

IN THE MARYLAND HEALTH CARE COMMISSION

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



Co-Applicants

Dimensions Health Corporation
d/b/a Prince George's Hospital Center
and

Mt. Washington Pediatric Hospital, Inc.
January 16, 2015

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MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

13-16-2351

DATE DOCKETED

HOSPITAL APPLICATION FOR CERTIFICATE OF NEED

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: Prince George's Regional Medical Center

Address:

<u>The Boulevard At The Capital Centre (Project Site)</u>	<u>Largo</u>	<u>20774</u>	<u>Prince George's</u>
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Street	City	Zip	County
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Name of Owner (if differs from applicant):

2. OWNER

Name of owner: _____

3. APPLICANT. *If the application has co-applicants, provide the detail regarding each co-applicant in sections 3, 4, and 5 as an attachment.*

Legal Name of Project Applicant

Dimensions Health Corporation d/b/a Prince George's Hospital Center

Address:

<u>3001 Hospital Drive</u>	<u>Cheverly</u>	<u>20785</u>	<u>MD</u>	<u>Prince George's</u>
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Street	City	Zip	State	County
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Telephone: 301-618-2000

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

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from applicant:

5. LEGAL STRUCTURE OF APPLICANT (and LICENSEE, if different from applicant).

Check or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

- A. Governmental
 - B. Corporation
 - (1) Non-profit
 - (2) For-profit
 - (3) Close State & date of incorporation
Maryland, 10/05/1982
 - C. Partnership
 - General
 - Limited
 - Limited liability partnership
 - Limited liability limited partnership
 - Other (Specify): _____
 - D. Limited Liability Company
 - E. Other (Specify): _____
- To be formed:
- Existing:

6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Name and Title: Jeff Johnson, Healthcare Strategy Consultant

Mailing Address:
 Prince George's Hospital Center Cheverly 20785 MD
 3001 Hospital Drive

 Street City Zip State
Telephone: 301-618-2000; 443-521-9680
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Fax: 301-618-3966

B. Additional or alternate contacts:

Name and Title: Mary Miller, CFO/Vice President
of Finance and Business Development

Mailing Address:
 Mt. Washington Pediatric Hospital Baltimore 21209 MD
 1708 W. Rogers Avenue

 Street City Zip State
Telephone: 410-578-5163
E-mail Address (required): MMiller@MWPH.org
Fax: 410-578-0566

project: what it is; why you need/want to do it; and what it will cost. A one-page response will suffice. Please include:

- (1) Brief description of the project – what the applicant proposes to do;
- (2) Rationale for the project – the need and/or business case for the proposed project;
- (3) Cost – the total cost of implementing the proposed project; and
- (4) Master Facility Plans – how the proposed project fits in long term plans.

Dimensions Health Corporation (“Dimensions”) and the Mt. Washington Pediatric Hospital (“MWP”) propose the construction of a new hospital, Prince George’s Regional Medical Center (“PGRMC”), to replace Prince George’s Hospital Center (“PGHC”), and the relocation of the MWP unit currently at PGHC to the new hospital.

B. Comprehensive Project Description: The description must include details, as applicable, regarding:

- (1) Construction, renovation, and demolition plans;
- (2) Changes in square footage of departments and units;
- (3) Physical plant or location changes;
- (4) Changes to affected services following completion of the project; and
- (5) If the project is a multi-phase project, describe the work that will be done in each phase. If the phases will be constructed under more than one construction contract, describe the phases and work that will be done under each contract.

Comprehensive Project Description

The overriding purpose of this proposed project is to transform the healthcare delivery system for Prince George’s County residents, who for far too long have been underserved.

I. BACKGROUND: THE STATE OF HEALTH CARE IN PRINCE GEORGE’S COUNTY

A. Introduction

Prince George’s County is the second most populous county in Maryland, and is Maryland’s most diverse county. In 2010, minority groups accounted for more than 80 percent of the County’s population of 863,420.

Despite the population size, higher-than-average median income, and rich diversity of Prince George’s County, available statistics paint a concerning picture of the health of County residents, and their access to care, when compared to neighboring Maryland counties. County residents suffer from higher rates of chronic diseases, including diabetes, heart disease, hypertension, asthma and cancer, than those residing in neighboring counties. A 2011 report by Maryland Nonprofits found that Prince George’s County’s mortality rate ranked 17th out of Maryland’s 24 counties. By contrast, neighboring Howard and Montgomery Counties had the State’s lowest mortality rates.¹

¹ The 2011 Maryland Nonprofit report is available at: <http://marylandnonprofits.org/Portals/0/Files/Pages/Nonprofit%20Resources/Nonprofit%20Research/PG%20Co%20Health%20Ra>

The health of County residents is exacerbated by the lack of a well-functioning ambulatory care safety net. Prince George's County has a substantially lower ratio of primary care providers to the population compared to surrounding counties and the state. A 2009 study by the Rand Corporation (the "Rand Study") found that Prince George's County had higher rates of ambulatory care-sensitive hospitalizations and emergency department visits than surrounding jurisdictions. That Study further found that these admissions were concentrated in poor regions of the County, suggesting that more affluent residents are able to access primary care outside of the County.

Patient trends also suggest County residents are either dissatisfied with or have limited access to inpatient care within the County, as the majority of County residents who receive inpatient care are discharged from hospitals outside of the County.² As the Editorial Board of the Washington Post stated in August of 2013, "[t]he absence of a top-flight hospital in a locality of 880,000 people — one that provides a variety of specialty care and tertiary services — is a long-running scandal." See **Exhibit 3**.

Prince George's Hospital Center ("PGHC"), managed by Dimensions Health Corporation d/b/a Dimensions Healthcare System ("Dimensions"), plays a vital and unique role in the health security of the County. While Dimensions has made efforts over the years to address the healthcare needs of County residents, these efforts have been thwarted by financial challenges and operational limitations. Historically, PGHC has had the highest percentage of Medicaid and self-pay patients compared to any other hospital in the County, and it has become the healthcare safety net for low-income Prince George's County residents. Since fiscal year 1999, as a result of the changing demographics of the County and growth in the high proportion of uninsured and underinsured patients that it served, PGHC has been burdened with significant operating losses. In addition, the PGHC facility is aging and in need of a variety of improvements. PGHC's current facilities are not designed for modern, patient centered, family oriented medicine, and are undersized in various critical areas. Absent a significant overhaul involving an investment in facilities as well as the growth of an ambulatory-care network that will enable County residents to seek preventive care and primary care treatment rather than relying on inpatient and emergency care, PGHC risks being unable to continue serving its already underserved population.

The proposal set forth in this CON application results from the collaboration of numerous stakeholders who have agreed to assume leadership in addressing the public health problems in Prince George's County and the difficult financial and operational status of the current PGHC facility. The proposed Prince George's County Regional Medical Center ("PGRMC") aims to provide County residents with the hospital and health care network they deserve by transforming PGHC into a thriving regional medical center that will provide efficient, high-quality care while minimizing reliance on inpatient care and improving the health of its service area population by building a strong ambulatory care network.

An academically-affiliated regional medical center greatly enhances the probability that new care models and technologies will speed improvements in raising health status and

[nkings.pdf](#) (last accessed 11/26/14); the 2009 Rand Study is available at http://www.rand.org/pubs/technical_reports/TR655.html (last accessed 11/26/2014).

² The Rand Study found, for example, that in 2006, "[a]mong all inpatients who resided in Prince George's County, 37.2 percent were discharged from Prince George's County hospitals. By contrast, 77.0 percent of patients from Montgomery County were hospitalized in Montgomery County, and 92.4 percent of patients from the District of Columbia were hospitalized in the District of Columbia."

limiting the effects of health disparities. This plan creates the capacity to train and attract more of the health professionals needed. It is important that the new regional medical center partner with academic institutions to foster a comprehensive ambulatory care network so that Prince Georgians will no longer feel compelled to go outside of the County to seek health care services.

The support for a new regional medical center is strong, as demonstrated by the Memorandum of Understanding entered by the County, the State, Dimensions, the University of Maryland Medical System (“UMMS”), and the University of Maryland System. Strong backing also is evidenced by a substantial number of letters of support, and the demonstrated commitment of the stakeholders, and many other parties – citizens, government officials, health care providers, community leaders, academic institutions, and business people who have supported this proposal. The diversity, number, and enthusiasm of the expressions of support for the project may be unprecedented in the history of Maryland health planning. Many of these supporters noted the benefits of Dimensions’ commitment to connect the regional medical center to a health care system that will promote improved access to primary care in Prince George’s County as well as the planned affiliation with the University of Maryland School of Medicine. As Jane E. Clark, Dean, University of Maryland School of Public Health stated, “This unprecedented partnership of academic, government, and health care institutions to establish a new health care system for the County could be a model for transforming health throughout the nation.”

B. History of Prince George’s Hospital Center

Prince George’s General Hospital, the 100-bed, one story predecessor of PGHC, opened its doors on March 21, 1944 on its current campus on Hospital Drive in Cheverly, Maryland. In the beginning, the hospital was operated under the auspices of the Prince George’s County Hospital Commission. In its first 15 years, the hospital grew from 100 to 385 beds and became the central health care facility in Prince George’s County.

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

However, during this time period, the County faced management issues and operating deficits, leading to the decision to privatize the County hospital system, including Prince George’s General Hospital. In 1982, the Prince George’s County Council voted to discontinue the County’s Hospital Commission and established a private, not-for-profit corporation to lease and manage the county’s public hospitals, including PGHC. The new private corporation was named Community Hospital and Health Care Systems which, in 1986, changed its name to Dimensions Health Corporation. By that time, the Dimensions facilities included Prince George’s Hospital Center, Laurel Regional Hospital, Bowie Health Center, and Gladys Spellman Specialty Hospital and Nursing Center.

Beginning in the mid-1990s, the demographic profile of Prince George’s County shifted, influenced by a significant net in-migration of low-income residents. Since fiscal year 1999, as a result of the changing demographics of the County and growth in the high proportion of uninsured and underinsured patients that it served, PGHC has been burdened with significant operating losses.

PGHC is the second busiest trauma center in the State, with a growing number of Medicaid and self-pay patients. PGHC's administrators have found it increasingly necessary to compensate physicians for on-call coverage to provide needed medical and surgical services 24 hours a day, 365 days a year. To a large extent, such physician expenses are not included in the hospital's reimbursement rates approved by the HSCRC. Without an offsetting source of funding, these payments for physician services have been a major factor in the deterioration of Dimensions and PGHC's financial position since 1999.

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

C. Prince George's Hospital Center Today

PGHC is currently licensed for 215 inpatient beds, including 141 MSGA beds, 8 pediatric beds, 38 obstetrical beds, and 28 adult psychiatric beds. The emergency department has 43 treatment bays, plus three triage areas. PGHC is located at 3001 Hospital Drive, Cheverly, Maryland, within Zip Code 20785. The following map identifies the geographic service area of PGHC's primary and secondary service area Zip Codes.

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

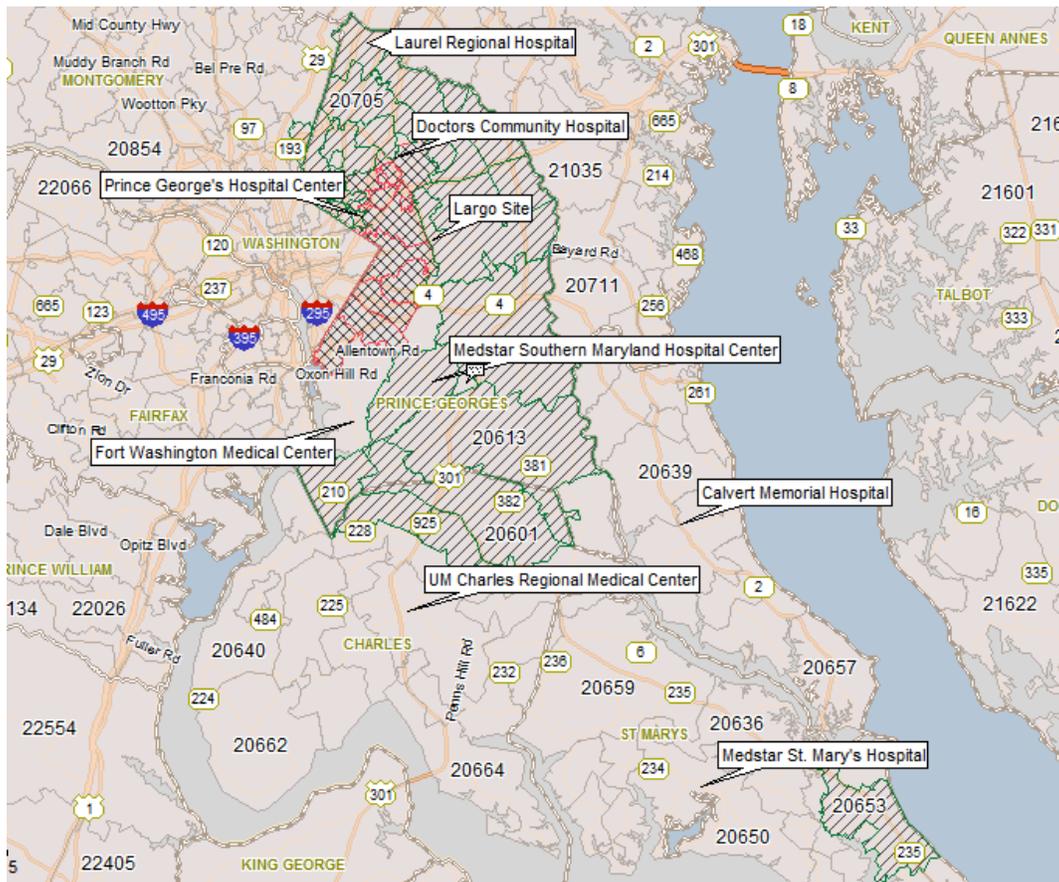


Exhibit 4 lists the Zip Codes within PGHC's current primary and secondary service areas and includes patient discharge data. The vast majority of Zip Codes within PGHC's service area are located within Prince George's County. However, PGHC does serve as a Level II Regional Trauma Center and a Level III NICU serving the entire Southern Maryland region.

Along with the trauma program, PGHC also provides cardio-thoracic (including open heart) surgical services. PGHC currently has agreements with the University of Maryland School of Medicine to provide physician resources for trauma/thoracic surgery, orthopedic surgery, cardio-thoracic surgery, and emergency medicine specialties. PGHC also is designated by Maryland Institute for Emergency Medical Services Systems as a ST Elevation Myocardial Infarction (STEMI) Center. It is designated a Level IIIB Neonatal Intensive Care Unit.

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

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

PGHC also has multiple outpatient centers offering diagnostic imaging and laboratory testing, primary care, specialty treatment, and senior health services. PGHC manages its emergency department in partnership with UMMS, the University of Maryland School of Medicine, and the Maryland Emergency Medicine Network Inc. In addition to PGHC's emergency department, PGHC also operates a freestanding emergency center under its license at the Bowie Health Center location.

The PGHC medical staff includes physicians, dentists, podiatrists, and certified nurse midwives. The medical staff provides a full range of clinical services including family medicine and general internal medicine. PGHC also has physicians who practice the following specialty services: anesthesiology, medical imaging, pediatrics, psychiatry, critical care medicine, pathology, emergency medicine and obstetrics/gynecology. The medical subspecialists represent allergy/immunology, dermatology, endocrinology, gastroenterology, hematology/ oncology, radiation oncology, infectious disease, nephrology, neurology, nuclear medicine, physical medicine and rheumatology. Surgical specialists represent cardiac/thoracic/vascular surgery, dentistry & oral surgery, neurosurgery, ophthalmology, ENT, plastic surgery, podiatry, traumatology and urology. PGHC also has a hospitalists service that consults with its physicians 24 hours a day.

The current PGHC facility is not designed for modern, patient centered, family oriented medicine. The existing building is undersized in various critical areas in need of a variety of improvements. Dimensions assessed the PGHC facility by conducting departmental interviews, and meeting with representatives from many clinical and service-oriented departments. The internal assessment revealed numerous existing physical space deficiencies and limitations affecting nearly every department in the hospital. A summary of many of the facility deficiencies, by department, is presented in **Exhibit 5**.

II. TRANSFORMING PRINCE GEORGE'S COUNTY'S HEALTH CARE DELIVERY SYSTEM

Due to the deteriorating physical condition of PGHC and financial condition of Dimensions, the State provided Dimensions with financial support to assist with the orderly sale or closure of its facilities. In May, 2008, The Maryland General Assembly enacted legislation to create the Prince George's County Hospital Authority, whose mission was to implement an open, transparent, and competitive bidding process for the purpose of facilitating the acquisition of Dimensions. Although the Hospital Authority received three proposals, none of the proposals committed to purchasing all of the Dimensions facilities. Dimensions continued to explore alternatives that would keep its facilities open to residents of the County, which resulted the Memorandum of Understanding described below and ultimately the proposal set forth in this application.

A. The July 2011 Memorandum of Understanding

On July 21, 2011, Dimensions, UMMS, Prince George's County, the University System of Maryland, and the State of Maryland signed a Memorandum of Understanding ("MOU") (**Exhibit 6**) that committed the signatories to developing a comprehensive plan to strengthen health care in Prince George's County, increase access to primary care, and enhance the County's overall health infrastructure.

In furtherance of that commitment, the MOU parties commissioned the University of Maryland School of Public Health to perform a study of the health care needs of Prince George's County. That study resulted in a report produced by the School of Public Health, *Transforming Health in Prince George's County: A public health impact study* (2012) (the

“Public Health Impact Study”). Part I of that study, which details the study’s findings, is attached as **Exhibit 7**.³

Following completion, review, and approval of Public Health Impact Study by the parties, UMMS agreed to assist Dimensions in the planning of the proposed project. UMMS is dedicated to providing quality health care through a market-responsive regional system composed of a world-class academic medical center partnered with University of Maryland School of Medicine and premier community and specialty hospitals. A discussion of the history of UMMS and its medical system is included in the supplemental statement attached as **Exhibit 8**. The MOU parties also agreed to develop a plan to transfer Dimensions’ assets and to discharge its current debt and liabilities. The County and the State will provide funding as needed to sustain operations during the transition, and will assist in the discharge of liabilities.

B. The Public Health Impact Study

The Public Health Impact Study addresses the design of a new health care delivery system for Prince George’s County, using population health management principles. This assessment was integral in the MOU parties’ design consideration and planning for the proposed regional medical center. The Public Health Impact Study’s analysis included:

- (1) a survey of Prince George’s County residents;
- (2) interviews with State, County, and local stakeholders;
- (3) healthcare workforce assessment;
- (4) overview of public health resources;
- (5) examination of hospital discharges and readmissions of County residents; and
- (6) national interviews with leaders from 13 health care systems to help identify best practices in achieving integrated, coordinated, high-quality care that improves population health and reduces costs.

The Study is based on the premise that an efficient, effective and financially viable healthcare system must (i) promote health, prevent disease, support wellness, and support health equity and quality of life in the County; (ii) address population health broadly, not just focus on those who seek health care; and (iii) have the capacity to deliver high-quality primary prevention and health and hospital care.

Among the study’s key findings and recommendations were the following:

Health Status and Treatment of Prince George’s County Residents

- **Findings**: County residents suffer from higher rates of chronic diseases, including diabetes, heart disease, hypertension, asthma and cancer, than those residing in neighboring counties. Racial and ethnic differences reveal even greater disparities. In addition, County hospitals demonstrate a significant number of ambulatory-care sensitive discharges.
- **Recommendation**: Emphasize primary prevention and strong collaborative primary care networks that can coordinate care management for such

³ Part II of the Public Health Impact Study includes technical reports with more detailed data, and is available at http://sph.umd.edu/sites/default/files/files/UMDSPH_ImpactStudy.pdf (last accessed 12/3/14).

ambulatory-care sensitive conditions and lead to improvements that save lives and reduce costly hospital visits.

Health Care Workforce Capacity

- **Finding:** The County has far fewer primary care providers for the population compared to surrounding counties and the state. The areas with the highest primary care need are within the Beltway and in the southern region of the County. The study shows a need for an additional 61 primary care physicians (a 13% increase) to meet minimum need in the County and recommends expanding community-based health facilities and outreach programs.
- **Recommendation:** Establish a high quality academically-affiliated regional medical center that will serve as an anchor for transforming the health care system, including attracting providers who can assist in developing a strong and collaborative ambulatory care network.

Community-based Care Capacity

- **Finding:** While the County has many assets that can be mobilized to support a new system, the capacity of community-based care, including safety-net clinics, remains severely limited. The study concludes that County-led efforts are needed to increase this capacity and to guide the integration of primary care and public health services.
- **Recommendation:** Develop a County-led plan to improve public health and expand access to high quality primary care and support systems integration, by:
 - (i) Creating an inclusive central planning process;
 - (ii) Coordinating efforts to maximize impact;
 - (iii) Addressing workforce and facilities needs in areas with insufficient primary care; and
 - (iv) Supporting innovation in health care, prevention and public health care delivery.

Perception of County Health Care Facilities

- **Finding:** Many Prince George's County residents seek health care outside of the County. This is driven by insurance carriers, provider referrals, the availability of specialty care, and perceptions of the quality of care at local hospitals. Residents and key stakeholders emphasized the importance of establishing an academically affiliated regional medical center for the County to improve actual and perceived quality of care. County residents identified services such as nutrition, physical activities, mental health and substance abuse treatment, and family planning as vital to a new health care system. They also reported difficulty in learning about their medical conditions, identifying the need to enhance health literacy as another issue to consider.
- **Recommendation:** Develop a clear brand that promotes a high quality health system and encourages residents to return to the County for care. Coordinate efforts to improve health literacy and education. Continue to examine these issues during the planning phase of the new health system.

C. Development of the Proposed Regional Medical Center

The combined analysis of the Public Health Impact Study resulted in the development and implementation of a strategy to transform the current health system into an efficient,

effective, and financially viable healthcare delivery system with a new regional medical center, located in Prince George's County, supported by a comprehensive ambulatory care network, which will help improve the health of the residents of Prince George's County and the Southern Maryland region. Based on the Public Health Impact Study, the MOU parties developed the following specific objectives critical to their overall goal of improving the health status of the regional population while improving care delivery effectiveness and efficiencies:

- Improve access of primary/community care, specialty care, and other healthcare services to the region to reduce healthcare disparities and improve health status
- Help strengthen / coordinate care continuum-from primary/community care through post-acute care
- Invest in ambulatory based clinics and other health education programs to manage chronic diseases
- Integrate academic medical teaching and research in a new approach to care for the region; to become a Learning Healthcare System
- Strengthen / improve access to tertiary care through the proposed regional medical center
- Attract residents of Prince George's County and Southern Maryland region who now receive care from hospitals outside the State of Maryland
- Transform an existing healthcare system to become more efficient and financially viable while changing focus to population health management practices

The proposed new regional medical center and its clinical programs will be designed to further these objectives. The MOU parties incorporated the following significant design elements and considerations into the development of the proposed regional medical center set forth in this application:

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

D. Commitment to Primary and Community Care

The plan to transform the healthcare delivery system in Prince George's County relies on the collaboration of the MOU parties not only in the development of a new regional medical center, but also on significant efforts outside of hospital care. Achieving objectives will require increased access to primary care, increased safety-net clinic capacity that is integrated with overall health care and social service system in the County, and further mobilization of public sector programs through schools, mobile care, and parks/recreation facilities. In addition to developing plans for a new regional medical center supported by a

comprehensive ambulatory care network, the Prince George's County Government worked with JSI Inc., with participation from Dimensions, UMMS, and other healthcare providers and community stakeholders, to develop a strategic plan to improve access to integrated primary and community care (the "Primary Healthcare Strategic Plan" or the "Plan").

The Primary Healthcare Strategic Plan aims to increase access to patient-centered primary care, to improve health outcomes, and to foster economic development in Prince George's County. The current conditions that have informed the development of the Plan overlap with those that informed the planning of PGRMC, among them:

- Higher rates of chronic disease and poor health status of County residents as compared to neighboring counties
- Fewer primary care practices that have achieved patient-centered medical home status than neighboring counties
- Lack of adequately sized space for medical practices, especially in low-income areas
- Larger percentage of low income, uninsured patients
- Maryland's shift to global payment

The Primary Healthcare Strategic Plan is centered on the following recommendations to address these concerns.

1. Increase patient-centered primary care practices in health investment zones

- Provide incentives that attract primary care providers to practice in the Health Investment Zones. Establish *Prince George's Cares*, a program of funding for low-income, uninsured or underinsured
 - Secure reduced lease payment
 - Establish plan to secure federal and state medical and dental school loan repayment for qualifying providers
 - Provide low-cost working capital loans, with loan forgiveness opportunities
 - Establish plan for subsidized malpractice costs
- Support the development of medical practices to expand access within specified the *Health Investment Zones*, proposed as:
 - Medical Practice 1, located in Zip Code 20784: Adult, pediatric, and women's health services with on-site dental and pharmacy, co-located in community complex, FQHC new site.
 - Medical Practice 2, located in Zip Code 20613: Adult primary care with on-site dental, located in medical office building: Shared private practice contracts with management service organization for non-medical support services.
 - Medical Practice 3, located in Zip Code 20745: Family practice model, located in medical office complex, collaborate with community dentists, shared practice or FQHC site
 - Medical Practice 4, located on the border of Zip Codes 20747 and 20743: Adult, pediatric, and women's health services with onsite dental and pharmacy, urban redevelopment of stand along facility, FQHC site or faculty practice

2. Build capacity of existing primary care practices to operate as patient-centered medical homes (PCMH)

- Develop management service organization (MSO) to support transformation and operation as PCMH (Services include but not limited to practice management, health information technology, and care management)
- Create systematic work force development efforts to meet the needs and demands of PCMH model
- Expand clinical training sites within the County
- Prioritize improving quality of customer service and provide customer service training for clinical, public health, and administrative support staff

3. Build collaboration among Prince George's County hospitals

- Develop complementary centers of excellence and support development of hospital-based integrated delivery systems, including the new regional medical center
- Promote transitional care between hospitals and primary care providers
- Collaborate on community health needs assessments (CHNA) and community health improvement programs (CHIP), including creation of Prince George's County Community Health Benefits Partnership (PGC CHBP) and shared measurement system
- Expand opportunities for provider residency programs

4. Develop workforce to support patient-centered primary care

- Convene stakeholders with a shared mission of increasing and improving workforce capacity
- Develop a systematic workforce development plan
- Give priority consideration to County residents and educational resources to achieve the proposed workforce
- Prioritize quality customer service

5. Deploy marketing and branding campaign

- Implement marketing and branding strategy to:
 - Recruit and retain primary care providers
 - Increase number of residents that choose to receive primary care services in Prince George's County
- Conduct primary research to design and test campaigns for target populations
- Use common branding across all marketing efforts
- Monitor and evaluate results of marketing campaigns Implementation process and outcomes

6. Establish a primary healthcare authority

- Primary Healthcare Authority, an independent, stakeholder-led entity whose mission would be to transform health and health care in Prince George's County by leading, collaborating, and aligning efforts to improve primary care delivery
- Governed by a Board of Directors
- Roles and Responsibilities of the Primary Healthcare Authority Facilitate implementation of the Primary Healthcare Strategic Plan
 - Administer the Prince George's Care Program

- Create and provide support to the management service organization (MSO)
- Create and provide support to Prince George's County Community Health Benefit Partnership (PGC CHBP)
- Oversee the monitoring and evaluation plan

7. Develop and implement a monitoring and evaluation plan

- Monitor and evaluate process to assess if the Primary Healthcare Strategic Plan is being successfully implemented and achieving desired outcomes
- Develop a monitoring and evaluation process, including metrics, data sources, base line values, and benchmarks
- Report results using scorecard or selected reporting tool

The Primary Healthcare Strategic Plan also involves a marketing and branding strategy aimed at attracting and retaining providers, as well as encouraging primary care utilization among County residents.

- **Marketing Strategy Goals**

- Convey message that good health matters and that quality, patient-centered primary care can be found in Prince George's County
- Segment the patient population
- Differentiate messaging to accommodate diversity and cultures
- Monitor and evaluate outcomes of the marketing campaigns and adjust tactics accordingly

- **Marketing Strategy**

- #1 Recruit and retain providers

- Encourage providers to live and work in the County
- Opportunities for professional growth and economic security
- Potential for positive impact on community
- Economic opportunities
- Potential for County-provided incentives

- #2 Recapture patients, reduce outmigration

- Inform residents that high quality, patient-centered primary care is accessible in the County
- Relay messages that speak to culturally-diverse audiences

In furtherance of the Primary Healthcare Strategic Plan, the County, Dimensions, and UMMS have undertaken, or are committed to undertake, several initiatives revolving around improving community health and wellness and fostering the growth of the primary care network in the County. These initiatives are described more fully in the response Standard .04B(2) – Identification of Bed Need and Addition of Beds, under the heading, “Recapture Assumptions.” See pp. 67-76.

E. Vision & Rationale For An Academic-Affiliated Regional Tertiary Medical Center

In completeness questions posed following the original CON application, MHCC Staff inquired about the benefits an academic affiliated tertiary medical center brings to the service area in light of the increased size and budget implications that come with such a project. The discussion in this section addresses the benefits the new health system can bring to the service area as planned and presented within this section.

As previously noted, studies of health care in the County demonstrate that a majority of County residents seek health care services outside of the County. While PGHC has become a safety net of uninsured and underinsured residents of the County, more affluent County residents seek care from facilities in neighboring counties, the District of Columbia, and Virginia. The proposed health system, accompanied by an ambulatory care network and a new academic-affiliated regional tertiary medical center will have a significant impact on improving the access of quality healthcare within Prince George's County and the region. Through its partnership with UMMS and the University System of Maryland, PGRMC will have access to a greater network of high quality physicians, and the creation of a new, modern facility with teaching and training capabilities will attract more high quality members of the professional medical community that may have previously sought practice opportunities outside of the service area.

The MOU parties initiated a healthcare planning process more than three years ago with the objective of transforming Prince George's County's existing healthcare system into an efficient, effective, and financially viable healthcare delivery system. The overall goal of this initiative is to improve the health status of residents of Prince George's County and Southern Maryland region by: improving community-based provider access to high quality, cost effective medical care; establishing population health management practices; developing an ambulatory care network; and developing a new regional medical center to replace PGHC, with a recommendation that the new regional medical center be affiliated with an academic medical center.

This initiative design is based on the recommendations from Public Health Impact Study. The new regional healthcare delivery system is a public health plan to improve health status of a regional population while improving care delivery effectiveness and efficiencies. This health care delivery system design complements Dimensions' new vision: ***"To be the healthcare system of choice, recognized for clinical, academic, and service excellence, through compassionate and innovative healthcare."***

Through a partnership with the University System of Maryland and UMMS, Dimensions strives to become a leading "learning healthcare delivery system" that will drive health improvement, high-quality outcomes, and efficient care delivery. University System of Maryland proposes to create the establishment of the University of Maryland Research Institute, with a focus on developing inter-professional healthcare education and training in Prince George's County and throughout Southern Maryland.

The proposed new regional medical center and its clinical programs will be designed to further the objectives of the Public Health Impact Study. The MOU parties incorporated the following significant design elements and considerations into the development of the proposed regional medical center set forth in this application:

- Dimensions took into consideration declining inpatient utilization rates in the service area as a result of population health management.
- The regional medical center will be forecasted to have an ALOS less than what the current PGHC facility is experiencing.
- The regional medical center's clinical programs will be designed to include better coordinated community care with primary care physicians as well as within the patients' home environment.
- The health system will have specialized ambulatory clinics to manage high-risk patients having chronic conditions such as diabetes, COPD, and CHF.
- The regional medical center will have an academic affiliation in order to attract high quality providers, which will foster the development of a strong and collaborative ambulatory care network.

