indicated, the CON application tables referenced below apply to the scenario (with inflation) that assumes that the revenue associated with the projected HSCRC to-be-approved market shift adjustment for the projected volume increases for fiscal years (FY; FYs) 2020, 2021 and 2022 would be added to the HSCRC approved GBR and charged by PGRMC during the year of the shifting market share.

Since only the HSCRC can decide how to apply the HSCRC to-be approved market shift adjustment for FYs 2020, 2021 and 2022, the HSCRC should determine which scenario is appropriate. We note that the impact of the difference is quite significant. Comparing the two CON application projections indicates a cumulative difference of more than $24 million over the FY 2020-2022 projection period. Please note that this $24 million does not include the additional loss associated with the six month delay issue discussed above. The negative impact on FY 2022 alone is $8.45 million and makes the difference between net income of $1,653,000 and a net loss of $6,797,000 in FY 2022.

The HSCRC also should be consulted regarding the appropriate application of the MSA methodology and resulting projections. This policy is currently under development by HSCRC. The CON application assumes that all volume increases are the result of HSCRC approvable market shift, but this appears to be implausible. This assumption needs special attention by MHCC and HSCRC since the amount of revenue assumed to be added to PGRMC's GBR as a result of MSA is a "make it or break it" issue. For example, if 1,000 of the projected increased number of cases at

PGRMC were deemed not to be the result of a market shift in accordance with the HSCRC policy, the 50% variability would likely not apply for these cases. At $19,000, (as derived from Applicant's Schedule H-1), per discharge, the market shift adjustment would be $9.5 million less for FY 2022, which would reduce net income and cash flow for the new hospital by approximately $7.9 million for FY 2022 and all years thereafter. It would also have a similar but slightly lower negative impact on FYs 2020 and 2021. Anything close to these reductions renders the Project not financially feasible.

Limitations on Payments for "Recaptured" Market Share -

As currently noted, the HSCRC has not reviewed or approved a proposal by the HSCRC staff on how to adjust a hospital's target budget for increases or decreases in the hospital's share of the hospital service market. The most recent HSCRC staff MSA (market shift adjustment) proposal has four features that would have a significant impact on the revenue projections of the CON. The four features are:

- The MSAs for an urban hospital such as PGRMC would be calculated by hospital service product line and Maryland zip code (MSA Cells) and the results totaled to derive the MSA of the particular hospital;
- The MSAs only account for changes in the level of service (Adjusted Cases) of Maryland hospitals, thereby excluding decreases in the Adjusted Cases provided by a DC hospital in an MSA Cell;
- The maximum variable cost percentage used to calculated the MSAs is 50%, but the amount of the aggregate positive MSAs in an MSA Cell is governed by a "budget neutrality" provision that may reduce the effective variable cost percentage of the MSA to much less than 50%; and
- The "budget neutrality" provision requires that the aggregate amount of the positive MSAs of an MSA Cell be fully funded by the negative MSAs of hospitals with a decline in their level of Adjusted Cases in the MSA Cell, which as noted includes only Maryland hospitals.

For example, if PGHC were to have a spike in its Adjusted Cases in any given MSA Cell (of which there are many) solely as a result of relocating Adjusted Cases from DC hospitals, and the

other Maryland hospitals had no change in their level of Adjusted Cases in that particular MSA Cell, there would be no negative MSAs, and the MSA for PGHC in this MSA Cell would be $0 because there would be no funding source to offset for positive MSAs in the MSA Cell. Since as noted in Table C PGRMC contemplates recapturing 2,210 cases from out of state hospitals by 2022, there are bound to be many such cases in many of the PGRMC MSA cells.

Even if there were MSA gains (for shifts from Maryland hospitals serving the same zip codes), the initial estimates of the MSAs of the Maryland hospitals indicate that only approximately 26% of the incremental charges of hospitals with increases in their Adjusted Cases would be reimbursed through the MSA methodology. These results suggest that a central assumption of the PGRMC CON - that the MSA will provide target budget adjustments equal to 50% of the hospital's charges for its projected growth in volume - is almost certainly significantly overstated given the current provisions of the MSA methodology.

Therefore, it would be reasonable for the MHCC to assess the financial feasibility of the PGRMC CON based on a more realistic assessment of the projected level of PGRMC's MSA allowances. This potential difference in revenue is monumental and throws into question the ongoing financial feasibility of the Project, even if the new hospital is successful in recapturing the large numbers of Prince George's County residents who have elected for decades to receive hospital care in District of Columbia and other Maryland hospitals.

Additional Financial Issues

In addition to the impact of the MSA issue, there are several other problems with the financial projections submitted by the Applicant, which will be discussed below. Table H1 in the Application presents positive net income for each projected fiscal year during the projection period, FYs 2016-2022 (with the exception of FY 2020). Additionally, the line item labeled "cash flow from operations" in the table shows positive cash flow from operations during the entire projection

period, FYs 2016-2022. Summing FYs 2016-2022 cash flows produces total positive cash flow from operations of $191 million. The presented $191 million cash flow from operations is inaccurate and misleading. First the cash flow from operations erroneously excludes additional needed cash to fund increased operations. And, second, cash flow from operations is not a complete picture of total cash flows. For example, to measure feasibility one also needs to consider cash needs for capital expenditures and principal repayment, as well as the assumed line of credit (as a source of funds).

Both net income and cash flow rely heavily on assumptions made, and if these assumptions do not come into existence the financial picture is drastically different. Outlined in Table E below are areas that would impact cash flow negatively. It should be noted that when the questionable net income/expense and cash flow items discussed below are factored in, PGRMC is not able to generate positive cash flow by FY 2022.

TABLE E

Assuming GBR Immediately Impacted by Market Shift Adjustment (MSA)	Total (thousands)
Additional Needed Working Capital	($10,000)
Routine Capital Expenditures	($76,500)
Principal Payments on Bonds	($8,800)
FTE Reductions	($67,600)
Contractual Allowance Reductions	($71,700)
HSCRC Approved Increase to GBR for Capital Effective 7/1/19	($55,400)
Total - Assuming GBR Immediately Impacted by MSA	($290,000)

The following are some of the CON application assumptions by category and the related issues to be considered by MHCC and HSCRC when considering financial feasibility:

- **Revenues** - Gross Patient Service Revenue – HSCRC Approved Adjustment to GBR

Applicant's assumption: Capital related rate increase 7.0% or $21.5 million increase effective the opening of new hospital in July 2019 (FY 2020).

Comments: If the capital related GBR adjustment is not approved, in whole or in part, projected net income and cash flows would decrease by a as much as $18 million per year for FYs 2020-2022 (total of $55.4 million for the three year period). The HSCRC does not currently have an adopted

methodology regarding capital projects. In the past, the methodologies employed by HSCRC included analyses that included reasonableness of charges (ROC). In the last ROC analysis, (*see* **Exhibit H**), Prince George's Hospital Center's charges were by far the highest in its peer group. HSCRC needs to weigh in on this requested capital adjustment. However it would be unprecedented for a hospital with one of the highest charges in its peer group to receive an increase of this magnitude.

- **Revenues** - Contractual Allowances (CA)

Applicant's assumption: Applicant assumes in the Interim Periods (FYs 2015-2019) it will see a CA decline by 1.55% of Gross Patient Service Revenue (GPSR) for FY 2015, (no explanation is provided), and another decline of 1.07% for FY 2016 due to improved collections as a result of an increase in the EMTALA charge required of Medicaid even on denied claims. The assumption for the new hospital (covers FYs 2020-2022) is that it will see a CA decline by yet another 0.90% of GPSR as the relocation of the hospital and recapture of market share will change the payor mix to reflect more Medicare and commercial patients and fewer poor patients.

Comments: Applicant projects a contractual allowance as percentage of GPSR of 9.78% for FY 2015 and 7.72% for FY 2022. Historically, PGHC reported contractual allowances as percentage of GPSR as 9.11% and 11.35% (2013 and 2014, respectively). Thus the application assumes a 30% reduction from 2014, which appears aggressive and unsupported (in sufficient detail to verify). MHCC (and HSCRC) need to carefully review this 30% reduction given its importance to the feasibility of the proposed project. Applying the most recent experience, 11.4%, throughout projection period would reduce cash flow by $71.7 million over the projection period. Please note that the state-wide average of contractual allowance as percent of gross patient service revenue is 12.49%, as reported by HSCRC annual filing data for 2014, (*see* **Exhibit I**).

- **Expenses** - Salaries & Wages (including Benefits)

Applicant's assumption: Applicant projects that salaries and wages will decrease during the interim period until the new hospital is opened as a result of reduction of FTEs per average occupied bed from 6.5 for FY 2015 to 5.8 for FY 2022 (a 10.8% reduction). About half of this FTE per average occupied bed appears to be attributed to a reduction of $8 million during FYs 2016-2018 based on change in workforce rules in its Service Employees International Union (SEIU) agreement.

Comments: FY 2014 Salaries & Wages in the Application totalled $133.8 million and this total decreases in the Project to $117.6 million for FY 2018 (a $16.2 million reduction). These amounts are illustrated in Table G1 (revised) Revenues & Expenses, un-inflated – Entire Facility. Assuming that the staffing levels and related expenses would remain at the FY 2014 levels after adjusting for the $8 million assumed reduction for FYs 2016-2018 (and thereafter) associated with the SEIU agreement workforce rules change, cash flows over the FYs 2015-2022 period would decrease by $6.0 to $8.2 million per year from FY 2016 to FY 2022, totalling $67.6 million, which includes 2.5% inflation per year (note: FTE increases due to projected volume increases over FYs 2015-2018, which would increase this difference, were not included in this analysis).

TABLE F **(in $'000s)**

FTEs Reduction	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Salaries & Wages (uninflated)	133,828	127,822	125,269	121,438	117,607	117,228	120,053	123,817	128,047
FTE Reductions starting FY2015	0	6,006	8,559	12,390	16,221	16,221	16,221	16,221	16,221
SEIU Workforce Rules change	0	0	-2,664	-5,334	-8,000	-8,000	-8,000	-8,000	-8,000
Adjusted FTE Reductions	0	6,006	5,895	7,056	8,221	8,221	8,221	8,221	8,221
Expense inflation - from Key Assumptions	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%
Compounding period	0	1	2	3	4	5	6	7	8
	-	6,156	6,193	7,599	9,074	9,301	9,534	9,772	10,016

Source: Table G1 (revised) Revenues & Expenses, un-inflated – Entire Facility

Support for the significant assumption regarding staffing should be obtained and thoroughly reviewed by MHCC and HSCRC since this is such a material assumption, requiring a change prior to the new facility opening that is not supported by past PGHC management actions.

- **Cash Flow -** Applicant's definition of cash flow from operations is computed as net income and adding back depreciation and amortization expense in "Table H1 (revised) Revenues & Expenses, Inflated – Entire Facility". However, to assess financial feasibility one needs to consider more than this truncated cash flow from operations, since the Applicant's approach neglects to include working capital needs, routine capital expenditures and principal payments, and financing activities, each of which is discussed in more detail below. Note, the new project costs and related funding are not included; however the line of credit borrowing has been.

- **Cash Flow -** Additional Needed Working Capital

Applicant's assumption: None.

Comments: The projected cash flow requires additional cash to meet additional working capital needs, build-up of patient accounts receivables and inventories, net of accounts payable and accrued expenses and salaries payable. If an 8.41% working capital allowance is applied (8.41% of annual incremental net revenue), which is based on the outstanding accounts receivable, accounts payable and accrued liabilities currently reported by PGHC as of June 30, 2014 total and operating cash flow would be reduced by a total of $10.0 million by 2022. (*See* **Exhibit J**.)

- **Cash Flow** - Routine Capital Expenditures (CapEx)

Applicant's assumption: During the interim period (FYs 2016-2019), Applicant assumed CapEx of $10 million per year. During the period when the new hospital is open (FYs 2020-2022) it assumed CapEx of $5 million for FY 2020, $8.5 million for FY 2021 and $13 million for FY 2022.

Comments: Applicant did not consider these routine capital expenditures in its calculation of cash flow. Offsetting these expenditures from the Application's cash flow projection would reduce cash

flow over the time periods in the Financial Forecast in the Application by a total of $76.5 million (it was assumed the $10 million per year for FYs 2016-2019 would also apply to FY 2015).

- **Cash Flow** - Principal Payment

Applicant's assumption: $206.5M Bond issuance in December 2015 at 5.5% over 30 years. Interest expense during construction will be capitalized. Principal payments will begin upon the new hospital's commencement of operations in July 2019.

Comments: The cash flow statement omits the principal payments starting in July 2019, when the new hospital is projected to open. Adding these principal payments would reduce cash flow, (*see* **Exhibit K**), by a total of $8.8 million.

- **Financial Feasibility Conclusions** -

DCH believes that there are numerous unanswered questions that must be answered in order to determine whether the new hospital is financially feasible. It is not apparent that the project could be financially feasible unless all of these questions are addressed and answered in a manner that will permit the new hospital to generate the new revenue it requires. DCH believes that it is absolutely essential that the HSCRC address these issues prior to approving the Project. As noted before, the Applicant could be requested to redesign the Project to reduce its cost and demonstrate financial feasibility for a redesigned project.

Standard: ***Methodologies for Projecting Acute Care Hospital Bed Need; Assumptions. (COMAR 10.24.10.05 D))***

COMMENT: Applicant did not address the methodologies and therefore DCH has no additional comments at this time. The Applicant appears to have largely ignored all parts of this Standard.

Standard: *Data Sources: Migration (COMAR 10.24.10.05 E))*

COMMENT: Applicant has assumed without providing any basis in support of the assumption that the long history of outmigration of approximately 50% of all Prince George's County residents

for acute hospital care will be reversed by the new Hospital. DCH does not believe this assumption is consistent with the SHP methodology used to project the need for beds, much less common sense.

Standard: *Method of Calculation to Project Need for Medical/Surgical/Gynecological/Additional Beds. (COMAR 10.24.10.05 F) (1) Baseline Projection.*
Method of Calculation to Project Need for Medical/Surgical/Gynecological/Additional Beds. (COMAR 10.24.10.05 F) H. Mathematical Formulas.
Method of Calculation to Project Need for Medical/Surgical/Gynecological/Additional Beds. (COMAR 10.24.10.05 F)

COMMENT: See Applicant's comments on the failure of the Applicant to address the fact that it is proposing to add MSGA beds despite the fact that the current SHP MSGA bed forecast shows a negative need for MSGA beds and that number is likely to continue declining.

IV. ALTERNATIVES – COMAR 10.24.01.08G

The applicant failed to address common sense cost saving alternatives, such as: a) re-use of some portion of the existing PGHC campus; b) shifting some services to Laurel, also a member of Dimensions; c) use of some of the excess capacity of MSGA beds at other Prince George's County Hospitals (DCH alone has 36 unlicensed beds that are fully capable of being used for MSGA patients with no additional capital costs); or d) development of a non-rate regulated ambulatory care center. Regulated outpatient care charges in Maryland hospitals are historically much higher than unregulated community charges paid by Medicare under the Medicare fee schedule or commercial payors. Moreover, rate regulated clinics involve separate billings by the hospital and the physician, exposing the patient to two separate co-payments, unlike the single co-payment of an unregulated clinic (i.e., one paid essentially as an office visit). Building a large rate regulated hospital based ambulatory care clinic (ACC), while it may make more money for the hospital, violates several aspects of the Triple Aim – it provides more expensive care at more cost to the patient, and it spends money that would be more appropriately spend on community-based, non-rate regulated care. Moving the ACC to a community-based center would be a much more cost effective

approach. (*See* **Exhibit B** and **Exhibit L**, describing other existing Prince George's County community Centers.) We note there is no discussion of the 233,000 sq. ft. Kaiser-Permanente facility in Largo, located a short distance from the new hospital, in the Application. (*See* **Exhibit M,** for a description.) A large, non-hospital, community based center modeled after the Kaiser Permanente facility – combining urgent cases, 24/7 radiology, pharmacy and lab services – is the future. This project is based on the past. The failure to even consider any of these logical alternatives fails to meet the spirit or letter of this requirement.

V. PROPOSAL ON IMPACT ON DCH

COMAR 10.24.01.08 G(3)(f) – An applicant shall provide information and analysis with respect to the impact of the proposed Project on existing healthcare providers in the health planning region. (*See* **Exhibit N** for the remainder of the regulation text.)

The Applicant faces a problem. It professes to want to be a regional referral center. Its history says otherwise. The Applicant's response to all questions on this issue is simply trust us, it will be different in the new hospital. But if you trust them, you would expect that a real regional hospital center would profoundly affect other hospitals in the Region. The Applicant does not predict significant impacts. Our analysis says otherwise.

Exhibit O, at Table N, (attached), presents DCH's analysis of the likely impact of the Project on the loss of admissions at DCH should the proposed Project go forward. It explains that DCH will lose a minimum of 393 admissions, even assuming that Applicant's unsupported projections of recapturing a large proportion of the residents of the 25% of County residents who have consistently chosen to receive care in hospitals in the District of Columbia and Virginia. The impact would be expected to be greater if that recapture does not occur. We refer you to the exhibit for the basis of the calculation. The discussion below explains the impact on DCH of a loss of 400 MSG admissions.

Impact of Reduction of 400 Inpatient Cases at Doctors Community Hospital

Table G (below) calculates the impact of a reduction of 400 inpatient cases at DCH. Doctors' FY 2014 Inpatient Charge per Case was $13,364. Doctors' estimated Charge per Case for FY 2020, 2021 and 2022, assuming an annual inflation of 2.3% and a demographic adjustment of 0.53% (DCH's FY 2015 GBR Demographic Adjustment), is shown below.

TABLE G

	Inpatient Charge per Case	Gross Patient Service Revenue Lost at 100%	Gross Patient Service Revenue Lost at 50%[6]
FY 2020	$ 15,811	$ 6,300,000	$ 3,160,000
FY 2021	$ 16,261	$ 6,500,000	$ 3,250,000
FY 2022	$ 16,723	$ 6,700,000	$ 3,350,000

FY 2014 Inpatient Charge Per Case	$ 13,364	
Assumed Inflation	2.30%	
Assumed Population Adjustment	0.53%	

Doctors has not yet computed in detail the likely costs that could be reduced associated with these lost cases, but, based on past experience, estimates no more than 25% expense variability, and even that is questionable for several reasons. Although the loss of revenue is great, the actual impact on an operational level is small. The loss of less than 8 patients a week is not the type of impact that can realistically lead to reduced personnel costs, and DCH's high capital costs are completely unaffected. Revenue is the true loss. Assuming 25% expense variability, the impact on consolidated excess of expenses over revenue could be more than $1,000,000 per year. Doctors consolidated excess of revenue over expenses for 2014 was $652,000; and the consolidated excess of expenses over revenue for 2013 was ($1,415,000). A reduction to its consolidated excess of expenses over revenue of $1,000,000 per year could lead to a bond rating downgrade thereby impeding Doctors'

[6] *See* "Limitations on Payments for Recaptured Market Share" regarding discussion of probable GBR adjustment amounts associated with Market Shift Adjustment. Table G assumes that all cases lost by Doctors result from an HSCRC approved market share adjustment and that the adjustment is at 50%. As noted, the HSCRC has not yet finalized its treatment of MSA, which will affect this dollar loss.

ability to incur debt needed to maintain competitiveness in the market. If the reduction were greater, DCH's viability would be threatened.

As a practical matter, if the new PGRMC cannot reverse decades of use of Washington D.C. and Maryland hospitals, it must either fail or attract patients from nearby hospitals – like DCH. In an unregulated environment, DCH could take actions to combat this erosion of patients. In Maryland, its GBR revenue will go down and its rates will go up, reducing the cost competitiveness of DCH, leading to potentially greater losses of volumes from cost conscious purchasers.

Further, DCH is concerned that it could lose staffing to the new hospital approximately six miles away. The impact on maintaining needed personnel when facing a well-funded competitor so close is hard to predict, but nonetheless very real.

VI. CONCLUSION

The State of Maryland and Prince George's County have given more money to Dimensions ... a private charitable organization ... over the years than all other hospitals in Maryland, (in fact, well over $700 million has been given or pledged to Dimensions or the new hospital, with no requirement that any of it be paid back). *See* **Exhibit P**. While Maryland Legislators have enacted legislation authorizing Dimensions to receive this money, it is not certain that it will be granted in later years of the Applicant's projections. When funding has been promised or provided, it has been granted outright, with no caveats and no requirements. That makes sense because the General Assembly knew the Application would be carefully scrutinized by this Commission and the Health Services Cost Review Commission, agencies of the State to which that duty is delegated. This application – the only largely government funded private hospital ever presented for review to this Commission – requires the most painstaking review that this Commission can provide.

Any careful review would reveal that the application simply is not consistent with the State Health Plan requirements. A new hospital is needed, but the right hospital, not this proposal.

PGRMC did not meet its burden of proving that the need for a hospital this large and this expensive exists, or that the hospital is financially feasible. PGRMC ignored the untoward impact on existing providers, particularly Doctors Hospital. Finally, significant additional questions have been asked of the Applicant when the Application was docketed that have as of this date not been answered. (*See* 4/23/2015 letter from the MHCC to Applicant requesting significant additional information).

The issues with the existing proposal are many. It is inconsistent with Maryland's current and future health care planning objectives. The All-Payer Model Demonstration and its successor will increasingly adopt population-based payment for hospital and physician services. The organizations, including hospitals and payers, that sponsor population-based payment will seek to maximize the value of their purchasing decisions, ushering in an era of price competition between urban and suburban hospitals and non-hospital providers. The existence of the 233,000 sq. ft. Kaiser Permanente facility in Largo, (*see* **Exhibit L**), is a prime example of high quality, lower cost non Hospital, non-rate regulated community care that population based health demands but this Project ignores. "Population based health care" requires hospitals to be smaller, have fewer patient rooms, smaller emergency departments, avoid duplicating existing services in the same service area, and foster care in the community. It is difficult to see how the PGRMC meets any of the State's new goals.

DCH does not believe that the project as submitted can be approved. DCH believes a replacement hospital is necessary, and therefore urges the Commission to request a modification better geared to the Triple Aim to better serve the County and the State.

Respectfully submitted,

May 4, 2015

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Counsel for Doctors Community Hospital

4th

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this __ of May, 2015, a copy of *INTERESTED PARTY DOCTORS COMMUNITY HOSPITAL'S COMMENTS TO THE MODIFIED APPLICATION FOR CERTFICATE OF NEED FOR PRINCE GEORGE'S REGIONAL MEDICAL CENTER* was served, first-class mail, postage prepaid, on:

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

Thomas Dane, Esq.
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Kevin McDonald
Chief
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

May 4, 2015

Peter P. Parvis

VII. AFFIRMATIONS

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the following Comments: Geographic Accessibility (COMAR 10.24.10.04 B(1)); and Identification of Bed Need and Addition of Beds COMAR 10.24.10.04 B(2); and Impact on Existing Providers COMAR 10.24.01.08 G(3)(f), and the exhibits referenced therein are true and correct to the best of my knowledge, information, and belief.

4 May 2015
Date

Richard Coughlan

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in Interested Party Doctors Community Hospital's Comments to the Modified Application for Certificate of Need for Prince George's Regional Medical Center and the referenced exhibits are true and correct to the best of my knowledge, information, and belief.

May 3, 2015
Date

mCamille R Bash
Camille R. Bash

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in Interested Party Doctors Community Hospital's Comments to the Modified Application for Certificate of Need for Prince George's Regional Medical Center and the referenced exhibits are true and correct to the best of my knowledge, information, and belief.

5/4/2015
Date

Courtney Young

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in Interested Party Doctors Community Hospital's Comments to the Modified Application for Certificate of Need for Prince George's Regional Medical Center and the referenced exhibits are true and correct to the best of my knowledge, information, and belief.

5/4/2015
Date

Jack S Cook
Jack S. Cook

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in Interested Party Doctors Community Hospital's Comments to the Modified Application for Certificate of Need for Prince George's Regional Medical Center and the referenced exhibits are true and correct to the best of my knowledge, information, and belief.

5-4-15
Date

Philip B. Down
Philip B. Down

EXHIBIT A

Update: Licensed Acute Care Hospital Beds
Fiscal Year 2015

Background

An Annual Report profiling changes in licensed acute care hospital beds in Maryland's acute care hospitals was initiated in 2001 to document and track changes in the licensed bed inventory following implementation of a standardized annual licensure renewal process based on inpatient census. The process involves notifying hospitals prior to the beginning of each fiscal year concerning the calculated total number of licensed acute care beds for the coming fiscal year. In turn, the hospitals identify the allocation of the total licensed acute care beds across four service categories: medical/surgical/gynecological/addictions ("MSGA"); obstetric, pediatric, and acute psychiatric services. Over time, additional information on hospital service capacity, covering emergency department services, surgical services, obstetric and perinatal services, and non-acute care bed capacity have been added to the survey undertaken to update acute care bed licensure.

This interim update provides information on licensed acute care hospital beds for fiscal year 2015, which began July 1, 2014. The full report, *Annual Report on Selected Maryland Acute Care Hospital Services, Fiscal Year 2015,* will be released later this year. That report, in addition to profiling changes in licensed acute care hospital beds, will also include updated information on emergency department capacity, surgical services capacity, obstetric and perinatal services capacity, non-acute care beds in the general hospital setting, and specialty hospital beds.

Acute Care Hospital Bed Capacity

Licensed bed capacity for acute care hospitals in the State of Maryland is dynamic, calculated annually based on average daily acute care inpatient census. The Maryland Health Care Commission, in conjunction with the Health Services Cost Review Commission, calculates the average daily census (ADC) of acute care patients for each hospital for the 12-month period ending with the first quarter of each year and total licensed acute care bed capacity is established for the next fiscal year at 140% of the hospital's average daily census. This licensure approach reflects an assumption that an average annual occupancy rate of approximately 71.4% for acute care hospital beds is an appropriate bench-mark for determining the maximum number of beds an acute care hospital needs to operate.

The initial implementation of this licensure process in FY 2001 resulted in a total of 9,562 licensed acute care beds, removing 2,773 beds from the licensure rolls. Total licensed acute care bed capacity increased, in response to increases in average daily patient census each year after the initial reduction in 2001, peaking at 10,880 beds in FY 2011. The total number of licensed acute care hospital beds in Maryland has declined in every following year, declining to 9,804 beds in the current fiscal year. Thus, Maryland experienced a 13.8% increase in the average daily census of acute care patients between 2000 and 2010 and has experienced a 9.9% decline in acute care ADC between 2010 and 2014.

Licensed Acute Care Hospital Beds in Maryland: FY 2015

Table 1 shows the licensed acute care bed capacity for each acute care hospital, by service, effective July 1, 2015. The calculation of licensed beds for FY 2015, based on each hospital's ADC during the period April 1, 2013 through March 31, 2014, results in a total of 9,804 licensed acute care hospital beds in Maryland. Table 2 shows the ten-year trend in licensed acute care beds by hospital. Table 3 shows the percent change by region.

Table 1. Licensed Acute Care Beds by Hospital and Service: Maryland, FY 2015

Jurisdiction/ Region	Hospital	Acute Care Services				
		MSGA	Obstetric	Pediatric	Psychiatric	Total
Allegany County	Western Maryland Regional Medical Center	160	10	2	20	192
Frederick County	Frederick Memorial Hospital	200	27	10	21	258
Garrett County	Garrett County Memorial Hospital	20	2	1	0	23
Washington County	Meritus Medical Center	193	17	5	16	231
	WESTERN MARYLAND TOTAL	**573**	**56**	**18**	**57**	**704**
Montgomery County	Holy Cross Hospital of Silver Spring	277	88	26	0	391
	MedStar Montgomery Medical Center	87	11	2	20	120
	Shady Grove Adventist Hospital	224	56	25	0	305
	Suburban Hospital	190	0	6	24	220
	Washington Adventist Hospital	171	21	0	40	232
	MONTGOMERY COUNTY TOTAL	**949**	**176**	**59**	**84**	**1,268**
Calvert County	Calvert Memorial Hospital	66	7	1	11	85
Charles County	University of Maryland Charles Regional Medical Center	99	12	4	0	115
Prince George's County	Doctors Community Hospital	182	0	0	0	182
	Fort Washington Medical Center	31	0	0	0	31
	Laurel Regional Hospital	50	10	0	14	74
	MedStar Southern Maryland Hospital Center	148	30	4	25	207
	Prince George's Hospital Center	141	38	8	28	215
	Total: Prince George's County	*552*	*78*	*12*	*67*	*709*
St. Mary's County	MedStar St. Mary's Hospital	52	12	6	12	82
	SOUTHERN MARYLAND TOTAL	**769**	**109**	**23**	**90**	**991**
Anne Arundel County	Anne Arundel Medical Center	316	60	8	0	384
	University of Maryland Baltimore Washington Medical Center	271	15	10	14	310
	Total: Anne Arundel County	*587*	*75*	*18*	*14*	*694*
Baltimore City	Bon Secours Hospital	56	0	0	32	88
	Johns Hopkins Bayview Medical Center	293	17	7	20	337
	MedStar Good Samaritan Hospital	177	0	0	0	177
	MedStar Harbor Hospital	90	25	5	0	120
	MedStar Union Memorial Hospital	177	0	2	26	205
	Mercy Medical Center	170	32	5	0	207
	Sinai Hospital of Baltimore	334	23	26	24	407
	St. Agnes Hospital	239	20	5	0	264
	The Johns Hopkins Hospital	799	35	140	108	1,082
	University of Maryland Medical Center	657	30	58	56	801
	University of Maryland Medical Center Midtown Campus	82	0	0	28	110
	University of Maryland Rehabilitation and Orthopaedics Institute	10	0	0	0	10
	Total: Baltimore City	*3,084*	*182*	*248*	*294*	*3,808*
Baltimore County	Greater Baltimore Medical Center	177	60	8	0	245
	MedStar Franklin Square Hospital	268	37	9	40	354
	Northwest Hospital Center	222	0	0	23	245
	University of Maryland St. Joseph Medical Center	195	20	4	19	238
	Total: Baltimore County	*862*	*117*	*21*	*82*	*1,082*
Carroll County	Carroll Hospital Center	100	20	7	20	147
Harford County	University of Maryland Harford Memorial Hospital	57	0	0	27	84
	University of Maryland Upper Chesapeake Medical Center	168	12	3	0	183
	Total: Harford County	*225*	*12*	*3*	*27*	*267*
Howard County	Howard County General Hospital	199	34	8	20	259
	CENTRAL MARYLAND TOTAL	**5,057**	**440**	**303**	**457**	**6,257**
Cecil County	Union Hospital of Cecil County	60	5	2	8	75
Dorchester County	University of Maryland Shore Medical Center at Dorchester	23	0	0	16	39
Kent County	University of Maryland Shore Medical Center at Chestertown	30	0	1	0	31
Somerset County	Edward W. McCready Memorial Hospital	4	0	0	0	4
Talbot County	University of Maryland Shore Medical Center at Easton	87	17	8	0	112
Wicomico County	Peninsula Regional Medical Center	235	20	8	12	275
Worcester County	Atlantic General Hospital	48	0	0	0	48
	EASTERN SHORE TOTAL	**487**	**42**	**19**	**36**	**584**
	MARYLAND TOTAL	**7,835**	**823**	**422**	**724**	**9,804**

Source: Maryland Health Care Commission: Acute Care Hospital Inventory (ACHI) FY2015

Table 2. Trend in Licensed Acute Care Beds by Hospital: Maryland, FY 2006 - 2015*

Jurisdiction/Region	Hospital	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Allegany County	Braddock Hospital	144	148	155	154	-	-	-	-	-	-
	Memorial Hosp & Med Ctr. of Cumberland	124	120	109	117	-	-	-	-	-	-
	Western Maryland Regional Medical Center	-	-	-	-	262	252	250	234	200	192
	Total: Allegany County	*268*	*268*	*264*	*271*	*262*	*252*	*250*	*234*	*200*	*192*
Frederick County	Frederick Memorial Hospital	232	227	246	269	274	276	309	298	297	258
Garrett County	Garrett County Memorial Hospital	33	31	34	36	33	31	30	29	26	23
Washington County	Meritus Medical Center	246	243	264	258	260	258	252	245	237	231
WESTERN MARYLAND TOTAL		**779**	**769**	**808**	**834**	**829**	**817**	**841**	**806**	**760**	**704**
Montgomery County	Holy Cross Hospital of Silver Spring	365	379	404	408	404	402	409	396	397	391
	MedStar Montgomery General Hospital	144	144	149	165	170	159	158	138	132	120
	Shady Grove Adventist Hospital	269	268	275	293	320	336	339	331	312	305
	Suburban Hospital	228	212	228	238	239	222	233	229	236	220
	Washington Adventist Hospital	292	285	294	292	288	281	271	252	252	232
MONTGOMERY COUNTY TOTAL		**1,298**	**1,288**	**1,350**	**1,396**	**1,421**	**1,400**	**1,410**	**1,346**	**1,329**	**1,268**
Calvert County	Calvert Memorial Hospital	105	107	105	106	98	98	95	95	92	85
Charles County	Univ. of MD Charles Regional Medical Center	117	109	121	129	120	120	124	110	121	115
Prince George's County	Doctors Community Hospital	181	186	192	195	190	195	219	207	198	182
	Fort Washington Medical Center	41	42	42	43	43	42	41	31	33	31
	Laurel Regional Hospital	108	96	95	97	95	87	83	77	78	74
	MedStar Southern Maryland Hospital Center	246	257	258	255	246	235	238	239	227	207
	Prince George's Hospital Center	269	268	264	246	254	244	242	224	214	215
	Total: Prince George's County	*845*	*849*	*851*	*836*	*828*	*803*	*823*	*778*	*750*	*709*
St. Mary's County	MedStar St. Mary's Hospital	88	105	108	108	103	96	90	90	89	82
SOUTHERN MARYLAND TOTAL		**1,155**	**1,170**	**1,185**	**1,179**	**1,149**	**1,117**	**1,132**	**1,073**	**1,052**	**991**
Anne Arundel County	Anne Arundel Medical Center	265	265	278	301	316	324	336	380	385	384
	Univ. of MD Baltimore Washington Medical Center	278	286	293	298	311	321	308	307	319	310
	Total: Anne Arundel County	*543*	*551*	*571*	*599*	*627*	*645*	*644*	*687*	*704*	*694*
Baltimore City	Bon Secours Hospital	142	141	151	125	126	141	127	115	107	88
	Johns Hopkins Bayview Medical Center	316	323	333	345	346	348	348	355	355	337
	MedStar Good Samaritan Hospital	279	265	265	245	235	235	222	224	206	177
	MedStar Harbor Hospital	182	186	203	215	221	193	179	160	136	120
	MedStar Union Memorial Hospital	287	279	283	292	295	271	231	236	221	205
	Mercy Medical Center	228	224	235	243	244	244	226	233	225	207
	Sinai Hospital of Baltimore	392	393	398	415	413	424	416	426	421	407
	St. Agnes Hospital	308	323	314	307	318	314	296	267	276	284
	The Johns Hopkins Hospital	956	956	982	979	990	994	992	1,000	1,060	1,082
	University of Maryland Medical Center	665	669	689	705	731	757	779	800	816	801
	Univ. of MD Medical Center Midtown Campus	196	205	209	191	180	167	164	155	128	110
	Univ. of MD Rehabilitation & Orthopaedic Institute	10	11	10	11	10	10	9	9	10	10
	Total: Baltimore City	*3,961*	*3,977*	*4,072*	*4,073*	*4,110*	*3,921*	*3,989*	*3,836*	*3,961*	*3,808*
Baltimore County	Greater Baltimore Medical Center	287	292	298	310	300	285	281	270	255	245
	MedStar Franklin Square Hospital	343	357	362	380	371	376	347	355	347	354
	Northwest Hospital Center	209	214	213	218	221	215	221	225	243	245
	Univ. of MD St. Joseph Medical Center	342	370	364	354	345	300	263	247	232	238
	Total: Baltimore County	*1,181*	*1,233*	*1,237*	*1,262*	*1,237*	*891*	*1,112*	*1,097*	*1,077*	*1,082*
Carroll County	Carroll Hospital Center	199	210	216	218	213	195	189	158	151	147
Harford County	Univ. of MD Harford Memorial Hospital	91	94	91	104	105	101	97	89	89	84
	Univ. of MD Upper Chesapeake Medical Center	149	167	168	182	196	186	175	181	185	183
	Total: Harford County	*240*	*261*	*259*	*286*	*301*	*287*	*272*	*270*	*274*	*267*
Howard County	Howard County General Hospital	204	208	219	209	227	238	249	249	253	259
CENTRAL MARYLAND TOTAL		**6,328**	**6,440**	**6,574**	**6,647**	**6,715**	**6,177**	**6,455**	**6,297**	**6,420**	**6,257**
Cecil County	Union Hospital of Cecil County	111	99	105	116	113	113	106	92	85	75
Dorchester County	Univ. of MD Shore Medical Center at Dorchester	58	53	49	54	54	53	52	46	41	39
Kent County	Univ. of MD Shore Medical Center at Chestertown	57	58	62	57	53	47	46	42	41	31
Somerset County	Edward W. McCready Memorial Hospital	8	9	8	9	8	8	9	5	4	4
Talbot County	Univ. of MD Shore Medical Center at Easton	129	120	123	120	125	120	116	112	112	112
Wicomico County	Peninsula Regional Medical Center	360	371	366	362	358	362	363	317	288	275
Worcester County	Atlantic General Hospital	40	49	51	53	55	53	53	48	45	48
EASTERN SHORE TOTAL		**763**	**759**	**764**	**771**	**766**	**756**	**745**	**662**	**616**	**584**
MARYLAND TOTAL		**10,323**	**10,426**	**10,681**	**10,827**	**10,880**	**10,729**	**10,583**	**10,184**	**10,177**	**9,804**

Source: Maryland Health Care Commission.

*Prior to FY2001, the number of licensed acute care hospital beds was based on physical bed capacity. Statewide, there were 12,328 licensed acute care beds in FY2000. In FY2001, the first year that state law required licensure of acute care hospital beds based on actual patient census, the total number of licensed acute care hospital beds in Maryland declined to 9,662.

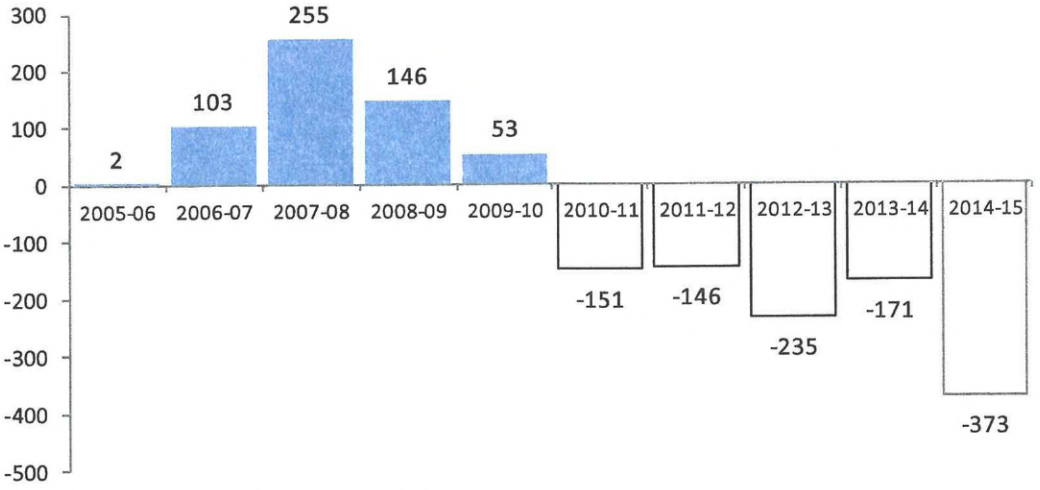
Table 3. Percent Change in Total Licensed Acute Care Hospital Beds, by Maryland Region: Fiscal Years 2006 - 2015

Region	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Average Annual Change 2006 - 2017
Western Maryland	-0.4%	-1.3%	5.1%	3.2%	-0.6%	-1.4%	2.9%	-4.2%	-5.7%	-7.4%	-1.0%
Montgomery County	-3.0%	-0.8%	4.8%	3.4%	1.8%	-1.5%	0.7%	-4.5%	-1.3%	-4.6%	-0.5%
Southern Maryland	-2.9%	1.3%	1.3%	-0.5%	-2.5%	-2.8%	1.3%	-5.2%	-2.0%	-5.8%	-1.8%
Central Maryland	1.1%	1.8%	2.1%	1.1%	1.0%	-1.1%	2.8%	0.1%	-0.6%	-2.5%	0.6%
Eastern Shore	1.3%	-0.5%	0.7%	0.9%	-0.6%	-1.3%	1.5%	-11.1%	-6.9%	-5.2%	-2.1%
Maryland Total	0.0%	1.0%	2.4%	1.4%	0.5%	-1.4%	-1.4%	-2.2%	-1.7%	-3.7%	-0.5%

Source: Maryland Health Care Commission

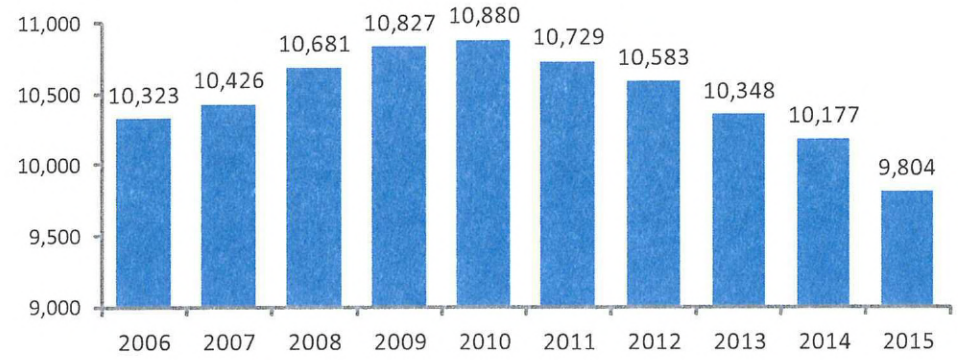
Chart 1 displays the annual net change in licensed acute care beds over the last ten years, while Chart 2 shows the total number of licensed beds over the same time period.