- The new health system and its MOU partners will work together to promote increased access to primary care resources (both physicians and mid-level practitioners).

The benefits that will be gained from a new academically-affiliated regional tertiary medical center include the following:

- The new regional medical center will be connected to a health system that will promote improved access to community care with a focus on delivering care based upon population health management principles. It will be a community partner in helping to improve the health status of Prince George's County residents. The academic teaching component will help improve / increase both professional medical education programs as well as community health education programs.
- The new regional medical center will serve as a catalyst to successfully recruit needed physicians of many specialties to the region, with a particular emphasis on reducing the primary care access deficiency within Prince George's County. Increasing the number of health care professionals within the Southern Maryland region will help address health care disparity issues currently being experienced and can assist in building the components necessary to have an effective population health management program in place. Examples of academic medical education programs to be located at the PGRMC campus include:
 - ACGME accredited Internal Medicine Residency Program
 - ACGME accredited Family Practice Residency Program
 - Expansion of current education rotations of fellows, medical students, residents, and allied health professionals in partnership with other medical academic institutions
- The new regional medical center will be more centrally located within Prince George's County, with improved accessibility to residents of Southern Maryland for secondary and tertiary care. The planned location for the new regional medical center will be easily accessible given its proximity to I-495 and the Largo Town Center Metro transportation station.
- The new regional medical center project will create opportunities to improve access and quality of health care services to Prince George's County residents.
- The new regional medical center will allow for the potential development of an on-site educational health science program in partnership with the University of Maryland, Baltimore ("UMB").
- The new facility's connections with UMB will provide high quality, clinically advanced medical care to support the regional medical center's continuing mission of being a tertiary center. The partnership will improve access to the most "up-to-date" clinical best practices for the region and promote team-based medical care practice.
- The regional medical center will serve as a catalyst of bringing back some of the approximately 23,000 residents of Prince George's County who currently seek inpatient care in Washington D.C. and Virginia hospitals. The project will enable residents to receive secondary and tertiary care services without leaving their home county to receive care. Traveling to D.C. for inpatient care can be difficult for some population groups with limited means or resources.

- The new regional medical center will have a significant positive economic impact to Prince George's County as well as having a positive impact on the State's economy.
- The regional medical center will serve as a teaching venue for University System of Maryland.

The regional medical center will provide the following services to Prince George's County / Southern Maryland Region:

- Regional Trauma Center: PGHC is designated as a Maryland Level II Trauma Center by the Maryland Institute for Emergency Medical Services Systems ("MIEMSS").
- Cardio-Thoracic (Cardiac Surgery) Center. PGHC is designated by MIEMSS as a ST Elevation Myocardial Infarction (STEMI) Center.
- Neonatal Care (NICU): PGHC is designated as a Level IIIB Neonatal Intensive Care Unit (NICU).
- Comprehensive Regional Cancer: Oncology services are being planned including medical and radiation oncology. Plans are to have an affiliation / collaborative arrangement with University of Maryland Medical Center to provide subspecialty oncology services and possibly a clinical trials program.
- Stroke / Neuro-Care Services. Plans are to have the regional medical center become a designated "stroke center."

III. THE PROPOSED PROJECT

The proposed project involves building a new regional medical center, located in Prince George's County, supported by a comprehensive ambulatory care network. The proposal will support many of the objectives identified by the MOU parties and will have a positive impact on the health of County residents. The new regional medical center will be connected to a health system that will promote improved access to community care with a focus on delivering care based upon population health management principles. It will be a community partner in helping to improve the health status of Prince George's County residents. In addition, the new regional medical center is projected to have positive financial performance, in comparison to the negative financial performance of the current PGHC. Lack of action will have a negative economic impact on both Prince George's County and the State of Maryland since PGHC's current financial situation is not sustainable in the long-term.

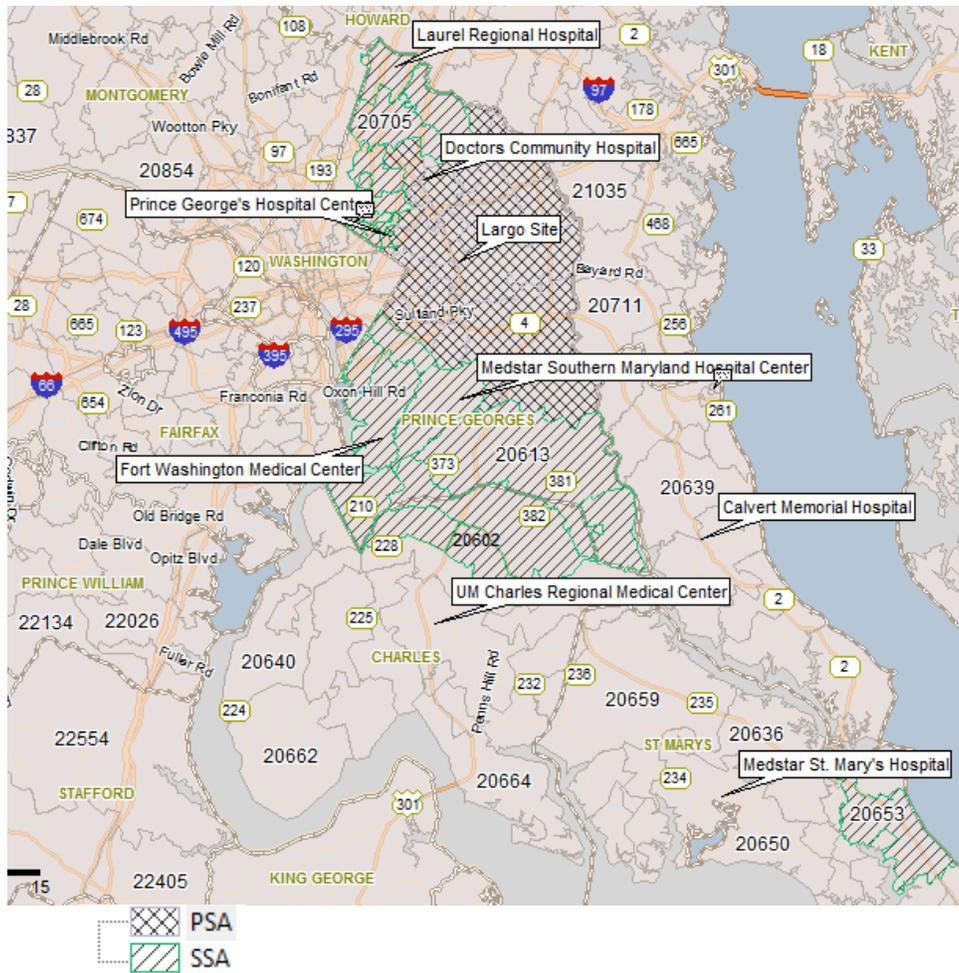
A. Project Location and Service Area

The proposed project involves relocating the current PGHC facility to a site known as The Boulevard at the Capital Centre. The site is south of Arena Drive in Largo, Maryland 20774. It is approximately five miles southeast of the present location in Cheverly. This site is a central location within Prince George's County with access to I-495, and also for convenient access by car, bus, Metro, and foot. A Metro subway station (Blue/Silver Lines) is located onsite.

Most of the Zip Codes within the projected total service area are within Prince George's County. The map shown in Figure 2 below identifies the geographic service area of PGRMC's primary and secondary service area Zip Codes.

Exhibit 9 lists the projected Zip Codes within PGRMC's primary and secondary service areas for MSGA patients and includes the number of inpatient discharges projected for the new PGRMC by Zip Code for the year 2022. Dimensions calculated the projected service area for the new facility using a travel time/distance ranking methodology, identifying and comparing hospital locations to population centroid points within Zip Codes. The response to COMAR standard 10.24.10.04B(1), Geographic Accessibility, pp. 45-48, contains a more detailed discussion of the projected service area and methodology used to calculate it.

**Figure 2
PGRMC's Primary and Secondary Service Area Zip Codes**



B. Regional Medical Center Proposed Services

Dimensions proposes that the regional medical center be licensed for 216 inpatient beds, comprised of 133 MSGA beds, 1 Pediatric bed, 22 obstetrical (post-partum) beds, 32 ICC/CCU care beds, and 28 adult psychiatric beds. As a separate facility, Mount Washington Pediatric Hospital will operate a 15 bed specialty pediatric hospital within the new PGRMC. These beds are currently licensed as Special Hospital – Pediatric beds.

The regional medical center is projected to open in July 2019 with volume maturity in 2022. In fiscal year 2022, the facility is projected to have 16,837 inpatient discharges, including newborns. Like the current PGHC, the regional medical center will be a designated Maryland Level II Trauma Center, a cardiac center with open heart surgery and ST Elevation Myocardial Infarction (STEMI) Center, a designated Level IIIB Neonatal Intensive Care Unit (NICU), and a designated Stroke Center.

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

Concourse Floor:

- Dietary / Dining Services
- Materials Management
- Facilities Support
- Pharmacy
- Laboratory
- Physical Therapy
- Women's Health Services

- Cardio/Neuro Diagnostics
- Registration Area
- IT/Telecommunications

Level 1:

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

Level 2:

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

Level 3:

- Mechanical
- Academic Space

Level 4:

- Behavioral Health Unit

Level 5:

- ICU
- Dialysis

Levels, 6, 7, 8 & 9

- Medical Inpatient Units

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

The current site plan includes 380 surface parking spaces. A parking garage, a necessary component of the medical campus, is planned to be located on the medical campus with approximately 1,200 additional parking spaces. The County (through the Prince George's County Revenue Authority) will construct the parking facility to coincide with the construction schedule of PGRMC and the medical campus, and the County will operate the facility. **Exhibit 10** contains CR-92-2014, enacted by the Prince George's County Council, and signed by the Prince George's County Executive on November 20, 2014. This County Resolution designates the Largo Town Center Metro Development District, which includes the PGRMC site, pursuant to State law related to the Tax Increment Financing Act. CR-92-2014 further provides for the creation of a Tax Increment Fund with respect to the Largo Town Center Metro Development District and the allocation of certain property taxes to the Development District. This action has been taken to demonstrate the County's financial commitment and intent to finance various public improvements and infrastructure in support of PGRMC, optimally including a parking facility to be completed and operational at the opening of the proposed PGRMC. PGHC will keep the MHCC staff advised of further developments in the County's plan to construct the garage.

C. Program Descriptions

In light of the MHCC Staff's prior completeness questions seeking descriptions of certain programs and the patient populations served, Dimensions is providing detailed information about certain of the services identified above.

i. Perioperative Care Suite

In the proposed facility, the Perioperative Care Suite will serve as a universal care area serving pre and post procedural / surgical care for inpatient surgery patients, outpatient surgery patients, endoscopic procedure patients, cardiac catheterization patients, and interventional imaging patients. This universal concept promotes operational efficiencies. The Perioperative Care Suite will be adjacent to both the Surgical Department and the Catheterization Laboratory. This unit will consist of 48 pre-op/Stage II recovery patient spaces and 15 PACU beds. The Perioperative Care Suite will be adjacent to the Surgical Services Department.

ii. Clinical Decision Unit (CDU)

The CDU (observation unit) is designed to serve those patients who do not require inpatient hospitalization but may require nursing care for several hours or overnight. This 20-bed unit is designed to increase accessibility, operational efficiency, and capacity for the emergency and surgery departments, while also providing space for outpatients and observation status patients requiring up to 24 hours of nursing care. Advances in technology such as minimally invasive procedures are shifting patient census from inpatient to outpatient and reducing recovery time and the need for inpatient admissions.

iii. Cardio/Neuro Diagnostics

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

iv. Ambulatory Care Center Outpatient Clinics

The outpatient clinics in the Ambulatory Care Center will include clinics designed to assist with the hospital's population health management initiatives. Such ambulatory clinics will include a regional diabetes center, a chronic heart failure clinic, pulmonary disease (COPD) clinic, and a wound care clinic. Physician-based clinics planned include trauma, orthopedics, obstetrics, general surgery, and other subspecialties, designed to provide improved access to subspecialty services for the community. The first floor of the ambulatory care building will be the location of a planned regional cancer center, providing both radiation and medical oncology services, which is planned to be affiliated with a university oncology program.

D. Mount Washington Pediatric Hospital

Mt. Washington Pediatric Hospital ("MWPH"), a specialty pediatric and rehabilitation hospital with 15 licensed beds at Prince Georges Hospital Center, seeks to relocate these 15 beds to the proposed new PGRMC facility. This move would allow MWPH to continue to serve the pediatric population in this County.

The 15 beds have remained licensed to MWPH under its lease arrangement with PGHC, and the beds would continue to be licensed to MWPH at the new facility. A history of MWPH and its relationship with PGHC is included in the supplemental statement attached as **Exhibit 11**. Initially, it was anticipated that most patients would be referred from PGHC, including those who previously were being referred for care to Washington, D.C. Over the past six years, however, only about 6% of admissions to the MWPH unit have come from PGHC. About 33% have come from Johns Hopkins Hospital, 11% have come from Johns Hopkins Bayview Medical Center, and another 8% have come from Children's National Medical Center in Washington, DC.

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

MWPH will continue to provide the staff and services it currently provides to PGHC. A description of these staff and services is in Exh. 11, at pages 2-3.

E. Use of Existing PGHC Campus After Relocation of Hospital

Dimensions and the County have not yet determined the future use of the existing PGHC campus. However, the parties are currently evaluating uses for the current Gladys Spellman Building, including converting the building into an ambulatory center that would have primary care, specialty care, as well as some diagnostic services.

Dimensions is conscious of the primary healthcare needs of the Cheverly community and plans to address the needs of primary care and some specialty care services for this community. Dimensions plans on seeking input from the Prince George's County Health Department to determine the appropriate scope of physician / ambulatory services for this community, so to prevent any significant primary health care access disparities associated with the relocation of the hospital. Population health management services, including chronic disease management clinics, will be reviewed for need. The Prince George's County Health Department currently has a facility and services adjacent to the current PGHC location, thus allowing for the possibility of developing services collaboratively.

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

F. Proposed Project Size and Cost Comparison

Proposed Project Size

The current proposal for the hospital space only, exclusive of the Ambulatory Care Center, C.U.P. and Tunnel buildings is 648,190 SF / 231 beds = 2,806 SF / bed. HOK, the initial design firm for the project, maintains area summaries for recently built projects, both community and academically affiliated hospitals. For these recent HOK-designed projects, the area per bed shows a range from 1,966-3,619 SF / bed, with the average of these being 2,555 SF / bed. These comparison projects follow industry standards for determining building gross area and are exclusive of ambulatory care centers, central utility plants and tunnels. The area per bed range of 2,806 SF for the proposed project is well within the per bed range of other recent comparable projects.⁴

In response to PGHC's initial application, the MHCC Staff asked a number of completeness questions regarding the size of the proposed PGRMC and how it compares to

⁴ During a meeting with MHCC Staff on January 22, 2014, MHCC Staff provided a chart entitled "Space and Cost Comparison: Prince George's proposed project with other recent projects". The MHCC Project Comparison Chart purports to compare the space and cost of PGRMC with four other hospital construction projects and also includes data from an unspecified "architect survey." The comparison projects included in the MHCC Project Comparison Chart are not directly comparable in scope or level of service to PGRMC. As detailed in the supplemental statement at Exh. 12, after adjusting the PGRMC project space to compare to the same program scope as the other projects on the chart, the PGRMC facility should be regarded as 2,448 SF / bed.

other proposed hospital projects. A more detailed discussion of the reasonableness of the size and cost of the proposed regional medical center is attached as **Exhibit 12**.

Proposed Project Scope and Cost⁵

The collaboration between PGRMC, University of Maryland School of Medicine, and UMMS creates facility needs above those of a general community hospital. The presence of students and residents requires a different use of space. Some potential differences with academic - associated regional medical centers include:

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

The supplemental statement attached as Exh. 12 includes a more detailed discussion of the impact the academic component of the project has on its space needs.

In addition to space designed based on the academic component of the project, hospitals of the future must be designed for clinical practice management changes as the industry moves toward population health management practices. Accordingly, the proposed facility includes more ambulatory space, designed for more emphasis on ambulatory / observation / clinic care.

The proposed design of mechanical space takes into consideration the best approach to project construction that considers a spectrum of potential future needs of ambulatory care, inpatient care, and health education facility growth without negatively impacting current hospital operations. As set forth more fully in Exh. 12 and in Part IV of this application, the size and cost of the proposed project are reasonable and feasible.

⁵ The cost analysis (per bed and per square foot) contained in the MHCC Project Comparison Chart does not appropriately assess and compare the project costs for the various projects to determine reasonableness of the costs. As set forth more fully in Exh. 12, the proposed project costs should be measured against the regulatory benchmark, not the proposed project costs of dissimilar projects. The comparison of the costs of the proposed project to projects of different scopes, proposed different years and/or different geographical regions does not comport with the regulatory standard, COMAR 10.24.10.04B(7).

Complete the DEPARTMENTAL GROSS SQUARE FEET WORKSHEET (Table B) in the CON TABLE PACKAGE for the departments and functional areas to be affected.

Please see **Exhibit 1** (the tables required by the MHCC are attached collectively as Exh. 1).

9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES

Complete the Bed Capacity (Table A) worksheet in the CON Table Package if the proposed project impacts any nursing units.

Please see Exh. 1.

10. REQUIRED APPROVALS AND SITE CONTROL

- A. Site size: approximately 26 acres
- B. Have all necessary State and local land use approvals, including zoning, for the project as proposed been obtained? YES _____ NO X (If NO, describe below the current status and timetable for receiving necessary approvals.)

<p>The applicants plan to replace and relocate Prince George’s Hospital Center (“PGHC”) with a new regional medical center, Prince George’s Regional Medical Center (“PGRMC”), located in Largo, Maryland on a site known as the “Boulevard at the Capital Centre,” the former location of the Capital Centre Arena. The site is bordered on the west by the Capital Beltway (I-95/495), on the north by Arena Drive, and by Lottsford Road on the east side. The site is comprised of approximately 26 acres assembled from two parcels: the 17-acre “Cap Centre” parcel, and the 8.49 acre “Powell” property. As of December 13, 2014, both sites are zoned M-X-T (Mixed Use Transportation Oriented). The Approved Largo Town Center Sector Plan and Section Map Amendment is available at http://issuu.com/mncppc/docs/largo_town_center_plan. A hospital is a permitted use in M-X-T zones. See Exhibit 13.</p> <p>An M-X-T zone is traditionally subject to the requirements of Prince George’s County Zoning Ordinance, Subtitle 27 of the Public Local Laws of Prince George’s County. That section mandates an order of approvals that requires a Conceptual Site Plan, a Preliminary Plan of Subdivision, and a Detailed Site Plan. However, the Approved Largo Town Center Sector Plan and Section Map Amendment may act as a Conceptual Site Plan. See Exh. 13, p. 87. In addition, because the site is a part of a legally subdivided lot, no Preliminary Plan of Subdivision is needed. See Public Local Laws of Prince George’s County, Subdivision 24. This allowed the project applicants to file a Detailed Site Plan directly, which they did in November 2014. The applicants anticipate the following timeline:</p>	
File Detailed Site Plan:	September 21, 2014 (completed)
Anticipated Acceptance of Detailed Site Plan for Review by MNCPPC:	January 15, 2015
Anticipated Planning Board Hearing Date:	March 19, 2015

C. Form of Site Control (Respond to the one that applies. If more than one, explain.): **See C(5) below.**

- (1) Owned by: _____
Please provide a copy of the deed.
- (2) Options to purchase held by: _____
Please provide a copy of the purchase option as an attachment.
- (3) Land Lease held by: _____
Please provide a copy of the land lease as an attachment.
- (4) Option to lease held by: _____
Please provide a copy of the option to lease as an attachment.
- (5) Other: X
Explain and provide legal documents as an attachment.

As noted above, the proposed site is comprised of two adjacent parcels of approximately 26 total acres located in Largo, Prince George’s County. The “Cap Centre” parcel consists of approximately 17 acres that is currently part of the 70 acre parcel known as the “Boulevard of The Capital Centre” retail complex. This 70 acre parcel is owned by the Prince George’s County government (Prince George’s Revenue Authority), and is currently being leased on a long-term basis to RPAI US Management (“RPAI”). The 17 acre portion will be divided from the current 70 acres being leased by RPAI. RPAI will relinquish its leasehold rights over that portion of the property to Prince George’s County.

An adjacent 8.49 acre parcel, known as the Powell property, will also be obtained for the medical center campus. The combined 26 acres will be developed as one parcel.

Acreage adjacent to the 26 acre project site is planned to be developed as an urban town centre concept with smart growth design. Access to the medical campus will be via Arena Drive and Lottsford Road, and by Metrorail and Metro buses.

Means of control of property currently consists of the following: the Prince George’s County government, Prince George’s County Revenue Authority, RPAI-Capital Centre LLC, Dimensions Health Corporation, and an affiliate of the University of Maryland Medical System Corporation have executed a contingency sales contract for the conveyance of land, subject to final Certificate of Need approval to proceed with the development / construction of the new regional medical center. Pursuant to that contract:

- RPAI currently has control of the Powell property. Once the CON is approved, the Powell Property will be purchased.
- The County will obtain land to trade with RPAI in exchange for RPAI’s leasehold rights over the 17 acre “Cap Centre” parcel. The County will then donate that parcel to PGRMC after purchasing the leasehold interests and development rights of certain third parties. As reflected in the Project Budget, the County will pay these amounts with funds committed to the PGRMC project.

11. PROJECT SCHEDULE

In completing this section, please note applicable performance requirement time frames set forth at COMAR 10.24.01.12B & C. Ensure that the information presented in the following table reflects information presented in Application Item 7 (Project Description).

	Proposed Project Timeline	
<u>Single Phase Project</u>		
Obligation of 51% of capital expenditure from CON approval date	8	months
Initiation of Construction within 4 months of the effective date of a binding construction contract, if construction project	1	months
Completion of project from capital obligation or purchase order, as applicable	36	months

12. PROJECT DRAWINGS

A project involving new construction and/or renovations must include scalable schematic drawings of the facility at least a 1/16” scale. Drawings should be completely legible and include dates.

Project drawings must include the following before (existing) and after (proposed) components, as applicable:

- A. Floor plans for each floor affected with all rooms labeled by purpose or function, room sizes, number of beds, location of bathrooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as “shell space”.
- B. For a project involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.
- C. For a project involving site work schematic drawings showing entrances, roads, parking, sidewalks and other significant site structures before and after the proposed project.
- D. Exterior elevation drawings and stacking diagrams that show the location and relationship of functions for each floor affected.

Please see **Exhibit 2**

13. FEATURES OF PROJECT CONSTRUCTION

- A. If the project involves new construction or renovation, complete the Construction Characteristics (Table C) and Onsite and Offsite Costs (Table D) worksheets in the CON Table Package.
- B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project, and the steps necessary to obtain

utilities. Please either provide documentation that adequate utilities are available or explain the plan(s) and anticipated timeframe(s) to obtain them.

Water and Sewer. The site has existing private water and sewer utilities. After the required subdivision of the site, new onsite water and sewer will be needed. Soltesz, Inc. an engineering firm engaged by the applicants, studied adjacent water lines and determined that there appears to be significant water volume and pressure, and that water and sewer capacity appears to be available.

Electricity. Electric service is available and will be provided by PEPCO.

Gas. Verizon and Washington Gas utilities are located on Arena Drive and are accessible to the project site.

PART II - PROJECT BUDGET

Complete the Project Budget (Table E) worksheet in the CON Table Package.

Note: Applicant must include a list of all assumptions and specify what is included in all costs, as well the source of cost estimates and the manner in which all cost estimates are derived.

TABLE E: PROJECT BUDGET

		<i>Hospital Building</i>	<i>CUP</i>	<i>Total</i>
A. USE OF FUNDS				
1. CAPITAL COSTS				
a.	Land Purchase / Value <i>(See Comment 1)</i>	\$11,972,775	\$377,225	\$12,350,000
b.	New Construction			
(1)	Building	\$276,046,707	\$8,697,383	\$284,744,090
(2)	Fixed Equipment			\$0
(3)	Site and Infrastructure	\$16,603,282	\$530,668	\$17,133,951
(4)	Architect/Engineering Fees	\$15,676,523	\$501,048	\$16,177,571
(5)	Permits (Building, Utilities, Etc.)	\$10,590,589	\$338,493	\$10,929,082
	SUBTOTAL	\$318,917,102	\$10,067,591	\$328,984,693
c.	Renovations			
(1)	Building			\$0
(2)	Fixed Equipment (not included in construction)			\$0
(3)	Architect/Engineering Fees			\$0
(4)	Permits (Building, Utilities, Etc.)			\$0
	SUBTOTAL	\$0	\$0	\$0
d.	Other Capital Costs			
(1)	Movable Equipment <i>(See Comment 2)</i>	\$126,420,566	\$32,496,000	\$158,916,566
(2)	Contingency Allowance <i>(See Comment 3)</i>	\$28,582,481	\$1,417,519	\$30,000,000
(3)	Gross interest during construction period <i>(See Comment 4)</i>	\$36,385,339	\$3,376,661	\$39,762,000

		Hospital Building	CUP	Total
(4)	Other (Specify) UMMS PM, Builder's Risk, Commissioning/Testing, Warehousing, Testing, Traffic Study, Davis Langdon, CM Pricing, Scheduling, Helipad, Survey, Risk Assesment, Code, review, ICRA, MET Testing, Curtainwall Testing, Legal, Office Consolidation, Enabling, Equipment Planning, IT Design, Offsite Improvements, IT Design, Original site leave behind <i>(See Comment 5)</i>	\$20,079,220		\$20,079,220
	SUBTOTAL	\$211,467,606	\$37,290,180	\$248,757,786
	TOTAL CURRENT CAPITAL COSTS	\$542,357,482	\$47,734,997	\$590,092,479
e.	Inflation Allowance	\$23,469,012	\$2,355,508	\$25,824,521
	TOTAL CAPITAL COSTS	\$565,826,494	\$50,090,506	\$615,917,000
2. Financing Cost and Other Cash Requirements				
a.	Loan Placement Fees	\$3,795,039	\$335,961	\$4,131,000
b.	Bond Discount			\$0
c.	Legal Fees	\$917,814	\$82,186	\$1,000,000
d.	Non-Legal Consultant Fees	\$826,033	\$73,967	\$900,000
e.	Liquidation of Existing Debt			\$0
f.	Debt Service Reserve Fund	\$13,573,398	\$1,201,602	\$14,775,000
g.	Other (Specify) Purchase of leasehold and development rights of third parties	\$13,308,310	\$1,191,690	\$14,500,000
	SUBTOTAL	\$32,420,594	\$2,885,406	\$35,306,000
3.	Working Capital Startup Costs (See Comment 6)			\$0
	TOTAL USES OF FUNDS	\$598,247,089	\$52,975,911	\$651,223,000
B. Sources of Funds (See Comment 7)				
1.	Cash			\$0
2.	Philanthropy (to date and expected)			\$0
3.	Authorized Bonds (See Comment 8)			\$206,760,000
4.	Interest Income from bond proceeds listed in #3 (See Comment 6)			\$16,113,000
5.	Mortgage			\$0

		<i>Hospital Building</i>	<i>CUP</i>	<i>Total</i>
6.	Working Capital Loans (See Comment 5)			\$0
7.	Grants or Appropriations			
a.	Federal			\$0
b.	State (See Comment 9)			\$208,000,000
c.	Local (See Comment 9)			\$208,000,000
8.	Other, includes Land Donation (rounding)			\$12,350,000
	TOTAL SOURCES OF FUNDS			\$651,223,000

**TABLE E
Project Budget
COMMENTS**

The following comments address issues raised in completeness questions following submission of the original CON application or in discussions with the MHCC Staff and the HSCRC Staff following the original application.

Comment 1:

The donation of the property is discussed in Part I, Section C.10, Form of Site Control. Regarding the value of the donated land, the total 25.5 acreage site is estimated to have a value of approximately \$12,350,000.

The appraised value of the Powell property (approximately 8.49 acres) ranges from \$7.5 million to \$8.2 million, based upon two independent appraisals of the Powell parcel by both the County and Retail Properties of America, Incorporated. There are no current appraisals for the other 17 acre parcel. The County estimates that the value for the 17 acre parcel is approximately \$4.5 million. The Powell property (8.49 acres) was appraised at a higher value per acre because it has a residential use development potential that is not available for the 17-acre parcel.

Comment 2: Equipment and Furnishings

The Project Budget assumes that all equipment and furnishing will be replaced. The new hospital is projected to open in July 2019; much of the existing equipment will be four years older than it is today. Also, PGHC will need to be fully operational until the day that PGRMC opens, requiring that the furniture and equipment remain on line through the last day of operation of PGHC.

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

Comment 3: Contingency Estimate

The contingency amount was calculated as 6.1% of the subtotal of new construction items plus major and minor moveable equipment.

Comment 4: Calculation of Capitalized Interest

The projection of \$39.7M of gross interest expense during construction (Project Budget, Item A.1.d(3)) less the \$16.1M of interest income on bond proceeds (Project Budget, Item

B.4) equals \$23.6M of capitalized interest that is depreciated along with other assets included in the Project costs. The interest expense and interest income relate to the following assumed debt issuance:

- \$206.7M to be issued in December 2015
- Annual interest expense calculated at 5.5% on the outstanding balance
- Amortization on a straight line basis over 30 years
- Principal payments will begin upon the commencement of operations at the new hospital in July 2019

The projection of interest income presented as a source of funds represents the investment income earned on the available balance of bond proceeds prior to their expenditure. An investment earning rate of 3.0% is applied to the average balance of these funds each year.

Comment 5: Costs Associated with Parking Garage

The costs and revenues associated with the parking garage are not included in the project budget because PGRMC will not pay rent or receive payments or parking fee revenue. The County Government or the Revenue Authority of Prince George's County could own and operate the garage. PGRMC will be a customer. Under this scenario, the County/Revenue Authority would collect parking fees from the general public at an hourly rate. The County / Revenue Authority would charge PGRMC a fixed amount for parking spaces leased by PGRMC for employees, physicians, etc. It is anticipated that PGRMC would charge employees (with some exemptions) for use of the parking facility to help offset the cost of leasing spaces from the County / Revenue Authority. However, PGRMC will not operate the garage, nor will it bear the garage's operating expenses or receive revenue that the garage generates.

Comment 6: Elimination of Working Capital Costs and Loan from the Project Budget

In the CON application that was submitted in October 2013, there was a presentation of \$109.2M of Working Capital Startup Costs. This cost was funded by a Line of Credit for an equal amount. Subsequent to the submission, it was determined that this amount was incorrectly presented as a Startup Cost. It is not a Startup Cost that would be incurred during construction and therefore capitalized along with the other assets, rather it is a deposit from a Line of Credit into PGRMC's operating account to fund operating expenses while payments are collected from payors for services provided to patients.

This Line of Credit and deposit of cash into PGRMC's operating account is still assumed in the financial projections for PGRMC. The deposit is expected to equal \$77.1M at the commencement of operations of the new hospital. This amount reflects 100 days of expected cash expenses in FY2020, the first year of operation for the new hospital.

It is expected that this Line of Credit will be paid off over the first six years of operation as cash flow over 100 days of cash on hand is available.