Chart 1. Year to Year Change in Total Licensed Acute Care Beds: Maryland Hospitals, FY 2005 - 2015



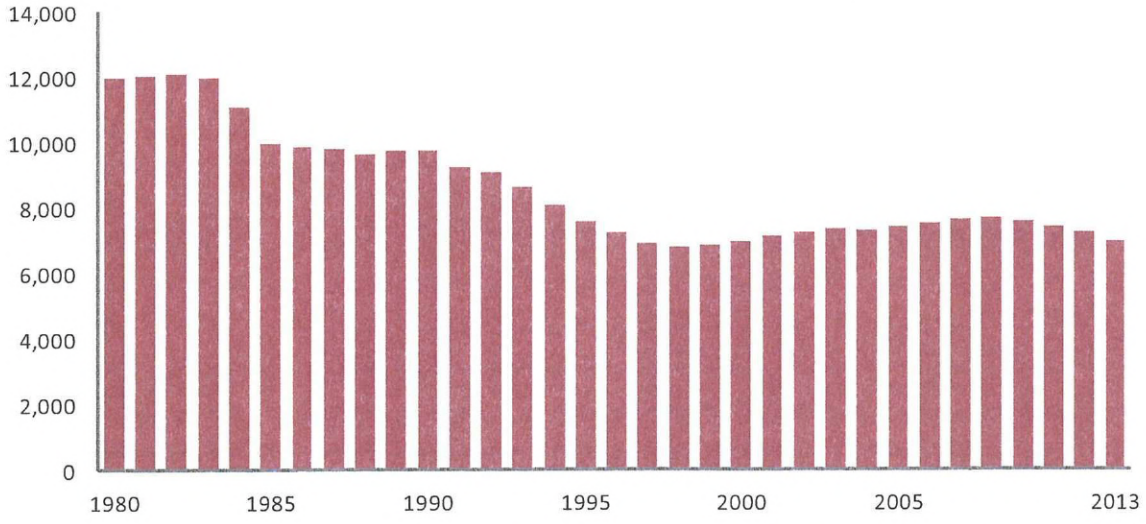
Source: Maryland Health Care Commission

Chart 2. Total Licensed Acute Care Beds: Maryland Hospitals, FY 2006 - 2015



Source: Maryland Health Care Commssion

Chart 3. Trend in Average Daily Acute Care Patient Census: Maryland Hospitals, CY 1980 - 2013



Source: Maryland Health Care Commission. Note: Data reported is based on the Hospital Discharge Abstract Data Base for calendar years 1980 - 2013 and reflects the average daily census for all services excluding newborn and rehabilitation services.

While the average daily census of acute care patients began to gradually trend upward in the late 1990's, hospital utilization in Maryland never returned to historic peaks. During calendar year 2009 average daily census saw the first decline since dynamic hospital bed licensure went into effect in 2001. The average daily census declined again in calendar year 2010. Chart 3 shows the trend of declining acute care census from the early 1980s through the late 1990s, the extent of the rebound in census that occurred in the next ten years and the recent return to gradual decline after 2008.

Table 4 profiles the FY 2014 - 2015 change in total licensed acute care hospital beds from a regional perspective. The State as a whole experienced an overall decrease of 3.7% in bed capacity. All Maryland health planning regions saw an overall decrease in bed capacity for FY 2015, Central Maryland had the lowest decrease in bed capacity, Western Maryland showed the largest overall decrease in bed capacity. Statewide, five (5) hospitals saw an increase in bed capacity, thirty-seven (37) hospitals saw a decrease in bed capacity and four hospitals had no change in bed capacity from the previous year.

Table 4. Change in Number of Total Licensed Acute Care Beds by Region: Maryland Hospitals, FY 2014 - FY 2015

Region	Total Number of Hospitals	Net Change in Number of Total Licensed Beds	Percent Change	Number of Hospitals with an Increase in Beds	Number of Hospitals with a Decrease in Beds	Number of Hospitals with No Change in Hospital Beds
Western Maryland	4	(56)	-7.4%	0	4	0
Montgomery County	5	(61)	-4.6%	0	5	0
Southern Maryland	8	(61)	-5.8%	1	7	0
Central Maryland	22	(163)	-2.5%	3	17	2
Eastern Shore	7	(32)	-5.2%	1	4	2
MARYLAND TOTAL	**46**	**(373)**	**-3.7%**	**5**	**37**	**4**

Source: Maryland Health Care Commission

Tables 5 and 6 profile the change in the inventory of licensed acute care hospital beds for the past ten fiscal years for the four acute care bed service categories. As can be seen, there have been no dramatic changes in the allocation of acute care beds by Maryland's hospitals over this period, with MSGA beds accounting for an average of 80% of total acute care beds, obstetric beds comprising an average of 8%, acute psychiatric beds, on average, 7% of total, and pediatric beds, 4% of total.

Table 5. Allocation of Licensed Acute Care Beds by Service
Maryland Hospitals, FY 2006 - 2015

Service Category	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
MSGA	8,349	8,451	8,694	8,827	8,890	8,738	8,590	8,352	8,198	7,835
Obstetric	840	838	848	854	851	848	851	851	827	823
Pediatric	457	459	458	459	451	452	447	442	438	422
Acute Psychiatric	677	678	681	687	688	691	695	703	714	724
TOTAL	10,323	10,426	10,681	10,827	10,880	10,729	10,583	10,348	10,177	9,804

Source: Maryland Health Care Commission

Table 6. Allocation of Licensed Acute Care Beds by Service (Percentage),
Maryland Hospitals, FY 2006 - FY 2015

Service Category	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
MSGA	80.9%	81.1%	81.4%	81.5%	81.7%	81.4%	81.2%	80.7%	80.6%	79.9%
Obstetric	8.1%	8.0%	7.9%	7.9%	7.8%	7.9%	8.0%	8.2%	8.1%	8.4%
Pediatric	4.4%	4.4%	4.3%	4.2%	4.1%	4.2%	4.2%	4.3%	4.3%	4.3%
Acute Psychiatric	6.6%	6.5%	6.4%	6.3%	6.3%	6.4%	6.6%	6.8%	7.0%	7.4%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

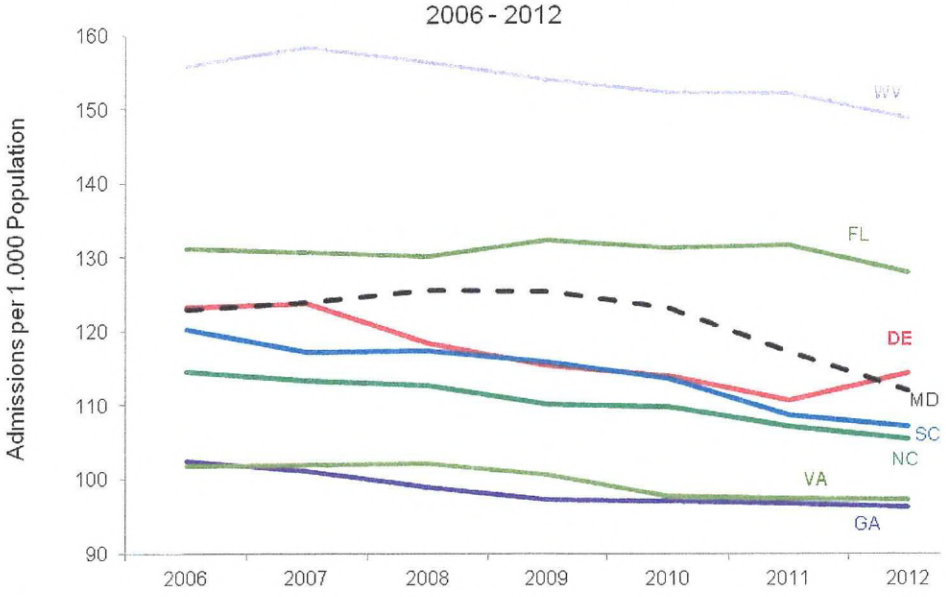
Source: Maryland Health Care Commission

Demand for Hospital Beds in Maryland Compared with Regional and National Trends

The following graphs profile information from *Hospital Statistics*, an annual publication of the American Hospital Association. They reflect this publication's reported acute care hospital use rates and average stay statistics for Maryland and contrasts the demand reported for other Southeastern States and the U.S. experience.

The first two graphs compare hospital admissions per thousand population and average length of hospital stay in Maryland with the experience of the seven other states in the South Atlantic Census Region. This data is not age-adjusted. The relative age of the population in these states is an important factor in its interpretation. To provide some context, the accompanying table compares the proportion of 65 and older persons in the total population of these states, as recorded in the estimated 2012 U.S. Census of population.

Chart 4: Hospital Admissions per 1,000 Population
All Hospital Unit Admissions (Excludes NH Unit Admissions)
South Atlantic Census Region States
2006 - 2012



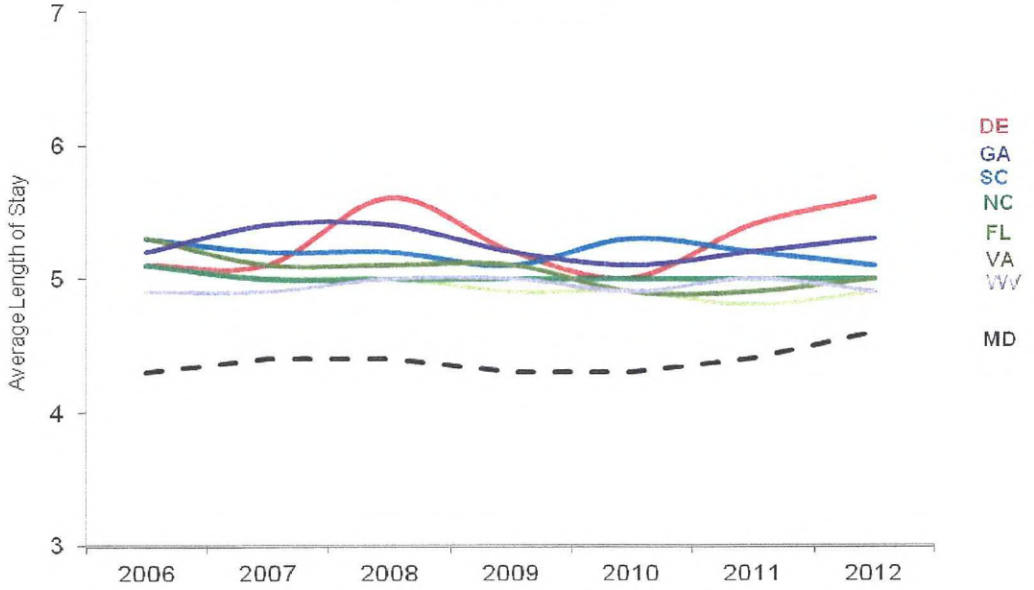
Source: AHA Hospital Statistics (2013) Edition)

Table 7.
Proportion of Total Population Aged 65 and Older
South Atlantic Census Region States, 2013

State	Percentage of Population Aged 65 and Older
Florida	18.7%
West Virginia	17.3%
Delaware	15.9%
South Carolina	15.2%
North Carolina	14.3%
Maryland	13.4%
Virginia	13.4%
Georgia	12.0%

Source: U.S. Census Bureau, Estimated 2014

Chart 5: Hospital Average Length of Stay
All Hospital Unit Admissions (Excludes NH Unit Admissions
South Atlantic Census Region
2006 - 2012

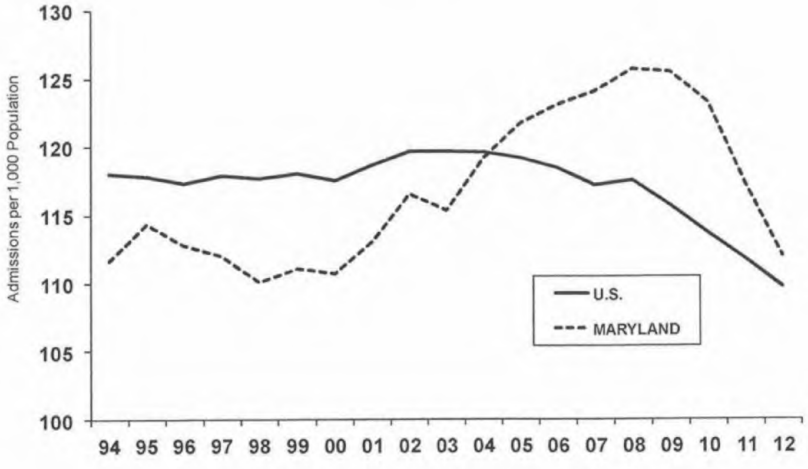


As will be noted, from a regional perspective, Maryland's admissions rate has been lower than that of the states in the South Atlantic region with a higher percentage of population aged 65 and older, Florida and West Virginia, as would be expected. Maryland's admissions rate does not compare well in this recent time period with the Carolinas, Delaware, or Virginia, all of which have only slightly older populations or populations comparable in age to that of Maryland. However, Maryland stands out as having a distinctly shorter average length of stay, when compared with these other states, as shown in Chart 5.

The following graphs, taken from the same data source, provide a longer-term perspective on Maryland and the Nation. Maryland had an enviable record with respect to admissions rate and average length of hospital stay in the 1990s but this changed during the previous decade. Hospital use rates in Maryland peaked in the 2008-09 period, at approximately 8-9% higher than the overall National use rate but has declined steeply in the following years.

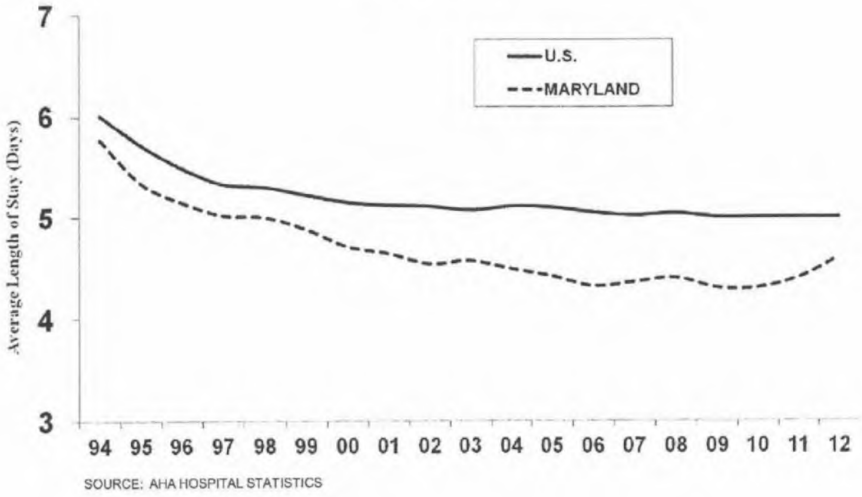
Maryland has been steadily discharging hospital patients more quickly, on average, than has been the National experience. Some narrowing of the gap between Maryland's ALOS and that of the U.S. has occurred as Maryland's hospitals have reduced short stays, in many cases, replacing such stays with "observation" admissions that are not recorded as hospital admissions in this data. The Health Services Cost Review Commission initiated policy changes in recent years aimed at reducing very short-stay admissions, prompted by data indicating a relatively high proportion of one day stays in the State. Further narrowing of the gap between Maryland and the nation with respect to hospital length of stay can be anticipated.

Chart 6: Hospital Admissions per 1,000 Population
All Hospital Unit Admissions (Excludes NH Unit Admissions)
U.S. and Maryland
1994-2012



Source: AHA Hospital Statistics (Average of Published Rates, 2000, 2002-2007, 2009-2014 Editions)

Chart 7: Hospital Average Length of Stay
All Hospital Unit Admissions (Excludes NH Unit Admissions)
U.S. and Maryland
1994-2012

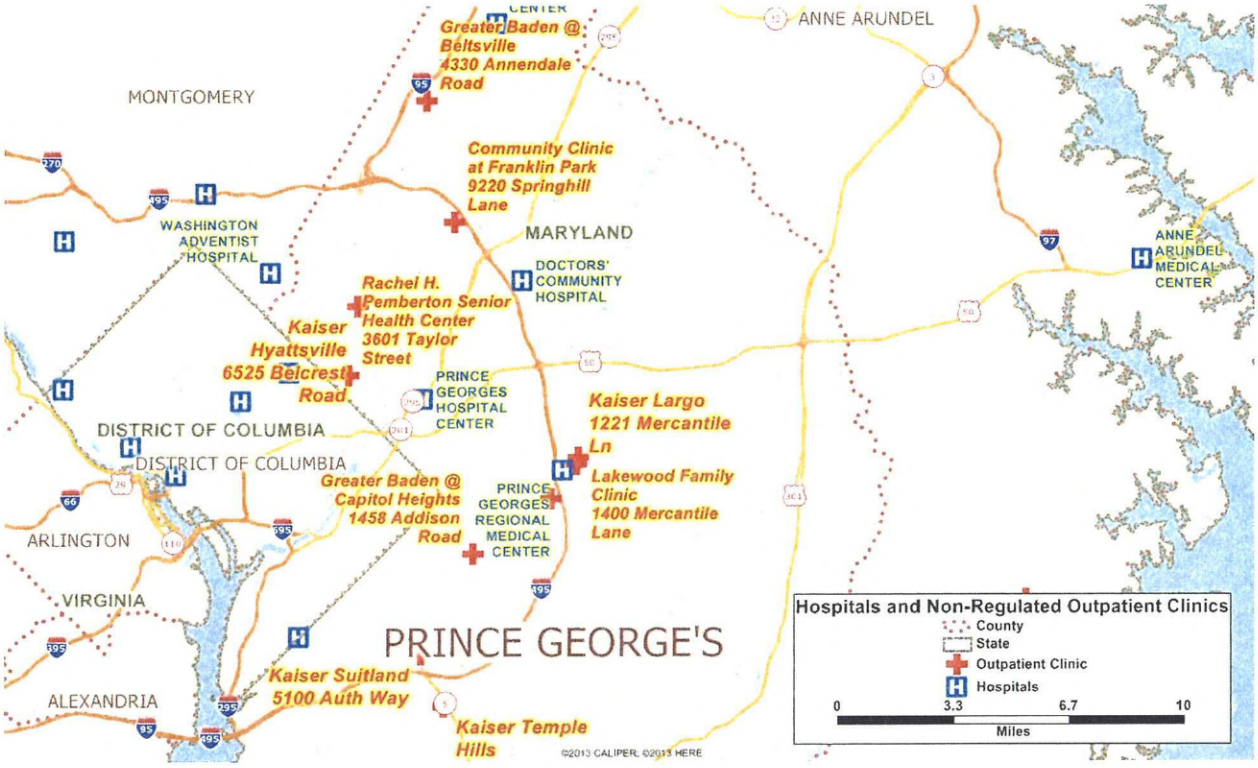


SOURCE: AHA HOSPITAL STATISTICS

Note concerning the AHA data: The American Hospital Association (AHA) conducts an annual survey of all hospitals, both AHA-registered and nonregistered, in the U.S. and its associated areas. AHA reports, overall, the average response rate over the past five years has been approximately 85 percent.

EXHIBIT B

EXHIBIT B


Greater Baden @ Beltsville 4330 Annendale Road
Community Clinic at Franklin Park 9220 Springhill Lane
MONTGOMERY
ANNE ARUNDEL
WASHINGTON ADVENTIST HOSPITAL
MARYLAND
DOCTORS' COMMUNITY HOSPITAL
ANNE ARUNDEL MEDICAL CENTER
Rachel H. Pemberton Senior Health Center 3601 Taylor Street
Kaiser Hyattsville 6525 Belcrest Road
PRINCE GEORGES HOSPITAL CENTER
Kaiser Largo 1221 Mercantile Ln
DISTRICT OF COLUMBIA
DISTRICT OF COLUMBIA
Greater Baden @ Capitol Heights 1458 Addison Road
PRINCE GEORGES REGIONAL MEDICAL CENTER
Lakewood Family Clinic 1400 Mercantile Lane
ARLINGTON
VIRGINIA
PRINCE GEORGE'S
Kaiser Suitland 5100 Auth Way
ALEXANDRIA
Kaiser Temple Hills
©2013 CALIPER, ©2013 HERE
Hospitals and Non-Regulated Outpatient Clinics
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Outpatient Clinic
Hospitals
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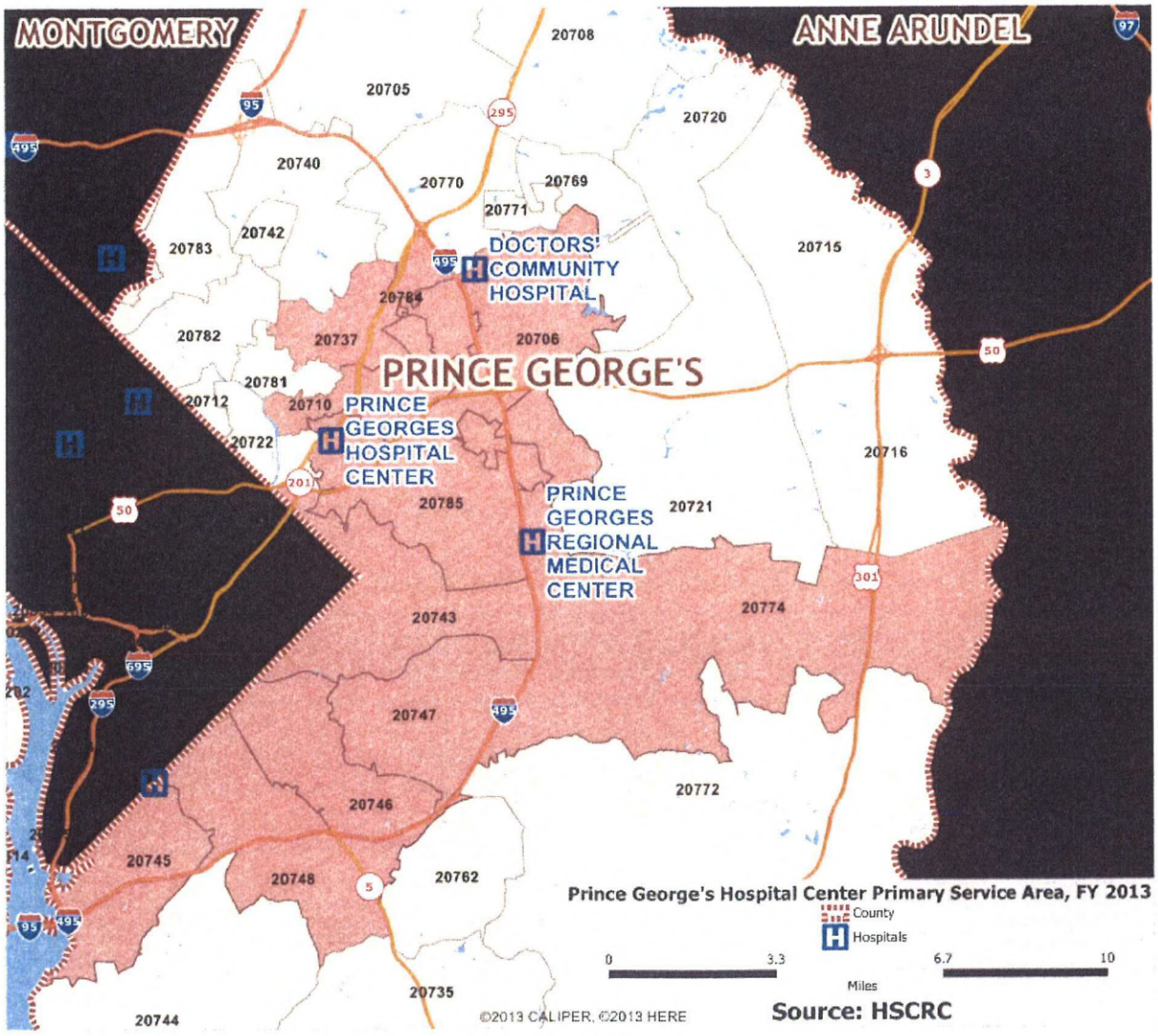
MONTGOMERY
ANNE ARUNDEL
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DOCTORS' COMMUNITY HOSPITAL
PRINCE GEORGES HOSPITAL CENTER
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Prince George's Hospital Center Primary Service Area, FY 2013
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Miles
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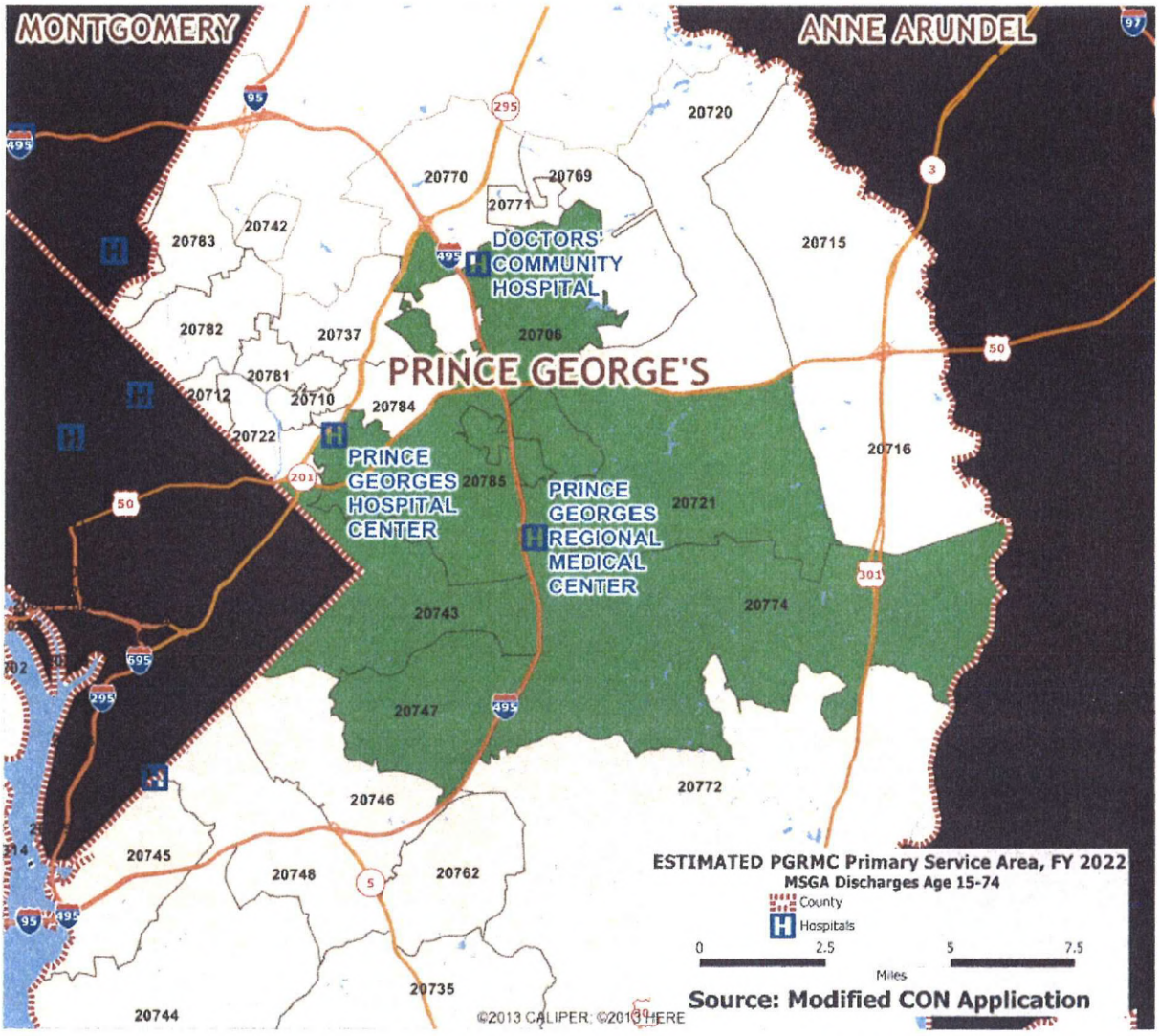
Source: HSCRC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ESTIMATED PGRMC Primary Service Area, FY 2022
MSGA Discharges Age 15-74
County
Hospitals
0
2.5
5
7.5
Miles
Source: Modified CON Application
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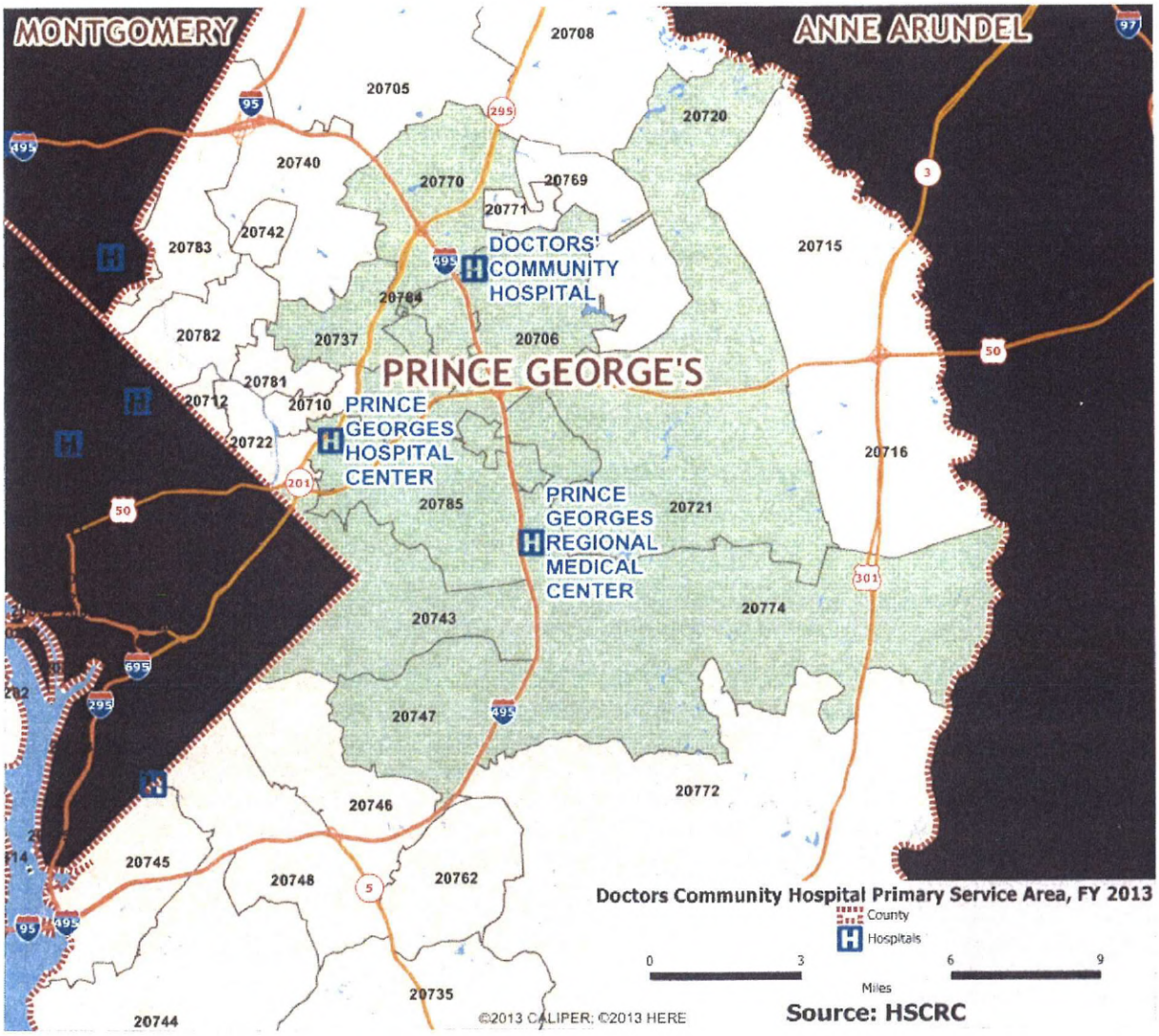
MONTGOMERY
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PRINCE GEORGE'S
DOCTORS COMMUNITY HOSPITAL
PRINCE GEORGES HOSPITAL CENTER
PRINCE GEORGES REGIONAL MEDICAL CENTER
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©2013 CALIPER; ©2013 HERE
Doctors Community Hospital Primary Service Area, FY 2013
County
Hospitals
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Miles
Source: HSCRC

EXHIBIT C

FQHCs interested in being considered to receive State funds for capital development should download an application packet from: http://dhmh.maryland.gov/ocpbes/SitePages/bond.aspx, or request an application as soon as possible from Mr. Ahmed Awad, Administrator, Administration-Sponsored Capital Programs, at the Office of Capital Planning, Budgeting, and Engineering Services, Department of Health and Mental Hygiene, 201 West Preston Street, Room 535H, Baltimore, MD 21201-2399, telephone 410-767-6589.

Applicants should submit an application to the Office of Capital Planning, Budgeting, and Engineering Services by April 18, 2014 in order to receive full consideration, should a bond loan be established in the 2015 General Assembly session (Fiscal Year 2016 funding). Applications received after April 18, 2014will be considered; however, ranking on the departmental priority list cannot be guaranteed.

Applicants who received planning (architectural and engineering) funds in previous years must submit a complete application if they want to be considered for funding in Fiscal Year 2016.

Technical assistance for preparation of the application will be provided by Department of Health and Mental Hygiene staff upon request. For further information, please call Mr. Ahmed Awad at 410-767-6589.

Contact: Mr. Ahmed Awad, 410-767-6589

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[14-05-54]

MARYLAND HEALTH CARE COMMISSION

GROSS AND NET 2022 BED NEED PROJECTION FOR MEDICAL/SURGICAL/ GYNECOLOGICAL/ADDICTIONS AND PEDIATRIC BEDS BY JURISDICTION

In accordance with the requirements of COMAR 10.24.10.05F(4)(f) and 10.24.10.05G(4)(f), the Maryland Health Care Commission (MHCC) publishes the following notice of jurisdictional gross and net bed need for medical/surgical/gynecological/addictions (MSGA) beds and pediatric beds. These jurisdictional gross and net bed need projections will apply in the review of Certificate of Need (CON) applications acted on by MHCC after the date of their publication. Updated projections published in the *Maryland Register* supersede any published in either the *Maryland Register* or any plan approved by MHCC. Published projections of gross bed need remain in effect until MHCC publishes updated acute care hospital bed need projections. Projections of net bed need can change during the interim between bed need projection updates as a result of changes in the number of licensed MSGA and pediatric beds and/or changes in approved beds resulting from MHCC CON or CON exemption decisions, or changes to correct errors in the data or computation.

Gross and Net Bed Need Projection for MSGA Beds: Maryland, 2022

Jurisdiction	2022 Gross Bed Need		Licensed and Approved Beds	2022 Net Bed Need (Net of Currently Licensed and Approved Beds)	
	Minimum	Maximum		Minimum	Maximum
Western Maryland					
Allegany	129	174	167	-38	7
Frederick	211	288	256	-45	32
Garrett	26	34	35	-9	-1
Washington	162	220	197	-35	23
Montgomery County					
Montgomery	805	1,103	1,080	-275	23
Southern Maryland					
Calvert	77	101	72	5	29
Charles	104	134	105	-1	29
Prince George's	487	663	595	-108	68
St. Mary's	83	109	59	24	50
Central Maryland					
Anne Arundel	500	664	605	-105	59
Baltimore City	2,104	2,957	3,356	-1,252	-399
Baltimore County	685	927	873	-188	54
Carroll	132	175	104	28	71
Harford	216	290	232	-16	58
Howard	163	226	191	-28	35

Eastern Shore					
Cecil	72	98	71	1	27
Dorchester	29	39	25	4	14
Kent	38	51	40	-2	11
Somerset	5	6	4	1	2
Talbot	91	121	87	4	34
Wicomico	207	284	250	-43	34
Worcester	55	68	45	10	23

Gross and Net Bed Need Projection for Pediatric Beds: Maryland, 2022

Jurisdiction	2022 Gross Bed Need		Licensed and Approved Beds	202 Net Bed Need (Net of Currently Licensed and Approved Beds)	
	Minimum	Maximum		Minimum	Maximum
Western Maryland					
Allegany	3	4	4	-1	0
Frederick	5	5	10	-5	-5
Garrett	1	1	1	0	0
Washington	4	5	5	-1	0
Montgomery County					
Montgomery	20	24	59	-39	-35
Southern Maryland					
Calvert	3	3	1	1	2
Charles	3	3	4	-1	-1
Prince George's	2	2	12	-10	-10
St. Mary's	3	4	6	-3	-2
Central Maryland					
Anne Arundel	12	14	18	-6	-4
Baltimore City	138	160	272	-134	-112
Baltimore County	12	15	21	-9	-6
Carroll	2	2	7	-5	-5
Harford	4	4	3	1	1
Howard	4	5	6	-2	-1
Eastern Shore					
Cecil	1	1	3	-2	-2
Dorchester	0	0	0	0	0
Kent	0	0	1	-1	-1
Somerset	0	0	0	0	0
Talbot	3	4	8	-5	-4
Wicomico	4	5	8	-4	-3
Worcester	0	0	0	0	0

NOTES:

Gross Bed Need

The minimum and maximum gross bed need projections shown in the tables were calculated using the methodologies outlined in COMAR 10.24.10.05, using a base year of 2012 and a target year of 2022

Licensed and Approved Bed Inventory

The licensed and approved bed inventory has two components. First, for every jurisdiction, this inventory number includes the total number of MSGA or pediatric beds designated within the total acute care license of all of the hospitals in that jurisdiction for FY2014. (These licensed bed numbers can be found at Table 1 of the *Annual Report on Selected Maryland Acute Care and Special Hospital Services: Fiscal Year 2014*, available on the MHCC web site.)

Secondly, for some jurisdictions, the licensed and approved inventory also includes beds that were approved, through the CON process, as additions to bed capacity at hospitals in those jurisdictions. If a CON has been issued to a hospital that affected MSGA and or pediatric bed inventory and MHCC records indicate that a first use approval has not been issued for the project authorized through the CON or annual

revision of the hospital's acute care bed license (which occurs on July 1 of every year) has not yet occurred following issuance of a first use approval, this may have an impact on the bed inventory of these tables, as follows:

1. If the number of designated MSGA or pediatric beds within the total acute care license of that hospital for FY2014 equals or exceeds the total number of MSGA or pediatric beds approved for that hospital in the CON, then no additional beds are added to the jurisdictional inventory for purposes of net bed need projection. The licensed and approved bed inventory will simply be the total number of MSGA or pediatric beds designated within the total acute care licenses of all of the hospitals in that jurisdiction for FY2014;
2. If the number of designated MSGA or pediatric beds within the total acute care license of that hospital for FY2014 is less than the total number of MSGA or pediatric beds approved for that hospital in the CON, then additional beds are added to the jurisdictional inventory for purposes of net bed need projection, if the project has been completed (as indicated by issuance of a first use approval) and an annual re-designation of licensed bed capacity after the completion of the project has not yet occurred. The additional number of beds is the difference between the total number of MSGA or pediatric beds approved for all hospitals in that jurisdiction through the CON process and the total number of MSGA or pediatric beds designated within the total acute care licenses of all of the hospitals in that jurisdiction for FY2014.