Comment 7: Expected Covenants on Long Term Bond Financing and Other Financing

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

Covenant Not to Encumber:

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

Liquidity Covenant/Days Cash on Hand:

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

Coverage Ratio/Rate Covenant:

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

Debt to Capitalization Ratio:

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

Comment 8: Ability to Obtain Debt Financing

Dimensions has not yet secured firm debt commitments because the commencement of the project is still too distant in the future. However, upon consultation with its financial advisors and parties involved in hospital financing, Dimensions is confident that it will be able to obtain the anticipated debt financing for the following reasons:

- Dimensions has successfully accessed the bond market in the past.
- Dimension has existing relationships with banks for working capital loans.
- Dimensions has conservatively assumed an interest rate of 5.5%, which would be in the higher range of the market for long term bonds and will make them more attractive to investors.
- In 2013, Prince George’s County assumed Dimensions’ outstanding Series 1994 Bonds. The County reissued new debt in the form of certificates of participation from which the proceeds was used to advance refund Dimensions’ Series 1994 Bonds. Dimensions recognized a gain from extinguishment of this debt.

- The State and County have committed to fund 66% of the total project costs.
- The long term debt associated with the project equals 34% of the total project costs resulting in significant equity associated with the project, making the debt attractive to bond holders and lenders.
- A short term Line of Credit to fund initial working capital requirements is expected to be repaid within five years of the opening of the new hospital.

Dimensions' recent history and success issuing bonds on the bond market and obtaining loans from banks is as follows:

1994 Series Bonds. As of June 30, 2013, approximately \$53.5 million of the Series 1994 Bonds remained outstanding. These 30-year bonds were composed of two parts with interest rates of 5.38% and 5.3%. As part of its commitment to this project, Prince George's County has recently assumed and paid off the remaining balance of these bonds on behalf of the Corporation.

Other Long Term Debt. Dimensions has had success securing a number of capital leases, primarily for the acquisition of equipment and other long term debt for various projects. From 1996 through 2013 the Corporation has carried outstanding capital lease obligations ranging from less than \$1 million to \$4.3 million for acquisition of various types of equipment. Currently, the Corporation has approximately \$5 million in capital leases on its balance sheet. The table below depicts some of the more recent activities.

<u>Year</u>	<u>Amount Borrowed</u>
2008	\$2.8 million
2009	\$1.0 million
2011	\$1.1 million
2012	\$1.3 million
2013	\$2.1 million

In 2013, Dimensions received a letter of commitment to finance \$9 million, of approximately \$20 million of its intended spend on a new Electronic Medical Records (EMR) system. Dimensions also has trust mortgage with a balance of \$3.0 million as of June 30, 2013 with a three-year adjustable interest rate of 3.25%.

Comment 9: Financial Commitments of Prince George's County and Maryland

Dimensions expects Prince Georges County and Maryland State to contribute \$416 million for this proposed project, in the amount of \$208 million each. The County's \$208 million commitment is exclusive of any consideration or costs associated with any real estate transactions between the County and RPAI for the 8.4 acre parcel and the 17 acre parcel discussed elsewhere in this application.

Exhibit 14 includes the County's approved capital improvement program for FY 2014 through FY 2019, which includes the \$208,000,000 commitment to partially fund the proposed regional medical center.

Exhibit 15 includes excerpts of the State's FY 2014 and FY 2015 capital budgets and five-year capital improvement programs, which show the State's plan to partially fund the proposed regional medical center in the amount of \$200,000,000. Exhibit 16 an excerpt of a Report on the Fiscal 2015 State Operating Budget, which demonstrates that the FY 2015 commitment was subsequently altered, but that the total commitment amount remains at \$200,000,000.

The signatories to the Memorandum of Understanding dated July 21, 2011 will meet with State legislators to ask that an additional \$8,000,000 in funding be placed in the State's Capital Budget to achieve the original capital funding amount agreed to be committed by Prince George's County and the State (\$208,000,000 each). Dimensions will keep the MHCC Staff advised of its progress in obtaining an additional funding commitment of \$8,000,000 from the State.

If the additional \$8,000,000 is not funded by the State, then the \$8,000,000 shortfall in funds will be acquired either through a Prince George's County community capital campaign program and/or if necessary, additional borrowing for funds (issuance of long-term debt).

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

1. List names and addresses of all owners and individuals responsible for the proposed project.

**Neil J. Moore, President and CEO
Dimensions Healthcare System
3001 Hospital Drive
Cheverly, MD 20785**

**Sheldon Stein
President & CEO
Mt. Washington Pediatric Hospital
1708 West Rogers Avenue
Baltimore, MD 21209-4596**

2. Is any applicant, owner, or responsible person listed above now involved, or has any such person ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each such facility, including facility name, address, the relationship(s), and dates of involvement.

Neil J. Moore facilities:

Dimensions Healthcare System, President & CEO 2011-present
 Dimensions Healthcare System, Chief Financial Officer 2005-2011
 New York Health & Hospitals Corp:
 Harlem Hospital Health Network, CFO 2003-2005
 Woodhull Hospital Health Network, Deputy CFO 1999-2003
 Dr. McKinney Skilled Nursing Facility, COO / CFO 1998-1999
 Kings County Hospital, Interim Dep CFO 1996-1997
 Kings County Hospital, various positions in HR and Network Management 1989-1996

Sheldon Stein facilities:

University Hospital – University of Colorado Health Science Center
 April 1984 to February 1995

3. In the last 5 years, has the Maryland license or certification of the applicant facility, or the license or certification from any state or the District of Columbia of any of the facilities listed in response to Question 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) ? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant(s), owners, or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

No

No

Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) ever received inquiries from a federal or any state authority, the Joint Commission, or other

regulatory body regarding possible non-compliance with Maryland, another state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

No

No

5. Has any applicant, owner, or responsible individual listed in response to Question 1, above, ever pled guilty to, received any type of diversionary disposition, or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

No

No

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Date

1/7/15

Signature of Owner or Board-designated Official

President and CEO
Dimensions Healthcare System
Position/Title

Neil J. Moore
Printed Name

Date

Signature of Owner or Board-designated Official

President and CEO
Mt. Washington Pediatric Hospital
Position/Title

Sheldon Stein
Printed Name

regulatory body regarding possible non-compliance with Maryland, another state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

No | No

5. Has any applicant, owner, or responsible individual listed in response to Question 1, above, ever pled guilty to, received any type of diversionary disposition, or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

No | No

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Date

Signature of Owner or Board-designated Official

President and CEO
Dimensions Healthcare System

Position/Title

Neil J. Moore

Printed Name

Date



Signature of Owner or Board-designated Official

President and CEO
Mt. Washington Pediatric Hospital

Position/Title

Sheldon Stein

Printed Name

**PART IV - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR
10.24.01.08G(3):**

INSTRUCTION: Each applicant must respond to all criteria included in COMAR 0.24.01.08G(3), listed below.

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

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

COMAR 10.24.10 ACUTE CARE CHAPTER

.04A. GENERAL STANDARDS

The following general standards encompass Commission expectations for the delivery of acute care services by all hospitals in Maryland. Each hospital that seeks a Certificate of Need for a project covered by this Chapter of the State Health Plan must address and document its compliance with each of the following general standards as part of its Certificate of Need application. Each hospital that seeks a Certificate of Need exemption for a project covered by this Chapter of the State Health Plan must address and demonstrate consistency with each of the following general standards as part of its exemption request.

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

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

- (a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;
- (b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and
- (c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

Applicant Response:

Dimensions has a written policy in place at PGHC that meets the requirements of this standard. See **Exhibit 17**. The current list of representative services and charges that is readily available to the public, both at PGHC and on the hospital's internet web site (<http://www.dimensionshealth.org/wp-content/uploads/2015/01/PGHC-Est-Avg-Chrgs-Common-Procedures-9-1-2014.pdf>) is attached as **Exhibit 18**. Procedures are in place to respond

promptly to individual requests for information regarding current charges for specific services and procedures. See Exh. 17 at 1. The staff training that Dimensions uses at PGHC to ensure that inquiries regarding charges are handled appropriately is described on page 1 of the policy attached as Exh. 17. All of the existing policies and procedures will be used at the new hospital.

Standard .04A(2) – Charity Care Policy.

Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual’s ability to pay.

(a) The policy shall provide:

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

(ii) Minimum Required Notice of Charity Care Policy.

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

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

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

Applicant Response:

PGHC provides inpatient and other care to all patients regardless of the ability to pay. In fact, as discussed below, on the basis of a percentage of operating expenses, PGHC is among the top three Maryland hospitals in providing charity care. A copy of Dimensions’ Financial Assistance Policy is attached as **Exhibit 19**. Notices regarding the availability of charity care at the hospital are posted in the Emergency Department and in the admissions area and in the hallway near the cashier. A copy of that notice is attached as **Exhibit 20**. An annual notice is published in several newspapers, including *The Gazette*, *The Washington Post*, and *The Laurel Leader*. A copy of the notice is attached as **Exhibit 21**. Each patient or patient representative is advised of Dimensions’ charity care policy at the time of admission or outpatient registration. The Financial Assistance Policy specifically states, “DHS will make a determination of probable eligibility within two (2) business days following a patient’s request for charity care services, application for medical assistance, or both.” Financial counselors assist individuals to prepare and file all documents required to seek charity care at the Hospital. All existing policies and procedures will be used at the new hospital.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review

Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

Applicant Response:

As reported in the most recent HSCRC Community Benefit Report (for FY 2013) posted on its website (accessed 12/8/2014), PGHC ranks third out of 46 Maryland hospitals for charity care as a percentage of total operating expenses. In terms of gross dollars, PGHC ranked eighth in amount of charity care (\$21,929,900), behind University of Maryland Medical Center (UMMC), Johns Hopkins Hospital, Holy Cross Hospital, Johns Hopkins Bayview, Baltimore Washington Medical Center, UM – Midtown, and St. Agnes Health Care.

**Table 1
HSCRC Community Benefit Report, Data Excerpts
FY2013**

Hospital	Total Charity Care	Total Operating Expenses	Percent
UM - Midtown	\$23,597,000	\$190,985,000	12.36%
Bon Secours Hospital	\$13,885,743	\$123,096,854	11.28%
Prince George's Hospital Center	\$21,929,900	\$211,129,800	10.39%
Doctor's Community Hospital	\$15,889,496	\$178,022,901	8.93%
Chester River Health System	\$4,169,000	\$51,866,000	8.04%
Garrett County Memorial Hospital	\$2,848,631	\$37,345,320	7.63%
Holy Cross Hospital	\$26,812,613	\$379,906,397	7.06%
Baltimore Washington Medical Center	\$25,709,288	\$364,852,000	7.05%
Dorchester General	\$2,768,000	\$42,329,000	6.54%
Calvert Memorial Hospital	\$7,447,389	\$118,592,518	6.28%
Western Maryland Health System	\$17,477,763	\$290,611,752	6.01%
St. Agnes Health Care	\$22,405,394	\$386,454,162	5.80%
Laurel Regional Hospital	\$5,836,000	\$101,679,200	5.74%
Memorial Hospital at Easton	\$8,301,400	\$156,018,000	5.32%
St. Mary's Hospital	\$6,250,461	\$122,895,946	5.09%
Washington Adventist Hospital	\$10,766,757	\$220,596,102	4.88%
Johns Hopkins Bayview	\$26,313,000	\$541,313,000	4.86%
Peninsula Regional Medical Center	\$16,680,700	\$369,259,350	4.52%
Union Memorial Hospital	\$17,514,687	\$397,895,616	4.40%
Harford Memorial Hospital	\$3,648,200	\$83,530,000	4.37%
Meritus Medical Center	\$12,006,630	\$285,886,346	4.20%
Montgomery General Hospital	\$5,999,259	\$143,428,725	4.18%
Mercy Medical Center	\$17,220,776	\$413,737,200	4.16%
McCready Memorial Hospital	\$633,321	\$15,337,808	4.13%
Harbor Hospital	\$8,102,570	\$198,800,877	4.08%
University of Maryland Medical Center (UMMC)	\$50,504,000	\$1,280,648,000	3.94%
Atlantic General Hospital	\$3,700,771	\$94,139,531	3.93%

Hospital	Total Charity Care	Total Operating Expenses	Percent
Franklin Square Hospital Center	\$14,943,857	\$450,358,826	3.32%
Ft. Washington Medical Center	\$1,241,478	\$38,806,279	3.20%
University of Maryland Rehabilitation & Orthopaedic Institute	\$3,248,000	\$101,635,160	3.20%
Carroll County General Hospital	\$6,198,891	\$207,816,000	2.98%
Frederick Memorial Hospital	\$9,980,036	\$339,915,000	2.94%
Howard County General Hospital	\$6,093,350	\$223,533,000	2.73%
Union Hospital of Cecil County	\$3,767,210	\$141,135,143	2.67%
Upper Chesapeake Medical Center)	\$5,760,273	\$225,852,000	2.55%
Shady Grove Adventist Hospital	\$7,088,997	\$292,521,487	2.42%
Good Samaritan Hospital	\$7,360,438	\$307,783,651	2.39%
Suburban Hospital	\$5,177,296	\$218,872,188	2.37%
St. Joseph's Medical Center	\$6,346,817	\$312,000,000	2.03%
Northwest Hospital	\$3,957,922	\$206,698,000	1.91%
Anne Arundel Medical Center	\$8,859,700	\$516,696,000	1.71%
Johns Hopkins Hospital	\$31,612,000	\$1,897,158,000	1.67%
Sinai Hospital of Baltimore	\$11,038,200	\$674,192,000	1.64%
Civista Medical Center	\$1,436,027	\$115,151,000	1.25%
Greater Baltimore Medical Center (GBMC)	\$4,616,593	\$379,063,000	1.22%
Southern Maryland Hospital Center	\$981,819	\$126,371,201	0.78%

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

Standard .04A (3) – Quality of Care.

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

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

(ii) Accredited by the Joint Commission; and

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

Applicant Response:

PGHC is licensed by the Department of Health and Mental Hygiene, is accredited by The Joint Commission, and is in compliance with all Medicare and Medicaid conditions of participation. Copies of the hospital's license and most recent accreditation letter are attached as **Exhibit 22**.

(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.

Applicant Response:

Collaboration with UMMS for PGHC's Quality Management Program

As described elsewhere in this application, UMMS has partnered with Dimensions to strengthen the delivery of high quality of care to the citizens of Prince George's County at PGHC. Included among the partnership initiatives, Dimensions and UMMS have embarked on a joint program to improve the quality of patient care that will result in measurably improved clinical performance and financial reimbursement.

The most urgent requirements for quality management at PGHC are: (1) to strengthen quality management capabilities; and (2) to improve the delivery of high quality and safe patient care. In September 2014, Dimensions engaged an UMMS employee, Deborah Youngquist, as Senior Director of Clinical Quality & Patient Safety under a management agreement with UMMS. Prior to her present position at Dimensions, Ms. Youngquist served in a similar role at the University of Maryland Medical Center Midtown Campus (UMMC-MTC) for five years. When Ms. Youngquist assumed leadership of the Quality Management Department, UMMC-MTC had the worst performance in the area of Core Measure performance among all UMMS constituent hospitals. Upon her departure from that position, UMMC-MTC had been elevated to the best performer among UMMS hospitals and had achieved three awards from the Delmarva Foundation, one from Press Ganey, one from Midas and two from The Joint Commission related to the hospitals excellent Core Measure performance.

In addition to contracting with UMMS to engage Ms. Youngquist, Dimensions engaged Maverick Consulting in September 2014 to assist in establishing a plan for improving the quality of patient care. Improvement activities focused on the quality measures required by the Health Services Cost Review Commission (HSCRC), including Maryland Hospital Acquired Conditions (MHAC), Quality Based Reimbursement (QBR), readmissions and Potentially Avoidable Utilization (PAU).

PGHC's Quality Performance under the Maryland Hospital Performance Evaluation Guide

Following submission of the original CON application, the MHCC launched a new and significantly re-designed Maryland Hospital Performance Evaluation Guide (the "Guide"). Under the new Guide, assessing quality measure performance within the bottom quartile of all hospitals, as required by the standard, is not apparent. Based on guidance received from staff from MHCC's Center for Quality Measurement and Reporting, Dimensions is reporting on all quality measures for which PGHC was "below average" as shown in the Guide. Thus, the reports on quality measures in this response are over-inclusive.

Attached as **Exhibit 23** is a chart showing the quality measures for which PGHC is shown as scoring below average in the Guide for the time period from October 1, 2012 through September 30, 2013. For each quality measure, the chart also shows any data available for more recent time periods, including, most significantly, the last quarter of CY 2014 when Dimensions entered the arrangement with UMMS to manage the quality patient care initiatives

for PGHC.⁶ Although the new quality patient care program has been underway for only a few months, in most cases, the quality measures have improved at PGHC. Dimensions and UMMS expect to see significant further improvement.

Improvements have been realized beginning in the month of November 2014 related to Core Measure performance. Dashboards are being developed in key clinical areas such as Maternal Child Health and Cardiac Surgery. The implementation of the Tactical Action Plan is on target. Ongoing improvement is anticipated with the interventions and investments made by DHS to improve the quality and safety of patient care.

⁶ Many of the quality measures reported in the current Guide have been retired or eliminated for Maryland hospital abstraction. These changes were made as most hospitals within the State have sustained top performance over time. In some cases, PGHC has not made the same improvements as other Maryland hospitals. Therefore, despite the discontinuation of certain of the measures by HSCRC and MHCC, Dimensions will continue to monitor and improve performance for key measures in which performance at PGHC is below the state expected levels.

COMAR 10.24.10 ACUTE CARE CHAPTER
.04B. PROJECT REVIEW STANDARDS

Standard .04B(1) – Geographic Accessibility.

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

Applicant Response:

Dimensions engaged Spatial Insights, Inc. to calculate the moderate driving time⁷ from each Zip Code to both the project site (Largo) and the existing facility (Cheverly). The Largo site is slightly closer to the PGRMC service area population than the Cheverly site is to the current PGHC service area population.

As shown in Table 2, the average driving time from the PGHC service area zip codes to the Cheverly site is 19.20 minutes, while the average driving time from the PGRMC service area zip codes to the Largo site is 18.31 minutes. Currently, 86.9% of the PGHC service area population lives within a 30 minute drive of the Cheverly site. In comparison, 87.7% of the PGRMC service area population lives within a 30 minute drive of the Largo site.

Table 2
Driving Time from Zip Codes in the PGHC/PGRMC Service Areas
To the Existing Cheverly and Proposed Largo Sites for All Services
Population = 2022

Zip Code	PGHC Service Area to Cheverly			PGRMC Service Area to Largo		
	Drive Time	2022 Total Population (1)	Drive Time XPop.	Drive Time	2022 Total Population (1)	Drive Time XPop.
20601	35.27	26,485	934,140	29.67	26,485	785,822
20602	39.77	28,907	1,149,624	34.17	28,907	987,746
20603	43.12	34,210	1,475,130	37.52	34,210	1,283,555
20607	34.63	12,035	416,759	35.42	12,035	426,266
20608	49.7	905	44,959	44.1	905	39,893
20613	36.4	13,898	505,876	30.8	13,898	428,049
20623	30.73	2,923	89,811	21.38	2,923	62,485
20653	94.48	29,687	2,804,872	88.88	29,687	2,638,622
20703	11.55	-	-	9.83	-	-
20704	13.6	-	-	16.08	-	-

⁷ Dimensions sought to replicate the methodology the MHCC used in its analysis of driving time in Commissioner Barbara McLean’s proposed decision on the CON application for the relocation of Washington Adventist Hospital (Docket No. 09-15-2295) (see Proposed Decision, pp. 157-162).

Zip Code	PGHC Service Area to Cheverly			PGRMC Service Area to Largo		
	Drive Time	2022 Total Population (1)	Drive Time XPop.	Drive Time	2022 Total Population (1)	Drive Time XPop.
20705	14.58	29,137	424,822	17.07	29,137	497,374
20706	9.18	40,802	374,559	7.43	40,802	303,156
20707	21.85	37,201	812,839	23.78	37,201	884,637
20708	16.53	26,091	431,290	18.47	26,091	481,908
20709	15.3	-	-	17.23	-	-
20710	2.62	10,435	27,341	10.7	10,435	111,659
20712	5.93	9,245	54,824	15.05	9,245	139,141
20715	19.58	26,022	509,512	17.22	26,022	448,100
20716	19.27	22,205	427,890	15.37	22,205	341,291
20717	20.58	-	-	14.22	-	-
20718	18.53	-	-	16.2	-	-
20719	19.03	-	-	18.18	-	-
20720	14.88	26,291	391,208	12.52	26,291	329,162
20721	15.33	31,175	477,906	7.85	31,175	244,720
20722	4.2	6,309	26,497	13.32	6,309	84,034
20725	21.13	-	-	23.07	-	-
20726	19.98	-	-	21.92	-	-
20731	7.08	-	-	7.18	-	-
20735	24.43	39,080	954,730	18.83	39,080	735,881
20737	4.5	22,303	100,362	10.72	22,303	239,085
20738	5.1	-	-	11.27	-	-
20740	10.75	28,743	308,988	13.38	28,743	384,582
20741	7.98	-	-	14.05	-	-
20742	10.03	10,261	102,916	16.22	10,261	166,431
20743	7.7	40,391	311,007	7.05	40,391	284,753
20744	23.53	56,807	1,336,671	24.18	56,807	1,373,595
20745	17.07	29,999	512,084	17.42	29,999	522,583
20746	13.07	30,636	400,408	13.45	30,636	412,050
20747	12.77	41,404	528,728	9.3	41,404	385,056
20748	15.23	37,201	566,574	13.87	37,201	515,981
20749	25.87	-	-	26.6	-	-
20752	11.03	-	-	12.82	-	-
20753	12.3	-	-	9.52	-	-
20757	14.97	-	-	14.23	-	-
20762	20.5	4,024	82,483	11.83	4,024	47,599
20768	8.73	-	-	10.67	-	-
20769	14.77	7,910	116,837	13.42	7,910	106,158
20770	8.15	27,177	221,496	10.35	27,177	281,286
20771	10.2	3	31	10.65	3	32
20772	28.12	49,260	1,385,181	18.77	49,260	924,603

Zip Code	PGHC Service Area to Cheverly			PGRMC Service Area to Largo		
	Drive Time	2022 Total Population (1)	Drive Time XPop.	Drive Time	2022 Total Population (1)	Drive Time XPop.
20773	27.07	-	-	17.25	-	-
20774	16	49,684	794,944	6.45	49,684	320,462
20775	16.3	-	-	6.68	-	-
20781	3.88	12,401	48,114	12.77	12,401	158,356
20782	7.97	33,178	264,432	16.72	33,178	554,743
20783	12.22	48,808	596,439	19.3	-	-
20784	5.48	29,011	158,983	7.58	29,011	219,907
20785	5.7	37,402	213,191	5.5	37,402	205,710
20787	6.23	-	-	13.8	-	-
20788	6.32	-	-	15.47	-	-
20791	7.03	-	-	7.55	-	-
20792	16.07	-	-	6.45	-	-
20797	7.08	-	-	7.18	-	-
20799	12.17	-	-	2.35	-	-
20903	14.55	16,778	244,113	18.68	-	-
20904	19.45	44,776	870,887	21.93	-	-
20912	12.88	25,664	330,555	20.83	-	-
Total	19.20	1,136,863	21,830,016	18.31	974,809	17,852,781
> 30 Min.	49.79	146,049	7,421,171	48.51	119,641	5,804,131
% < 30 Min.		86.9%			87.7%	

Sources: Driving Time was provided by Spatial Insights

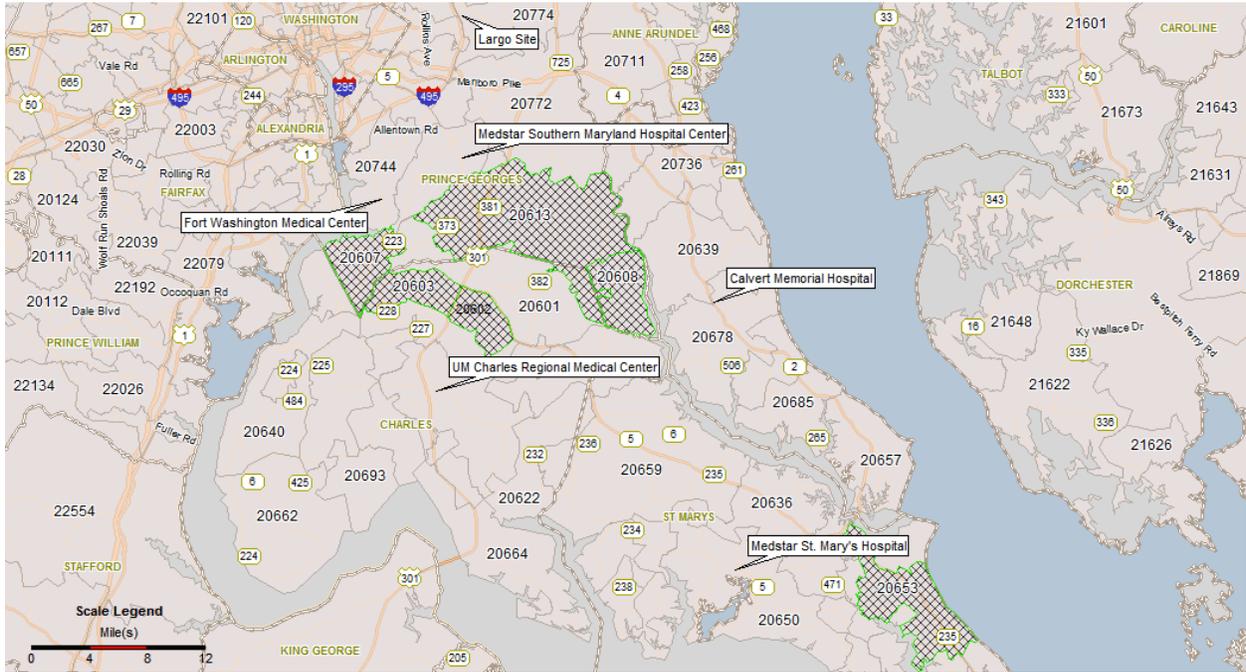
Population is projected to 2022 using a Compounded Average Growth Rate from 2013-2018 population projection provided by Claritas

Note (1): Zip codes with no projected 2022 population had at least one hospital discharge but represents a P.O. Box or is not in the respective service area

Using the methodology for defining service area described in the Proposed Decision on the 2009 CON Application for the Relocation of Washington Adventist Hospital (Docket No. 09-15-2295), Dimensions developed a slightly different service area for the Largo site. This method is based on ranking the proximity of the hospital to the population in comparison to other hospitals. Dimensions' use of this methodology is described in response to Standard .04B(2), pp. 49-79. The service area for the Largo Site resulting from the application of the MHCC methodology includes four fewer Zip Codes than the existing Cheverly service area. Consequently, the average driving time for the PGRMC service area population to the Largo site is less than the average driving time for the PGHC service area population to the Cheverly site.

There are six Zip Codes that have longer driving times to the Largo site (20602, 20603, 20607, 20608, 20613, and 20653). Two are in the most southern part of Prince George's County. Three are in Charles County, and one is in St. Mary's County. These six Zip Codes are shown in Figure 3. Also, the locations of existing hospitals are identified, as is the Largo Site. With these six zip code exceptions, the service area population for the proposed Largo site has optimal driving time access, as defined by Standard .04B(1).

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



Excerpts from Table 2 show that these Zip Codes have a greater than 30-minute drive to the Largo site for MSGA and Pediatric services. At least 90% of the rest of the service area population for the proposed Largo site has optimal driving time access, as defined by \ Standard .04B(1).

Table 2 (Excerpts)
Driving Time from Selected Zip Codes To a Hospital

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

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

Standard .04B(2) – Identification of Bed Need and Addition of Beds.

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

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

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

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

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

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

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

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

Applicant Response:

PGHC is licensed to operate 215 acute care beds in FY15, including 141 MSGA beds, 38 obstetrical beds, eight pediatric beds, and 28 psychiatric beds. Dimensions proposes to reconfigure its acute care beds at the replacement hospital and operate 133 MSGA beds, 32 ICU/CCU beds, 22 obstetrical beds, one pediatric bed, and 28 psychiatric beds at the new location (in addition, MWPH will operate 15 pediatric beds under its own license). Since Dimensions’ total MSGA bed capacity will not exceed the most recent calculation of jurisdictional bed need, the proposed project is consistent with Subsection (c)(ii) of this standard because the minimum jurisdictional MSGA bed need for Prince George’s County in 2018 is 671 MSGA beds. See 37 *Maryland Register* 589-91 (March 26, 2010). The MHCC’s Annual Report on Selected Maryland Acute Care and Special Hospital Services Fiscal Year 2014 shows that there are 595 licensed MSGA beds in Prince George’s County. Finally, in terms of pediatric

beds, Subsection (c) of this standard is inapplicable as Dimensions is not proposing additional pediatric beds.

Defining PGRMC's New Service Area

Methodology

To project the number of admissions that it should expect in the new service area, Dimensions utilized the methodology outlined in Commissioner Barbara McLean's proposed decision on the CON application for the relocation of Washington Adventist Hospital (Docket No. 09-15-2295) (see Proposed Decision, pp. 157-162). Dimensions utilized the services of Spatial Insights to identify population centroid points of the various ZIP codes within the designated service area. Spatial Insights utilized the 2012 US TIGER version of Freeway software product. Moderate traffic conditions were specified. Freeway 2012 documentation is attached as **Exhibit 24**. "Moderate" speed assignments used for the analysis are listed on page 5. Washington D.C. hospitals were included in determining the proximity ranking (MedStar Washington Hospital Center, Providence Hospital, Children's National Hospital Center, MedStar Georgetown University Hospital, George Washington University Hospital).

In this case, the service area is shifting from one based on PGHC's current location in Cheverly, MD to PGRMC's new location in Largo, MD. Utilizing the methodology outlined in Commissioner Barbara McLean's proposed decision on the CON application for the relocation of Washington Adventist Hospital, PGHC split its 2013 inpatient discharges into six cohorts:

- MSGA 15-64
- MSGA 65-74
- MSGA 75+ (age group broken out from the MSGA 65+ age cohort at the request of the HSCRC)
- Obstetrics (OB)
- Pediatrics (PED)
- Psychiatry (PSY)

The service area for each of these cohorts should represent approximately 85% of the discharges to the hospital in its new location. To determine the zip codes to include in the expected 85% service area for the Largo site, Dimensions used the drive times generated by Spatial Insights from zip codes in Prince George's County and selected surrounding zip codes to each Maryland, District of Columbia, and Virginia hospital. The zip codes were sorted by proximity, as defined by drive time, to PGHC's current location.

- The 2013 discharges within those zip codes were summed until they equaled 85% of PGHC's total 2013 discharges within each cohort.
- Discharges from out of state zip codes were excluded from the service area definition.
- The zip codes that fall within the 85% of total discharges for each cohort were grouped by a ranking of PGHC's proximity relative to other hospitals that serve those zip codes.

Definition of PGRMC Service Area

As presented below, the service area for MSGA 15-64 was defined as those zip codes that contributed 78.3% of PGHC's 2013 MSGA 15-64 discharges. MSGA 15-64's service area equaled less than 85% of PGHC's total 2013 MSGA 15-64 discharges because the rest were predominately out of state volumes. For this cohort, PGHC was ranked the closest hospital up

to the ninth closest hospital for the identified zip codes. The hospital rankings were then applied to the zip codes surrounding the future Largo site for PGRMC to determine those zip codes for which PGRMC would be the closest up to the ninth most proximate hospital.

Table 3
Defining PGRMC's Service Area
MSGA 15 – 64
FY2013

Prince George's Hospital Center							PGRMC - Largo Location Using Ranking as Service Area Cut-Off					
Zip Code	Town	Drive Time	Rank	FY 2013		Cumulative %	Zip Code	Town	PGHC		Rank	
				Discharges	%				Drive Time	PGHC Rank		
20785	Hyattsville - Landover	5.70	1	631	14.0%	14.0%	20785	Hyattsville - Landover	5.7	1	5.5	1
20743	Capitol Heights Area	7.70	1	564	12.5%	26.6%	20743	Capitol Heights Area	7.7	1	7.05	1
20747	District Heights - Forestville	12.77	1	248	5.5%	32.1%	20774	Upper Marlboro	16	2	6.45	1
20737	Riverdale	4.50	1	121	2.7%	34.8%	20747	District Heights - Forestville	12.77	1	9.3	1
20710	Bladensburg	2.62	1	120	2.7%	37.4%	20721	Bowie	15.33	2	7.85	1
20781	Hyattsville Area	3.88	1	72	1.6%	39.0%	20716	Bowie - South East	19.27	3	15.37	1
20722	Colmar Manor	4.20	1	52	1.2%	40.2%	20753	District Heights	12.3	1	9.52	1
20791	Capitol Heights	7.03	1	5	0.1%	40.3%	20775	Upper Marlboro	16.3	2	6.68	1
20753	District Heights	12.30	1	3	0.1%	40.4%	20773	Upper Marlboro	27.07	3	17.25	1
20787	Hyattsville	6.23	1	-	0.0%	40.4%	20731	Capitol Heights	7.08	1	7.18	1
20731	Capitol Heights	7.08	1	-	0.0%	40.4%	20752	Suitland	11.03	1	12.82	1
20752	Suitland	11.03	1	-	0.0%	40.4%	20717	Bowie	20.58	3	14.22	1
20738	Riverdale Park	5.10	1	-	0.0%	40.4%	20791	Capitol Heights	7.03	1	7.55	1
20797	Southern MD Facility	7.08	1	-	0.0%	40.4%	20797	Southern MD Facility	7.08	1	7.18	1
20774	Upper Marlboro	16.00	2	231	5.1%	45.5%	20799	Capitol Heights	12.17	2	2.35	1
20784	Hyattsville - Landover Hills	5.48	2	217	4.8%	50.3%	20792	Upper Marlboro	16.07	2	6.45	1
20706	Lanham-Glenarden	9.18	2	171	3.8%	54.1%	20784	Hyattsville - Landover Hills	5.48	2	7.58	2
20721	Bowie	15.33	2	105	2.3%	56.5%	20706	Lanham-Glenarden	9.18	2	7.43	2
20746	Suitland	13.07	2	105	2.3%	58.8%	20772	Upper Marlboro	28.12	3	18.77	2
20715	Bowie - North	19.58	2	46	1.0%	59.8%	20746	Suitland	13.07	2	13.45	2
20770	Greenbelt Area	8.15	2	42	0.9%	60.8%	20770	Greenbelt Area	8.15	2	10.35	2
20712	Mount Rainier	5.93	2	38	0.8%	61.6%	20720	Bowie - North	14.88	2	12.52	2
20720	Bowie - North	14.88	2	33	0.7%	62.4%	20715	Bowie - North	19.58	2	17.22	2
20769	Glenn Dale	14.77	2	10	0.2%	62.6%	20769	Glenn Dale	14.77	2	13.42	2
20775	Upper Marlboro	16.30	2	1	0.0%	62.6%	20718	Bowie	18.53	2	16.2	2
20788	Hyattsville	6.32	2	1	0.0%	62.6%	20623	Cheltenham	30.73	4	21.38	2
20703	Lanham-Seabrook	11.55	2	1	0.0%	62.6%	20703	Lanham-Seabrook	11.55	2	9.83	2
20718	Bowie	18.53	2	-	0.0%	62.6%	20762	Andrews AFB	20.5	3	11.83	2
20741	College Park	7.98	2	-	0.0%	62.6%	20768	Greenbelt	8.73	2	10.67	2
20768	Greenbelt	8.73	2	-	0.0%	62.6%	20771	Greenbelt	10.2	2	10.65	2
20771	Greenbelt	10.20	2	-	0.0%	62.6%	20748	Temple Hills	15.23	3	13.87	3
20799	Capitol Heights	12.17	2	-	0.0%	62.6%	20735	Clinton	24.43	3	18.83	3
20792	Upper Marlboro	16.07	2	-	0.0%	62.6%	20602	Waldorf	39.77	3	34.17	3
20772	Upper Marlboro	28.12	3	112	2.5%	65.1%	20601	Waldorf	35.27	3	29.67	3
20748	Temple Hills	15.23	3	64	1.4%	66.6%	20708	South Laurel	16.53	3	18.47	3
20735	Clinton	24.43	3	48	1.1%	67.6%	20603	Waldorf	43.12	3	37.52	3
20716	Bowie - South East	19.27	3	38	0.8%	68.5%	20613	Brandywine	36.4	3	30.8	3
20740	College Park	10.75	3	34	0.8%	69.2%	20608	Aquasco	49.7	3	44.1	3
20708	South Laurel	16.53	3	33	0.7%	70.0%	20719	Bowie	19.03	3	18.18	3
20603	Waldorf	43.12	3	18	0.4%	70.4%	20757	Temple Hills	14.97	3	14.23	3
20601	Waldorf	35.27	3	15	0.3%	70.7%	20709	Laurel	15.3	3	17.23	3
20613	Brandywine	36.40	3	15	0.3%	71.0%	20710	Bladensburg	2.62	1	10.7	4
20602	Waldorf	39.77	3	14	0.3%	71.3%	20737	Riverdale	4.5	1	10.72	4
20773	Upper Marlboro	27.07	3	4	0.1%	71.4%	20738	Riverdale Park	5.1	1	11.27	4
20719	Bowie	19.03	3	2	0.0%	71.5%	20704	Beltsville	13.6	5	16.08	5
20608	Aquasco	49.70	3	1	0.0%	71.5%	20745	Oxon Hill	17.07	6	17.42	6
20717	Bowie	20.58	3	1	0.0%	71.5%	20781	Hyattsville Area	3.88	1	12.77	6
20757	Temple Hills	14.97	3	-	0.0%	71.5%	20744	Fort Washington	23.53	6	24.18	6
20709	Laurel	15.30	3	-	0.0%	71.5%	20705	Beltsville	14.58	5	17.07	6
20762	Andrews AFB	20.50	3	-	0.0%	71.5%	20740	College Park	10.75	3	13.38	6
20782	Hyattsville-Chillum	7.97	4	37	0.8%	72.3%	20653	Lexington Park	94.48	6	88.88	6
20623	Cheltenham	30.73	4	3	0.1%	72.4%	20607	Accokeek	34.63	6	35.42	6
20742	College Park	10.03	4	1	0.0%	72.4%	20725	Laurel	21.13	5	23.07	6
20705	Beltsville	14.58	5	28	0.6%	73.0%	20749	Fort Washington	25.87	6	26.6	6
20704	Beltsville	13.60	5	-	0.0%	73.0%	20726	Laurel	19.98	5	21.92	6
20725	Laurel	21.13	5	-	0.0%	73.0%	20722	Colmar Manor	4.2	1	13.32	7
20726	Laurel	19.98	5	-	0.0%	73.0%	20707	Laurel	21.85	6	23.78	7
20745	Oxon Hill	17.07	6	55	1.2%	74.3%	20787	Hyattsville	6.23	1	13.8	7
20783	Hyattsville-Adelphi	12.22	6	55	1.2%	75.5%	20741	College Park	7.98	2	14.05	7
20744	Fort Washington	23.53	6	40	0.9%	76.4%	20742	College Park	10.03	4	16.22	8
20707	Laurel	21.85	6	39	0.9%	77.3%	20782	Hyattsville-Chillum	7.97	4	16.72	9
20653	Lexington Park	94.48	6	10	0.2%	77.5%	20712	Mount Rainier	5.93	2	15.05	9
20912	Takoma Park	12.88	6	9	0.2%	77.7%	20788	Hyattsville	6.32	2	15.47	9
20607	Accokeek	34.63	6	8	0.2%	77.9%	20903	Silver Spring-Hillandale	14.55	9	18.68	10
20749	Fort Washington	25.87	6	1	0.0%	77.9%	20904	Silver Spring-Colesville	19.45	8	21.93	10
20904	Silver Spring-Colesville	19.45	8	12	0.3%	78.1%	20783	Hyattsville-Adelphi	12.22	6	19.3	11
20903	Silver Spring-Hillandale	14.55	9	7	0.2%	78.3%	20912	Takoma Park	12.88	6	20.83	11
Total Discharges in Service Area				3,521								

Similar analyses were performed for each of the other cohorts. For MSGA 65-74, the service area included those zip codes that accounted for 86.0% of PGHC's 2013 MSGA 65-74

discharges. For this cohort, PGHC was ranked the closest hospital up to the sixth closest hospital for the identified zip codes, see table below.

Table 4
Defining PGRMC's Service Area
MSG A 65-74
FY 2013

Prince George's Hospital Center							PGRMC - Largo Location Using Ranking as Service Area Cut-Off					
Zip Code	Town	Drive Time	Rank	FY 2013			PGHC Drive Time	PGHC Rank	Drive Time	Rank		
				Discharges	%	Cumulative %						
20743	Capitol Heights Area	7.70	1	189	18.0%	18.0%	7.7	1	7.05	1		
20785	Hyattsville - Landover	5.70	1	128	12.2%	30.2%	5.7	1	5.5	1		
20747	District Heights - Forestville	12.77	1	59	5.6%	35.8%	16	2	6.45	1		
20710	Bladensburg	2.62	1	31	3.0%	38.8%	15.33	2	7.85	1		
20722	Colmar Manor	4.20	1	27	2.6%	41.3%	12.77	1	9.3	1		
20737	Riverdale	4.50	1	18	1.7%	43.0%	19.27	3	15.37	1		
20781	Hyattsville Area	3.88	1	11	1.0%	44.1%	27.07	3	17.25	1		
20753	District Heights	12.30	1	1	0.1%	44.2%	12.3	1	9.52	1		
20791	Capitol Heights	7.03	1	-	0.0%	44.2%	7.03	1	7.55	1		
20787	Hyattsville	6.23	1	-	0.0%	44.2%	20775 Upper Marlboro	16.3	2	6.68	1	
20731	Capitol Heights	7.08	1	-	0.0%	44.2%	20731 Capitol Heights	7.08	1	7.18	1	
20752	Suitland	11.03	1	-	0.0%	44.2%	20752 Suitland	11.03	1	12.82	1	
20738	Riverdale Park	5.10	1	-	0.0%	44.2%	20717 Bowie	20.58	3	14.22	1	
20797	Southern MD Facility	7.08	1	-	0.0%	44.2%	20797 Southern MD Facility	7.08	1	7.18	1	
20774	Upper Marlboro	16.00	2	115	11.0%	55.1%	20799 Capitol Heights	12.17	2	2.35	1	
20721	Bowie	15.33	2	48	4.6%	59.7%	20792 Upper Marlboro	16.07	2	6.45	1	
20784	Hyattsville - Landover Hills	5.48	2	44	4.2%	63.9%	20784 Hyattsville - Landover Hills	5.48	2	7.58	2	
20706	Lanham-Glenarden	9.18	2	31	3.0%	66.9%	20706 Lanham-Glenarden	9.18	2	7.43	2	
20715	Bowie - North	19.58	2	17	1.6%	68.5%	20772 Upper Marlboro	28.12	3	18.77	2	
20746	Suitland	13.07	2	11	1.0%	69.5%	20715 Bowie - North	19.58	2	17.22	2	
20770	Greenbelt Area	8.15	2	11	1.0%	70.6%	20746 Suitland	13.07	2	13.45	2	
20720	Bowie - North	14.88	2	8	0.8%	71.3%	20720 Bowie - North	14.88	2	12.52	2	
20769	Glenn Dale	14.77	2	6	0.6%	71.9%	20770 Greenbelt Area	8.15	2	10.35	2	
20712	Mount Rainier	5.93	2	4	0.4%	72.3%	20769 Glenn Dale	14.77	2	13.42	2	
20741	College Park	7.98	2	2	0.2%	72.5%	20623 Cheltenham	30.73	4	21.38	2	
20718	Bowie	18.53	2	-	0.0%	72.5%	20718 Bowie	18.53	2	16.2	2	
20775	Upper Marlboro	16.30	2	-	0.0%	72.5%	20703 Lanham-Seabrook	11.55	2	9.83	2	
20788	Hyattsville	6.32	2	-	0.0%	72.5%	20788 Hyattsville	6.32	2	11.83	2	
20703	Lanham-Seabrook	11.55	2	-	0.0%	72.5%	20768 Greenbelt	8.73	2	10.67	2	
20768	Greenbelt	8.73	2	-	0.0%	72.5%	20768 Greenbelt	8.73	2	10.65	2	
20771	Greenbelt	10.20	2	-	0.0%	72.5%	20771 Greenbelt	10.2	2	10.65	2	
20799	Capitol Heights	12.17	2	-	0.0%	72.5%	20748 Temple Hills	15.23	3	13.87	3	
20792	Upper Marlboro	16.07	2	-	0.0%	72.5%	20735 Clinton	24.43	3	18.83	3	
20772	Upper Marlboro	28.12	3	29	2.8%	75.2%	20602 Waldorf	39.77	3	34.17	3	
20716	Bowie - South East	19.27	3	21	2.0%	77.2%	20708 South Laurel	16.53	3	18.47	3	
20748	Temple Hills	15.23	3	19	1.8%	79.0%	20613 Brandywine	36.4	3	30.8	3	
20735	Clinton	24.43	3	8	0.8%	79.8%	20601 Waldorf	35.27	3	29.67	3	
20740	College Park	10.75	3	4	0.4%	80.2%	20603 Waldorf	43.12	3	37.52	3	
20601	Waldorf	35.27	3	3	0.3%	80.5%	20719 Bowie	19.03	3	18.18	3	
20708	South Laurel	16.53	3	2	0.2%	80.7%	20608 Aquasco	49.7	3	44.1	3	
20613	Brandywine	36.40	3	2	0.2%	80.9%	20757 Temple Hills	14.97	3	14.23	3	
20773	Upper Marlboro	27.07	3	2	0.2%	81.0%	20709 Laurel	15.3	3	17.23	3	
20603	Waldorf	43.12	3	1	0.1%	81.1%	20710 Bladensburg	2.62	1	10.7	4	
20602	Waldorf	39.77	3	-	0.0%	81.1%	20737 Riverdale	4.5	1	10.72	4	
20719	Bowie	19.03	3	-	0.0%	81.1%	20738 Riverdale Park	5.1	1	11.27	4	
20608	Aquasco	49.70	3	-	0.0%	81.1%	20704 Beltsville	13.6	5	16.08	5	
20757	Temple Hills	14.97	3	-	0.0%	81.1%	20745 Oxon Hill	17.07	6	17.42	6	
20709	Laurel	15.30	3	-	0.0%	81.1%	20781 Hyattsville Area	3.88	1	12.77	6	
20717	Bowie	20.58	3	-	0.0%	81.1%	20744 Fort Washington	23.53	6	24.18	6	
20762	Andrews AFB	20.50	3	-	0.0%	81.1%	20740 College Park	10.75	3	13.38	6	
20782	Hyattsville-Chillum	7.97	4	7	0.7%	81.8%	20705 Beltsville	14.58	5	17.07	6	
20623	Cheltenham	30.73	4	1	0.1%	81.9%	20653 Lexington Park	94.48	6	88.88	6	
20742	College Park	10.03	4	-	0.0%	81.9%	20607 Accokeek	34.63	6	35.42	6	
20705	Beltsville	14.58	5	3	0.3%	82.2%	20725 Laurel	21.13	5	23.07	6	
20704	Beltsville	13.60	5	-	0.0%	82.2%	20749 Fort Washington	25.87	6	26.6	6	
20725	Laurel	21.13	5	-	0.0%	82.2%	20726 Laurel	19.98	5	21.92	6	
20745	Oxon Hill	17.07	6	14	1.3%	83.5%	20722 Colmar Manor	4.2	1	13.32	7	
20744	Fort Washington	23.53	6	13	1.2%	84.8%	20787 Hyattsville	6.23	1	13.8	7	
20707	Laurel	21.85	6	7	0.7%	85.4%	20741 College Park	7.98	2	14.05	7	
20783	Hyattsville-Adelphi	12.22	6	4	0.4%	85.8%	20742 College Park	10.03	4	16.22	8	
20912	Takoma Park	12.88	6	1	0.1%	85.9%	20712 Mount Rainier	5.93	2	15.05	9	
20607	Accokeek	34.63	6	1	0.1%	86.0%	20782 Hyattsville-Chillum	7.97	4	16.72	9	
20653	Lexington Park	94.48	6	-	0.0%	86.0%	20788 Hyattsville	6.32	2	15.47	9	
20749	Fort Washington	25.87	6	-	0.0%	86.0%	20783 Hyattsville-Adelphi	12.22	6	19.3	11	
20749	Fort Washington	25.87	6	-	0.0%	86.0%	20912 Takoma Park	12.88	6	20.83	11	
Total Discharges in Service Area				903								

For MSGA 75+ discharges, the service area was defined as those zip codes that contributed 85.2% of PGHC's 2013 MSGA 75+ discharges. For this cohort, PGHC was ranked the closest hospital up to the ninth closest hospital for the identified zip codes, see table below.

Table 5
Defining PGRMC's Service Area
MSGA 75+
FY 2013

Prince George's Hospital Center							PGRMC - Largo Location Using Ranking as Service Area Cut-Off					
Zip Code	Town	Drive Time	Rank	FY 2013			PGHC Drive Time	PGHC Rank	Drive Time	Rank		
				Discharges	%	Cumulative %						
20743	Capitol Heights Area	7.70	1	207	17.8%	17.8%	7.7	1	7.05	1		
20785	Hyattsville - Landover	5.70	1	134	11.5%	29.2%	5.7	1	5.5	1		
20747	District Heights - Forestville	12.77	1	45	3.9%	33.1%	16	2	6.45	1		
20710	Bladensburg	2.62	1	44	3.8%	36.9%	15.33	2	7.85	1		
20737	Riverdale	4.50	1	23	2.0%	38.9%	12.77	1	9.3	1		
20781	Hyattsville Area	3.88	1	13	1.1%	40.0%	19.27	3	15.37	1		
20722	Colmar Manor	4.20	1	8	0.7%	40.7%	27.07	3	17.25	1		
20753	District Heights	12.30	1	-	0.0%	40.7%	12.3	1	9.52	1		
20791	Capitol Heights	7.03	1	-	0.0%	40.7%	7.03	1	7.55	1		
20787	Hyattsville	6.23	1	-	0.0%	40.7%	16.3	2	6.68	1		
20731	Capitol Heights	7.08	1	-	0.0%	40.7%	7.08	1	7.18	1		
20752	Suitland	11.03	1	-	0.0%	40.7%	11.03	1	12.82	1		
20738	Riverdale Park	5.10	1	-	0.0%	40.7%	20.58	3	14.22	1		
20797	Southern MD Facility	7.08	1	-	0.0%	40.7%	7.08	1	7.18	1		
20774	Upper Marlboro	16.00	2	83	7.1%	47.8%	12.17	2	2.35	1		
20721	Bowie	15.33	2	77	6.6%	54.4%	16.07	2	6.45	1		
20706	Lanham-Glenarden	9.18	2	61	5.2%	59.6%	5.48	2	7.58	2		
20784	Hyattsville - Landover Hills	5.48	2	53	4.5%	64.2%	9.18	2	7.43	2		
20715	Bowie - North	19.58	2	16	1.4%	65.5%	28.12	3	18.77	2		
20770	Greenbelt Area	8.15	2	15	1.3%	66.8%	19.58	2	17.22	2		
20746	Suitland	13.07	2	10	0.9%	67.7%	13.07	2	13.45	2		
20720	Bowie - North	14.88	2	8	0.7%	68.4%	14.88	2	12.52	2		
20712	Mount Rainier	5.93	2	7	0.6%	69.0%	8.15	2	10.35	2		
20769	Glenn Dale	14.77	2	4	0.3%	69.3%	14.77	2	13.42	2		
20718	Bowie	18.53	2	1	0.1%	69.4%	30.73	4	21.38	2		
20741	College Park	7.98	2	-	0.0%	69.4%	18.53	2	16.2	2		
20775	Upper Marlboro	16.30	2	-	0.0%	69.4%	11.55	2	9.83	2		
20788	Hyattsville	6.32	2	-	0.0%	69.4%	20.5	3	11.83	2		
20703	Lanham-Seabrook	11.55	2	-	0.0%	69.4%	8.73	2	10.67	2		
20768	Greenbelt	8.73	2	-	0.0%	69.4%	10.2	2	10.65	2		
20771	Greenbelt	10.20	2	-	0.0%	69.4%	15.23	3	13.87	3		
20799	Capitol Heights	12.17	2	-	0.0%	69.4%	24.43	3	18.83	3		
20792	Upper Marlboro	16.07	2	-	0.0%	69.4%	39.77	3	34.17	3		
20772	Upper Marlboro	28.12	3	38	3.3%	72.6%	16.53	3	18.47	3		
20716	Bowie - South East	19.27	3	18	1.5%	74.2%	20613	3	30.8	3		
20748	Temple Hills	15.23	3	15	1.3%	75.5%	20601	3	29.67	3		
20735	Clinton	24.43	3	12	1.0%	76.5%	20603	3	37.52	3		
20740	College Park	10.75	3	10	0.9%	77.4%	20719	3	18.18	3		
20601	Waldorf	35.27	3	8	0.7%	78.0%	20608	3	44.1	3		
20708	South Laurel	16.53	3	7	0.6%	78.6%	20757	3	14.23	3		
20603	Waldorf	43.12	3	6	0.5%	79.2%	20709	3	17.23	3		
20602	Waldorf	39.77	3	4	0.3%	79.5%	20710	3	10.7	4		
20613	Brandywine	36.40	3	3	0.3%	79.8%	20737	3	10.72	4		
20608	Aquasco	49.70	3	1	0.1%	79.8%	20738	3	11.27	4		
20773	Upper Marlboro	27.07	3	-	0.0%	79.8%	20704	3	16.08	5		
20719	Bowie	19.03	3	-	0.0%	79.8%	20745	3	17.42	6		
20757	Temple Hills	14.97	3	-	0.0%	79.8%	20781	3	12.77	6		
20709	Laurel	15.30	3	-	0.0%	79.8%	20744	3	24.18	6		
20717	Bowie	20.58	3	-	0.0%	79.8%	20740	3	13.38	6		
20762	Andrews AFB	20.50	3	-	0.0%	79.8%	20705	3	17.07	6		
20782	Hyattsville-Chillum	7.97	4	5	0.4%	80.3%	20653	3	88.88	6		
20623	Cheltenham	30.73	4	2	0.2%	80.4%	20607	3	35.42	6		
20742	College Park	10.03	4	1	0.1%	80.5%	20725	3	23.07	6		
20705	Beltsville	14.58	5	5	0.4%	81.0%	20749	3	26.6	6		
20704	Beltsville	13.60	5	-	0.0%	81.0%	20726	3	21.92	6		
20725	Laurel	21.13	5	-	0.0%	81.0%	20722	3	13.32	7		
20726	Laurel	19.98	5	-	0.0%	81.0%	20707	3	23.78	7		
20744	Fort Washington	23.53	6	13	1.1%	82.1%	20787	3	13.8	7		
20745	Oxon Hill	17.07	6	8	0.7%	82.8%	20741	3	14.05	7		
20783	Hyattsville-Adelphi	12.22	6	7	0.6%	83.4%	20742	3	16.22	8		
20707	Laurel	21.85	6	6	0.5%	83.9%	20712	3	15.05	9		
20653	Lexington Park	94.48	6	3	0.3%	84.1%	20782	3	16.72	9		
20912	Takoma Park	12.88	6	2	0.2%	84.3%	20788	3	15.47	9		
20607	Accokeek	34.63	6	2	0.2%	84.5%	20904	3	21.93	10		
20749	Fort Washington	25.87	6	1	0.1%	84.6%	20903	3	18.68	10		
20904	Silver Spring-Colesville	19.45	8	3	0.3%	84.8%	20783	3	19.3	11		
20903	Silver Spring-Hillandale	14.55	9	4	0.3%	85.2%	20912	3	20.83	11		
Total Discharges in Service Area				993								

For PED discharges, the service area includes those zip codes that accounted for 87.5% of PGHC's 2013 Pediatric discharges. For this cohort, PGHC was ranked the closest hospital up to the sixth closest hospital for the identified zip codes, see table below.

Table 6
Defining PGRMC's Service Area
PEDS
FY 2013

Prince George's Hospital Center							PGRMC - Largo Location Using Ranking as Service Area Cut-Off					
Zip Code	Town	Drive Time	Rank	FY 2013			PGHC Drive Time	PGHC Rank	Drive Time	Rank		
				Discharges	%	Cumulative %						
20785	Hyattsville - Landover	5.70	1	8	33.3%	33.3%	5.7	1	5.5	1		
20743	Capitol Heights Area	7.70	1	4	16.7%	50.0%	7.7	1	7.05	1		
20737	Riverdale	4.50	1	2	8.3%	58.3%	12.77	1	9.3	1		
20747	District Heights - Forestville	12.77	1	-	0.0%	58.3%	16	2	6.45	1		
20710	Bladensburg	2.62	1	-	0.0%	58.3%	15.33	2	7.85	1		
20781	Hyattsville Area	3.88	1	-	0.0%	58.3%	19.27	3	15.37	1		
20722	Colmar Manor	4.20	1	-	0.0%	58.3%	7.03	1	7.55	1		
20791	Capitol Heights	7.03	1	-	0.0%	58.3%	7.08	1	7.18	1		
20787	Hyattsville	6.23	1	-	0.0%	58.3%	27.07	3	17.25	1		
20731	Capitol Heights	7.08	1	-	0.0%	58.3%	12.3	1	9.52	1		
20753	District Heights	12.30	1	-	0.0%	58.3%	16.3	2	6.68	1		
20752	Suitland	11.03	1	-	0.0%	58.3%	11.03	1	12.82	1		
20738	Riverdale Park	5.10	1	-	0.0%	58.3%	20.58	3	14.22	1		
20797	Southern MD Facility	7.08	1	-	0.0%	58.3%	7.08	1	7.18	1		
20774	Upper Marlboro	16.00	2	5	20.8%	79.2%	12.17	2	2.35	1		
20721	Bowie	15.33	2	1	4.2%	83.3%	16.07	2	6.45	1		
20784	Hyattsville - Landover Hills	5.48	2	-	0.0%	83.3%	5.48	2	7.58	2		
20706	Lanham-Glenarden	9.18	2	-	0.0%	83.3%	9.18	2	7.43	2		
20746	Suitland	13.07	2	-	0.0%	83.3%	13.07	2	13.45	2		
20770	Greenbelt Area	8.15	2	-	0.0%	83.3%	8.15	2	10.35	2		
20720	Bowie - North	14.88	2	-	0.0%	83.3%	28.12	3	18.77	2		
20712	Mount Rainier	5.93	2	-	0.0%	83.3%	14.88	2	12.52	2		
20715	Bowie - North	19.58	2	-	0.0%	83.3%	19.58	2	17.22	2		
20769	Glenn Dale	14.77	2	-	0.0%	83.3%	14.77	2	13.42	2		
20741	College Park	7.98	2	-	0.0%	83.3%	11.55	2	9.83	2		
20703	Lanham-Seabrook	11.55	2	-	0.0%	83.3%	30.73	4	21.38	2		
20718	Bowie	18.53	2	-	0.0%	83.3%	18.53	2	16.2	2		
20775	Upper Marlboro	16.30	2	-	0.0%	83.3%	20.5	3	11.83	2		
20788	Hyattsville	6.32	2	-	0.0%	83.3%	8.73	2	10.67	2		
20768	Greenbelt	8.73	2	-	0.0%	83.3%	10.2	2	10.65	2		
20771	Greenbelt	10.20	2	-	0.0%	83.3%	15.23	3	13.87	3		
20799	Capitol Heights	12.17	2	-	0.0%	83.3%	24.43	3	18.83	3		
20792	Upper Marlboro	16.07	2	-	0.0%	83.3%	16.53	3	18.47	3		
20748	Temple Hills	15.23	3	-	0.0%	83.3%	36.4	3	30.8	3		
20735	Clinton	24.43	3	-	0.0%	83.3%	43.12	3	37.52	3		
20772	Upper Marlboro	28.12	3	-	0.0%	83.3%	39.77	3	34.17	3		
20708	South Laurel	16.53	3	-	0.0%	83.3%	35.27	3	29.67	3		
20740	College Park	10.75	3	-	0.0%	83.3%	19.03	3	18.18	3		
20716	Bowie - South East	19.27	3	-	0.0%	83.3%	49.7	3	44.1	3		
20613	Brandywine	36.40	3	-	0.0%	83.3%	14.97	3	14.23	3		
20603	Waldorf	43.12	3	-	0.0%	83.3%	15.3	3	17.23	3		
20602	Waldorf	39.77	3	-	0.0%	83.3%	4.5	1	10.72	4		
20601	Waldorf	35.27	3	-	0.0%	83.3%	2.62	1	10.7	4		
20719	Bowie	19.03	3	-	0.0%	83.3%	5.1	1	11.27	4		
20608	Aquasco	49.70	3	-	0.0%	83.3%	13.6	5	16.08	5		
20757	Temple Hills	14.97	3	-	0.0%	83.3%	17.07	6	17.42	6		
20773	Upper Marlboro	27.07	3	-	0.0%	83.3%	23.53	6	24.18	6		
20709	Laurel	15.30	3	-	0.0%	83.3%	3.88	1	12.77	6		
20717	Bowie	20.58	3	-	0.0%	83.3%	14.58	5	17.07	6		
20762	Andrews AFB	20.50	3	-	0.0%	83.3%	10.75	3	13.38	6		
20782	Hyattsville-Chillum	7.97	4	-	0.0%	83.3%	34.63	6	35.42	6		
20623	Cheltenham	30.73	4	-	0.0%	83.3%	25.87	6	26.6	6		
20742	College Park	10.03	4	-	0.0%	83.3%	94.48	6	88.88	6		
20705	Beltsville	14.58	5	-	0.0%	83.3%	21.13	5	23.07	6		
20704	Beltsville	13.60	5	-	0.0%	83.3%	19.98	5	21.92	6		
20725	Laurel	21.13	5	-	0.0%	83.3%	4.2	1	13.32	7		
20726	Laurel	19.98	5	-	0.0%	83.3%	21.85	6	23.78	7		
20707	Laurel	21.85	6	1	4.2%	87.5%	6.23	1	13.8	7		
20744	Fort Washington	23.53	6	-	0.0%	87.5%	10.03	4	16.22	8		
20783	Hyattsville-Adelphi	12.22	6	-	0.0%	87.5%	7.97	4	16.72	9		
20607	Accokeek	34.63	6	-	0.0%	87.5%	5.93	2	15.05	9		
20912	Takoma Park	12.88	6	-	0.0%	87.5%	6.32	2	15.47	9		
20749	Fort Washington	25.87	6	-	0.0%	87.5%	12.22	6	19.3	11		
20653	Lexington Park	94.48	6	-	0.0%	87.5%	12.88	6	20.83	11		
Total Discharges in Service Area				21								

For OB discharges, the service area includes those zip codes that accounted for 90.8% of PGHC's 2013 OB discharges. For this cohort, PGHC was ranked the closest hospital up to the fourth closest hospital for the identified zip codes. In determining the ranking of closest hospitals for OB, PGHC was compared only to those hospitals offering OB services, see table below.