Net Bed Need

The minimum and maximum net bed need projections shown in the tables are the difference between the minimum and maximum gross bed need projections and the licensed and approved bed inventory.

Other

Licensed MSGA and pediatric bed capacity is not necessarily equivalent to the actual physical capacity to set up and staff acute care beds of this type in any given hospital, which is a function of building space and appropriate patient room space and the manner in which the rooms are equipped. Physical bed capacity is not necessarily equivalent to the actual bed capacity that an acute care hospital can safely, effectively, and efficiently operate, which is a function of both actual room capacity and the relationship between units of rooms and the circulation pattern within buildings and floors of buildings that connect units of patient rooms and other spaces within the hospital, including diagnostic, treatment, and support space.

Total licensed bed capacity for acute care hospital services is determined by a formula based on observed average daily patient census and is recalculated every year. Hospitals are allowed to designate the assigned acute care service (MSGA, pediatric, obstetric, or psychiatric) for their total licensed acute care beds. For this reason, licensed bed capacity can exceed actual physical bed capacity in any given hospital. For most hospitals, this is not the case. They report more physical bed capacity than licensed bed capacity.

Licensed acute care beds and other physical bed capacity that exceeds the licensed bed capacity of a hospital is used to accommodate patients that are not admitted to the hospital for inpatient hospital services but are classified as patients under observation. Bed use of this kind is not accounted for in the MSGA and pediatric bed need projections developed by MHCC. More information on the use of licensed and/or physical acute care hospital bed capacity for observation patients can be found on the MHCC website at http://mhcc.dhmh.maryland.gov/hospital/Documents/hospital_services/Final_FY2014_Annual_Report_Acute_Care_and_Special_Hospitals.pdf

[14-05-56]

EXHIBIT D

Maryland Register

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MARYLAND HEALTH CARE COMMISSION

Gross and Net 2018 Bed Need Projection for Medical/Surgical/Gynecological/Addictions and Pediatric Beds by Jurisdiction

In accordance with the requirements of COMAR 10.24.10.05F(4)(f) and 10.24.10.05G(4)(f), the Maryland Health Care Commission (MHCC) publishes the following notice of jurisdictional gross and net bed need for medical/surgical/ gynecological/ addictions (MSGA) beds and pediatric beds. These jurisdictional gross and net bed need projections will apply in the review of Certificate of Need (CON) applications acted on by MHCC after the date of their publication. Updated projections published in the Maryland Register supersede any published in either the Maryland Register or any plan approved by MHCC. Published projections of gross bed need remain in effect until MHCC publishes updated acute care hospital bed need projections. Projections of net bed need can change during the interim between bed need projection updates as a result of changes in the number of licensed MSGA and pediatric beds and changes in approved beds resulting from MHCC CON or CON exemption decisions, or changes to correct errors in the data or computation.

Gross and Net Bed Need Projection for MSGA Beds: Maryland, 2018

Jurisdiction	Gross Bed Need — 2018		Licensed and Approved Beds	Net Bed Need (Net of Currently Licensed and Approved Beds)—2018	
	Minimum	Maximum		Minimum	Maximum
WESTERN MARYLAND					
Allegany	208	240	229	-21	11
Frederick	222	267	219	3	48
Garrett	37	42	28	9	14
Washington	183	221	214	-38	7

MONTGOMERY COUNTY					
Montgomery	995	1,193	1,094	-99	99
SOUTHERN MARYLAND					
Calvert	98	111	93	5	18
Charles	119	136	119	0	17
Prince George's	671	787	663	8	124
St. Mary's	131	149	95	36	54
CENTRAL MARYLAND					
Anne Arundel	514	601	551	-37	50
Baltimore City	2,585	3,058	3,361	-776	-303
Baltimore County	1,167	1,336	1,041	126	295
Carroll	194	221	169	25	52
Harford	309	351	277	32	74
Howard	166	200	170	-4	30
EASTERN SHORE					
Cecil	109	124	122	-13	2
Dorchester	49	57	38	11	19
Kent	57	67	46	11	21
Somerset	13	15	8	5	7
Talbot	126	136	100	26	36
Wicomico	273	336	320	-47	16
Worcester	70	75	55	15	20

Gross and Net Bed Need Projection for Pediatric Beds: Maryland, 2018

Jurisdiction	Gross Bed Need—2018		Licensed and Approved Beds	Net Bed Need (Net of Currently Licensed and Approved Beds)—2018	
	Minimum	Maximum		Minimum	Maximum
WESTERN MARYLAND					
Allegany	6	7	5	1	2
Frederick	7	8	10	-3	-2
Garrett	2	2	1	1	1
Washington	7	8	10	-3	-2
MONTGOMERY COUNTY					
Montgomery	34	37	59	-25	-22
SOUTHERN MARYLAND					
Calvert	4	4	2	2	2
Charles	3	4	4	-1	0
Prince George's	5	5	14	-9	-9
St. Mary's	6	6	6	0	0
CENTRAL MARYLAND					
Anne Arundel	15	17	19	-4	-2
Baltimore City	178	197	258	-80	-61
Baltimore County	24	26	22	2	4
Carroll	5	6	7	-2	-1
Harford	12	14	6	6	8
Howard	9	10	6	3	4

EASTERN SHORE					
Cecil	5	6	3	2	3
Dorchester	0	0	0	0	0
Kent	3	3	3	0	0
Somerset	0	0	0	0	0
Talbot	7	7	8	-1	-1
Wicomico	8	9	8	0	1
Worcester	0	0	0	0	0

Gross Bed Need

The minimum and maximum gross bed need projections shown in the tables were calculated using the methodologies outlined in COMAR 10.24.10.05, using a base year of 2008 and a target year of 2018.

Licensed and Approved Bed Inventory

The licensed and approved bed inventory has two components. First, for every jurisdiction, this inventory number includes the total number of MSGA or pediatric beds designated within the total acute care license of all of the hospitals in that jurisdiction for FY2010. (These licensed bed numbers can be found at Table 1 of the *Annual Report on Selected Maryland Acute Care and Special Hospital Services: Fiscal Year 2010*, available on the MHCC web site.)

Secondly, for some jurisdictions, the licensed and approved inventory also includes beds that were approved, through the CON process, as additions to bed capacity at hospitals in those jurisdictions. This only applies to CONs issued after October, 2000, when the current acute care hospital bed licensure law went into effect and rebased the licensed bed inventory of every general hospital. If a CON was issued to a hospital after October, 2000, that authorized the hospital to construct a number of MSGA or pediatric beds that exceeded the number of licensed MSGA or pediatric beds at that hospital in the fiscal year in which the CON was issued, this may have an impact on the bed inventory of these tables, as follows:

- If the number of designated MSGA or pediatric beds within the total acute care license of that hospital for FY2010 equals or exceeds the total number of MSGA or pediatric beds approved for that hospital in the CON, then no additional beds are added to the jurisdictional inventory for purposes of bed need projection. The licensed and approved bed inventory will simply be the total number of MSGA or pediatric beds designated within the total acute care licenses of all of the hospitals in that jurisdiction for FY2010; or
- If the number of designated MSGA or pediatric beds within the total acute care license of that hospital for FY2010 is less than the total number of MSGA or pediatric beds

approved for that hospital in the CON, then additional beds are added to the jurisdictional inventory for purposes of bed need projection. The additional number of beds is the difference between the total number of MSGA or pediatric beds approved for any hospital in that jurisdiction through the CON process and the total number of MSGA or pediatric beds designated within the total acute care licenses of all of the hospitals in that jurisdiction for FY2010.

Net Bed Need

The minimum and maximum net bed need projections shown in the tables are the difference between the minimum and maximum gross bed need projections and the licensed and approved bed inventory.

[10-07-48]

EXHIBIT E

Table 12. Total Available Physical Acute Care Bed Capacity Reported by Maryland Hospitals, June 1, 2014

Hospital Name	Licensed Beds FY 2015	Total Available Physical Capacity	Difference
Anne Arundel Medical Center	384	366	(18)
Atlantic General Hopital	48	62	14
Bon Secours Hospital	88	152	64
Calvert Memorial Hospital	85	126	41
Carroll Hospital Center	147	215	68
Doctors Community Hospital, Inc.	182	218	36
Edward W. McCready Memorial Hospital	4	26	22
Fort Washington Medical Center	31	37	6
Frederick Memorial Hospital	258	315	57
Garrett County Memorial Hospital	23	45	22
Greater Baltimore Medical Center, Inc.	245	342	97
Holy Cross Hospital	391	379	(12)
Howard County General Hospital	259	238	(21)
Johns Hopkins Bayview Medical Center	337	348	11
Laurel Regional Hospital	74	171	97
MedStar Franklin Square Hospital Center	354	342	(12)
MedStar Good Samaritan Hospital	177	253	76
MedStar Harbor Hospital	120	213	93
MedStar Montgomery Medical Center	120	187	67
MedStar Southern Maryland Hospital Center	207	339	132
MedStar St. Mary's Hospital	82	129	47
MedStar Union Memorial Hospital	205	308	103
Mercy Medical Center, Inc.	207	238	31
Meritus Medical Center	231	258	27
Northwest Hospital Center	245	224	(21)
Peninsula Regional Medical Center	275	380	105
Prince George's Hospital Center	215	311	96
Shady Grove Adventist Hospital	305	342	37
Sinai Hospital of Baltimore	407	407	0
St. Agnes Hospital	264	367	103
Suburban Hospital	220	247	27
The Johns Hopkins Hospital	1082	971	(111)
Union Hospital of Cecil County	75	118	43
University of Maryland Baltimore Washington Medical Center	310	320	10
University of Maryland Charles Regional Medical Center	115	155	40
University of Maryland Harford Memorial Hospital, Inc.	84	128	44
University of Maryland Medical Center	801	742	(59)
University of Maryland Medical Center Midtown Campus	110	159	49
University of Maryland Rehabilitation & Orthopaedic Institute	10	28	18
University of Maryland Shore Medical Center at Chestertown	31	46	15
University of Maryland Shore Medical Center at Dorchester	39	80	41
University of Maryland Shore Medical Center at Easton	112	150	38
University of Maryland St. Joseph Medical Center	238	315	77
University of Maryland Upper Chesapeake Medical Center	183	195	12
Washington Adventist Hospital	232	304	72
Western Maryland Regional Medical Center	192	250	58
TOTAL	9,804	11,546	1,742

Source: Maryland Health Care Commission

Note: Total available physical capacity is defined as the total number of acute inpatient beds that are available for use, including those that could be physically set up in space appropriate for licensed acute inpatient care as admissions might warrant. This should be a count of potentially available physical bed capacity rather than a measure of staffing capacity or a reflection of current use of patient care rooms. This is determined by the number of headwalls and/or gas lines that could be made available for inpatient use, without renovations. Rooms with two headwalls/gas lines should be counted as having capacity for two beds, and rooms with one headwall/gas line should be counted as having capacity for one bed, regardless of their current use. It does not include space currently used for non-acute or special hospital beds.

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TOTAL 5

P.6.

EXHIBIT F

EXHIBIT F

	MSGA Discharges, FY 2009	MSGA Patient Days, FY 2009	MSGA Discharges, FY 2013	MSGA Patient Days, FY 2013	Licensed MSGA Beds, FY 2010	Licensed MSGA Beds, FY 2014
Hospital						
PGHC	9,632	47,258	6,950	40,752	176	142
DCH	17,159	74,669	16,837	76,679	190	198
SMHC	12,066	48,717	10,538	49,071	187	168
FWMC	3,012	10,941	2,264	8,489	43	33
LRH	4,435	18,560	3,701	14,123	67	54
TOTAL	**46,304**	**200,145**	**40,290**	**189,114**	**663**	**595**

EXHIBIT G

Figure 14
Existing EMS Catchment Areas

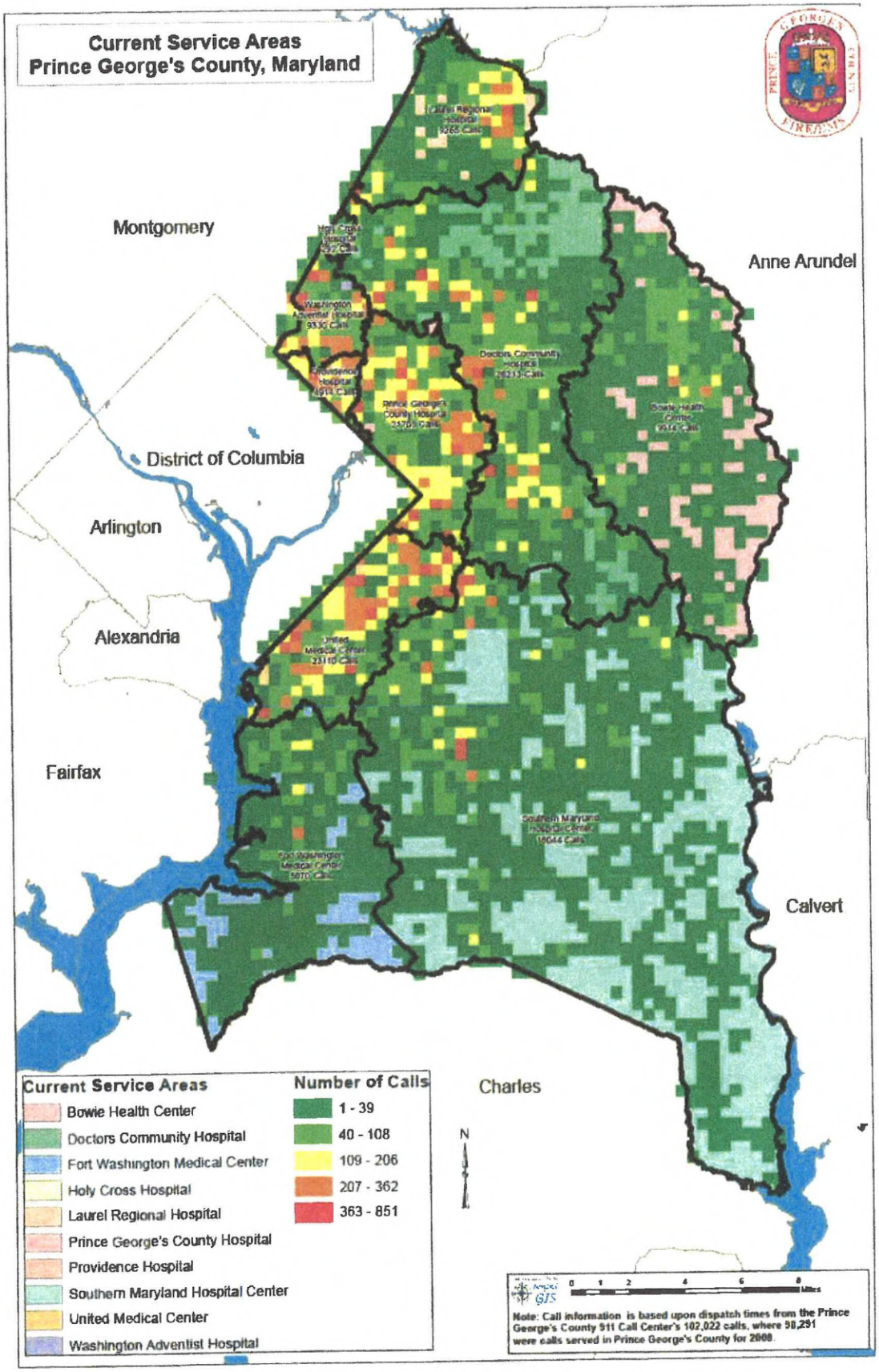

Figure 15
Resultant EMS Catchment Areas

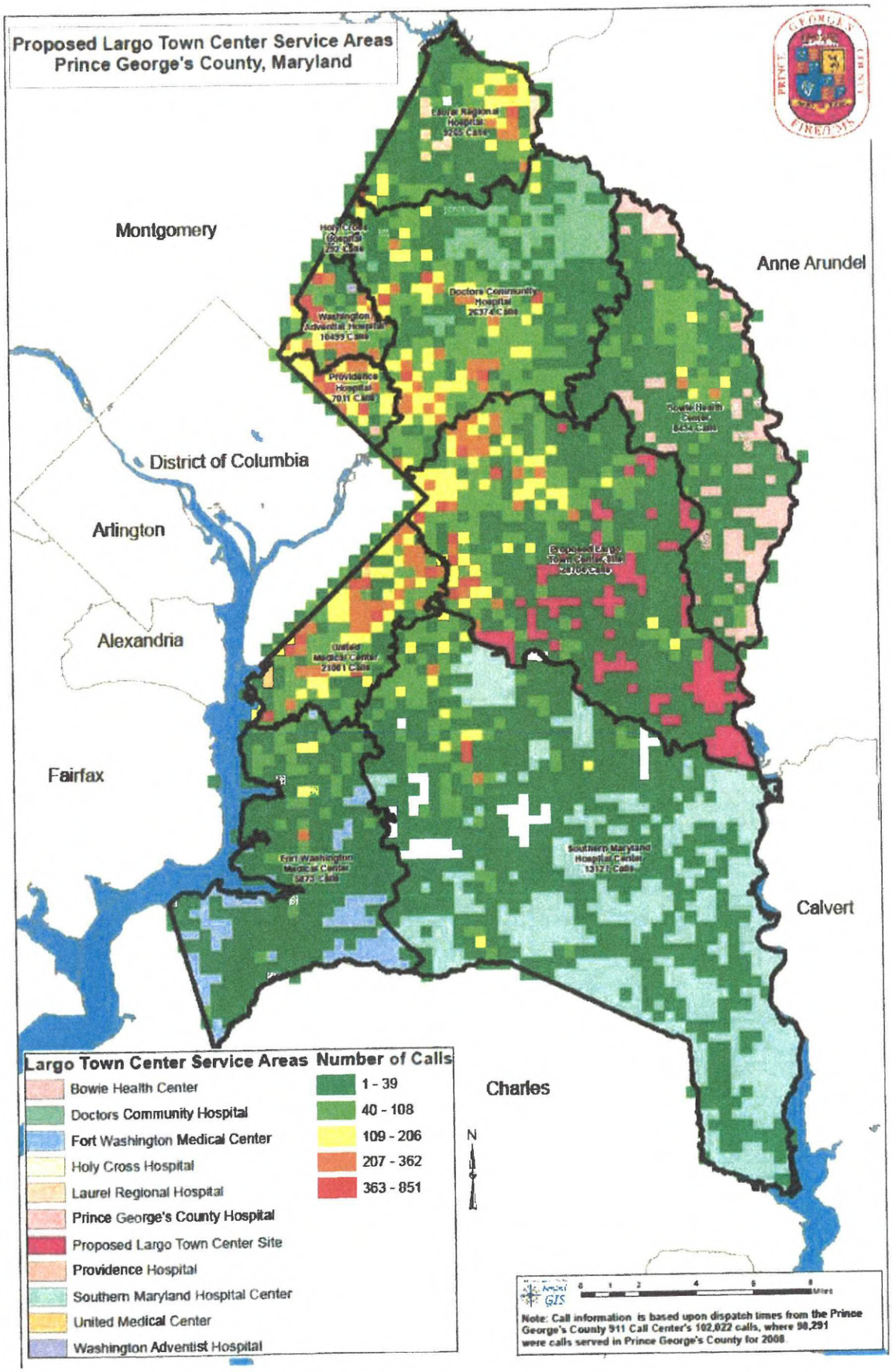

EXHIBIT H

EXHIBIT H

Summary of 2011 Maryland Hospitals' Reasonableness of Charges Comparison by Peer Groups

HOSPID	HOSPITAL NAME	ROC POSITION
PEER GROUP 1		-2.71%
210043	Baltimore Washington Medical Center	2.24%
210015	Franklin Square Hospital Center	-1.40%
210056	Good Samaritan Hospital	-1.41%
210044	Greater Baltimore Medical Center	-1.90%
210004	Holy Cross Hospital	-0.86%
210058	James Lawrence Kernan Hospital	3.65%
210011	St. Agnes Hospital	0.07%
210022	Suburban Hospital	4.41%
PEER GROUP 2		-1.86%
210023	Anne Arundel Medical Center	-0.69%
210061	Atlantic General Hospital	4.64%
210039	Calvert Memorial Hospital	-3.81%
210033	Carroll Hospital Center	-2.48%
210030	Chester River Hospital Center	7.92%
210035	Civista Medical Center	-0.56%
210051	Doctors Community Hospital	4.48%
210010	Dorchester General Hospital	-4.42%
210060	Fort Washington Medical Center	-3.79%
210005	Frederick Memorial Hospital	-3.51%
210017	Garrett County Memorial Hospital	-6.58%
210006	Harford Memorial Hospital	3.27%