Table 7
Defining PGRMC's Service Area
OB
FY 2013

Prince George's Hospital Center							PGRMC - Largo Location Using Ranking as Service Area Cut-Off					
Zip Code	Town	Drive Time	Rank	FY 2013 Discharges	%	Cumulative %	Zip Code	Town	PGHC Drive Time	PGHC Rank	Drive Time	Rank
20785	Hyattsville - Landover	5.70	1	244	10.7%	10.7%	20785	Hyattsville - Landover	5.7	1	5.5	1
20743	Capitol Heights Area	7.70	1	227	9.9%	20.6%	20743	Capitol Heights Area	7.7	1	7.05	1
20706	Lanham-Glenarden	9.18	1	176	7.7%	28.3%	20784	Hyattsville - Landover Hills	5.48	1	7.58	1
20784	Hyattsville - Landover Hills	5.48	1	171	7.5%	35.8%	20706	Lanham-Glenarden	9.18	1	7.43	1
20747	District Heights - Forestville	12.77	1	168	7.3%	43.1%	20747	District Heights - Forestville	12.77	1	9.3	1
20737	Riverdale	4.50	1	125	5.5%	48.6%	20774	Upper Marlboro	16	1	6.45	1
20774	Upper Marlboro	16.00	1	81	3.5%	52.1%	20770	Greenbelt Area	8.15	1	10.35	1
20710	Bladensburg	2.62	1	57	2.5%	54.6%	20721	Bowie	15.33	1	7.85	1
20781	Hyattsville Area	3.88	1	49	2.1%	56.7%	20720	Bowie - North	14.88	1	12.52	1
20770	Greenbelt Area	8.15	1	41	1.8%	58.5%	20716	Bowie - South East	19.27	2	15.37	1
20721	Bowie	15.33	1	32	1.4%	59.9%	20715	Bowie - North	19.58	1	17.22	1
20720	Bowie - North	14.88	1	16	0.7%	60.6%	20769	Glenn Dale	14.77	1	13.42	1
20722	Colmar Manor	4.20	1	12	0.5%	61.1%	20773	Upper Marlboro	27.07	2	17.25	1
20715	Bowie - North	19.58	1	12	0.5%	61.7%	20753	District Heights	12.3	1	9.52	1
20769	Glenn Dale	14.77	1	7	0.3%	62.0%	20775	Upper Marlboro	16.3	1	6.68	1
20787	Hyattsville	6.23	1	4	0.2%	62.2%	20731	Capitol Heights	7.08	1	7.18	1
20753	District Heights	12.30	1	-	0.0%	62.2%	20791	Capitol Heights	7.03	1	7.55	1
20731	Capitol Heights	7.08	1	-	0.0%	62.2%	20752	Suitland	11.03	1	12.82	1
20791	Capitol Heights	7.03	1	-	0.0%	62.2%	20717	Bowie	20.58	2	14.22	1
20752	Suitland	11.03	1	-	0.0%	62.2%	20797	Southern MD Facility	7.08	1	7.18	1
20738	Riverdale Park	5.10	1	-	0.0%	62.2%	20799	Capitol Heights	12.17	1	2.35	1
20797	Southern MD Facility	7.08	1	-	0.0%	62.2%	20792	Upper Marlboro	16.07	1	6.45	1
20718	Bowie	18.53	1	-	0.0%	62.2%	20718	Bowie	18.53	1	16.2	1
20775	Upper Marlboro	16.30	1	-	0.0%	62.2%	20703	Lanham-Seabrook	11.55	1	9.83	1
20741	College Park	7.98	1	-	0.0%	62.2%	20768	Greenbelt	8.73	1	10.67	1
20703	Lanham-Seabrook	11.55	1	-	0.0%	62.2%	20771	Greenbelt	10.2	1	10.65	1
20768	Greenbelt	8.73	1	-	0.0%	62.2%	20746	Suitland	13.07	2	13.45	2
20771	Greenbelt	10.20	1	-	0.0%	62.2%	20748	Temple Hills	15.23	2	13.87	2
20799	Capitol Heights	12.17	1	-	0.0%	62.2%	20735	Clinton	24.43	2	18.83	2
20792	Upper Marlboro	16.07	1	-	0.0%	62.2%	20772	Upper Marlboro	28.12	2	18.77	2
20748	Temple Hills	15.23	2	124	5.4%	67.6%	20708	South Laurel	16.53	2	18.47	2
20746	Suitland	13.07	2	108	4.7%	72.3%	20613	Brandywine	36.4	2	30.8	2
20772	Upper Marlboro	28.12	2	34	1.5%	73.8%	20602	Waldorf	39.77	2	34.17	2
20735	Clinton	24.43	2	31	1.4%	75.1%	20601	Waldorf	35.27	2	29.67	2
20740	College Park	10.75	2	21	0.9%	76.0%	20603	Waldorf	43.12	2	37.52	2
20712	Mount Rainier	5.93	2	20	0.9%	76.9%	20719	Bowie	19.03	2	18.18	2
20716	Bowie - South East	19.27	2	19	0.8%	77.8%	20623	Cheltenham	30.73	2	21.38	2
20708	South Laurel	16.53	2	18	0.8%	78.5%	20762	Andrews AFB	20.5	2	11.83	2
20613	Brandywine	36.40	2	8	0.3%	78.9%	20608	Aquasco	49.7	2	44.1	2
20602	Waldorf	39.77	2	5	0.2%	79.1%	20757	Temple Hills	14.97	2	14.23	2
20601	Waldorf	35.27	2	5	0.2%	79.3%	20709	Laurel	15.3	2	17.23	2
20623	Cheltenham	30.73	2	1	0.0%	79.4%	20653	Lexington Park	94.48	2	88.88	2
20603	Waldorf	43.12	2	-	0.0%	79.4%	20737	Riverdale	4.5	1	10.72	3
20719	Bowie	19.03	2	-	0.0%	79.4%	20710	Bladensburg	2.62	1	10.7	3
20788	Hyattsville	6.32	2	-	0.0%	79.4%	20738	Riverdale Park	5.1	1	11.27	3
20773	Upper Marlboro	27.07	2	-	0.0%	79.4%	20745	Oxon Hill	17.07	4	17.42	4
20608	Aquasco	49.70	2	-	0.0%	79.4%	20744	Fort Washington	23.53	4	24.18	4
20757	Temple Hills	14.97	2	-	0.0%	79.4%	20781	Hyattsville Area	3.88	1	12.77	4
20709	Laurel	15.30	2	-	0.0%	79.4%	20607	Accokeek	34.63	4	35.42	4
20717	Bowie	20.58	2	-	0.0%	79.4%	20749	Fort Washington	25.87	4	26.6	4
20762	Andrews AFB	20.50	2	-	0.0%	79.4%	20704	Beltsville	13.60	4	-	4
20653	Lexington Park	94.48	2	-	0.0%	79.4%	20725	Laurel	19.98	4	21.92	5
20742	College Park	10.03	3	-	0.0%	79.4%	20726	Laurel	19.98	4	21.92	5
20745	Oxon Hill	17.07	4	111	4.9%	84.2%	20787	Hyattsville	6.23	1	13.8	5
20744	Fort Washington	23.53	4	78	3.4%	87.6%	20741	College Park	7.98	1	14.05	5
20782	Hyattsville-Chillum	7.97	4	45	2.0%	89.6%	20742	College Park	10.03	3	16.22	6
20705	Beltsville	14.58	4	20	0.9%	90.5%	20782	Hyattsville-Chillum	7.97	4	16.72	7
20607	Accokeek	34.63	4	7	0.3%	90.8%	20712	Mount Rainier	5.93	2	15.05	7
20749	Fort Washington	25.87	4	-	0.0%	90.8%	20728	Hyattsville	6.32	2	15.47	7
20704	Beltsville	13.60	4	-	0.0%	90.8%						
20725	Laurel	21.13	4	-	0.0%	90.8%						
20726	Laurel	19.98	4	-	0.0%	90.8%						
Total Discharges in Service Area				2,077								

For PSY discharges, the service area includes those zip codes that accounted for 85.7% of PGHC's 2013 Psychiatric discharges. For this cohort, PGHC was ranked the closest hospital up to the eighth closest hospital for the identified zip code, see table below.

Table 8
Defining PGRMC's Service Area
PSY 18+
FY 2013

Prince George's Hospital Center							PGRMC - Largo Location Using Ranking as Service Area Cut-Off					
Zip Code	Town	Drive Time	Rank	FY 2013 Discharges	%	Cumulative %	Zip Code	Town	PGHC Drive Time	PGHC Rank	Drive Time	Rank
20785	Hyattsville - Landover	5.70	1	171	12.6%	12.6%	20743	Capitol Heights Area	7.7	1	7.05	1
20743	Capitol Heights Area	7.70	1	115	8.5%	21.0%	20785	Hyattsville - Landover	5.7	1	5.5	1
20747	District Heights - Forestville	12.77	1	80	5.9%	26.9%	20774	Upper Marlboro	16	2	6.45	1
20737	Riverdale	4.50	1	48	3.5%	30.5%	20747	District Heights - Forestville	12.77	1	9.3	1
20710	Bladensburg	2.62	1	26	1.9%	32.4%	20721	Bowie	15.33	2	7.85	1
20781	Hyattsville Area	3.88	1	19	1.4%	33.8%	20716	Bowie - South East	19.27	3	15.37	1
20722	Colmar Manor	4.20	1	10	0.7%	34.5%	20791	Capitol Heights	7.03	1	7.55	1
20731	Capitol Heights	7.08	1	1	0.1%	34.6%	20731	Capitol Heights	7.08	1	7.18	1
20791	Capitol Heights	7.03	1	-	0.0%	34.6%	20773	Upper Marlboro	27.07	3	17.25	1
20787	Hyattsville	6.23	1	-	0.0%	34.6%	20753	District Heights	12.3	1	9.52	1
20753	District Heights	12.30	1	-	0.0%	34.6%	20775	Upper Marlboro	16.3	2	6.68	1
20752	Suitland	11.03	1	-	0.0%	34.6%	20752	Suitland	11.03	1	12.82	1
20738	Riverdale Park	5.10	1	-	0.0%	34.6%	20717	Bowie	20.58	3	14.22	1
20797	Southern MD Facility	7.08	1	-	0.0%	34.6%	20797	Southern MD Facility	7.08	1	7.18	1
20774	Upper Marlboro	16.00	2	98	7.2%	41.8%	20799	Capitol Heights	12.17	2	2.35	1
20706	Lanham-Glenarden	9.18	2	77	5.7%	47.5%	20792	Upper Marlboro	16.07	2	6.45	1
20784	Hyattsville - Landover Hills	5.48	2	71	5.2%	52.7%	20706	Lanham-Glenarden	9.18	2	7.43	2
20746	Suitland	13.07	2	37	2.7%	55.4%	20784	Hyattsville - Landover Hills	5.48	2	7.58	2
20770	Greenbelt Area	8.15	2	28	2.1%	57.5%	20772	Upper Marlboro	28.12	3	18.77	2
20721	Bowie	15.33	2	27	2.0%	59.5%	20746	Suitland	13.07	2	13.45	2
20715	Bowie - North	19.58	2	22	1.6%	61.1%	20770	Greenbelt Area	8.15	2	10.35	2
20712	Mount Rainier	5.93	2	14	1.0%	62.1%	20715	Bowie - North	19.58	2	17.22	2
20720	Bowie - North	14.88	2	11	0.8%	62.9%	20720	Bowie - North	14.88	2	12.52	2
20769	Glenn Dale	14.77	2	9	0.7%	63.6%	20769	Glenn Dale	14.77	2	13.42	2
20741	College Park	7.98	2	1	0.1%	63.6%	20703	Lanham-Seabrook	11.55	2	9.83	2
20792	Upper Marlboro	16.07	2	1	0.1%	63.7%	20623	Cheltenham	30.73	4	21.38	2
20703	Lanham-Seabrook	11.55	2	-	0.0%	63.7%	20718	Bowie	18.53	2	16.2	2
20718	Bowie	18.53	2	-	0.0%	63.7%	20762	Andrews AFB	20.5	3	11.83	2
20775	Upper Marlboro	16.30	2	-	0.0%	63.7%	20768	Greenbelt	8.73	2	10.67	2
20788	Hyattsville	6.32	2	-	0.0%	63.7%	20771	Greenbelt	10.2	2	10.67	2
20768	Greenbelt	8.73	2	-	0.0%	63.7%	20748	Temple Hills	15.23	3	13.87	3
20771	Greenbelt	10.20	2	-	0.0%	63.7%	20735	Clinton	24.43	3	18.83	3
20799	Capitol Heights	12.17	2	-	0.0%	63.7%	20708	South Laurel	16.53	3	18.47	3
20748	Temple Hills	15.23	3	38	2.8%	66.5%	20602	Waldorf	39.77	3	34.17	3
20772	Upper Marlboro	28.12	3	32	2.4%	68.9%	20613	Brandywine	36.4	3	30.8	3
20716	Bowie - South East	19.27	3	22	1.6%	70.5%	20603	Waldorf	43.12	3	37.52	3
20735	Clinton	24.43	3	21	1.5%	72.0%	20608	Aquasco	49.7	3	44.1	3
20740	College Park	10.75	3	17	1.3%	73.3%	20757	Temple Hills	14.97	3	14.23	3
20708	South Laurel	16.53	3	9	0.7%	74.0%	20601	Waldorf	35.27	3	29.67	3
20613	Brandywine	36.40	3	2	0.1%	74.1%	20719	Bowie	19.03	3	18.18	3
20603	Waldorf	43.12	3	1	0.1%	74.2%	20709	Laurel	15.3	3	17.23	3
20762	Andrews AFB	20.50	3	1	0.1%	74.2%	20737	Riverdale	4.5	1	10.72	4
20602	Waldorf	39.77	3	-	0.0%	74.2%	20710	Bladensburg	2.62	1	10.7	4
20608	Aquasco	49.70	3	-	0.0%	74.2%	20738	Riverdale Park	5.1	1	11.27	4
20757	Temple Hills	14.97	3	-	0.0%	74.2%	20704	Beltsville	13.6	5	16.08	5
20601	Waldorf	35.27	3	-	0.0%	74.2%	20745	Oxon Hill	17.07	6	17.42	6
20773	Upper Marlboro	27.07	3	-	0.0%	74.2%	20744	Fort Washington	23.53	6	24.18	6
20719	Bowie	19.03	3	-	0.0%	74.2%	20740	College Park	10.75	3	13.38	6
20709	Laurel	15.30	3	-	0.0%	74.2%	20781	Hyattsville Area	3.88	1	12.77	6
20717	Bowie	20.58	3	-	0.0%	74.2%	20705	Beltsville	14.58	5	17.07	6
20782	Hyattsville-Chillum	7.97	4	25	1.8%	76.1%	20607	Accokeek	34.63	6	35.42	6
20623	Cheltenham	30.73	4	1	0.1%	76.2%	20653	Lexington Park	94.48	6	88.88	6
20742	College Park	10.03	4	-	0.0%	76.2%	20725	Laurel	21.13	5	23.07	6
20705	Beltsville	14.58	5	11	0.8%	77.0%	20749	Fort Washington	25.87	6	26.6	6
20704	Beltsville	13.60	5	-	0.0%	77.0%	20726	Laurel	19.98	5	21.92	6
20725	Laurel	21.13	5	-	0.0%	77.0%	20707	Laurel	21.85	6	23.78	7
20726	Laurel	19.98	5	-	0.0%	77.0%	20722	Colmar Manor	4.2	1	13.32	7
20745	Oxon Hill	17.07	6	35	2.6%	79.5%	20787	Hyattsville	6.23	1	13.8	7
20783	Hyattsville-Adelphi	12.22	6	28	2.1%	81.6%	20741	College Park	7.98	2	14.05	7
20707	Laurel	21.85	6	17	1.3%	82.9%	20742	College Park	10.03	4	16.22	8
20744	Fort Washington	23.53	6	16	1.2%	84.0%	20782	Hyattsville-Chillum	7.97	4	16.72	9
20912	Takoma Park	12.88	6	6	0.4%	84.5%	20712	Mount Rainier	5.93	2	15.05	9
20607	Accokeek	34.63	6	3	0.2%	84.7%	20788	Hyattsville	6.32	2	15.47	9
20653	Lexington Park	94.48	6	-	0.0%	84.7%	20903	Silver Spring-Hillandale	14.55	9	18.68	10
20749	Fort Washington	25.87	6	-	0.0%	84.7%	20904	Silver Spring-Colesville	19.45	8	21.93	10
20904	Silver Spring-Colesville	19.45	8	14	1.0%	85.7%	20783	Hyattsville-Adelphi	12.22	6	19.3	11
Total Discharges in Service Area				1,165								

Impact of Changes in Population and Use Rates

The projection of inpatient utilization takes into consideration a number of factors including:

- Change in service area population related to the relocation of the hospital
- Projected increase in over-65 population for Prince George's County

- Current Prince George’s County inpatient utilization rate in comparison to national and State inpatient utilization rates
- PGHC’s existing recent initiatives to reduce inpatient cases (conversion of one-day inpatient stays into observation cases, progress on reducing readmissions / avoidable admissions, etc.).

Redefining the service area for the new location results in a reduction in the 2012 service area population by 16.9%. Based on PGRMC’s future service area, population growth assumptions through 2022 were obtained from Claritas at the six cohort levels.

**Table 9
PGRMC Projected Service Area Population
2022**

Age Group	PGHC Service Area Population 2012	PGRMC Service Area Population		
		2012	2022	% Change
75+	42,466	34,792	51,601	48.3%
65-74	68,447	55,106	92,052	67.0%
15-64	746,598	644,648	658,017	2.1%
0-14	198,006	168,128	173,139	3.0%
Total	1,055,517	902,674	974,809	8.0%
PSY 18+	813,989	670,188	737,554	10.1%
OB	197,916	169,791	160,659	-5.4%

Note: PSY and OB are subsets of the total population

For Pediatrics, Dimensions used the population age 0-14. For Psychiatric, Dimensions used the population 18 and older. For OB, PGHC used the population of women age 15-44.

PGHC, like many hospitals, has experienced a significant conversion of admissions with one day lengths of stay (“ODS”) to outpatient observation status. The impact of this is to reduce inpatient admission use rates. Dimensions looked at the admissions in Prince George’s County zip codes and analyzed the use rates with and without the impact of ODS. Table 10 shows that the 14% reduction in the total inpatient admission use rate from 2008 to 2013 was exacerbated by the 25% reduction in use rate for admissions with one day lengths of stay.

Table 10
ODS Analysis – Prince George’s County Zip Codes
FY 2008 – FY 2013

Rankings Service Area	MSGA (15+)						2008-13 % Change
	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	
Population	666,842	672,666	678,489	684,312	694,965	703,372	
% Change		0.9%	0.9%	0.9%	1.6%	1.2%	5.5%
Utilization							
Admissions, excluding ODS	71,578	74,165	71,450	70,570	67,853	66,453	
% Change		3.6%	-3.7%	-1.2%	-3.9%	-2.1%	-7.2%
ODS	14,997	16,324	15,641	14,554	12,798	11,775	
% Change		8.8%	-4.2%	-6.9%	-12.1%	-8.0%	-21.5%
Total Admissions	86,575	90,489	87,091	85,124	80,651	78,228	
% Change		4.5%	-3.8%	-2.3%	-5.3%	-3.0%	-9.6%
Use Rates per 1000 Population							
Admissions, excluding ODS	107.3	110.3	105.3	103.1	97.6	94.5	
% Change		2.7%	-4.5%	-2.1%	-5.3%	-3.2%	-12.0%
ODS	22.5	24.3	23.1	21.3	18.4	16.7	
% Change		7.9%	-5.0%	-7.7%	-13.4%	-9.1%	-25.6%
Total Admissions	129.8	134.5	128.4	124.4	116.1	111.2	
% Change		3.6%	-4.6%	-3.1%	-6.7%	-4.2%	-14.3%

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

Table 11
PGHC Observation Cases
FY2008-FY2013

	Inpatient	Outpatient	Total
FY 2008			785
FY 2009			1,471
FY 2010	124	2,261	2,385
FY 2011	171	3,006	3,177
FY 2012	878	4,519	5,397
FY 2013	943	4,056	4,999

Dimensions projects that the ODS conversion will continue with the majority of the decline through 2017.

To calculate the projected use rates, Dimensions relied upon forecasts from Sg2 and Milliman. The projected change in inpatient utilization rates were developed in conjunction with a review of 10-year inpatient utilization forecasts from Sg2, a health care analytics consulting firm, and Milliman, an actuarial firm with claims data for approximately half of the nation’s commercial insurers.

The table below shows Sg2 forecasts for the years of 2013, 2018 and 2023 averaged across the US population. The table outlines the forecasted number of discharges for the US,

total US projected population and the number of discharges per 1,000 population, and illustrates a projected national ten-year decline of total discharges of 3.7% and a projected national inpatient utilization rate decline of 9.7%.

Table 12: Select Sg2 Forecast of Discharges

Year	Projected US Discharges	Projected US Population	Discharges per 1,000 Population
2013	39,568,076	314,861,807	125.7
2018	39,137,520	325,322,193	120.3
2023	38,101,000	335,782,579	113.5

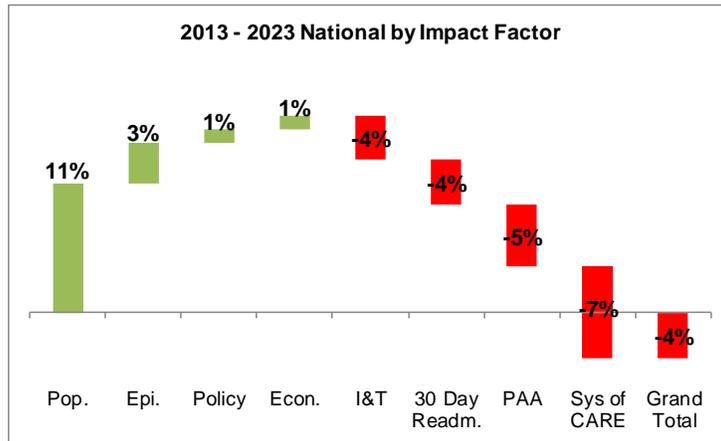
The table below shows Sg2's national inpatient forecast by year, illustrating factors that are considered in their forecast model. The forecast shows inpatient discharges and includes all DRGs including neonatal/newborn discharges. Factors considered include the population growth, economic factors, changes in healthcare technology, policy formation, and changes in provision of care. **Exhibit 25** provides more detail on Sg2's modeling for inpatient forecasting. The 3.7% decline in the table represents the net impact of population, utilization rate, and other factors. The national inpatient utilization rate alone declined 9.7% over the period 2013-2023.

Table 13: Sg2 National Inpatient Forecast

Sg2 National Inpatient Forecast												
Impact Factor	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	
Index	39,568,076	39,568,076	39,568,076	39,568,076	39,568,076	39,568,076	39,568,076	39,568,076	39,568,076	39,568,076	39,568,076	
Population		420,391	840,782	1,261,173	1,681,564	2,101,955	2,522,347	2,942,738	3,363,129	3,783,520	4,203,911	
Epidemiology		227,899	453,722	673,030	876,606	1,056,518	1,200,741	1,287,231	1,325,207	1,327,255	1,315,373	
Economy		51,142	129,087	249,666	387,261	527,176	584,209	581,680	531,231	480,164	428,483	
Policy		204,795	278,861	325,196	371,776	420,903	444,482	426,398	410,203	411,155	415,835	
Innovation and Technology		-135,815	-280,739	-437,862	-609,127	-775,892	-919,361	-1,044,784	-1,169,181	-1,290,715	-1,412,047	
30-Day Readmissions		-228,209	-468,056	-714,231	-900,138	-1,033,407	-1,143,116	-1,214,873	-1,289,961	-1,368,361	-1,446,357	
Potentially Avoidable Admissions		-66,878	-200,157	-431,151	-766,680	-1,097,362	-1,368,320	-1,582,872	-1,726,768	-1,873,544	-2,022,210	
Systems of CARE		-228,286	-490,145	-822,788	-1,226,180	-1,630,448	-1,964,818	-2,237,276	-2,479,372	-2,713,841	-2,950,064	
Grand Total	39,568,076	39,813,115	39,831,432	39,671,109	39,383,159	39,137,520	38,924,239	38,726,318	38,532,563	38,323,709	38,101,000	
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	10 Year Growth
Sg2 Forecast	39,568,076	39,813,115	39,831,432	39,671,109	39,383,159	39,137,520	38,924,239	38,726,318	38,532,563	38,323,709	38,101,000	-3.7%
Population-based Only	39,568,076	39,988,467	40,408,858	40,829,249	41,249,640	41,670,032	42,090,423	42,510,814	42,931,205	43,351,596	43,771,987	10.6%

The following graph shows how various individual factors impact the projected forecast of inpatient discharges in Sg2's forecasting model.

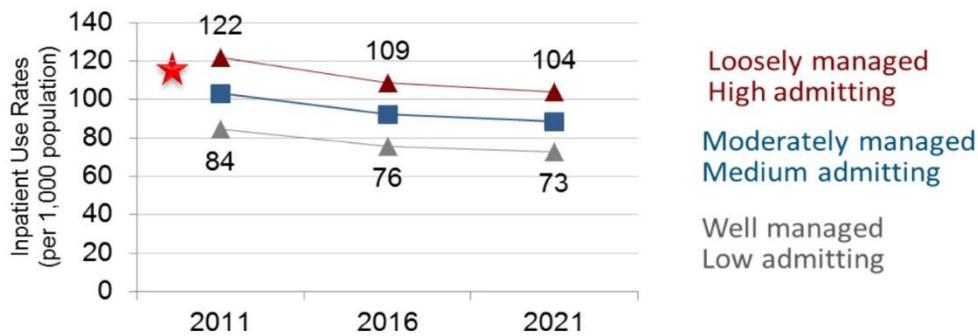
Figure 4: Factors for Sg2 National Forecast



The following graph shows a 10-year trend line, as estimated by Milliman in a private study conducted in 2011 for Kaufman, Hall & Associates. According to Milliman, “moderate” levels of management are likely to be more representative of aggregate best practice for overall levels of medical service utilization, with inpatient admissions per 1,000 projected to drop from 103 in 2011 to 88 in 2021. Loosely managed healthcare markets are expected to see declines to reach the 104 discharges per 1,000 population utilization rate.

According to Kaufman Hall & Associates, Milliman’s projected utilization rates are exclusive of newborn discharges. The Sg2 inpatient forecasts include newborn discharges. Therefore, in studying these forecasts of inpatient rates, it is important to recognize this difference for comparison purposes. Generally, newborn/neonatal discharges represent approximately 9-10% of total inpatient discharges for a population segment (Source: Sg2 forecast model). Given this assumption, the Milliman projected moderate managed care inpatient utilization rate for 2021 would be approximately 97-98 discharges per 1,000 population.

Figure 5: Milliman Projections for Inpatient Use Rates for Total Population (2011-2021)



★ 2010 National Inpatient Use Rate = 115

Sources: Independent actuarial database, Kaiser State Health Facts, AHA

Based on the national forecasts and current inpatient utilization rates of Prince George’s County, Dimensions concluded it is appropriate to reduce MSGA utilization rates by

approximately 11.2% over the projection period. In comparison to forecasted utilization rates by Sg2, the projected utilization rates for the PGRMC service area are significantly lower than what is being projected for national rates by Sg2. This is illustrated in the following table.

Table 14
Projected Utilization Rates PGRMC
PGRMC vs. National Rates
2012, 2018

		National Source: Sg2	Prince George's vs. Nation
Prince George's County			
2012 Total Discharges (incl. Births)	95,850		
2012 Total Population	891,455		
2012 PG County Use Rate	107.52	125.67 ⁽¹⁾	-14.40%
Prince George's Regional Medical Center Service Area			
2018 Projected Discharges (incl. Births)	96,094		
2018 Projected Population	975,840		
2018 PGRMC Service Area Use Rate	98.47	120.3	-18.10%
% Change	-8.40%	-4.30%	

(1) 125.67 represents the 2013 National utilization rate. The PG County utilization rate is based on 2012 data.

In addition, Dimensions expects a 2% decline in OB use rates at PGHC/PGRMC. An increase in the PED use rate in 2013 will be offset by reductions in 2014 through 2017. The PSY use rate is not projected to change over the projection period.

Dimensions concluded that it is appropriate to estimate decreases in the utilization rates in the early years of the projection period and estimate stable rates in the later projection years. For the later years, Dimensions believes utilization rate decline drivers (e.g., reductions of readmission rates, reduced avoidable admissions, medical home management initiatives, etc.) will be offset by the increased demands of inpatient care driven by the increasing over-65 age population within Prince George's County.

The projected changes in use rates, by cohort by year, is presented below:

Table 15: Projected Utilization Rates for PGHC / PGRMC

	Actual		Projected									FY12 - FY22
	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	Change
MSGA 75+	404.15	384.92	373.37	365.91	362.25	359.03	359.03	359.03	359.03	359.03	359.03	
% Change		-4.8%	-3.0%	-2.0%	-1.0%	-0.9%	0.0%	0.0%	0.0%	0.0%	0.0%	-11.2%
MSGA 65-74	212.75	207.35	201.13	195.10	191.20	189.28	188.91	188.91	188.91	188.91	188.91	
% Change		-2.5%	-3.0%	-3.0%	-2.0%	-1.0%	-0.2%	0.0%	0.0%	0.0%	0.0%	-11.2%
MSGA 15-64	64.74	61.31	59.47	58.28	57.69	57.49	57.49	57.49	57.49	57.49	57.49	
% Change		-5.3%	-3.0%	-2.0%	-1.0%	-0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	-11.2%
PSY 18+	5.50	5.48	5.50	5.50	5.50	5.50	5.50	5.50	5.50	5.50	5.50	
% Change		-0.4%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
OB	66.68	66.21	65.55	65.34	65.34	65.34	65.34	65.34	65.34	65.34	65.34	
% Change		-0.7%	-1.0%	-0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-2.0%
PEDS	20.08	22.26	21.60	20.95	20.53	20.12	20.08	20.08	20.08	20.08	20.08	
% Change		10.9%	-3.0%	-3.0%	-2.0%	-2.0%	-0.2%	0.0%	0.0%	0.0%	0.0%	0.0%

The projected 2022 use rates were applied to the 2022 population at the cohort level for the proposed PGRMC service area to determine expected service area discharges by cohort.

**Table 16
PGRMC Service Area Discharges, by Cohort
FY 2022**

	FY 2022 Use Rate	FY 2022 Service Area Population	FY 2022 Service Area Discharges
MSGA 75+	359.0	51,601	18,526
MSGA 65-74	188.9	92,052	17,390
MSGA 15-64	57.5	658,017	37,827
PSY 18+	5.5	737,554	4,060
OB	65.3	160,659	10,498
PEDS	20.1	173,139	3,477
Total	94.1	974,809	91,778

Note (1): OB and PSY populations are subsets of the total population

Total discharges by zip code were determined using each zip code's proportion of the service area in 2013

Change in Market Share due to Relocation

For each of the zip codes in PGRMC's projected service areas, the initial expected market share at PGRMC was based on PGHC's average market share for zip codes of a similar proximity ranking in FY 2013. Using PGHC's 2013 data, Dimensions calculated the average market share for all of the zip codes where PGHC was the closest hospital. Dimensions then applied this average market share to all zip codes where PGRMC would be the closest hospital.

The initial expected MSGA 15-64 market shares, by zip code, are presented on the following two pages with examples described below.

- In 2013, PGHC had an average market share of 21.2% of MSGA 15-64 discharges in zip codes where it ranked as the closest hospital. Upon moving to Largo, PGRMC

would be the closest hospital to zip code 20716. As a result, Dimensions assumes that PGRMC will have an initial market share in zip code 20716 of 21.2%.

- Similarly, PGHC was ranked as the closest hospital to zip code 20710 in 2013 and possessed a market share of 30.1% of MSGA 15-64 discharges. Upon moving to Largo, PGRMC would be the fourth closest hospital to this zip code. In 2013, PGHC's average market share in zip codes where it ranked as the fourth closest hospital was 3.4%. As such, PGHC assumes that PGRMC will have an initial market share in zip code 20710 of 3.4%.

Table 17
Effect of Relocation on Market Share MSGA 15 – 64

PGHC					PGRMC				
Zip Code	Ranking	Discharges	Code Discharges	Market Share	Zip Code	Ranking	Market Share	Total Zip Code Discharges	Projected Discharges
20743	1	564	2,328	24.2%	20743	1	21.2%	2,328	494
20785	1	631	2,112	29.9%	20785	1	21.2%	2,112	448
20747	1	248	2,139	11.6%	20774	1	21.2%	1,791	380
20737	1	121	812	14.9%	20747	1	21.2%	2,139	454
20710	1	120	399	30.1%	20721	1	21.2%	932	198
20781	1	72	440	16.4%	20716	1	21.2%	762	162
20722	1	52	238	21.8%	20773	1	21.2%	14	3
20787	1	-	11	0.0%	20753	1	21.2%	13	3
20753	1	3	13	23.1%	20775	1	21.2%	12	3
20731	1	-	16	0.0%	20731	1	21.2%	16	3
20791	1	5	34	14.7%	20791	1	21.2%	34	7
20752	1	-	7	0.0%	20752	1	21.2%	7	1
20738	1	-	4	0.0%	20717	1	21.2%	10	2
20797	1	-	-	0.0%	20797	1	21.2%	-	-
		1,816	8,553	21.2%	20799	1	21.2%	-	-
					20792	1	21.2%	14	3
20784	2	217	1,235	17.6%	20784	2	9.3%	1,235	115
20706	2	171	1,777	9.6%	20706	2	9.3%	1,777	166
20774	2	231	1,791	12.9%	20746	2	9.3%	1,508	141
20721	2	105	932	11.3%	20772	2	9.3%	1,765	165
20746	2	105	1,508	7.0%	20770	2	9.3%	1,028	96
20770	2	42	1,028	4.1%	20715	2	9.3%	937	88
20715	2	46	937	4.9%	20720	2	9.3%	752	70
20720	2	33	752	4.4%	20769	2	9.3%	269	25
20712	2	38	400	9.5%	20718	2	9.3%	16	1
20769	2	10	269	3.7%	20623	2	9.3%	89	8
20718	2	-	16	0.0%	20703	2	9.3%	15	1
20775	2	1	12	8.3%	20762	2	9.3%	9	1
20741	2	-	6	0.0%	20768	2	9.3%	14	1
20703	2	1	15	6.7%	20771	2	9.3%	1	0
20788	2	1	3	33.3%	20748	3	3.3%	1,971	65
20768	2	-	14	0.0%	20735	3	3.3%	2,014	66
20771	2	-	1	0.0%	20708	3	3.3%	1,019	34
20799	2	-	-	0.0%	20602	3	3.3%	1,211	40
20792	2	-	14	0.0%	20601	3	3.3%	1,012	33
		1,001	10,710	9.3%	20613	3	3.3%	675	22
					20603	3	3.3%	928	31

PGHC				
Zip Code	Ranking	Discharges	Code Discharges	Market Share
20748	3	64	1,971	3.2%
20772	3	112	1,765	6.3%
20716	3	38	762	5.0%
20735	3	48	2,014	2.4%
20740	3	34	625	5.4%
20708	3	33	1,019	3.2%
20602	3	14	1,211	1.2%
20601	3	15	1,012	1.5%
20613	3	15	675	2.2%
20603	3	18	928	1.9%
20773	3	4	14	28.6%
20719	3	2	4	50.0%
20608	3	1	46	2.2%
20757	3	-	12	0.0%
20709	3	-	10	0.0%
20717	3	1	10	10.0%
20762	3	-	9	0.0%
		399	12,087	3.3%
20782	4	37	1,107	3.3%
20623	4	3	89	3.4%
20742	4	1	19	5.3%
		41	1,215	3.4%
20705	5	28	896	3.1%
20704	5	-	11	0.0%
20725	5	-	20	0.0%
20726	5	-	2	0.0%
		28	929	3.0%

PGCRM				
Zip Code	Ranking	Market Share	Total Zip Code Discharges	Projected Discharges
20719	3	3.3%	4	0
20608	3	3.3%	46	2
20757	3	3.3%	12	0
20709	3	3.3%	10	0
20737	4	3.4%	812	27
20710	4	3.4%	399	13
20738	4	3.4%	4	0
20704	5	3.0%	11	0
20745	6	2.4%	1,537	37
20744	6	2.4%	2,073	50
20781	6	2.4%	440	11
20705	6	2.4%	896	22
20740	6	2.4%	625	15
20653	6	2.4%	1,202	29
20607	6	2.4%	378	9
20749	6	2.4%	7	0
20725	6	2.4%	20	0
20726	6	2.4%	2	0
20722	7	2.4%	238	6
20707	7	2.4%	1,230	30
20787	7	2.4%	11	0
20741	7	2.4%	6	0
20742	8	0.7%	19	0
20782	9	1.0%	1,107	11
20712	9	1.0%	400	4
20788	9	1.0%	3	0
Total			39,921	3,601

(1) - There were no zip codes for which PGHC was the 7th ranked hospital. Thus, the 6th ranked average market share was used.

20745	6	55	1,537	3.6%
20744	6	40	2,073	1.9%
20783	6	55	1,711	3.2%
20707	6	39	1,230	3.2%
20653	6	10	1,202	0.8%
20607	6	8	378	2.1%
20912	6	9	858	1.0%
20749	6	1	7	14.3%
		217	8,996	2.4%
20904	8	12	1,699	0.7%
20903	9	7	736	1.0%
Total		3,521	44,925	7.8%

Impact of Proximity Adjustment

It was noted in Commissioner Barbara McLean's proposed decision on the CON application for the relocation of Washington Adventist Hospital (Docket No. 09-15-2295) that the

initial market share calculation as described above was imprecise on its own, and specifically it exaggerated the impact of the hospital's relocation. Consistent with the WAH response, a final market share was calculated using a proximity adjustment.

- This proximity adjustment more precisely calculates the expected impact of PGHC's relocation to the PGRMC service area as well as the expected impact on other hospitals.
- For each zip code within each of the six cohorts, an independent proximity adjustment calculation was performed.
- Only hospitals with more than a 3% market share in PGRMC's service area were expected to be impacted by PGHC's relocation ("Proximity Hospitals"). All other hospitals' market shares were assumed to remain the same after PGHC's relocation.
- To calculate PGRMC's final market share, PGRMC's initial market share as a percent of the 2013 Proximity Hospitals' market share (including PGRMC's initial market share) was applied against the 2013 proximity hospitals' market share (including PGHC's 2013 market share).

The final MSGA 15-64 market shares, by zip code, are presented on the following page with examples described below

- In zip code 20716 (Bowie) for MSGA 15-64, PGHC's 2013 actual market share was 5.0% and as noted above PGRMC's initial market share is expected to equal 21.2%.
- The first step to calculate PGRMC's final market share after relocation is to identify the hospitals with more than 3% market share in 2013, or the Proximity Hospitals. For zip code 20716, the Proximity Hospitals were DCH (15.4%), JHH (4.7%), Holy Cross (6.4%), AAMC (30.2%), WHC (9.7%), and Georgetown (3.1%).
- The total Proximity Hospital market share of 69.5% plus PGRMC's initial market share of 21.2% equals 90.7%. PGRMC's initial market share equates to 23.4% of the Proximity Hospital plus PGRMC total ($21.2\% \div 90.7\%$). The 23.4% is then applied against the total Proximity Hospital market share of 69.5% plus PGHC's 2013 actual market share of 5.0%, totaling 74.4%, which equals PGRMC's proximity-adjusted, or final market share of 17.4% ($23.4\% \times 74.4\%$).
- In this example, PGHC's actual 2013 market share for Zip Code 20716 was 5.0%. As a result of relocation and proximity adjustment, PGRMC's final market share is 17.4%. This 12.4% increase results in an expected 12.4% decline in the Proximity Hospitals' market shares which is allocated based on their respective 2013 market shares.

Similar calculations of proximity adjusted markets shares were performed for each of the other cohorts.

Table 18
Impact of Proximity Adjustment MSGA 15 – 64

	20743	20785	20774	20747	20721	20716	20773	20753	20775	20731	20791	20752	20717	20797
FY2013 PGHC Market Share (A)	24.2%	29.9%	12.9%	11.6%	11.3%	5.0%	28.6%	23.1%	8.3%	0.0%	14.7%	0.0%	10.0%	0.0%
Total of Impacted Proximity Hospitals with PGHC (B)	77.3%	75.2%	76.1%	77.1%	75.4%	74.4%	100.0%	92.3%	91.7%	93.8%	97.1%	100.0%	90.0%	0.0%
PGRMC Expected Market Share after Relocation (C)	21.2%	21.2%	21.2%	21.2%	21.2%	21.2%	21.2%	21.2%	21.2%	21.2%	21.2%	21.2%	21.2%	21.2%
Total of Impacted Proximity Hospitals with PGRMC (D)	74.3%	66.6%	84.4%	86.8%	85.4%	90.7%	92.7%	90.5%	104.6%	115.0%	103.6%	121.2%	101.2%	21.2%
Proximity-Adjusted PGRMC Market Share (E)	22.1%	24.0%	19.1%	18.9%	18.8%	17.4%	22.9%	21.7%	18.6%	17.3%	19.9%	17.5%	18.9%	0.0%
Impact of Proximity Adjustment (F)	2.1%	5.9%	-6.2%	-7.3%	-7.5%	-12.4%	5.7%	1.4%	-10.3%	-17.3%	-5.2%	-17.5%	-8.9%	0.0%
Total Expected Zip Code Discharges pre-recapture (G)	2,203	1,999	1,695	2,024	882	721	13	12	11	15	32	7	9	-
Initial Expected PGRMC Discharges pre-recapture (H)	468	424	360	430	187	153	3	3	2	3	7	1	2	-
Increase in expected discharges due to Proximity Adj. (I)	19	55	-	-	-	-	0	0	-	-	-	-	-	-
(Decrease) in expected discharges due to Proximity Adj. (J)	-	-	(36)	(48)	(22)	(27)	-	-	(0)	(1)	(0)	(0)	(0)	-
Proximity-Adjusted Expected PGRMC Discharges pre-recapture (K)	487	479	324	382	165	126	3	3	2	3	6	1	2	-
FY2013 Actual Market Share in PGRMC Service Area														
Prince George's Hospital Center	24.2%	29.9%	12.9%	11.6%	11.3%	5.0%	28.6%	23.1%	8.3%	0.0%	14.7%	0.0%	10.0%	0.0%
Doctor's Community Hospital	19.1%	22.7%	23.1%	11.5%	19.1%	15.4%	0.0%	0.0%	16.7%	18.8%	5.9%	0.0%	0.0%	0.0%
Southern Maryland Hospital Center	11.4%	2.3%	4.1%	25.1%	1.4%	1.7%	7.1%	38.5%	8.3%	6.3%	5.9%	57.1%	0.0%	0.0%
Washington Adventist Hospital	1.1%	3.5%	1.6%	1.3%	2.6%	1.3%	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0%
Laurel Regional Hospital	0.7%	1.0%	1.7%	1.1%	1.6%	2.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	10.0%	0.0%
Johns Hopkins Hospital	1.1%	0.9%	3.1%	1.1%	3.6%	4.7%	0.0%	0.0%	8.3%	0.0%	0.0%	0.0%	0.0%	0.0%
University of Maryland Medical Center	1.4%	2.5%	2.4%	1.0%	2.5%	2.1%	0.0%	0.0%	0.0%	6.3%	0.0%	14.3%	0.0%	0.0%
Holy Cross Hospital	3.4%	4.7%	5.5%	4.5%	5.7%	6.4%	7.1%	0.0%	8.3%	0.0%	8.8%	0.0%	10.0%	0.0%
Howard County General Hospital	0.2%	0.1%	0.2%	0.1%	0.4%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Fort Washington Medical Center	0.7%	0.2%	0.4%	2.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	5.9%	0.0%	0.0%	0.0%
Anne Arundel Medical Center	1.1%	2.1%	9.8%	1.0%	12.6%	30.1%	21.4%	0.0%	41.7%	0.0%	2.9%	0.0%	10.0%	0.0%
Suburban Hospital	0.9%	0.8%	1.0%	0.9%	1.2%	0.8%	7.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Shady Grove Hospital	0.2%	0.4%	0.2%	0.2%	0.3%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	10.0%	0.0%
Montgomery General Hospital	0.0%	0.0%	0.1%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other MD Hospitals	8.3%	3.8%	5.9%	3.3%	6.5%	7.7%	0.0%	7.7%	8.3%	6.3%	0.0%	0.0%	0.0%	0.0%
Total MD Hospitals	68.0%	75.1%	71.9%	64.1%	68.9%	78.9%	71.4%	69.2%	100.0%	50.0%	44.1%	71.4%	50.0%	0.0%
Washington Hospital Center	14.2%	10.8%	10.2%	15.5%	10.7%	9.7%	0.0%	15.4%	0.0%	50.0%	29.4%	0.0%	20.0%	0.0%
Children's National Medical Center	2.1%	1.0%	2.0%	1.9%	1.9%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Providence Hospital	2.1%	2.6%	2.3%	1.9%	4.1%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Georgetown University Hospital	2.8%	1.9%	4.5%	4.6%	4.1%	3.1%	0.0%	0.0%	0.0%	0.0%	0.0%	28.6%	0.0%	0.0%
George Washington University Hospital	5.0%	3.7%	3.0%	4.4%	4.3%	1.0%	0.0%	15.4%	0.0%	11.8%	0.0%	20.0%	0.0%	0.0%
Other DC Hospitals	3.6%	2.8%	2.9%	4.1%	3.2%	2.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total DC Hospitals	29.8%	22.8%	24.9%	32.4%	28.3%	18.1%	0.0%	30.8%	0.0%	50.0%	41.2%	28.6%	40.0%	0.0%
Inova Fairfax Hospital	0.5%	0.6%	1.1%	0.7%	0.6%	0.5%	28.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Inova Alexandria Hospital	0.6%	0.5%	0.6%	0.7%	0.5%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Virginia Hospital Center - Arlington	0.6%	0.4%	0.4%	0.9%	0.9%	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Inova Mount Vernon Hospital	0.1%	0.2%	0.5%	0.3%	0.2%	0.0%	0.0%	0.0%	0.0%	14.7%	0.0%	0.0%	0.0%	0.0%
Inova Fair Oaks Hospital	0.0%	0.2%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other VA Hospitals	0.4%	0.1%	0.5%	0.8%	0.5%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	10.0%	0.0%
Total VA Hospitals	2.2%	2.1%	3.2%	3.6%	2.8%	3.0%	28.6%	0.0%	0.0%	0.0%	14.7%	0.0%	10.0%	0.0%
MD/DC/VA Hospitals Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%
Market Share in PGRMC Service Area - After Proximity Adjustment														
Prince George's Hospital Center	22.1%	24.0%	19.1%	18.9%	18.8%	17.4%	22.9%	21.7%	18.6%	17.3%	19.9%	17.5%	18.9%	0.0%
Doctor's Community Hospital	19.9%	25.6%	20.8%	10.2%	16.9%	12.6%	0.0%	0.0%	14.6%	15.3%	5.5%	0.0%	0.0%	0.0%
Southern Maryland Hospital Center	11.9%	2.3%	3.7%	22.3%	1.4%	1.7%	7.7%	39.2%	7.3%	5.1%	5.5%	47.1%	0.0%	0.0%
Washington Adventist Hospital	1.1%	3.9%	1.6%	1.3%	2.6%	1.3%	0.0%	0.0%	0.0%	10.2%	0.0%	0.0%	0.0%	0.0%
Laurel Regional Hospital	0.7%	1.0%	1.7%	1.1%	1.6%	2.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.9%	0.0%
Johns Hopkins Hospital	1.1%	0.9%	2.8%	1.1%	3.2%	3.9%	0.0%	0.0%	7.3%	0.0%	0.0%	0.0%	0.0%	0.0%
University of Maryland Medical Center	1.4%	2.5%	2.4%	1.0%	2.5%	2.1%	0.0%	0.0%	0.0%	5.1%	0.0%	11.8%	0.0%	0.0%
Holy Cross Hospital	3.5%	5.3%	4.9%	4.0%	5.0%	5.3%	7.7%	0.0%	7.3%	0.0%	8.3%	0.0%	8.9%	0.0%
Howard County General Hospital	0.2%	0.1%	0.2%	0.1%	0.4%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Fort Washington Medical Center	0.7%	0.2%	0.4%	2.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	5.5%	0.0%	0.0%	0.0%
Anne Arundel Medical Center	1.1%	2.1%	8.9%	1.0%	11.1%	24.7%	23.1%	0.0%	36.5%	0.0%	2.9%	0.0%	8.9%	0.0%
Suburban Hospital	0.9%	0.8%	1.0%	0.9%	1.2%	0.8%	7.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Shady Grove Hospital	0.2%	0.4%	0.2%	0.2%	0.3%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.9%	0.0%
Montgomery General Hospital	0.0%	0.0%	0.1%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other MD Hospitals	2.5%	3.8%	5.9%	2.3%	6.5%	7.7%	0.0%	7.7%	8.3%	6.3%	0.0%	0.0%	0.0%	0.0%
Total MD Hospitals	67.2%	73.2%	73.7%	66.8%	71.6%	81.2%	69.2%	68.6%	100.0%	59.2%	47.6%	76.4%	54.4%	0.0%
Washington Hospital Center	14.7%	12.2%	9.2%	13.8%	9.5%	8.0%	0.0%	15.7%	0.0%	40.8%	27.6%	0.0%	17.8%	0.0%
Children's National Medical Center	2.1%	1.0%	2.0%	1.9%	1.9%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Providence Hospital	2.1%	2.6%	2.3%	1.9%	3.6%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Georgetown University Hospital	2.8%	1.9%	4.0%	4.1%	3.6%	2.6%	0.0%	0.0%	0.0%	0.0%	0.0%	23.6%	0.0%	0.0%
George Washington University Hospital	5.2%	4.2%	2.7%	3.9%	3.8%	1.0%	0.0%	15.7%	0.0%	0.0%	11.0%	0.0%	17.8%	0.0%
Other DC Hospitals	3.6%	2.8%	2.9%	4.1%	3.2%	2.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total DC Hospitals	30.6%	24.7%	23.2%	29.6%	25.6%	15.8%	0.0%	31.4%	0.0%	40.8%	38.6%	23.6%	35.6%	0.0%
Inova Fairfax Hospital	0.5%	0.6%	1.1%	0.7%	0.6%	0.5%	30.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Inova Alexandria Hospital	0.6%	0.5%	0.6%	0.7%	0.5%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Virginia Hospital Center - Arlington	0.6%	0.4%	0.4%	0.9%	0.9%	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Inova Mount Vernon Hospital	0.1%	0.2%	0.5%	0.3%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	13.8%	0.0%	0.0%	0.0%
Inova Fair Oaks Hospital	0.0%	0.2%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other VA Hospitals	0.4%	0.1%	0.5%	0.8%	0.5%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	10.0%	0.0%
Total VA Hospitals	2.2%	2.1%	3.2%	3.6%	2.8%	3.0%	30.8%	0.0%	0.0%	0.0%	13.8%	0.0%	10.0%	0.0%
MD/DC/VA Hospitals Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%

(1) - Proximity Hospitals defined as having 3%+ market share by zip code in FY2013

Note: For demonstration purposes, not all zip codes within the MSGA 15-64 service area are included in the Table above.

Pre-Recapture Projected Discharges

The effects of all adjustments 'except recapture' are shown below by Service Line. The discharges were spread from Cohorts to Service Lines based on FY2013's actual experience.

Table 19
Adjusted Discharges Before Market Recapture, by Service Line
FY 2022

	Based on FY 2013 PGRMC's Service Area		Population Adjustment	Use Rate Adjustment	Hospital Relocation Adjustment, Including Proximity Adjustment	Total Adjusted FY 2022 Discharges BEFORE Market Recapture	
	2013 Actual PGHC Vol	2013 Market Share	Change in Discharges	Change in Discharges	Change in Discharges	Discharges	Market Share
Burn	-	0.0%	-	-	-	-	0.0%
Dental / Oral	13	13.8%	2	(1)	1	14	14.4%
Cardiac Arrhythmia	132	9.6%	41	(13)	13	173	10.5%
Cardiac Surgery	13	2.7%	20	(9)	7	32	5.9%
Cardiology	716	10.1%	141	(54)	47	851	10.3%
Interventional Cardiology	135	13.4%	39	(16)	13	171	14.7%
Vascular	52	7.4%	15	(7)	6	66	8.2%
Vascular Surgery	89	7.8%	30	(12)	10	117	8.6%
Gastroenterology	375	6.6%	48	(25)	18	417	6.6%
Gynecology	58	3.1%	6	(5)	3	62	3.3%
HIV	60	15.5%	1	(3)	1	60	15.9%
Medical Oncology/ Hematology	195	4.7%	57	(27)	21	246	5.5%
Medicine	976	9.0%	127	(62)	47	1,089	9.1%
Nephrology	103	5.5%	18	(9)	7	119	5.6%
Neurology	478	9.0%	99	(39)	34	571	9.6%
Neuro Surgery	44	5.2%	10	(4)	3	53	5.8%
Ophthalmology	11	5.3%	2	(1)	1	13	5.8%
Orthopedics	450	7.8%	95	(43)	34	536	8.2%
Otolaryngology	44	5.6%	4	(3)	2	47	5.7%
Respiratory	544	7.2%	92	(39)	32	628	7.4%
Spine-Back/Neck Procedures	22	2.4%	12	(5)	4	33	3.3%
Substance Abuse	65	12.6%	2	(3)	2	65	12.9%
Surgery	415	6.2%	64	(31)	24	471	6.5%
Transplant	8	3.3%	1	(0)	0	9	3.5%
Trauma	149	23.6%	8	(8)	5	154	23.6%
Urology	139	4.5%	43	(15)	14	181	5.2%
Subtotal Med/Surg	5,286	7.6%	976	(434)	349	6,177	8.0%
Obstetrics	1,955	17.4%	(104)	(24)	(130)	1,697	16.2%
Psychiatry	1,078	29.0%	92	5	3	1,179	29.0%
Total In-Service Area	8,319	9.9%	965	(453)	222	9,053	9.9%

Recapture Assumptions

Growth opportunities

With a baseline of projected PGRMC discharges established for the PGRMC service area, Dimensions considered the initiatives and growth areas anticipated for the new hospital.

- Dimensions analyzed PGHC data by service line back to 2001 to determine historical trends and potential for reasonable market share recapture.
- Dimensions concluded that there were significant growth opportunities in the cardiac, vascular, oncology, orthopedics, and trauma service lines.
- These conclusions were based on interviews with physicians, recruitment plans, and new clinics and programs. In many cases, Dimensions is projecting that it will achieve a market share that is lower than that achieved within the last five years.
- Service line market share increases related to clinical program development will be supported by the recruitment of needed specialists into the region. Dimensions has generated a long- & short term plan(s) that address market area needs, number of FTE physicians to be recruited (LRH, Bowie & PGHC), capital and space

requirements. It encompasses the evaluation of the current service delivery model relative to existing community services.

- Dimensions is currently working with the University of Maryland School of Medicine (“UMSOM”) to assist with some of these physician specialty needs. For example, Dimensions now contracts with UMSOM to provide emergency medicine specialists to staff its emergency departments at PGHC, Laurel Regional, and at the Bowie Emergency Medical Center.

Cardiovascular Program Initiatives

With respect to increasing its market share for cardiovascular services, Dimensions’ Cardiovascular Program Strategic Business Plan sets forth multi-year business objectives for operational and infrastructure enhancements, developing the cardiovascular service line into a leading regional clinical program, supported by resources from UMMS and UMSOM. The Executive Summary of Dimensions’ Cardiovascular Program Strategic Business Plan and the Market Assessment associated with the Business Plan are attached, collectively, as **Exhibit 26**.⁸ Some initiatives that have been completed or are underway include:

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

Population Health Management Initiatives

As part of its strategic focus, Dimensions is emphasizing the development / expansion of primary care / ambulatory resources within its service area to improve access and develop population health management initiatives. In conjunction with Prince George’s County, Dimensions will dedicate resources to:

- Recruiting new specialists to Prince George’s County, addressing the issues of lack of access to specialists and the aging physician workforce within some specialties.
- Coordinating / enhance services at Laurel Regional Hospital and Bowie Health Campus to develop an efficient and effective healthcare delivery system among the existing facilities.

⁸ The full Business Plan is not included because it contains confidential and sensitive commercial information that may cause competitive harm to Dimensions and PGHC if disclosed publicly. Dimensions believes the Executive Summary and Market Assessment provide sufficient detail to address the Commission’s inquiry about Dimensions’ plan to strengthen the delivery of cardiovascular services at PGHC. Also, to protect the sensitive and confidential commercial information contained in the Executive Summary and the Market Assessment, certain limited text was redacted, as indicated in the documents. In addition, as indicated, several typographical errors were corrected from the original documents, although these errors were not material to the Dimensions Board’s consideration of the Business Plan.

- Dedicating resources to improve access to primary/community care by:
 - developing new primary care/community care sites;
 - recruiting new primary care physicians, mid-level providers, and other community health providers, especially to those regions within the County that show a high need for such care; and
 - working collaboratively with existing primary care providers to expand primary care/community care resources (Federally Qualified Community Health Centers, Health Department, as well as other community practitioners)
- Operating a disease management program for three chronic disease populations through a combination of specialty department resources, centralized shared resources at the System level, and community-based resources provided through working partnerships.
- Expanding ambulatory care configuration and diagnostic services at existing Dimensions facilities to expand service to locations at Cheverly (Gladys Spellman facility), Suitland (Health & Wellness Center) and Capital Heights.
- Creating strategic quality “Alliance” through use of EMR with community providers
- Developing MSO services to support community providers
- Completing gain-sharing models that will focus on selected clinical pathways

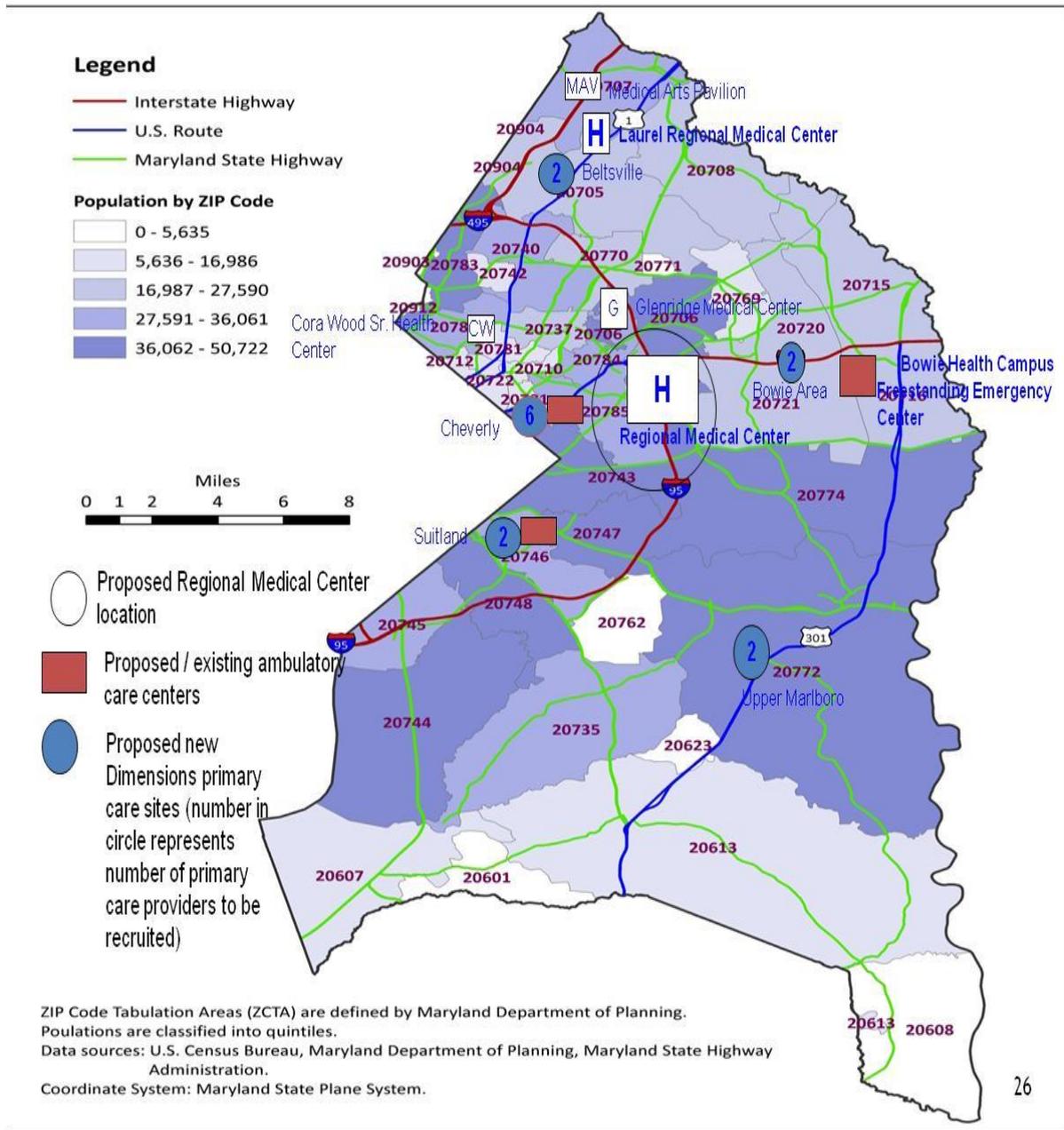
Development of a physician network for primary care and specialty care is a multi-strategy initiative that involves many steps, including:

- Combination of new recruitments and realignment of existing community physicians that were previously active at PGHC.
- Reaching out to both large and small physician practices.
- Identification of over 420 physicians that are still in the community and are active with PGHC currently or have been in the past, as illustrated in Table 20, below.

Table 20
Sample physicians by ZIP Code

<u>Zip Code</u>	<u>Number Physicians</u>
20706	31
20707	38
20737	11
20743	4
20744	14
20745	9
20746	18
20747	7
20748	22
20770	29
20774	29
20785	24
20772	8
20774	29
20785	24
Others	127
Total	424

Figure 6: Proposed Prince George's County Healthcare Delivery System



In addition to Dimensions' commitment, other MOU parties including the Prince George's County government and UMMS are collaborating to improve community health and wellness and foster the growth of the primary care network in the County.