210048	Howard County General Hospital	-1.91%
210055	Laurel Regional Hospital	7.75%
210045	McCready Memorial Hospital	53.05%
210037	Memorial Hospital at Easton	-3.00%
210018	Montgomery General Hospital	4.64%
210040	Northwest Hospital Center	4.26%
210019	Peninsula Regional Medical Center	-2.24%
210057	Shady Grove Adventist Hospital	-0.92%
210054	Southern Maryland Hospital Center	1.77%
210007	St. Joseph Medical Center	1.69%
210028	St. Mary's Hospital	3.23%
210032	Union of Cecil	-2.98%
210049	Upper Chesapeake Medical Center	-3.01%
210016	Washington Adventist Hospital	6.41%
210001	Washington County Hospital	-8.64%
210027	Western Maryland Regional Medical Center	2.97%
PEER GROUP 4		1.29%
210013	Bon Secours Hospital	5.36%
210034	Harbor Hospital Center	-4.99%
210029	Johns Hopkins Bayview Medical Center	-5.09%
210038	Maryland General Hospital	-2.06%
210008	Mercy Medical Center	0.36%
210003	Prince Georges Hospital Center	8.76%
210012	Sinai Hospital	1.83%
210024	Union Memorial Hospital	-0.35%
PEER GROUP 5		5.08%
910029	Johns Hopkins Bayview Medical Center	-8.52%
210009	Johns Hopkins Hospital	3.95%
910008	Mercy Medical Center	-3.26%
910003	Prince Georges Hospital Center	4.83%
910012	Sinai Hospital	-1.84%
910024	Union Memorial Hospital	-3.94%
210002	University of Maryland Hospital	2.74%

EXHIBIT I

EXHIBIT I

State-wide contractual adjustment as % of gross patient service revenue

BASEYEAR	HOSPNUMB	HNAME	FORM	CATEGORY	GREV_DHS	GREV_AMB	GREV_IAN	GREV_OAN	GREV_PAT	BAD_DEBT	CHARUNC	CONTRACT	CONTRACT/GREV_PAT
2014	210035	Charles Regional	RE	X_TOTAL	30,479	21,328	43,232	50,538	145,576	9,064	1,864	4,066	2.79%
2014	210032	Union of Cecil	RE	X_TOTAL	30,510	14,657	42,295	102,389	189,851	9,172	3,064	6,142	3.24%
2014	210008	Mercy	RE	X_TOTAL	74,477	60,095	154,184	201,181	489,937	14,580	24,883	16,870	3.44%
2014	210058	UMROI	RE	X_TOTAL	35,951	8,027	36,251	39,240	119,468	7,707	841	5,196	4.35%
2014	210063	UM St. Joseph	RE	X_TOTAL	70,383	27,049	145,747	122,883	366,062	15,690	7,376	16,214	4.43%
2014	210002	UMMC	RE	X_TOTAL	281,705	111,076	618,384	295,566	1,306,731	23,316	47,952	72,674	5.56%
2014	210038	Midtown	RE	X_TOTAL	51,488	40,081	73,419	73,249	238,236	18,800	14,756	13,887	5.83%
2014	218992	UM Shock Trauma	RE	X_TOTAL	78,844	8,895	102,619	17,172	207,529	33,104	7,492	12,757	6.15%
2014	210030	Chestertown	RE	X_TOTAL	13,660	8,440	15,195	30,769	68,065	4,661	2,067	4,898	7.20%
2014	210049	Upper Chesapeake	RE	X_TOTAL	24,376	16,344	46,378	70,491	157,590	5,977	2,265	12,195	7.74%
2014	210045	McCready	RE	X_TOTAL	1,398	4,094	2,280	10,264	18,036	894	572	1,438	7.97%
2014	214000	Sheppard Pratt	RE	X_TOTAL	114,579	12,909	11,947	741	140,176	1,322	8,289	11,270	8.04%
2014	210043	UM-BWMC	RE	X_TOTAL	91,584	40,588	132,527	157,447	422,145	27,697	14,097	34,370	8.14%
2014	210044	GBMC	RE	X_TOTAL	95,928	43,242	150,444	183,695	473,308	11,050	4,337	42,992	9.08%
2014	210023	AAMC	RE	X_TOTAL	124,462	69,132	183,096	184,312	561,001	22,624	5,722	51,362	9.16%
2014	210006	Harford	RE	X_TOTAL	13,875	8,535	11,943	19,427	53,779	3,749	1,494	4,947	9.20%
2014	210017	Garrett	RE	X_TOTAL	8,054	5,972	14,647	23,542	52,216	1,576	3,482	4,825	9.24%
2014	210088	Queen Anne's	RE	X_TOTAL	-	3,539	-	1,652	5,191	188	140	490	9.43%
2014	210022	Suburban	RE	X_TOTAL	60,414	25,627	128,566	84,313	298,919	8,267	4,501	28,480	9.53%
2014	210018	MedStar Montgomery	RE	X_TOTAL	37,120	23,447	50,822	64,999	176,387	4,631	4,722	17,385	9.86%
2014	210051	Doctors Community	RE	X_TOTAL	54,654	23,252	75,085	90,652	243,643	6,352	14,727	24,345	9.99%
2014	210019	Peninsula	RE	X_TOTAL	85,986	31,249	152,128	212,286	481,650	14,314	13,262	49,135	10.20%
2014	210055	Laurel Regional	RE	X_TOTAL	34,596	17,351	36,341	35,766	124,054	9,849	4,507	12,682	10.22%

2014	210009	Johns Hopkins	RE	X_TOTAL	587,083	222,263	778,777	596,747	2,184,869	58,044	32,721	228,422	10.45%
2014	210004	Holy Cross	RE	X_TOTAL	136,575	42,023	191,160	128,098	497,855	15,487	30,739	52,156	10.48%
2014	210003	Prince Georges	RE	X_TOTAL	84,474	31,120	121,418	49,340	286,351	22,302	15,861	30,446	10.63%
2014	210064	Levindale	RE	X_TOTAL	56,808	7,914	25,040	123	89,885	2,647	767	9,702	10.79%
2014	210028	MedStar St. Mary	RE	X_TOTAL	25,782	27,637	43,827	73,133	170,379	5,543	3,430	18,478	10.85%
2014	210062	MedStar Southern Maryland	RE	X_TOTAL	64,490	25,570	101,413	80,391	271,864	18,032	3,582	29,592	10.88%
2014	210039	Calvert	RE	X_TOTAL	29,964	24,415	38,337	59,460	152,176	2,677	7,011	17,095	11.23%
2014	210010	Dorchester	RE	X_TOTAL	17,148	10,678	14,203	20,314	62,343	3,353	2,305	7,190	11.53%
2014	210048	Howard County	RE	X_TOTAL	79,882	26,480	95,291	80,152	281,806	9,934	6,011	33,262	11.80%
2014	210061	Atlantic General	RE	X_TOTAL	13,158	48,786	25,387	40,776	128,107	4,926	3,775	15,463	12.07%
2014	210029	JH Bayview	RE	X_TOTAL	149,186	104,293	209,129	146,905	609,513	31,390	22,183	74,428	12.21%
2014	210013	Bon Secours	RE	X_TOTAL	28,967	22,502	43,168	61,419	156,056	9,168	12,074	21,595	13.84%
2014	215034	Mt. Washington	RE	X_TOTAL	24,544	1,884	23,207	13,862	63,497	658	214	8,828	13.90%
2014	210001	Meritus	RE	X_TOTAL	82,404	37,855	107,892	136,462	364,612	15,223	7,994	51,006	13.99%
2014	210037	Easton	RE	X_TOTAL	46,174	23,536	58,245	103,102	231,056	8,439	5,689	33,758	14.61%
2014	210005	Frederick	RE	X_TOTAL	72,293	29,331	114,641	193,393	409,658	10,665	14,274	61,969	15.13%
2014	210027	Western Maryland	RE	X_TOTAL	79,565	34,123	100,099	166,943	380,730	8,746	14,414	59,072	15.52%
2014	214003	Brook Lane	RE	X_TOTAL	10,302	7,870	2,980	696	21,848	468	554	3,606	16.50%
2014	210040	Northwest	RE	X_TOTAL	78,780	3,935	71,531	135,178	289,424	15,043	6,204	48,258	16.67%
2014	210011	St. Agnes	RE	X_TOTAL	92,228	32,927	148,011	301,790	574,956	21,841	11,750	104,712	18.21%
2014	210033	Carroll County	RE	X_TOTAL	64,014	30,349	77,506	154,729	326,598	9,143	3,356	62,683	19.19%
2014	210012	Sinai	RE	X_TOTAL	341,082	96,648	283,134	171,648	892,513	36,760	12,881	173,756	19.47%
2014	210333	Bowie Emergency	RE	X_TOTAL	-	-	-	26,366	26,366	2,291	1,014	5,405	20.50%
2014	210015	MedStar Franklin Square	RE	X_TOTAL	322,882	52,473	159,778	143,510	678,642	17,924	13,582	165,873	24.44%
2014	210024	MedStar Union Mem	RE	X_TOTAL	85,612	38,130	195,030	250,056	568,828	11,541	13,169	139,283	24.49%
2014	210034	MedStar Harbor	RE	X_TOTAL	45,349	24,752	98,090	115,461	283,651	6,273	6,998	72,025	25.39%
2014	210056	MedStar Good	RE	X_TOTAL									27.04%

Samaritan		178,435	37,657	104,517	120,984	441,593	11,707	7,582	119,395
	State Total					16,784,727			2,096,076
									12.49%

EXHIBIT J

Additional Cash Flow Required to Meet Build Up of Current Assets (Excluding Cash) Less Current Liabilities

Dollar Amounts in Thousands

	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Year to Year Change Net Patient Services Revenue (1)	$ 8,119	$ 13,495	$ 7,667	$ 7,510	$ 8,113	$ 36,879	$ 18,488	$ 18,425
Working Capital as a Percent of Net Patient Service Revenue	8.41%	8.41%	8.41%	8.41%	8.41%	8.41%	8.41%	8.41%
Additional Needed Working Capital	$ 683	$ 1,135	$ 645	$ 632	$ 682	$ 3,101	$ 1,555	$ 1,549

TOTALS FY 2015-2022	
change in Net Patient Services Revenue (1)	**$ 118,696**
Working Capital as a Percent of Net Patient Service Revenue	**8.41%**
Additional Needed Working Capital	**$ 9,982**

(1) Computed from Table H1 of CON appplication

(2) Computation of Working Capital as a Percent of Net Patient Service Revenue (Amounts From June 30, 2014 Audited Financial Statements Filed With CON)

	2014
Patient accounts receivables	$ 49,362
Other receivables	$ 2,620
Inventory	$ 6,299
Prepaid expenses	$ 6,398
Subtotal current assets (excluding cash)	$ 64,679
Accrued employee benefits	$ 10,539
Accounts payable and accrued expenses	$ 36,451
Subtotal current liabilities	$ 46,990
Net current assets Excluidng cash) and current liabilities	$ 17,689
Net Patient Services Revenue	$ 210,340
Working Capital as a Percent of Net Patient Service Revenu	8.41%

EXHIBIT K

Bond Amortization Shedule

First Four Years

Bond Information		
Original Principal	$	206,500,000
Bond Term (Years)		30
Annual Interest Rate		5.50%

FY	Month	Payment	Interest	Principal	Balance	Interest Rate
	0				206,500,000	
2020	1	1,172,484	946,458	226,026	206,273,974	5.50%
2020	2	1,172,484	945,422	227,062	206,046,912	5.50%
2020	3	1,172,484	944,382	228,103	205,818,810	5.50%
2020	4	1,172,484	943,336	229,148	205,589,661	5.50%
2020	5	1,172,484	942,286	230,198	205,359,463	5.50%
2020	6	1,172,484	941,231	231,253	205,128,210	5.50%
2020	7	1,172,484	940,171	232,313	204,895,896	5.50%
2020	8	1,172,484	939,106	233,378	204,662,518	5.50%
2020	9	1,172,484	938,037	234,448	204,428,071	5.50%
2020	10	1,172,484	936,962	235,522	204,192,548	5.50%
2020	11	1,172,484	935,883	236,602	203,955,946	5.50%
2020	12	1,172,484	934,798	237,686	203,718,260	5.50%
2021	13	1,172,484	933,709	238,776	203,479,485	5.50%
2021	14	1,172,484	932,614	239,870	203,239,615	5.50%
2021	15	1,172,484	931,515	240,969	202,998,645	5.50%
2021	16	1,172,484	930,410	242,074	202,756,571	5.50%
2021	17	1,172,484	929,301	243,183	202,513,388	5.50%
2021	18	1,172,484	928,186	244,298	202,269,090	5.50%
2021	19	1,172,484	927,067	245,418	202,023,673	5.50%
2021	20	1,172,484	925,942	246,542	201,777,130	5.50%
2021	21	1,172,484	924,812	247,672	201,529,458	5.50%
2021	22	1,172,484	923,677	248,808	201,280,650	5.50%
2021	23	1,172,484	922,536	249,948	201,030,702	5.50%

2021	24	1,172,484	921,391	251,094	200,779,609	5.50%
2022	25	1,172,484	920,240	252,244	200,527,364	5.50%
2022	26	1,172,484	919,084	253,401	200,273,964	5.50%
2022	27	1,172,484	917,922	254,562	200,019,402	5.50%
2022	28	1,172,484	916,756	255,729	199,763,673	5.50%
2022	29	1,172,484	915,584	256,901	199,506,772	5.50%
2022	30	1,172,484	914,406	258,078	199,248,694	5.50%
2022	31	1,172,484	913,223	259,261	198,989,433	5.50%
2022	32	1,172,484	912,035	260,449	198,728,983	5.50%
2022	33	1,172,484	910,841	261,643	198,467,340	5.50%
2022	34	1,172,484	909,642	262,842	198,204,498	5.50%
2022	35	1,172,484	908,437	264,047	197,940,451	5.50%
2022	36	1,172,484	907,227	265,257	197,675,194	5.50%
2023	37	1,172,484	906,011	266,473	197,408,721	5.50%
2023	38	1,172,484	904,790	267,694	197,141,026	5.50%
2023	39	1,172,484	903,563	268,921	196,872,105	5.50%
2023	40	1,172,484	902,330	270,154	196,601,951	5.50%
2023	41	1,172,484	901,092	271,392	196,330,559	5.50%
2023	42	1,172,484	899,848	272,636	196,057,923	5.50%
2023	43	1,172,484	898,599	273,885	195,784,038	5.50%
2023	44	1,172,484	897,344	275,141	195,508,897	5.50%
2023	45	1,172,484	896,082	276,402	195,232,495	5.50%
2023	46	1,172,484	894,816	277,669	194,954,827	5.50%
2023	47	1,172,484	893,543	278,941	194,675,885	5.50%
2023	48	1,172,484	892,264	280,220	194,395,666	5.50%

Bond Amortization Shedule

First Four Years

Bond Information		
Original Principal	$	206,500,000
Bond Term (Years)		30
Annual Interest Rate		5.50%

FY	Month	Payment	Interest	Principal	Balance	Interest Rate
	0				206,500,000	
2020	1	1,172,484	946,458	226,026	206,273,974	5.50%
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2020	11	1,172,484	935,883	236,602	203,955,946	5.50%
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2021	18	1,172,484	928,186	244,298	202,269,090	5.50%
2021	19	1,172,484	927,067	245,418	202,023,673	5.50%
2021	20	1,172,484	925,942	246,542	201,777,130	5.50%
2021	21	1,172,484	924,812	247,672	201,529,458	5.50%
2021	22	1,172,484	923,677	248,808	201,280,650	5.50%
2021	23	1,172,484	922,536	249,948	201,030,702	5.50%

EXHIBIT L

New Health Center to Open in Prince George's County

By JOSE LUIS DIAZ (Open Post) (/users/jose-luis-diaz00f0b61de208ea3dd171d61ab0e3ad8e82d9458e4b862e327f1c427da701e470)
August 2, 2013

As part of its continuing efforts to provide access to quality health services in underserved areas, on August 7, Community Clinic, Inc. (CCI) is opening a new health center in Greenbelt, Maryland. Nestled in the planned community of Franklin Park, and within minutes from the Greenbelt Metro Station, this conveniently located facility will have the capacity to provide primary care, behavioral health, and dental services to 6,000 patients.

The health center features twelve exam rooms, three dentist chairs, two on site labs, dental X-Ray room, a training classroom, and office spaces to be used for providing ancillary and administrative services (counseling, nutrition education, call center, referral, and billing). Staffed by CCI's experienced bilingual medical professionals, the center will operate under the patient-centered medical home (PCMH) model. This is an exciting new philosophy and approach to providing primary health care; one that delivers a more personalized, coordinated and effective care for patients and their families.

Community Clinic at Franklin Park was made possible by the generous financial contributions of CareFirst BlueCross BlueShield, United Health Foundation, Adventist HealthCare, Prince George's County, Dimensions Healthcare System, and Riverside Health. With their fiscal support, CCI was able to raise $2.3 million to cover construction costs as well as an initial operating budget. The interior design was developed by Interplan, Inc. and the construction was completed by The Korth Companies, Inc.

To mark this occasion and to launch a weeklong celebration of National Health Center Week, CCI is hosting an opening ceremony on the morning of August 7, 2013. A brief program with the participation of elected officials and funders will kick off the celebration, followed by tours of the facility. In the afternoon, CCI is hosting a Community Health Fair from 12:30 to 4 pm. The community will have an opportunity to receive a basic health screening

(blood pressure and glucose levels), and information about nutrition assistance programs, managed care organizations, and other health-related services.

Since incorporating as a non-profit local healthcare organization in 1972, and gaining distinction as a federally qualified health center (FQHC) in 2008, CCI has a history of success in serving people who need access to health services. Nationwide, FQHCs benefit the entire community by accomplishing the following:

- Reducing income and ethnic health disparities nationwide, in the most challenged communities.
- Producing $24 billion in annual health system savings.
- Reducing unnecessary hospitalizations and unnecessary visits to emergency rooms.
- Providing a system of preventive medicine that patients use regularly, thereby improving health outcomes.

The Franklin Park health center is the first CCI site to offer co-located services (Medical, Dental, and Behavioral Health) under one roof. CCI believes that good health is more than healthcare. It encompasses the overall well-being of individuals and families. The Community Clinic at Franklin Park is destined to become a valuable resource to Prince George's County residents.

ABOUT COMMUNITY CLINIC, INC.

Since 1972, Community Clinic, Inc. (CCI) has been the health home for residents of Montgomery and Prince George's Counties. CCI is a Joint Commission Accredited, Federally Qualified Health Center providing high-quality primary care and health-related services for medically under-served persons, promoting improved access to health care services, and conducting CCI's mission in a non-discriminatory manner, sensitive to the needs of the community and the dignity of every individual. In addition to primary care and dental services, CCI administers the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) –the largest in Maryland- and the Health Care for the Homeless program in Montgomery County. Community Clinic, Inc. can be found online at www.cciweb.org (http://greenbelt.patch.com/www.cciweb.org)

Community Clinic at Franklin Park
9220 Springhill Lane
Greenbelt, MD 20770
240-624-2278

EXHIBIT M

News & Views

Press Release

Expanded Wing of Kaiser Permanente's Largo Medical Center Now Open

Expansion adds eight new services, makes medical center the largest Kaiser Permanente facility in the Mid-Atlantic Region

July 8, 2013

TOPICS: EXPERT MEDICINE | REGIONS: MID-ATLANTIC | KEYWORDS: MD MENTIONS

ROCKVILLE, Md. – Kaiser Permanente of the Mid-Atlantic States, an award-winning not-for-profit health plan and care provider, opened the doors to its newly expanded Largo Medical Center on Monday, July 8, providing members in Prince George's County with numerous medical services including around-the-clock urgent care.

"Our expanded Largo Medical Center improves access for Kaiser Permanente members in Prince George's County, helping them receive care the right care at the right time," said Kim Horn, President, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. "This renovated and expanded medical center further demonstrates Kaiser Permanente's commitment to our members in Prince George's County."

Located at 1221 Mercantile Lane in Largo, Kaiser Permanente's Largo Medical Center is being expanded into a state-of-the-art multi-specialty facility. The first portion of the expansion opened today, July 8, and the remainder is expected to be completed in 2014. Once completed, the expansion will increase the medical center square footage from 127,000, to 233,000 square feet, making it the largest Kaiser Permanente facility in the Mid-Atlantic Region. The facility boasts multiple primary and specialty care services, with new services including:

- 24/7 Urgent Care and clinical observation unit
- 24/7 Radiology, pharmacy and lab services
- Ambulatory surgery center
- Podiatry
- Vascular surgery
- Sleep medicine

- Pain management
- Pre-surgical testing

"Our physicians are thrilled to practice at the newly expanded Largo Medical Center. This facility offers a broad array of Permanente specialists and primary care providers, as well as full-service imaging, pharmacy and lab. Open 24 hours a day, this facility allows our members to experience unparalleled convenience and clinical quality," said Bernadette Loftus, MD, The Permanente Medical Group associate executive director for the Mid-Atlantic States.

Designed with the member in mind, medical center exam rooms are fully wired with Kaiser Permanente HealthConnect®, the most advanced electronic medical record system available today. KP HealthConnect helps clinicians provide outstanding quality, assists patients in making certain they have received the preventive care they require, and maximizes patient safety by identifying risks to patients, such as potentially harmful drug combinations. Patients also have the added convenience of

accessing their medical records, scheduling appointments, sending secure e-mail to their physicians, and ordering prescription refills online, through My Health Manager at kp.org. Kaiser Permanente recently released a mobile optimized version of kp.org app for Android and iPhone devices that gives members access to their own medical information anywhere in the world.

The National Committee for Quality Assurance recognized Kaiser Permanente of the Mid-Atlantic States as the No. 1 Commercial and Medicare health plan in Maryland, Virginia and Washington, D.C., and No. 15 Commercial plan and No. 12 Medicare health plan in the nation in "NCQA's Health Insurance Plan Rankings 2012-2013." Kaiser Permanente of the Mid-Atlantic States also led the nation with the No. 1 performance in breast-cancer screening, and led the region on the majority of the Effectiveness of Care measures in The Healthcare Effectiveness Data and Information Set.

Kaiser Permanente of the Mid-Atlantic States has also been ranked "Highest Member Satisfaction among Commercial Health Plans in the Mid-Atlantic Region," five years in a row by J.D. Power and Associates.*

To learn more about Kaiser Permanente's Largo Medical Center, visit kp.org/largo.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. received the highest numerical score among commercial health plans in the Mid-Atlantic region in the proprietary J.D. Power and Associates 2013 U.S. Member Health Plan StudySM. Study based on 33,533 total member responses, measuring six plans in the Virginia-Maryland-D.C. region (excludes Medicare and Medicaid). Proprietary study results are based on experiences

and perceptions of members surveyed December 2012-January 2013. Your experiences may vary. Visit jdpower.com.

About Kaiser Permanente of the Mid-Atlantic States
Kaiser Permanente of the Mid-Atlantic States region, headquartered in Rockville, Maryland, provides and coordinates complete health care services for almost 500,000 members through 30 medical centers in Maryland, Virginia, and Washington, D.C. Founded in 1980, Kaiser Permanente of the Mid-Atlantic States is a total health organization comprised of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., and the Mid-Atlantic Permanente Medical Group, P.C., an independent medical group that features more than 1000 physicians who provide care for patients throughout the area. For more information about Kaiser Permanente of the Mid-Atlantic States, visit kp.org or follow us on Twitter, twitter.com/KPMidAtlantic.

+80

EXHIBIT N

EXHIBIT N

Text of the Relevant State Health Plan Standards

Standard: Quality of Care. (COMAR 10.24.10.04 A(3)

An acute care hospital shall provide high quality care.

* * *

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

Standard: Identification of Bed Need and Addition of Beds. COMAR 10.24.10.04 B(2)

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

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

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

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

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

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

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

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

Standard: Adverse Impact. (COMAR 10.24.10.04 B(4))

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

(a) If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted average Charge

Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group. In addition, if the project involves replacement of physical plant assets, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise demonstrate why the physical plant assets require replacement in order to achieve the primary objectives of the project; and

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

Standard: Cost Effectiveness. (COMAR 10.24.10.04 B(5))

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

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

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

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

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

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

Standard: Burden of Proof Regarding Need. (COMAR 10.24.10.04B(6))

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

Standard: Rate Reduction Agreement. (COMAR 10.24.10.04 B(10))

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

Standard: Financial Feasibility. (COMAR 10.24.10.04 B(13)

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

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

(b) Each applicant must document that:

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

(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;

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

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

Standard: Methodologies for Projecting Acute Care Hospital Bed Need; Assumptions. (COMAR 10.24.10.05 D))

(1) Interstate patterns of migration from the District of Columbia and states bordering Maryland (Delaware, Pennsylvania, Virginia, and West Virginia), by service and age group, will be accounted for in the baseline projection at the jurisdictional level, using the most recent jurisdictional population projections developed for official government use in the applicable state or the District of Columbia. Discharges and days originating from non-bordering states, foreign countries, or unidentified locations will be held constant as a proportion of total discharges and days from the base year to the target year in the baseline projections.

Standard: Statewide Lengths of Stays. (COMAR 10.24.10.05 D(3))

(a) Target year expected lengths of stay are calculated as follows:

(i) Calculate the average annual rate of change in the statewide MSGA Medicare average length of stay during the ten-year period preceding the base year by summing the percentage of change for each year to the next year during the ten-year period and dividing by ten.
(ii) Calculate the average annual rate of change in the statewide MSGA Medicare average length of stay during the five-year period preceding the base year by summing the percentage of change for each year to the next year during the five-year period and dividing by five.
(iii) Determine the minimum target year expected MSGA Medicare average length of stay by calculating the average length of stay for the target year if the average length of stay changed, year to year, from the base year to the target year, by the lowest average annual rate of change calculated in (i) or (ii) above.
(iv) Determine the maximum target year expected MSGA Medicare average length of stay by calculating the average length of stay for the target year if the average length of stay changed, year to year, from the base year to the target year, by the highest average annual rate of change calculated in (i) or (ii) above.
(v) Calculate the average annual rate of change in the statewide MSGA non-Medicare average length of stay during the ten-year period preceding the base year by summing the percentage of change for each year to the next year during the ten-year period and dividing by ten.
(vi) Calculate the average annual rate of change in the statewide MSGA non-Medicare average length of stay during the five-year period preceding the base year by summing the percentage of change for each year to the next year during the five-year period and dividing by five.
(vii) Determine the minimum target year expected MSGA non-Medicare average length of stay by calculating the average length of stay for the target year if the average length of stay changed, year to year, from the base year to the target year, by the lowest average annual rate of change calculated in (v) or (vi) above.
(viii) Determine the maximum target year expected MSGA non-Medicare average length of stay by calculating the average length of stay for the target year if the average length of stay changed, year to year, from the base year to the target year, by the highest average annual rate of change calculated in (v) or (vi) above.
(ix) Calculate the average annual rate of change in the statewide pediatric average length of stay during the ten-year period preceding the base year by summing the percentage of change for each year to the next year during the ten-year period and dividing by ten.
(x) Calculate the average annual rate of change in the statewide pediatric average length of stay during the five-year period preceding the base year by summing the percentage of change for each year to the next year during the five-year period and dividing by five.
(xi)Determine the minimum target year expected pediatric average length of stay by calculating the average length of stay for the target year if the average length of stay changed, year to year, from the base year to the target year, by the lowest average annual rate of change calculated in (ix) or (x) above.
(xii) Determine the maximum target year expected pediatric average length of stay by calculating the average length of stay for the target year if the average length of stay changed, year to year, from the base year to the target year, by the highest average annual rate of change calculated in (ix) or (x) above.
(b) Minimum allowable jurisdictional average lengths of stay are calculated as follows:

(i) The minimum allowable jurisdictional MSGA Medicare average length of stay is the first whole number of days below the minimum target year expected MSGA Medicare average length of stay determined in B(a)(iii) above.
(ii) The minimum allowable jurisdictional MSGA non-Medicare average length of stay is the first whole number of days below the minimum target year expected MSGA non-Medicare average length of stay determined in B(a)(vii) above.
(iii) The minimum allowable jurisdictional pediatric average length of stay is the first whole number of days below the minimum target year expected pediatric average length of stay determined in B(a)(xi) above.

Standard: Data Sources: Migration (COMAR 10.24.10.05 E))

(4) Migration data are obtained from the Commission's hospital discharge abstract data obtained under COMAR 10.24.02.

Standard: Method of Calculation to Project Need for Medical/Surgical/Gynecological/ Additional Beds. (COMAR 10.24.10.05 F)

(1) Baseline Projection.

(a) Calculate the ratio of target year to base year population, by area of residence and age group, by dividing the target year projected population, by area of residence and age group, by the base year estimated population, by area of residence and age group.

(b) Calculate the target year number of patient days, by area of residence, jurisdiction of care, and age group, by multiplying the base year number of patient days, by area of residence, jurisdiction of care and age group, by the ratio of target year to base year population, by area of residence and age group.

(c) Calculate the target year number of patient days, by jurisdiction of care, by summing, over area of residence and age group, the target year number of patient days, by area of residence, jurisdiction of care, and age group.

(d) Calculate the target year number of patient days, by jurisdiction of care and payor group, by multiplying the target year number of patient days, by jurisdiction of care, by the ratio of the base year number of patient days, by jurisdiction of care and payor group, to the base year number of patient days, by jurisdiction of care.

(e) Calculate the target year number of discharges, by area of residence, jurisdiction of care, and age group, by multiplying the base year number of discharges, by area of residence, jurisdiction of care, and age group, by the ratio of target year to base year population, by area of residence and age group.

(f) Calculate the target year number of discharges, by jurisdiction of care, by summing, over area of residence and age group, the target year number of discharges, by area of residence, jurisdiction of care, and age group.

(g) Calculate the target year number of discharges, by jurisdiction of care and payor group, by multiplying the target year number of discharges, by jurisdiction of care, by the ratio of the base year number of discharges, by jurisdiction of care and payor group, to the base year number of discharges, by jurisdiction of care.

(h) Calculate the target year average length of stay, by jurisdiction of care and payor group, by dividing the target year number of patient days, by jurisdiction of care and payor group, by the target year number of discharges, by jurisdiction of care and payor group.

(i) Calculate the target year average length of stay by dividing the target year number of patient days, summed over all jurisdictions of care and payor groups, by the target year number of discharges, summed over all jurisdictions of care and payor groups.

Standard: Method of Calculation to Project Need for Medical/Surgical/Gynecological/ Additional Beds. (COMAR 10.24.10.05 F)

(2) Adjustments in Discharges.

(a) Using the values found in §D(2) of this regulation, calculate the target year expected number of discharges, by payor group, by multiplying the target year expected discharge rate, by payor group, by the target year projected population, by age group, summing over all age groups, and dividing by 1,000.

(b) Calculate the proportional statewide change in number of discharges, by payor group, by subtracting the statewide target year expected number of discharges, by payor group, from the statewide target year numbers of discharges, by payor group, and dividing the result by the statewide target year number of discharges, by payor group.

(c) Calculate the adjusted target year number of discharges, by jurisdiction of care and payor group, by multiplying the proportional statewide change in number of discharges, by payor group. by the target year number of discharges, by jurisdiction of care and payor group, and subtracting the result from the target year number of discharges, by jurisdiction of care and payor group.

(d) Calculate the adjusted statewide expected number of discharges by summing, over all jurisdictions of care and payor groups, the adjusted target year number of discharges, by jurisdiction of care and payor group.

(e) Jurisdictional and adjusted statewide target year number of discharges are published as a notice in the Maryland Register.

Standard: Method of Calculation to Project Need for Medical/Surgical/Gynecological/ Additional Beds. (COMAR 10.24.10.05 F)

(3) Adjustments in Average Lengths of Stay.

(a) Calculate the base year average length of stay, by jurisdiction of care, by dividing the base year number of patient days, by jurisdiction of care and payor group, by the base year number of discharges, by jurisdiction of care and payor group, and summing over all payor groups.

(b) For each jurisdiction in which the actual overall MSGA average length of stay exceeded the case mix-adjusted average length of stay in the base year, calculate the case

mix-adjusted base year average length of stay, by payor group, by multiplying the case mix-adjusted base year average length of stay, by hospital and payor group, by the base year number of discharges, by hospital and payor group, summing over all hospitals in the jurisdiction, and dividing the result by the base year number of discharges, by payor group.

(c) For each jurisdiction in which the actual overall MSGA average length of stay exceeded the case mix-adjusted average length of stay in the base year, calculate the case mix factor, by payor group, by subtracting the case mix-adjusted base year average length of stay, by payor group, from the base year average length of stay, by payor group, and dividing the result by the base year average length of stay, by jurisdiction of care.

(d) Using the values found in §D(3)(a) of this regulation, calculate the proportional statewide change in average length of stay, by payor group, by subtracting the statewide expected average length of stay, by payor group, from the statewide target year average length of stay, by payor group, and dividing the result by the statewide target year average length of stay, by payor group.

(e) For each jurisdiction in which the actual overall MSGA average length of stay exceeded the case mix-adjusted average length of stay in the base year, calculate the adjusted target year average length of stay, by payor group, by adding the proportional statewide change in average length of stay, by payor group, to the case mix factor, by payor group, multiplying the result by the base year average length of stay, by payor group, and subtracting the result from the target year average length of stay, by payor group.

(f) For all other jurisdictions, calculate the adjusted target year average length of stay, by payor group, by multiplying the proportional statewide change in average length of stay by the base year average length of stay, by payor group, and subtracting the result from the target year average length of stay, by payor group.

(g) For jurisdictions in which the adjusted target year average length of stay, by payor group, is less than the minimum allowable average length of stay, by payor group, found in §D(3)(b) of this regulation, the adjusted target year average length of stay is set equal to the minimum allowable average length of stay.

(h) Calculate the adjusted statewide target year expected average length of stay by payor group, by multiplying the adjusted target year average length of stay, by jurisdiction of care and payor group, by the adjusted target year number of discharges, by jurisdiction of care and payor group, calculated in accordance with §F(2)(c) of this regulation, summing the product over all jurisdictions of care, and dividing the result by the adjusted statewide number of discharges, by payor group.

Standard: Method of Calculation to Project Need for Medical/Surgical/Gynecological/ Additional Beds. (COMAR 10.24.10.05 F)

(4) Gross and Net Bed Need Projection.

(a) Calculate the adjusted target year patient days, by jurisdiction of care, by multiplying the adjusted target year discharges, by jurisdiction of care and payor group, by the adjusted target year average length of stay, by jurisdiction of care and payor group, and summing the result over all payor groups.

(b) Calculate the average daily census, by jurisdiction of care, by dividing the adjusted target year patient days, by jurisdiction of care, by 365.

(c) Calculate the target year gross bed need, by jurisdiction of care, by dividing the average daily census, by jurisdiction of care, by the jurisdictional minimum occupancy standard found in §D(4) of this regulation. For jurisdictions with more than one hospital, the jurisdictional minimum occupancy standard used in calculating target year gross bed need will be calculated by pro-rating the MSGA occupancy standards found in §D(4) of

this regulation, at the hospital level, using the assumption that target year MSGA average daily census for the jurisdiction will be proportioned to each hospital in the jurisdiction at the same ratio in which total jurisdictional MSGA average daily census was allocated among the hospitals in the base year.

(d) Calculate the target year net bed need, by jurisdiction of care, by subtracting the licensed and Certificate of Need-approved bed capacity, by jurisdiction of care, from the target year gross bed need, by jurisdiction of care.

(e) Calculate the target year statewide net bed need by summing, over all jurisdictions of care, the target year net bed need, by jurisdiction of care.

(f) Jurisdictional gross and net bed need for the MSGA service will be calculated annually and published as a notice in the Maryland Register. The jurisdictional gross and net bed need for the MSGA service will apply in the review of a Certificate of Need application acted on by the Maryland Health Care Commission after the publication of the jurisdictional gross and net bed need in the Maryland Register.

Standard: Method of Calculation to Project Need for Medical/Surgical/Gynecological/ Additional Beds. (COMAR 10.24.10.05 F)

H. Mathematical Formulas.

1) The need projection methodologies described in §§F and G of this regulation are shown in this section in mathematical form.

2) Terms used in §§F and G of this regulation are defined in alphabetical order in the following table:

Term	Definition
h	hospital in a given jurisdiction
i	area of residence, where 1, ..., 24 = Maryland jurisdictions and 25, ..., 48 = out-of-state areas

* * *

3) Need for MSGA inpatient hospital beds in each jurisdiction, and statewide need, are calculated as shown in the following table of formulas:

(a) Baseline Projection.
(b) Adjustments in Discharges.
(c) Adjustments in Average Lengths of Stay.(d) Gross and Net Bed Need Projection.

4) Need for pediatric inpatient hospital beds in each jurisdiction, and statewide need, are calculated as shown in the following table of formulas:

(a) Baseline Projection.
(b) Adjustments in Discharges.
(c) Adjustments in Average Lengths of Stay.
(d) Gross and Net Bed Need Projection.

Standard: Method of Calculation to Project Need for Medical/Surgical/Gynecological/

Additional Beds. (COMAR 10.24.10.05 F)

I. Update, Correction, Publication, and Notification.

(1) The Commission will update acute care hospital bed need projections annually and publish them in the Maryland Register prior to use in Certificate of Need review and exemptions from Certificate of Need.

(2) Re-computation of gross bed need prior to a scheduled update will be done only when a substantial error has been identified.

(3) Updated projections published in the Maryland Register supersede any published in either the Maryland Register or any plan approved by the Commission.

(4) Published projections remain in effect until the Commission publishes updated acute care hospital bed need projections, and will not be revised during the interim other than to incorporate inventory changes resulting from Commission Certificate of Need decisions and changes exempted from Certificate of Need review, or to correct errors in the data or computation.

Standard: COMAR 10.24.01.08 G(3)(f) –

G. Criteria for Review of Application.

***

(3) Criteria for Review of an Application for Certificate of Need

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(f) Impact on Existing Providers and the Health Care Delivery System. An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

EXHIBIT O

EXHIBIT O

Methodology for Assessing and Challenging the Projected Impact of Prince George's Regional Medical Center on Doctors Community Hospital

INTRODUCTION

Projecting the negative impact on Doctors Community Hospital (DCH) of the development and operation of the proposed Prince George's Regional Medical Center (PGRMC) will involve analyses of multiple data sources which describe past hospital utilization. These include: population estimates, volumes of inpatient and outpatient hospital services of existing hospitals, and travel times. All three of these sources are found in the record of the PGRMC CON Application for its intended service area. Insofar as the intended hospital services and service area of PGRMC overlap the services and service area of DCH, the ability to quantify the negative impact will be determined on the extent to which this overlap can be reasonably projected.

The first important factor in this analysis is geographic. While the existing service area of DCH is clearly defined by the volume of services it provides to residents of multiple zip code areas, the intended zip code areas of the proposed PGRMC service area can only be projected based on assumptions of future utilization. These assumptions include the preference of service area residents to obtain hospital services at the closest hospital to their residence, but might also consider other factors such as physician referral patterns, health insurance contracts, perceptions of quality of care, patient and physician preferences, changes in ambulance catchment areas, use of non-hospital alternatives, impact of federal health care reform on future hospital utilization, the impact of the GBR and other policies of the HSCRC to alter the utilization of Maryland hospital services through financial support for clinical transformation, the availability of a new hospital facility with private rooms, and the distinctive specialty services provided by PGHC that will be relocated to PGRMC. The fact that we are also dealing with two distinct political jurisdictions within the same market for hospital services should also be considered, as increasing the competition for patients with hospitals located in the District of Columbia, especially the Washington Hospital Center, has been highlighted in the PGRMC CON Application as a principal objective.

The second important factor is demographic. Once the methodology to project a service area for PGRMC is determined, the demographic characteristics of the residents of the multiple zip codes in the identified service area can be summarized. These characteristics of those residents are assumed to be correlated to past hospital utilization, so as to permit projections of future utilization, e.g., discharge rates by age cohorts.