Prince George's County: In addition the collaborative initiatives described above, the County is currently involved in the following initiatives:

- The County is developing a Health Enterprise Zone which will create 5 new patient-centered medical home practices in 4 years pursuant to a grant awarded from the State of Maryland in a competitive process. Two practices have opened within the 20743 ZIP Code (Capitol Heights).

- The County partnered with Dimensions to establish a patient-centered medical home primary care practice in Suitland (two physicians, one dentist).
- The County partnered with Community Clinic Inc., a FQCHC to establish a patient-centered medical home practice in an underserved area in Greenbelt.
- Prince George's County Health Department (PGCHD) received a grant from CDC to develop the "Healthy Revolution" program, a community health and wellness outreach program.
- The County / PGCHD signed up 46,000 additional County residents for health insurance through the ACA program.
- PGCHD developed a mobile diabetes education program with other partners as well as developed one-stop services for colon and breast cancer screening and treatment.

The County has also taken the lead in the following health and wellness initiatives:

- Designed and implemented new program delivery model with local hospital that provides one stop services for breast cancer screening and treatment.
- Engaged community partners to implement nutrition and physical fitness programs by awarding community grants to 10 faith based and community-based organizations.
- Developed and implemented On the Road Diabetes community education and outreach program.
- Branded the Be a Part of the Healthy Revolution initiative using email marketing, a texting campaign, and the design of a new website
- Provided in-home resident assessments that facilitated at risk seniors to remain in their homes and communities.

UMMS: In addition to UMMS' potential affiliation with the new regional medical center and existing Dimensions' facilities, UMMS plans to take the following initiatives to improving access to primary and community care and ambulatory services in the region:

- Establish a research institute to drive the new healthcare delivery system (including PGRMC) to become a "learning healthcare system" defined by the Institute of Medicine in its publication, "Best Care At Lower Cost." Characteristics of a continuously learning health care system which the institute would promote include:
 - Real Time access to knowledge
 - Digital capture of the care experience
 - Engaged/empowered patients
 - Incentives aligned for value
 - Full transparency
 - Leadership-instilled culture of learning
 - Supportive system competencies
- Create a proposal for inter-professional healthcare education and training in Prince George's County and Southern Maryland
- Create a proposal to design inter-professional healthcare service delivery to support the existing and new healthcare providers in Prince George's County and Southern Maryland

Market Share Projections

To project the volume of discharges associated with the recapture of market share, it is necessary to first project the volume of FY2022 discharges in the Service Area, by Service Line, which are based on the FY2013 allocation of discharges

Table 21
Projected PGRMC Service Area Discharges, by Service Line
FY 2022

	FY 2013 Discharges				FY 2013 % of Total				FY 2022 Discharges				Total
	MSG A 75+	MSG A 65-74	MSG A 15-64	PEDS	MSG A 75+	MSG A 65-74	MSG A 15-64	PEDS	MSG A 75+	MSG A 65-74	MSG A 15-64	PEDS	
Burn	7	8	73	12	0.1%	0.1%	0.2%	0.3%	9	12	69	11	101
Dental / Oral	10	10	64	10	0.1%	0.1%	0.2%	0.3%	13	15	61	9	98
Cardiac Arrhythmia	443	345	577	8	3.2%	2.9%	1.4%	0.2%	596	502	547	7	1,652
Cardiac Surgery	92	116	227	38	0.7%	1.0%	0.6%	1.0%	124	169	215	35	543
Cardiology	1,954	1,545	3,499	70	14.2%	12.9%	8.8%	1.9%	2,630	2,246	3,316	65	8,257
Interventional Cardiology	193	260	554	2	1.4%	2.2%	1.4%	0.1%	260	378	525	2	1,165
Vascular	171	140	387	2	1.2%	1.2%	1.0%	0.1%	230	204	367	2	802
Vascular Surgery	264	316	541	24	1.9%	2.6%	1.4%	0.6%	355	459	513	22	1,350
Gastroenterology	1,212	938	3,270	285	8.8%	7.8%	8.2%	7.6%	1,631	1,364	3,099	265	6,359
Gynecology	90	119	1,672	8	0.7%	1.0%	4.2%	0.2%	121	173	1,584	7	1,886
HIV	-	14	372	2	0.0%	0.1%	0.9%	0.1%	-	20	352	2	375
Medical Oncology/ Hematology	578	643	2,589	356	4.2%	5.4%	6.5%	9.5%	778	935	2,453	332	4,497
Medicine	2,228	1,593	6,446	548	16.2%	13.3%	16.1%	14.7%	2,999	2,316	6,108	510	11,933
Nephrology	487	321	1,061	13	3.5%	2.7%	2.7%	0.3%	655	467	1,005	12	2,140
Neurology	1,133	954	2,940	266	8.2%	8.0%	7.4%	7.1%	1,525	1,387	2,786	248	5,945
Neuro Surgery	111	143	515	72	0.8%	1.2%	1.3%	1.9%	149	208	488	67	912
Ophthalmology	34	19	120	36	0.2%	0.2%	0.3%	1.0%	46	28	114	34	221
Orthopedics	1,163	1,218	3,226	184	8.4%	10.2%	8.1%	4.9%	1,565	1,771	3,057	171	6,564
Otolaryngology	107	107	368	197	0.8%	0.9%	0.9%	5.3%	144	156	349	183	832
Respiratory	1,668	1,293	3,377	1,195	12.1%	10.8%	8.5%	32.0%	2,245	1,880	3,200	1,113	8,437
Spine-Back/Neck Procedures	69	198	633	27	0.5%	1.7%	1.6%	0.7%	93	288	600	25	1,006
Substance Abuse	13	27	475	2	0.1%	0.2%	1.2%	0.1%	17	39	450	2	509
Surgery	864	1,027	4,625	219	6.3%	8.6%	11.6%	5.9%	1,163	1,493	4,382	204	7,242
Transplant	28	29	164	20	0.2%	0.2%	0.4%	0.5%	38	42	155	19	254
Trauma	54	64	493	20	0.4%	0.5%	1.2%	0.5%	73	93	467	19	651
Urology	791	516	1,653	117	5.7%	4.3%	4.1%	3.1%	1,065	750	1,566	109	3,490
Subtotal Med/Surg	13,764	11,963	39,921	3,733	100.0%	100.0%	100.0%	100.0%	18,526	17,390	37,827	3,477	77,220
	19.8%	17.2%	57.5%	5.4%					24.0%	22.5%	49.0%	4.5%	
Obstetrics													10,498
Psychiatry													4,060
Total In-Service Area													91,778

The following table presents (i) PGHC's 2013 market share, by service line; (ii) 2022 expected market share, by service line; and (iii) reasons why PGHC believes the expected recapture is reasonable.

Table 22
2013 Market Share by Service Line,
Projected 2022 Market Share, and Rationale

Service Line	2013 Market Share (PGRMC Service Area)	2022 Market Share (PGRMC Service Area)	Reason
Burn	0.0%	1.8%	PGHC achieved a 2.7% market share in 2011.
Dental/Oral	13.8%	26.9%	PGHC achieved a 27.0% market share in 2012.
Cardiac Arrhythmia	9.6%	14.7%	PGHC expects to recapture admissions based upon the implementation of a recently developed Cardiovascular Program Strategic Plan (described below).

Service Line	2013 Market Share (PGRMC Service Area)	2022 Market Share (PGRMC Service Area)	Reason
Cardiac Surgery	2.7%	33.0%	PGHC expects to recapture admissions based upon the implementation of a recently developed Cardiovascular Program Strategic Plan (described below). Currently in process of recruiting one or more cardio-thoracic surgeons to practice at PGHC now and later at the new regional medical center.
Cardiology	10.1%	13.0%	PGHC expects to recapture admissions based upon the implementation of a recently developed Cardiovascular Program Strategic Plan (described below).
Interventional Cardiology	13.4%	27.2%	PGHC expects to recapture admissions based upon the implementation of a recently developed Cardiovascular Program Strategic Plan (described below). PGHC is presently recruiting an additional interventional cardiologist.
Vascular	7.4%	18.5%	PGHC expects to recapture admissions based upon the implementation of a recently developed Cardiovascular Program Strategic Plan (described below).
Vascular Surgery	7.8%	18.5%	PGHC expects to recapture admissions based upon the implementation of a recently developed Cardiovascular Program Strategic Plan (described below).
Gastroenterology	6.6%	8.5%	PGHC achieved 9.2% market share in 2010.
Gynecology	3.1%	6.5%	PGHC achieved 7.5% market share in 2010 and 7.1% market share in 2011.
HIV	15.5%	21.2%	PGHC is in the process of establishing a sickle cell clinic, which will expand its current array of services for HIV patients. Also, PGHC has a residency association with The Ross School of Medicine for this service line.
Medical Oncology/ Hematology	4.7%	12.8%	PGHC is establishing a comprehensive cancer program that may possibly affiliate with the UMMS Greenebaum Cancer Center.
Medicine	9.0%	11.1%	PGHC achieved greater than 12% market share through 2011. PGHC is in the process of establishing a family medicine residency program.
Nephrology	5.5%	9.1%	PGHC achieved greater than 10% market share in 2010 and 2011.
Neurology	9.0%	13.6%	PGHC is in the process of establishing a stroke center, and has already employed a neurologist who will serve as director of the center.
Neurosurgery	5.2%	9.7%	PGHC recently lost one neurosurgeon, and is currently recruiting two neurosurgeons to build capacity and volume.
Obstetrics	17.4%	19.0%	PGHC achieved a 21.0% market share in 2010.
Ophthalmology	5.3%	12.0%	PGHC achieved a 13.5% market share in 2011.
Orthopedics	7.8%	14.1%	PGHC recently expanded the orthopedic department by adding three fellowship-trained physicians, allowing the hours of the orthopedic clinic to be soon expanded which will provide more consultation time for local physician referrals.

Service Line	2013 Market Share (PGRMC Service Area)	2022 Market Share (PGRMC Service Area)	Reason
Otolaryngology	5.6%	8.1%	PGHC achieved 8.7% market share in 2010, and even greater in previous years. A new physician recently joined the practice.
Psychiatry	29.0%	29.0%	PGHC achieved a 32.5% market share in 2011.
Rehab	0.0%	0.0%	No recapture volume projected.
Respiratory	7.2%	9.6%	PGHC achieved 10% market share and greater through 2010.
Spine-Back/Neck Procedures	2.4%	8.9%	PGHC is recruiting two neurosurgeons to build capacity and market share.
Substance Abuse	12.6%	16.6%	PGHC achieved 17.5% market share and greater through 2011.
Surgery	6.2%	9.4%	PGHC recruited a new surgeon. Also, the hospital expanded clinic hours. PGHC expects an increase in elective general surgery volume.
Transplant	3.3%	3.7%	PGHC achieved a 5.5% market share in 2010.
Trauma	23.6%	30.1%	PGHC achieved a 29.4% market share in 2011.
Urology	4.5%	8.5%	PGHC has made capital investments, including surgical equipment, to increase urology capabilities and volume.
Average/Total	9.9%	13.4%	

Applying the PGRMC FY2022 market shares by Service Line to total discharges for the service area, by Service Line, results in the following projected PGRMC FY2022 discharges.

Table 23
Projected PGRMC Discharges, by Service Line
FY 2022

Service Line	FY 2022 Total Service Area Discharges	FY 2022 PGRMC Discharges post-recapture	FY 2022 PGRMC Discharges
Burn	101	1.8%	2
Dental / Oral	98	26.9%	26
Cardiac Arrhythmia	1,652	14.7%	243
Cardiac Surgery	543	33.0%	179
Cardiology	8,257	13.0%	1,075
Interventional Cardiology	1,165	27.2%	317
Vascular	802	18.5%	149
Vascular Surgery	1,350	18.5%	250
Gastroenterology	6,359	8.5%	541
Gynecology	1,886	6.5%	122
HIV	375	21.2%	79
Medical Oncology/ Hematology	4,497	12.8%	577
Medicine	11,933	11.1%	1,330
Nephrology	2,140	9.1%	194
Neurology	5,945	13.6%	810
Neuro Surgery	912	9.7%	89
Ophthalmology	221	12.0%	26
Orthopedics	6,564	14.1%	923
Otolaryngology	832	8.1%	67
Respiratory	8,437	9.6%	807
Spine-Back/Neck Procedures	1,006	8.9%	89
Substance Abuse	509	16.6%	85
Surgery	7,242	9.4%	682
Transplant	254	3.7%	9
Trauma	651	30.1%	196
Urology	3,490	8.5%	297
Subtotal Med/Surg	77,220	11.9%	9,165
Obstetrics	10,498	19.0%	1,991
Psychiatry	4,060	29.0%	1,179
Total In-Service Area	91,778	13.4%	12,335

Recaptured discharges reflect the difference between the projected discharges, based on expected market share, and the projection of post-relocation/pre-recapture presented previously (Table 19).

Table 24
Projected PGRMC Recaptured Discharges, by Service Line
FY 2022

Service Line	FY 2022 PGRMC Discharges post-recapture	FY 2022 PGRMC Discharges pre-recapture	Recaptured Discharges
Burn	2	-	2
Dental / Oral	26	14	12
Cardiac Arrhythmia	243	173	70
Cardiac Surgery	179	32	147
Cardiology	1,075	851	224
Interventional Cardiology	317	171	146
Vascular	149	66	83
Vascular Surgery	250	117	134
Gastroenterology	541	417	124
Gynecology	122	62	60
HIV	79	60	20
Medical Oncology/ Hematology	577	246	331
Medicine	1,330	1,089	241
Nephrology	194	119	75
Neurology	810	571	239
Neuro Surgery	89	53	36
Ophthalmology	26	13	14
Orthopedics	923	536	387
Otolaryngology	67	47	20
Respiratory	807	628	179
Spine-Back/Neck Procedures	89	33	57
Substance Abuse	85	65	19
Surgery	682	471	211
Transplant	9	9	1
Trauma	196	154	42
Urology	297	181	117
Subtotal Med/Surg	9,165	6,177	2,988
Obstetrics	1,991	1,697	294
Psychiatry	1,179	1,179	-
Total In-Service Area	12,335	9,053	3,282

2022 Discharges

Applying the assumptions described above regarding population, use rates, and market share, Dimensions projected its service area discharges in FY2022, the year that PGRMC is expected to reach full occupancy. In addition to discharges from within the service area, PGHC developed assumptions regarding out of service area discharges that reflect 10% to 28% increases over the service area discharges depending on cohort.

- The relation between out of service area discharges to in-service area discharges is consistent with PGHC’s 2013 experience.

Combined, the total inpatient discharges for PGRMC in 2022 are presented in Table 25 by cohort.

**Table 25
Projected PGRMC Inpatient Discharges, by Cohort
FY 2022**

	FY 2022 Service Area Discharges	FY2022 PGRMC			Total Discharges
		In-Service Area Market Share	In-Service Area Discharges	Out of Service Area Discharges	
MSGA 75+	18,526	11.5%	2,135	372	2,507
MSGA 65-74	17,390	11.7%	2,036	331	2,367
MSGA 15-64	37,827	13.1%	4,966	1,377	6,343
PSY 18+	4,060	29.0%	1,179	196	1,375
OB	10,498	19.0%	1,991	202	2,193
PEDS	3,477	0.8%	28	4	32
Total	91,778	13.4%	12,335	2,483	14,818

Average Length of Stay

Dimensions projects decreases in ALOS for MSGA and OB patients who are admitted to PGRMC. Dimensions has implemented initiatives to decrease ALOS and has programs planned to further improve its position; these initiatives have produced progress already. Achievement of these initiatives would place PGRMC at the Statewide ALOS.

**Table 26
Projected PGRMC ALOS
FY 2022**

Cohort	Actual 2013	Projected 2022	% Change	} 19.0% Average Reduction
MSGA (75+)	6.51	5.00	-23.3%	
MSGA (65-74)	6.83	5.24	-23.3%	
MSGA (15 - 64)	5.40	4.47	-17.1%	
Peds	2.63	2.63	0.0%	
Obstetrics	2.78	2.65	-4.7%	
Psychiatry	5.45	5.76	5.7%	
Average	5.29	4.53	-14.4%	

Dimensions applied the 2022 average length of stay assumptions to PGRMC's projected 2022 discharges by cohort to determine the 2022 patient days at the new facility.

Occupancy Rates

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

Table 27
PGRMC Occupancy Rate, by Cohort

<u>Cohort</u>	<u>State Health Plan Standards</u>	<u>PGRMC Occupancy Rate⁽¹⁾</u>
MSGA 75+	85%	89%
MSGA 65-74	85%	89%
MSGA 15-64	85%	89%
PSY 18+	85%	85%
OB	75%	75%
PEDS	50%	50%

Note (1): Using the State Health Plan 85% occupancy standard for MSGA would result in more beds than included in the original CON. PGHC chose to keep the bed need consistent with the original CON and therefore used a higher occupancy percentage.

Bed Need

Dimensions applied the prescribed occupancy rates to the projected 2022 patient days at the new facility to arrive at the following bed needs by cohort.

Table 28
PGRMC Bed Needs, by Cohort
FY 2022

<u>Cohort</u>	<u>Bed Need</u>
MSGA 75+	39
MSGA 65-74	39
MSGA 15-64	87
PSY 18+	28
OB	22
PEDS	1
Total	<u>216</u>

Pediatric Beds

Dimensions used the methodology described above to project the need for Pediatric beds.

- Dimensions assumed that an increase in the PED use rate in 2013 will be offset by reductions in 2014 through 2017 for a zero net change in the use rates for Pediatrics from 2012 to 2022.
- Combined with 4 out of area admissions, Dimensions projects that PGRMC will have 32 pediatric admissions.
- Based on these projections, Dimensions proposes to reduce its current number of pediatric beds from 8 beds to 1 bed at PGRMC.

- Since this will be integrated with observation beds and the Pediatric ED, there will not be any inefficiencies and PGRMC will still maintain the same level of access that service area residents currently have.
- This will enable pediatric patients who should be admitted close to home to be able to do so.

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

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

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

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

Applicant Response:

This standard is inapplicable because project does not involve establishment of a new pediatric service.

In completeness questions following the original CON application, the MHCC Staff requested information about the proposed one bed pediatric unit. This unit is discussed below in the response to Standard .04B(4), Adverse Impact.

Standard .04B(4) – Adverse Impact.

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

Applicant Response:

As part of a full rate application to be filed with the Health Services Cost Review Commission (“HSCRC”), Dimensions is requesting an increase in rates equal to approximately

50% of the increase in capital costs (depreciation and interest) associated with the proposed project.

The total cost of the project is \$651.2 million of which \$588.6 million are depreciable assets. \$206.7 million of the depreciable assets will be funded with proceeds from the issuance of tax exempt bonds. With 66% of the project costs funded with equity contributions, there is a limited amount of debt and associated interest expense. Total depreciation and interest expense (i.e. capital costs) related to the project are projected to equal \$36.6 million in FY2020 with the opening of the new hospital facility.

PGRMC
Projected Capital Costs

	Projected Capital Costs (\$ in millions)
Depreciation	\$ 25.2
Interest	11.4
Total	\$ 36.6
% of Capital to Include in Revenue	50%
Capital Related Revenue Increase	\$ 18.2

Applying Dimensions' mark-up of 1.182 to the capital to be included in rates results in an estimate of gross revenue related to the project of \$21,487,000, which is expected to equate to a 7.0% increase on the 2019 projected HSCRC rates.

In the most recent Reasonableness of Charges Comparison ("ROC") (2011), PGHC was identified as being 8.76% above the average of its Peer Group (see **Exhibit 27**).

PGHC Most Recent ROC Performance

<u>Date of ROC</u>	<u>% Below Peer Group</u>
Spring 2011	8.76% Above

Because PGHC was above its Peer Group average in the ROC, the calculation of PGHC's FY2013 Debt to Capitalization and comparison to the average of its Peer Group is presented below.

Table 29
Prince George's Hospital Center
Comparison to Peer Group Debt to Capitalization
FY 2013
(\$ in thousands)

Hospital	Long Term Debt	Fund Balance	Debt to Capitalization
Mercy Medical Center	\$ 425,226	\$ 258,561	0.62
Sinai Hospital	233,242	272,734	0.46
Union Memorial Hospital	600	135,100	0.00
Harbor Hospital Center	-	22,300	-
Maryland General Hospital	34,993	71,280	0.33
Johns Hopkins Bayview Medical Center	76,114	58,732	0.56
Bon Secours Hospital	2,378	(84,673)	(0.03)
Peer Group Weighted Average	\$ 772,553	\$ 734,034	0.51
Prince George's Hospital Center	\$ 25,605	\$ 73,049	0.26

Source: FY13 Audited Financial Statements

In 2013, PGHC's Debt to Capitalization ratio of 0.26 was below the average of 0.51 for its peer group.

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

Table 30
Prince George's Hospital Center
Comparison to Peer Group Average Age of Capital
FY 2013
(\$ in thousands)

Hospital	Accumulated Depreciation	Current Depreciation	Average Age of Plant
Mercy Medical Center	\$ 278,076	\$ 33,074	8.41
Sinai Hospital	213,747	22,460	9.52
Union Memorial Hospital	272,058	17,377	15.66
Harbor Hospital Center	149,638	7,243	20.66
Maryland General Hospital	159,163	11,243	14.16
Johns Hopkins Bayview Medical Center	277,765	26,147	10.62
Bon Secours Hospital	65,275	3,814	17.11
Peer Group Weighted Average	\$ 1,415,722	\$ 121,359	11.67
Prince George's Hospital Center	\$ 105,140	\$ 6,608	15.91

Source: HSCRC data for 2013

In 2013, PGHC's Average Age of Plant of 15.9 years exceeded the average for its peer group of 11.7 years.

(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.

Applicant Response:

Dimensions does not propose to eliminate any services. Furthermore, none of the proposed changes in this project will impact access for indigent and/or uninsured patients. Dimensions will continue to care for patients regardless of their ability to pay.

Reduction of Obstetrics Beds

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

Reduction of Dimensions Pediatric Beds (excluding MWPH Beds)

Dimensions also proposes to reduce number of Pediatric beds from eight to one (not including the 15 pediatric beds separately operated by MWPH under its own license). As shown in Dimensions statistical projections, Exh. 1, MHCC Tables, Table G1 – Statistical Projections – Entire Facility – PGRMC, PGHC’s Pediatric unit has operated at an average daily census of approximately one patient per day for the last two years. In the new facility, Dimensions is proposing to integrate the one bed with four observation/short stay beds within the Pediatric Emergency Department.

It is part of Dimensions’ mission to provide basic pediatric services to families within its service area. For children facing a medical crisis that could result in hospitalization nothing is more traumatic for emotional and physical well-being than not having parents close by for love and support. The concept of the ED Clinical Decision/inpatient Unit achieves the goal of keeping children and families together whenever possible and providing an appropriate level of care for pediatric patients in the Prince George’s community.

Most hospitals are facing decreased census of pediatric inpatients, while determining what type of care model is appropriate in meeting basic needs of pediatric patients and their families. Of the 33 hospitals in Maryland with licensed pediatric beds, eleven are licensed for four beds or fewer. Five of these 33 hospitals have only one or two licensed beds. Despite the declining pediatric census, families expect to have basic pediatric services at their community hospitals, with specialized services being offered at larger hospital centers.

To meet community need, the proposed PGRMC has designed a care approach that maximizes the use of pediatric-competent staff that can provide emergency pediatric care, pediatric observation care, and limited inpatient pediatric care, thereby reducing the need to transfer stable pediatric patients further away from their families and residences. The PGRMC ED Pediatric Area will be a hybrid ED and inpatient/ clinical decision unit (“CDU”).⁹ The ED Pediatric Area will be used to provide cost-effective medical evaluation and/or management of children less than 15 years of age, for health-related conditions requiring treatment and close

⁹ “Clinical Decision Unit” is a clinical term for “Observation Unit.”

observation/monitoring. The hybrid unit includes four treatment /observation/short-stay rooms and one inpatient bed.

Treatment/Clinical Decision Component: The treatment/CDU component of the ED Pediatric Area will be used to provide both short-term diagnostic, treatment, and clinical observation of pediatric patients. Pediatric patients will be observed with medical conditions such as asthma, bronchiolitis/croup; gastroenteritis, dehydration and abdominal pain. The Treatment/ CDU component can also be used for observing ambulatory surgery/procedure pediatric patients who have a delayed recovery time from sedation or anesthesia or whose postoperative/procedure pain is not well controlled. Further, it can be used for pediatric patients who require extended post-surgery/procedure periodic monitoring by physicians, nursing and other staff, and other reasonable and necessary services to evaluate a patient's condition to determine the need for a possible inpatient admission to PGRMC or transfer to another facility for a higher level of care.

Four patients can be accommodated in this proposed unit at any given time. Care will be provided by emergency services physicians and pediatric-competent nursing staff. If the patient has a primary care physician, care will be collaborated with that physician.

Pediatric Inpatient Component: The Pediatric Area will have one inpatient general pediatric bed that will be used for pediatric patients who need in-patient level of care for exacerbated conditions listed above such as severe dehydration, viral infections, respiratory illnesses, pediatric ketoacidosis, or need for more recovery and observation time from elective or emergent surgical procedures. The inclusion of the inpatient component in the Pediatric Area will help prevent unnecessary transports of stable pediatric patients to a specialty center, saving both the trauma and cost of transport, while enabling stable pediatric patients and their parents the opportunity to remain closer to their homes.

Efficiency Gains: Having a pediatric CDU may reduce the rate of admissions to inpatient while generating few inappropriate short-stay hospitalizations, in part because a significant number of inpatient admissions among children are relatively short. A growing research base, largely descriptive to date, also suggests that CDUs enhance the care of children. It is the position of the Emergency Nurses Association that clinical decision units enhance the quality and safety of patient care and increase cost-effectiveness. Emergency Nurses Association Position Statement on Observation Units / Clinical Decision Units (revised and approved May 2011).

Staffing efficiencies can also be gained with this model versus the traditional inpatient model. Optimal management of a CDU requires a team approach, with all involved focused on the goal of efficient and safe patient management. To enhance efficiency and decrease CDU length of stay and waiting time, a well-organized system to schedule and interpret laboratory, imaging, and other test results is also important.

Recent studies in Health Affairs and supported by the Advisory Board Company explain the efficiency of using observation/clinical decision units.¹⁰ These units can be more efficient for

¹⁰ References include: (i) The Advisory Board Company: Emergency Departments Save by Using Observation Units By Shane Williams, AIA, ACHA, LGB, practice area leader for design at Array Architects (Apr. 24, 2013); (ii) Brigham and Women's Hospital, news release, September 26, 2012, http://www.brighamandwomens.org/about_bwh/publicaffairs/news/pressreleases/PressRelease.aspx?PageID=1279 (last accessed 1/6/2015); (iii) Pediatric Observation Units in the US: A Systematic Review: Michelle L. Macy, MD; Christopher S. Kim, MD; Comilla Sasson, MD; Marie M. Lozon, MD; and Matthew M. Davis, MD, J Hosp. Med. Mar

providing care to certain patients and can result in shorter lengths-of-stay and lower costs vs. admitting them to the hospital. According to one study at Brigham and Women's Hospital, researchers found that utilizing a clinical decision unit could avoid 3,600 inpatient admissions per year at that hospital and save \$4.6 million per year. Based on this study, the researchers found that the overall savings to the U.S. health care system would be \$3.1 billion. However, only about one in three hospitals in the U.S. utilizes a clinical decision unit.

To assess the impact of more widespread clinical decision unit use, researchers from Brigham and Women's Hospital, Northwestern University, and Yale University reviewed data in 16 studies to determine the average cost savings per clinical decision unit visit. They determined that each clinical decision unit visit saves \$1,572 compared to an inpatient admission.

Staffing an inpatient pediatric unit requires a minimum of 4.5 paid FTEs of a pediatric RN, a cost of approximately \$350,000. This is inefficient for an ADC of 1+. By utilizing the pediatric emergency room staff, Dimensions projects that caring for the pediatric patients in the observation room versus an inpatient unit will require only 1.5 paid FTEs for an average of one pediatric patient per day. This results in a savings of 3.5 paid FTEs or approximately \$233,000. Also, savings will be realized in support staff (e.g., Unit Clerks) as these resources will also be shared among all three components of the integrated unit.

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

Historical and Projected Pediatric ED Volumes:

PGHC currently admits very few pediatric patients as observation patients. Dimensions anticipates that the number of patients retained for observation will increase dramatically once PGHC has a pediatric hospitalist. Dimensions is working with CNMC and others to provide the appropriate services that will enable children to be seen near where they live, without the necessity or cost of transport.

Dimensions points the Commission to the Letter of Support, **Exhibit 28**, from Kurt Newman, MD, President and Chief Executive Officer of CNMC, which states in relevant part:

Children's National looks forward to working in collaboration with the leadership of the new Prince George's County Regional Medical Center to assure uninterrupted access to the highest quality of care to the children of the County. Specifically, Children's National supports the development of pediatric emergency department services and pediatric short stay beds at the regional medical center and looks forward to discussions regarding its provision of emergency and acute care at the hospital. Children's National is dedicated to working with the new regional medical center, its leadership and County leadership to develop effective collaborations and agreements that will assure

2010; 5(3); 172-182; (iv) From the American Academy of Pediatrics: Pediatric Observation Units. Gregory P. Conners, MD, MPH, MBA, Sanford M. Melzer, MD, MBA, Committee On Hospital Care, and Committee On pediatric Emergency medicine, Pediatrics 2012;130:172-179, originally published online June 25, 2012.

seamless delivery of health care services for children by the providers of Children's National.

Table 31 shows the Pediatric ED visits at PGHC by day of week and season during FY2013. Daily census data are provided in **Exhibit 29**.¹¹

**Table 31
ED Visits, Age 0-17
PGHC FY 2013**

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Grand Total
July-September	158	178	179	126	173	166	170	1,150
October-December	194	203	184	178	177	170	175	1,281
January-March	151	153	153	163	166	171	180	1,137
April-June	164	166	160	139	163	148	159	1,099
TOTAL	667	700	676	606	679	655	684	4,667

Source: PGHC

Table 32 shows the Pediatric Observation visits at PGHC by day of week and season during FY 2013. Daily census data are provided in **Exhibit 30**.

**Table 32
Observation Visits. Age 0-17
PGHC FY 2013**

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total
July-September	4	4	4	5	4	4	6	31
October-December	5	3	3	3	8	1	5	28
January-March	5	4	4	5	0	6	1	25
April-June	6	3	4	2	3	2	2	22
TOTAL	20	14	15	15	15	13	14	106

Source: PGHC

Projections of Pediatric Emergency visits are based on the same approach as the projections of ED visits set forth elsewhere in this application. The assumptions are straightforward and follow those in the application. Population is based on Claritas estimates and projections. Historical visits and transport information are from internal PGHC data.

¹¹ PGHC, like many hospitals, classifies all minors (ages 0-17) who come into the ED as pediatric patients. In Dimensions' bed need projections, pediatrics was defined as the MHCC defines it, ages 0-14.

Table 33
Projected PGRMC Pediatric ED Visits, Age 0-17
PGHC FY 2022

Total Population 0-14, 2013	203,716
ED Visits, PGHC, 0-14, 2013	3,638
Estimated Transports, PGHC, 0-14, 2013	904
Non-Transport Visits	2,734
Use Rate of Non-Transport Visits/Population	0.013421
Total Population, 2021	213,710
Non-Transport Visits 2021	2,868
Estimated Transports, 2013	904
2013 Pop of Largo EMS Catchment Area	54,933
2021 Pop of Largo EMS Catchment Area	55,367
Pop Ratio 2021/2013	1.007891
Projected Transports	911
Total Projected Visits, Age 0-14	3,779
2013 PGHC ED Visits, Age 15-17	1029
Ratio of Age 15-17 2013 Visits/Age 0-14 Visits	0.282848
Projected 2021 Visits Age 15-17	1,069
Projected Total ED Visits, 2021	4,848

Currently, Pediatric observation days compose 0.5% of Pediatric ED visits. As stated above, Dimensions anticipates that this will increase dramatically when PGRMC provides Pediatric Hospitalist services.