Third are the hospital services intended to be provided at PGRMC that will likely overlap with the future service offerings of DCH. These include: inpatient Medical/Surgical/Gynecological/Addictions (MSGA) services (discharges and patient days), observation visits, ambulatory surgery cases, and outpatient and Emergency Department visits. All other services to be provided by PGRMC, including inpatient Obstetrics, Pediatrics, Psychiatric, and Newborn/NICU, will not be included in the impact analysis.

Finally, are the types of MSGA patients served by DCH and PGHC, and how the composition of the patient population of PGRMC may be considerably different for reasons related to: 1) the proposed relocation, 2) the changes in medical staff composition and specialty services described in the business plan for PGRMC, and 3) the asserted but undocumented[1] involvement of UMMS as a partner with Dimensions to operate PGRMC. The applicant's increase in inpatient utilization projected at PGRMC between FY 2013 and FY 2022 is based on three factors: an overall growth in 512 discharges among residents of its anticipated service area, 222 discharges related to the relocation from Cheverly to Largo, and 3,282 discharges related to increased market share. The total growth among the residents of the intended service area of PGRMC is 4,016.

With respect to the timeline for the analysis, we have assumed that PGRMC will commence services on July 1, 2019. Because PGRMC will be both a new hospital in a new location and a replacement hospital for Prince George's Hospital Center (PGHC), projecting the utilization of PGRMC will necessarily involve projecting the utilization of PGHC through its closure as well, as the first operations of PGRMC will be the day after the last day of operations of PGHC. Because there are no specific plans to provide hospital services after PGHC closes, the analysis will assume that all forecasted hospital services will be provided at PGRMC. This means that certain distinctions will need to be made in the impact analysis with respect to the impact of PGHC on DCH prior to its closure, as well as the impact of PGRMC on DCH after the July 1, 2019 opening.

For this impact analysis, we assume that the service areas of the two existing hospitals, PGHC and DCH will not change between now and July 1, 2019. And because the PGRMC will be operated in a new location, the PGRMC service area is very likely to differ from that of PGHC, as residents alter their care-seeking behavior in response to changing travel times, proposed EMS catchment areas changes, and perhaps as a response other factors to be incorporated into the impact analysis, e.g., development of new or improved service offerings, the public appeal of a new hospital facility (the "shiny penny" effect), and the preference of physicians as to where to practice, which is increasingly affected by large expenditures by hospitals to acquired physician practices. This will require an assessment of the likely success of PGRMC in increasing its market share for services which overlap those of DCH, in comparison to the ability of DCH (and perhaps

[1] We note that when expressly asked the question (Q.1. completeness questions) the applicant expressly indicated that, Dimensions, and only Dimensions, would be the owner.

other Maryland and DC hospitals) intended business plan of PGRMC to "recapture" lost volumes of service area inpatients historically discharged from neighboring hospitals in Maryland, Virginia and the District of Columbia, particularly those related to "tertiary and secondary acute" cases. The likely success or failure of PGRMC to implement its "recapture" plans may have a profound impact on the projected volumes of services in the future and which hospitals with overlapping service areas will be providing those same services, including DCH, other Maryland hospitals and DC hospitals. In order to evaluate the likely success of both PGHC and PGRMC to "re-capture" their lost cases, and increase market share, it will be necessary to assess the plans of DCH to effectively compete with these "recapture" initiatives.

GEOGRAPHIC FACTORS

Definition of Hospital Service Area

For purposes of this analysis, we have assumed that hospital service area means Prince George's County and its residents. The applicant has provided analysis in which the service areas of PGHC and PGRMC are defined as the contiguous area comprised of the postal zip code areas from which the first 85% of a hospital's discharged patients originate during the most recent 12-month period, the point zip codes physically located within any of the zip code areas in the service area are also included, and those Maryland zip codes physically contiguous to any of the service area zip code from which 85% of the hospital's discharged patients originate, that provided 50% of more of their discharges to the hospital in the 12-month period. The applicant's analysis closely follows the definitions found in the State Health Plan, Acute Care Chapter.

Table 1 attached show the adult population (age 15+) estimates and projections for Prince George's County published by the Maryland Department of Planning:

TABLE 1

For Prince George's County

	Population Estimates and Projections		
Year /Cohorts	15-64	65-74	75+
2010	612,938	50,100	31,413
2011	615,728	52,829	32,633
2012	618,689	55,708	33,901
2013	621,823	58,744	35,219
2014	625,131	61,947	36,588
2015	628,665	65,336	38,028
2016	627,747	67,530	39,587
2017	626,964	69,816	41,212
2018	626,313	72,198	42,906
2019	625,795	74,681	44,670
2020	625,458	77,281	46,526
2021	624,539	78,835	48,824
2022	623,719	80,421	51,238

Source: Maryland Department of Planning.

(The projected growth shows growth in the population cohort age 15-64 through 2015, then a projected decline thereafter. This change in the State's forecast has implications for projecting future hospital utilization among PG County residents as shown below)

For purposes of our analysis, the most recent 12-month period for which Maryland hospital data is available for Prince George's County residents is Calendar Year (CY) 2014, and for DC hospitals, it is (CY) 2013. For this reason, we have assumed that CY 2013 values for CY 2014 for DC hospitals. We have also assumed that the CY 2014 data can provide an estimate of the FY 2015 period, based on six months of actual data.

A question arises regarding the service categories of discharged patients that will be included in the analysis. With respect to the impact analysis on Laurel Regional Hospital and Montgomery Medical Center presented in the CON review of the proposed relocation and replacement of Washington Adventist Hospital, all hospital discharges were included, with no distinction between Medical/Surgical services and other inpatient service categories. The PGRMC CON Application, in its impact analysis, disaggregated the service

categories in a portion of its impact analysis, but aggregated the results in another portion of the analysis. We would propose to conduct our analysis for Medical/Surgical inpatient services as discussed above, omitting inpatient utilization data on Obstetrics, Newborns, Pediatric, Psychiatric and Rehabilitation categories for residents of Prince George's county residents, since those services are not offered at DCH, and provide the impact analysis based on current market shares and likely future market shares.

Table B includes all of the MDC categories for patients age 15+ among Prince George's county residents to any Maryland or District of Columbia acute care general hospital, and very closely corresponds to the definition of MSGA discharges used by the applicant. Specifically, the Maryland data is by Fiscal Year; the DC Data is an estimated Fiscal Year based on data through CY 2013. For FY 2015, for Maryland hospitals, we have annualized the CY 2014 actual reported data.

For FY 2014 and FY 2015 estimated discharges by District of Columbia hospitals, we have assumed that the number of discharges reported by District of Columbia hospitals among Prince George's County residents in CY 2013 has not changed.

TABLE B

Shown below are the number of MSGA discharges estimated by Maryland and DC Hospitals:

Maryland Hospitals
PG Resident MSGA Discharges (Estimated)

FY Year /Cohorts	15-64	65-74	75+	TOTAL
2010	31,325	9,017	11,440	51,782
2011	30,361	9,246	11,760	51,367
2012	28,305	8,976	11,609	48,890
2013	26,244	8,989	11,123	46,356
2014	25,569	8,874	10,626	45,069
2015	24,955	8,896	10,547	44,398

DC Hospitals
PG Resident MSGA Discharges (Estimated)

FY Year /Cohorts	15-64	65-74	75+	TOTAL
2010	9,888	2,760	2,144	14,792
2011	9,601	3,055	2,278	14,934
2012	9,684	3,010	2,198	14,892
2013	9,473	2,933	2,235	14,641
2014	9,473	2,933	2,235	14,641
2015	9,473	2,933	2,235	14,641

TABLE C

DC & MD Hospitals
PG Resident MSGA Discharges (Estimated)

FY Year /Cohorts	15-64	65-74	75+	TOTAL
2010	41,213	11,777	13,584	66,574
2011	39,962	12,301	14,038	66,301
2012	37,989	11,986	13,807	63,782
2013	35,717	11,922	13,358	60,997
2014	35,042	11,807	12,861	59,710
2015	34,428	11,829	12,782	59,039

Source: Maryland Hospital Discharge Database and District of Columbia Discharge Database.

Shown below are the estimated market share percentages of Prince George's county resident MSGA discharges by Hospital:

TABLE D

	Market Shares: PG County MSGA Discharges				
Hospitals/FY	**2010**	**2011**	**2012**	**2013**	**2014**
PGHC	11%	10%	9%	9%	10%
DCH	17%	18%	17%	16%	14%
LRH	4%	4%	4%	5%	4%
FWMC	3%	3%	3%	3%	3%
MSMHC	15%	15%	16%	15%	14%
AAMC	3%	4%	5%	5%	5%
HX	7%	7%	7%	7%	8%
WAH	9%	8%	8%	7%	7%
All Others	8%	9%	10%	11%	11%
MD Subtotal	78%	77%	77%	76%	75%
WHC	10%	11%	12%	12%	12%
PROV	2%	2%	2%	2%	2%
CHNMC	1%	1%	1%	1%	1%
GWUH	3%	2%	2%	3%	3%
GUH	3%	3%	3%	4%	4%
All Others	3%	3%	3%	3%	3%
DC Subtotal	22%	23%	23%	24%	25%
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Maryland Hospital Discharge Database and District of Columbia Discharge Database.

The estimated MSGA discharge rates for Prince George's County residents are shown below:

TABLE E

	PG Residents Discharge Rates/1,000		
FY Year /Cohorts	15-64	65-74	75+
2010	67.24	235.07	432.43
2011	64.90	232.85	430.18
2012	61.40	215.16	407.28
2013	57.44	202.95	379.29
2014	56.06	190.60	351.51
2015	54.76	181.05	336.12

The annual reductions in the discharge rates are shown below:

TABLE F

	Annual Reductions		
FY Year /Cohorts	15-64	65-74	75+
2010			
2011	-3.47%	-0.95%	-0.52%
2012	-5.39%	-7.60%	-5.32%
2013	-6.45%	-5.68%	-6.87%
2014	-2.41%	-6.08%	-7.32%
2015	-2.30%	-5.01%	-4.38%

As is shown by reference to Table B, the sharp decline is significantly higher among Maryland hospitals.

We have made two assumptions concerning the projected discharge rates for the FY 2016 through FY 2022. First, we assumed that the annual rates of decline reported for FY 2010 through FY 2015 would not continue through FY 2022 for the age cohorts shown above. Instead, we assumed an annual rate of decline of 1% for all three age cohorts. This assumption is shown below.

TABLE G

	Annual Rate of Change		
Year /Cohorts	15-64	65-74	75+
2010			
2011	-3.47%	-0.95%	-0.52%
2012	-5.39%	-7.60%	-5.32%
2013	-6.45%	-5.68%	-6.87%
2014	-2.41%	-6.08%	-7.32%
2015	-2.30%	-5.01%	-4.38%
2016	-1.00%	-1.00%	-1.00%
2017	-1.00%	-1.00%	-1.00%
2018	-1.00%	-1.00%	-1.00%
2019	-1.00%	-1.00%	-1.00%
2020	-1.00%	-1.00%	-1.00%
2021	-1.00%	-1.00%	-1.00%
2022	-1.00%	-1.00%	-1.00%

Shown below are the estimated and projected MSGA discharge rates for Prince George's County adult residents:

TABLE H

	PG Residents Discharge Rates/1,000		
Year /Cohorts	15-64	65-74	75+
2010	67.24	235.07	432.43
2011	64.90	232.85	430.18
2012	61.40	215.16	407.28
2013	57.44	202.95	379.29
2014	56.06	190.60	351.51
2015	54.76	181.05	336.12
2016	53.50	171.98	321.41
2017	52.97	170.26	318.19
2018	52.44	168.55	315.01
2019	51.91	166.87	311.86
2020	51.39	165.20	308.74
2021	50.88	163.55	305.66
2022	50.37	161.91	302.60

If the discharge rates continue to decline at these very modest rates (much lower than the 201-2015 decline), the total number of MSGA discharges to MD and DC hospitals among residents of Prince George's County is projected as shown below:

TABLE I

	DC & MD Hospitals PG Resident MSGA Discharges			
Year /Cohorts	15-64	65-74	75+	TOTAL
2010	41,213	11,777	13,584	66,574
2011	39,962	12,301	14,038	66,301
2012	37,989	11,986	13,807	63,782
2013	35,717	11,922	13,358	60,997
2014	35,042	11,807	12,861	59,710
2015	34,428	11,829	12,782	59,039
2016	33,586	11,614	12,724	57,923
2017	33,208	11,887	13,114	58,208
2018	32,842	12,169	13,516	58,527
2019	32,487	12,462	13,931	58,880
2020	32,144	12,767	14,365	59,276
2021	31,776	12,893	14,923	59,593
2022	31,417	13,021	15,505	59,943

We then assumed that the MSGA Discharges forecast by PGHC/PGRMC in the modified application would be achieved, that is, an increase from 7,422 discharges in FY 2012 to 11,217 discharges in FY 2022, as shown below:

TABLE J

	PGHC/PGRMC
FY	MSGA Discharges
2012	7,422
2013	6,654
2014	7,603
2015	7,857
2016	7,964
2017	8,058
2018	8,178
2019	8,342
2020	9,300
2021	10,259
2022	11,217

Source: Modified CON Application, Exhibit 1.

We have also assumed that Prince George's County residents would continue to account for 78.69% of the total number of MSGA discharges at PGH/PGRMC through FY 2022, the number estimated for FY 2015. The balance of discharges would be from patients who do not reside in Prince George's County, such as Washington, DC and other Maryland jurisdictions.

In order for PGRMC to achieve its own forecasted number of 11,217 MSGA discharges in FY 2022, consistent with the total number of MSGA discharges projected for Prince George's County residents (59,943), PGRMC would have to achieve a market share of 14.7%, and increase of 43% above its 10.27% market share in FY 2015, as shown below:

TABLE K

	Market Shares: PG County MSGA Discharges							
Hospitals/FY	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
PGHC	**10.27%**	**10.80%**	**10.90%**	**11.00%**	**11.15%**	**12.35%**	**13.55%**	**14.70%**
DCH	**13.28%**	**13.20%**	**13.18%**	**13.17%**	**13.15%**	**12.97%**	**12.79%**	**12.62%**
LRH	3.66%	3.64%	3.64%	3.63%	3.63%	3.58%	3.53%	3.48%
FWMC	2.89%	2.88%	2.87%	2.87%	2.86%	2.83%	2.79%	2.75%
MSMHC	13.79%	13.71%	13.69%	13.68%	13.65%	13.47%	13.28%	13.11%
AAMC	4.80%	4.77%	4.76%	4.76%	4.75%	4.69%	4.62%	4.56%
HX	8.44%	8.39%	8.38%	8.37%	8.36%	8.24%	8.13%	8.02%
WAH	6.84%	6.80%	6.79%	6.78%	6.77%	6.68%	6.59%	6.50%
All Others	11.24%	11.17%	11.16%	11.14%	11.13%	10.98%	10.83%	10.68%
MD Subtotal	**75.20%**	**75.35%**	**75.38%**	**75.40%**	**75.44%**	**75.78%**	**76.11%**	**76.43%**
WHC	12.16%	12.09%	12.08%	12.07%	12.05%	11.88%	11.72%	11.56%
PROV	1.95%	1.94%	1.94%	1.94%	1.94%	1.91%	1.88%	1.86%
CHNMC	1.09%	1.08%	1.08%	1.08%	1.08%	1.06%	1.05%	1.04%
GWUH	2.64%	2.63%	2.62%	2.62%	2.62%	2.58%	2.55%	2.51%
GUH	3.77%	3.75%	3.74%	3.74%	3.73%	3.68%	3.63%	3.58%
All Others	3.18%	3.16%	3.16%	3.15%	3.15%	3.11%	3.06%	3.02%
DC Subtotal	**24.80%**	**24.65%**	**24.62%**	**24.60%**	**24.56%**	**24.22%**	**23.89%**	**23.57%**
TOTAL	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

With these market share changes, and the overall decline in the MSGA discharge rates among Prince George's County residents, the number of MSGA discharge following the establishment of PGRMC in FY 2020, 2021, and 2022 is shown below:

TABLE L

FY	PG County Residents MSGA Discharges	PGRMC MSGA Discharges	PGRMC PG MSGA Discharges	PGRMC Non-PG MSGA Discharges	PG County MSGA Market Share
2020	59,276	9,300	7,321	1,983	12.35%
2021	59,593	10,259	8,075	2,187	13.55%
2022	59,943	11,217	8,812	2,387	14.70%

In order to compare the impact of the PGRMC on DCH for MSGA discharges, we first forecasted the number of MSGA discharges at PGRMC and at DCH, assuming that the market share of both hospitals were held constant at the estimated FY 2015 level of 10.27% for PGRMC and 13.28% for DCH, rather than increasing for PGRMC, and decreasing for DCH. These are shown below:

TABLE M

FY	PG County Residents MSGA Discharges	PGRMC MSGA Discharges	PGRMC PG MSGA Discharges	PGRMC Non-PG MSGA Discharges	PG County MSGA Market Share
2020	59,276	7,730	6,086	1,643	10.27%
2021	59,593	7,771	6,119	1,652	10.27%
2022	59,943	7,817	6,155	1,662	10.27%

FY	PG County Residents MSGA Discharges	DCH MSGA Discharges	DCH PG MSGA Discharges	DCH Non-PG MSGA Discharges	PG County MSGA Market Share
2020	59,276	8,832	7,870	962	13.28%
2021	59,593	8,879	7,912	967	13.28%
2022	59,943	8,931	7,959	973	13.28%

In quantifying the negative impact of the PGRMC MSGA service on DGH, we assumed that PGRMC would meet its projected volumes as set forth in its Modified CON Application. Shown below are the projected reductions in DCH MSGA Discharges attributable only to the reductions in MSGA Discharges among Prince George's County residents. It is possible that DCH will also see a reduction in non-Prince George's County residents MSGA discharges, but these cannot be accurately forecast at this time.

TABLE N

FY	PG County Residents MSGA Discharges @ DCH	DCH Market Share w/o PGRMC	PG County Residents MSGA Discharges @ DCH	DCH Market Share w/ PGRMC	Impact of PGRMC on DCH MSGA Discharges Among PG County Residents
2020	7,870	13.28%	7,688	12.97%	-182
2021	7,912	13.28%	7,623	12.79%	-289
2022	7,959	13.28%	7,566	12.62%	-393

EXHIBIT P

Dimensions Health System
State of Maryland and Prince George's County
Grants
Amounts in Thousands

Public Operating Support	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	Total
	Dimensions Audited Financial Statements				Dimensions CON Application										
Other Operating Revenues - State Support	$ 11,263	$ 9,015	$ 15,086	$ 15,000	$ 10,650	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 3,333	$ 3,333	$ -	**$ 127,680**
Other Operating Revenues - County Support	$ 13,794	$ 12,661	$ 15,010	$ 15,242	$ 10,650	$ 12,165	$ 8,988	$ 6,516	$ 6,516	$ 6,516	$ 6,516	$ 3,333	$ 3,333	$ -	**$ 121,240**
Total	$ 25,057	$ 21,676	$ 30,096	$ 30,242	$ 21,300	$ 22,165	$ 18,988	$ 16,516	$ 16,516	$ 16,516	$ 16,516	$ 6,666	$ 6,666	$ -	**$ 248,920**

Bonds Issues for Dimensions and PGRMC	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	Total
State	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 208,000	$ -	$ -	$ -	$ -	$ -	**$ 208,000**
County	$ -	$ -	$ -	$ -	$ -	$ 55,000	$ -	$ -	$ 208,000	$ -	$ -	$ -	$ -	$ -	**$ 263,000**
Total	$ -	$ -	$ -	$ -	$ -	$ 55,000	$ -	$ -	$ 416,000	$ -	$ -	$ -	$ -	$ -	**$ 471,000**

Total Public Support	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	Total
State	$ 11,263	$ 9,015	$ 15,086	$ 15,000	$ 10,650	$ 10,000	$ 10,000	$ 10,000	$ 218,000	$ 10,000	$ 10,000	$ 3,333	$ 3,333	$ -	**$ 335,680**
County	$ 13,794	$ 12,661	$ 15,010	$ 15,242	$ 10,650	$ 67,165	$ 8,988	$ 6,516	$ 214,516	$ 6,516	$ 6,516	$ 3,333	$ 3,333	$ -	**$ 384,240**
Total	**$ 25,057**	**$ 21,676**	**$ 30,096**	**$ 30,242**	**$ 21,300**	**$ 77,165**	**$ 18,988**	**$ 16,516**	**$ 432,516**	**$ 16,516**	**$ 16,516**	**$ 6,666**	**$ 6,666**	**$ -**	**$ 719,920**