In 2012, PGHC had 4,434 total observation days (all ages) and 52,309 ED visits. This calculates to 8.5% of ED visits. ($4,434 / 52,309 = 0.0848$) At this percentage, Dimensions would expect PGHC to have 411 pediatric observation days ($4,848 \times 0.848 = 410.9$). However, because of overlapping stays and the need to accommodate peak periods, Dimensions has proposed four observation beds.

Standard .04B(5) – Cost-Effectiveness.

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.

Applicant Response:

I. Development of Objectives and Options

Consistent with the MOU, the School of Public Health study, and the needs of a modern regional medical center, Dimensions and the Prince George's County government identified six objectives for the proposed regional medical center and for selecting its optimal location. As Dimensions considered the alternatives, it found that the various stakeholders in the selection process accorded different weight to the various objectives. Nonetheless, Dimensions determined that the objectives were roughly of equal importance and, therefore, "weighting" any of them was not warranted. The following objectives were used to assess options:

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

Using these objectives, the following six options were considered:

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

In 2013, the architectural firm HOK was engaged to:

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

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

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

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

II. Evaluation of Existing Site and Facility

The deficiencies in the PGHC physical plant have been recognized for many years.¹² As a result of the aging physical plant, Dimensions has had a difficult time recruiting physicians to practice in the PGHC service area, it has lost market share to other, more modern hospitals (particularly, making Prince Georgians feel the need to travel to Washington, D.C. for care), and it has seen its volumes decline to unacceptable levels. As a result, Dimensions cannot serve the community with PGHC without substantial state and county subsidies.

A. Existing Facility Assessment.

To evaluate the existing PGHC site, HOK prepared a PGHC Facility Assessment Report, which is attached as **Exhibit 31**.

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

1. Site analysis consisting of accessibility, way-finding, and safety assessment.
2. Building analysis consisting of departmental space, functionality, and flexibility assessment.
3. Engineering systems analysis considering current condition and anticipated useful life of mechanical, electrical, plumbing, fire protection, and technology building systems.

¹² A recent example of the problems that arise due to the physical plant deficiencies occurred on September 15, 2013, when an electrical panel serving the plant, housing two transformers, caught fire and was severely damaged. As a result all elective surgeries, OB admissions, and Cath Lab admissions were canceled. Also, the Emergency Department was placed on Yellow Alert for 19 hours.

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

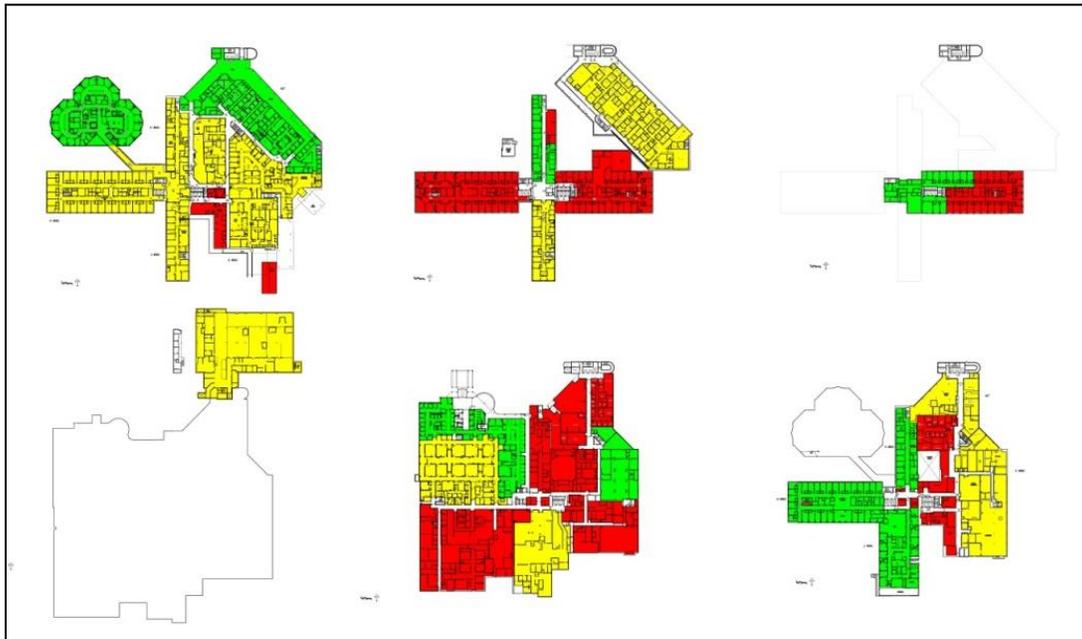
- POOR Space is below current standards and requires significant upgrades, replacement or demolition
- FAIR Space needs moderate upgrades or replacement to meet the required standards
- GOOD Space requires little or no upgrades to extend the useful life

Sample diagrams follow that depict the key findings of the HOK assessment, by level:

Figure 7
FUNCTION / KEY ROOM SIZE



**Figure 8
ADJACENCIES**



**Figure 9
FLEXIBILITY**



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

- Critical program adjacencies are missing:
 - Surgery and Central Sterile, MRI and CT, Imaging and ED, ED and ICU

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

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

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

Key building system and infrastructure deficiencies include:

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

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

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

B. Existing Site Assessment

The primary vehicular and emergency access to the existing PGHC site is from the north, from the Baltimore/Washington Parkway (I-295) and Landover Road (Maryland Route 202). The hospital is visible from I-295, but there is little visual cue, other than signage, to direct arriving patients and visitors to the facility.

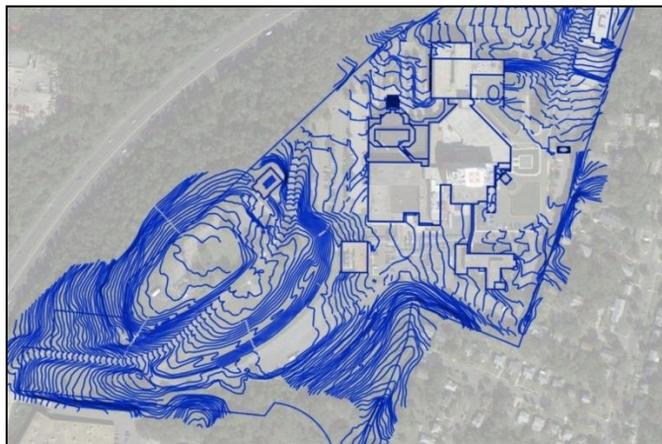
PGHC's parking access is convenient to the front door when arriving from the north, but arriving from the south, visitors must travel under the garage and around the building to access the visitor parking. The southern access from Kenilworth on Hospital Drive through an industrial area and neighborhoods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

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

The existing topography is quite severe across the site, as shown in Figure 10. While the hilltop site provides visibility from the community and good views from the upper floors of the hospital across Washington, D.C. to the National Mall and east to Maryland, the grade changes cause significant functional compromises. The main public entry and emergency entry are on level three, while the surgery entry is across campus on level one. The loading dock and support areas enter at level two to the south. The parking deck negotiates the grade changes by locating staff parking at the lower levels and visitor parking on the upper floors. The entrances from the parking garage to the hospital are not intuitive. Parking demand at peak periods is greater than site capacity.

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

Figure 10
Existing Topography

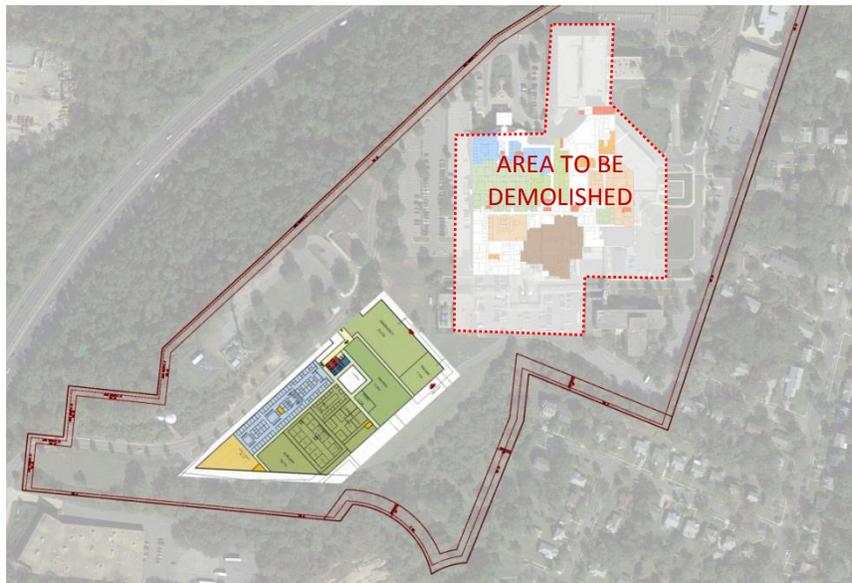


III. The Existing Site Options

A. Option 1 – Replacement of Facility on Current PGHC Site.

The open site at the southwest parcel behind the existing PGHC central utility plant (“CUP”), as shown in Figure 11, was studied as a possible site for the full replacement of the existing facility. The area of the site, however, does not offer enough space or the proper orientation/configuration for a new hospital, CUP, parking, and medical office building, especially considering the primary public and emergency vehicle access point in the northeast would cause traffic to cross through the existing site during the demolition process. And as noted earlier the severe topography would also require functional adjacency compromises.

Figure 11
Potential Replacement Hospital Site



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

**Table 34
Dimensions' Ranking of Option 1**

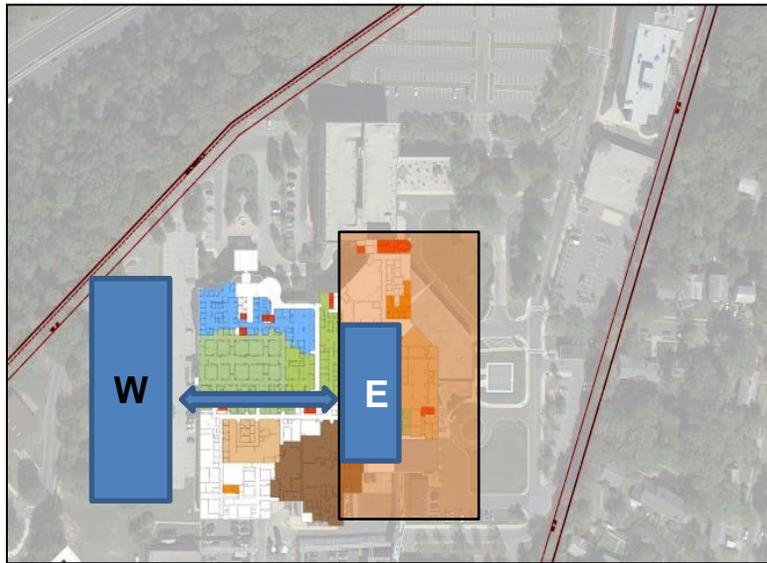
<i>Maintain PGHC's role as a regional medical center</i>	<i>Address public perceptions of PGHC.</i>	<i>Improvement in the ability to recruit physicians to serve its service area population.</i>	<i>Maintain/Improve access for its service area population</i>
Dimensions believes Option 1 would marginally improve PGHC's ability to remain a regional medical center. However, it is concerned that the continued association with the historical campus would limit the benefits of perception. <i>Score: 7</i>	The continued association with the existing site would limit the improvements in perception. <i>Score: 7</i>	Because the improvements in perception would be limited, Dimensions believes Option 1 would only marginally improve the ability to recruit physicians. <i>Score: 7</i>	Option 1 would maintain, but not improve, access. <i>Score:5</i>

<i>Enable collaboration with the University of Maryland Medical System and University of Maryland System.</i>	<i>Cost</i>	<i>Site Characteristics including Engineering and Traffic Considerations</i>
Option 1 would enable collaboration. However, Dimensions is concerned that the marginal improvements in perception would limit the synergistic value of UMMS collaboration. <i>Score: 7</i>	Costs would be comparable to building a new facility at a different site. <i>Score: 7</i>	Moderate engineering issues. No improvement in traffic issues. <i>Score: 5</i>

B. Option 2 – Major Addition and Renovations at Current PGHC Site.

As Option 2, HOK prepared a concept plan for major additions and renovations to the existing facility. Based on the Facility Assessment, the site immediately adjacent and to the west of the existing hospital ORs and ICUs, as shown in Figure 12, offers the best opportunity to expand the facility and maintain the best functioning areas of the existing hospital. In order to preserve the existing Labor and Delivery area, the H and J Wing would remain, but the E Wing and ACF Building would be demolished to allow for the construction of a new Main Entrance and Ambulatory Care Center to the East.

**Figure 12
Addition/Renovation/Demolition**



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

Figures 13A-13D below depict the conceptual layout of Option 2. Level 2 would include an interstitial space over the West Diagnostic Platform with ambulatory clinics in the East Pavilion. Level 3 West would house Clinical Support with ambulatory clinics in the East Addition. The West Addition would also accommodate 36 Bed Nursing Units at Level 4-9.

**Figure 13A
Concept Level 1**

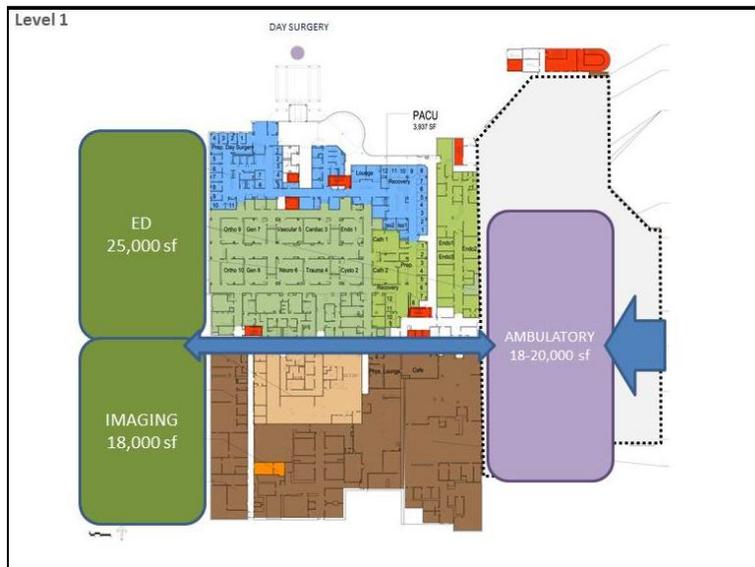


Figure 13B
Concept Level 2

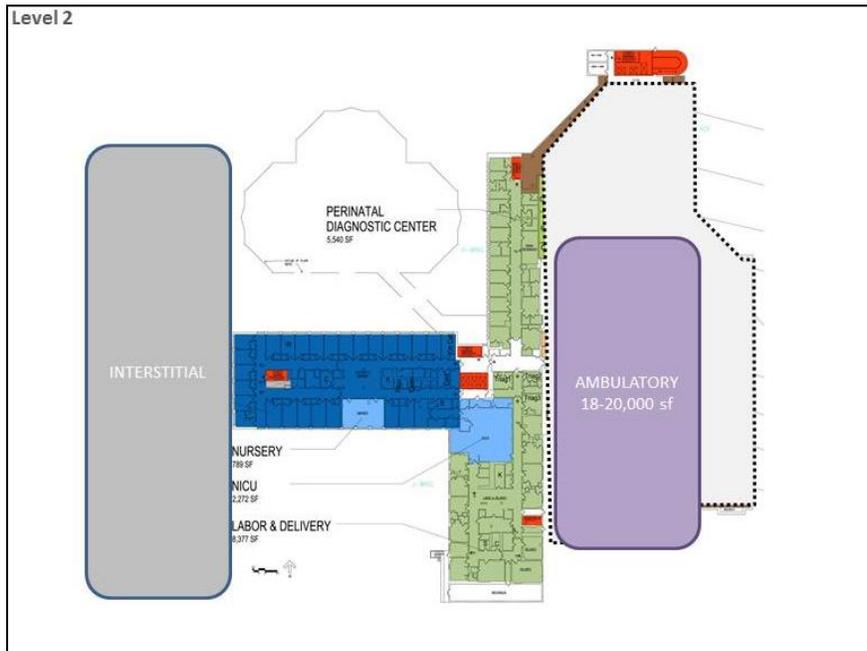
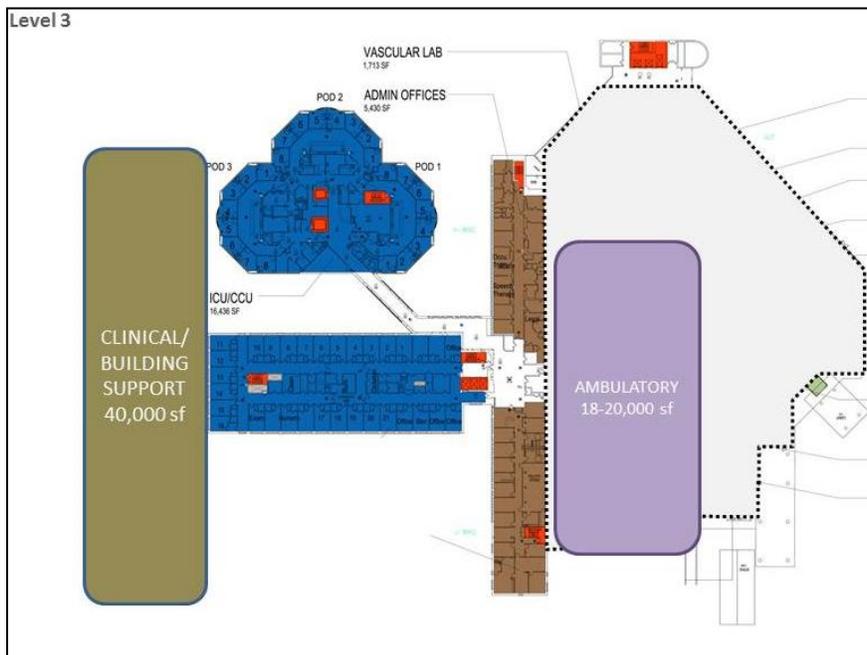
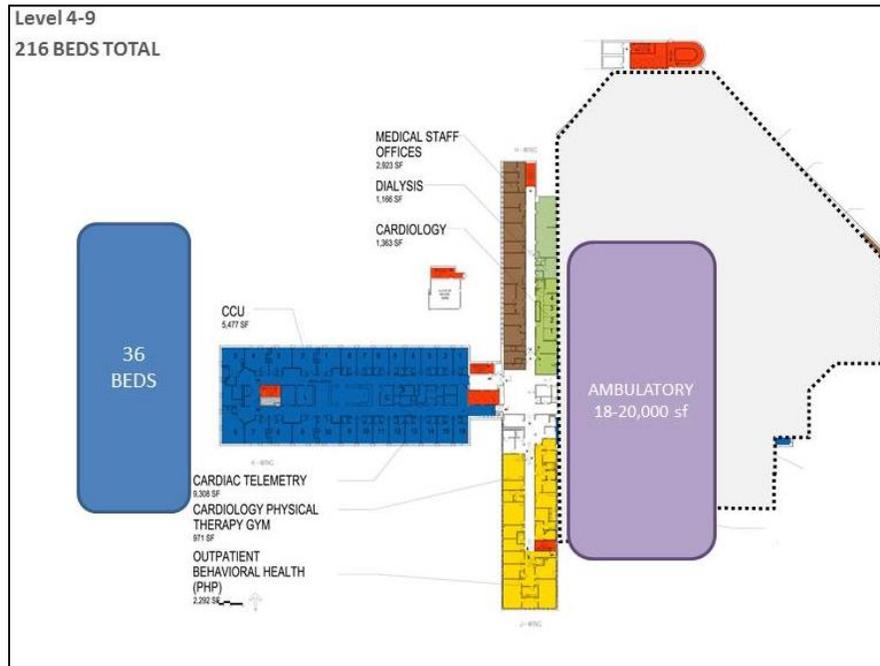


Figure 13C
Concept Level 3



**Figure 13D
Concept Level 4-9**



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

- Due to the severe topography and limited site placement, the main entrance must still be placed to the east, in conjunction with the Ambulatory Care Main Entrance.
- The plan does not resolve the existing flow problems between Surgery/CSP or ICU/ED.
- The total schedule for completing the multi-phased project will require a minimum of 10 years to complete:

• West Addition/CUP/Parking Deck	3 years
• East Demolition/Enabling	1 year
• East Addition	2 years
• Major Renovations (4 phases)	4 years
- There will be major disruption to all areas in the hospital during the new west construction, east demolition, east construction, and multiple phases of renovation to bring the hospital to the desired standards for optimizing the delivery of health care.
- The total cost including a significant escalation premium over the ten years could exceed \$600 Million.

Table 35
Projected Base Construction Costs of Option 2
(Major Addition/Renovation)

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

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

Table 36
Dimensions' Ranking of Option 2

<i>Maintain PGHC's role as a regional medical center</i>	<i>Address public perceptions of PGHC.</i>	<i>Improvement in the ability to recruit physicians to serve its service area population.</i>	<i>Maintain/Improve access for its service area population</i>
Dimensions believes Option 2 would marginally improve PGHC's ability to remain a regional medical center. However, it is concerned that continued association with the historical campus and use of existing buildings would significantly limit the benefits of perception. <i>Score: 6</i>	The continued association with the existing site and buildings would significantly limit the improvements in perception. <i>Score: 6</i>	Because the improvements in perception would be limited, Dimensions believes Option 2 would only marginally improve the ability to recruit physicians. <i>Score: 6</i>	Option 2 would maintain, but not improve, access. <i>Score: 5</i>

<i>Enable collaboration with the University of Maryland Medical System and University of Maryland System.</i>	<i>Cost</i>	<i>Site Characteristics Including Engineering and Traffic Considerations</i>
Option 2 would enable collaboration. However, Dimensions is concerned that the marginal improvements in perception would limit the synergistic value of UMMS collaboration. <i>Score: 6</i>	Because of the 10 year phasing, costs could actually be higher than building a new facility at a different site. <i>Score: 5</i>	Significant engineering issues. No improvement in traffic issues. <i>Score: 4</i>

C. Design Team Recommendation as to Current PGHC Site Options.

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

IV. New Site Options

A. Comparison of New Site Option Locations.

As part of Dimensions’ collaboration with Prince George’s County, the County is providing an alternative site. Four sites within the County were identified that would provide enough property at a reasonable cost to the County: (1) Morgan Boulevard Metro Station Area; (2) Woodmore Town Center Site; (3) Landover Mall site; and (4) the Largo/Capital Centre site.

On February 28, 2013, the Prince George’s County government hosted a public forum for citizens to voice their opinions on where they believe a new regional medical center should be located. Several hundred citizens attended the forum. The majority of the citizens spoke in favor of the Largo site location followed by the Landover site location. There was minimal interest expressed for the Morgan Boulevard and Woodmore sites. As a result of the community feedback, the County and Dimensions eliminated consideration of the Morgan Boulevard site and proceeded with assessment and consideration of the Woodmore Town Center site, Landover Mall site, and the Largo/Capital Centre site.

The Largo/Capital Centre site included two sub-alternatives for parcel allocation: (1) the “Powell property site;” and (2) the “Schwartz property site.”

The engineering consulting team comprised of Soltesz Inc. and Sabra, Wang & Associates, Inc. reviewed four site options to determine the best site for the development of a regional medical center to replace PGHC. The engagement required that the consulting team study each site relative to civil engineering, environmental issues, transportation aspects, and zoning issues to determine the substantive and comparative differences between the four sites studied.

The four sites, described as Option 3 – 6 above, were identified as follows:

1. Option 3: Woodmore Town Center site;
2. Option 4: Landover Mall site;
3. Option 5: Boulevard at the Capital Center / Powell property site; and
4. Option 6: Boulevard at the Capital Centre / Schwartz property site.

Options 5 and 6 are two variations of locating the site at the “Boulevard at the Capital Centre.”

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

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

1. Study Scope:

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

Utility analysis was undertaken to identify each site’s needs based on information available from the WSSC. Environmental and site constraint information was obtained from a variety of table top sources or actual field data, depending on the site. Topography, site boundary, wetland, floodplain, and stream information was obtained and located on each property so that a conceptual building program could be established. Once concept building programs were identified, entrance and site circulation, including emergency access, was reviewed.

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

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

2. New Site Options:

a. Option 3: Woodmore Town Center Site

Description: The proposed “Woodmore Town Center” site is a grouping of proximate properties located on the east side of the Capital Beltway. A variety of owners control the

property including Petrie-Ross, the Roman Catholic Archdiocese of Washington DC, and Prince George's County. During the review process, different property configurations were reviewed to identify the most likely combination for a successful hospital campus. Road access to the site is primarily located at the Route 202 and McCormick/St Joseph's Drive intersection. Campus Way could be used as secondary ingress/egress.

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

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

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

Zoning: All properties included with this selection are zoned M-X-T. The properties have a variety of entitlement approvals associated with them ranging from no approvals to approval of a Preliminary Plan of Subdivision/Final Plat. Under a standard Prince George's County development process for the M-X-T zone, a Conceptual Site Plan ("CSP") would appear to be required as a first step but there is no consistent approval across all the properties. Ultimately, a Detailed Site Plan would be required for District Council review. Hospital Use is not an allowed use in the M-X-T zone.

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

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

Apart from the failing intersection, site access seems inadequate. The proposed land bay appears to be split by the existing St Joseph's right-of-way. Additional road relocations may be necessary, to consolidate the land bay more efficiently. Secondary ingress/egress to the site

is only available through existing residential neighborhoods. Unless improved, these existing traffic conditions will negatively impact emergency service trips. The nearest Metrorail service is approximately 1.8 miles away, but other public transportation is available. An upgrade to those services would be necessary and may result in increased costs.

Table 37
Estimated Site Costs for Option 3
Woodmore Town Center

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

Table 38
Dimensions' Ranking of Option 3

<i>Maintain PGHC's role as a regional medical center</i>	<i>Address public perceptions of PGHC.</i>	<i>Improvement in the ability to recruit physicians to serve its service area population.</i>	<i>Maintain/Improve access for its service area population</i>
Dimensions believes Option 3 would significantly PGHC's ability to remain a regional medical center. Score: 10	The fresh start at a new site will significantly improve perception. Score: 10	Dimensions believes Option 3 would significantly improve the ability to recruit physicians. Score: 10	Option 3 would improve access, though the traffic issues would limit the improvements. Score:8

<i>Enable collaboration with the University of Maryland Medical System and University of Maryland System.</i>	<i>Costs</i>	<i>Site Considerations including Engineering and Traffic Considerations, Parcel Size, etc.</i>
Option 3 would enable collaboration with UMMS. Score: 10	Costs of Option 3 would be comparable to building a new facility at a different site. Most expensive site costs of the new sites. Score: 7	Moderate engineering issues. Significant traffic issues. Score: 7

b. Option 4: Landover Mall Site

Description: The proposed Landover Mall site was home to the Landover Mall before its demolition in 2006. It is located at the southwest side of the intersection of the Capital Beltway (I-95/495) and Landover Road (Maryland Route 202). The original offer was for 16 acres, but the review process determined that a larger site was required. The owner has suggested that additional acreage is available. Road access to the site is primarily from the Route 202 exit of I-95/495.

The land bay under consideration is zoned M-X-T (Mixed Use Transportation). Currently the site is mostly undeveloped with the exception of the free-standing Sears store, which remains after the demolition of the Landover Mall. This retail structure is under the control of the property owner and is planned for demolition. The project would be planned to fit in one quadrant of the site allowing up to 8 million square feet of retail and residential development as suggested by the Landover Sector Plan.

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

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

Zoning: All properties included with this selection are zoned M-X-T. The property does not have any entitlement approvals. Under a standard Prince George's County development process for the M-X-T zone, a Conceptual Site Plan (CSP) would appear to be required. Ultimately a Detailed Site Plan would be required for District Council review. Hospital Use is not an allowed use in the M-X-T zone.

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

Site access into the property is predicated on a continued ability to use the existing slip ramp located on Route 202. This exiting ramp along with the additional entrances will provide adequate ingress/egress. However, the on-site infrastructure is practically non-existent, and all interior roadwork and utilities will have to be factored into the cost of the project. Secondary ingress/egress to the site is adequate and available along existing arteries. The nearest Metrorail service is approximately 3 miles away, although other public transportation is available. An upgrade to those services would be necessary and may result in increased costs.

**Table 39
Estimated Site Costs of Option 4
Landover Mall**

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

**Table 40
Dimensions' Ranking of Option 4**

<i>Maintain PGHC's role as a regional medical center</i>	<i>Address public perceptions of PGHC.</i>	<i>Improvement in the ability to recruit physicians to serve its service area population.</i>	<i>Maintain/Improve access for its service area population</i>
Dimensions believes Option 4 would significantly PGHC's ability to remain a regional medical center. Score: 10	The fresh start at a new site will significantly improve perception. Score: 10	Dimensions believes Option 4 would significantly improve the ability to recruit physicians. Score: 10	Option 4 would improve access, though the traffic issues would limit the improvements. Score:8

<i>Enable collaboration with the University of Maryland Medical System and University of Maryland System.</i>	<i>Cost</i>	<i>Site Characteristics including Engineering and Traffic Considerations, Parcel Size, etc.</i>
Option 4 would enable collaboration with UMMS. Score: 10	Costs for Option 4 would be comparable to building a new facility at a different site. Second most expensive site costs of the new sites. Score: 8	Significant engineering issues. Significant traffic issues. Score: 6

c. Option 5: Powell Property Parcel at Boulevard at the Capital Centre Site

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

The land bay under consideration totals approximately 8.5 acres of land zoned M-A-C (Major Activity Center) and approximately 16 acres of land zoned R-R (Rural Residential). The current configuration of the land bay under review exists as a combination of a portion of the Capital Center Mall (including existing and occupied buildings) and the adjacent Powell property. The Powell property is currently undeveloped. In order to develop the property as a hospital campus, the existing buildings would need to be demolished. The site is adjacent to an existing Metrorail Station facility. This relationship between a hospital and a Metrorail Station is clearly a significant benefit to operations and provides this property combination an advantage that the other sites cannot provide. It would be expected that additional bus services would be planned for the area as well.

Figure 14
Option 5 Parking Area



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

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

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

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

Traffic: The main access to the site will be along Arena Drive. A right turn lane will likely need to be added along Arena Drive, but all of the intersections around the site in both the existing and proposed condition are adequate. The site can also be accessed from Harry S Truman Drive. This provides quick access to the Route 214 exit from I-95/495. Site access is more than adequate from all directions. This is important for emergency access vehicles. The site is adjacent to the Largo Metrorail facility. There is an existing pedestrian bridge to the site

from the Metrorail site that will be within a 10 minute walk radius pattern. In addition to the Metro site, there is an existing bus drop off area located at the existing Metro facility.

Table 41
Estimated Site Costs of Option 5
Powell Property / Boulevard At The Capital Centre

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

**Table 42
Dimensions' Ranking of Option 5**

<i>Maintain PGHC's role as a regional medical center</i>	<i>Address public perceptions of PGHC.</i>	<i>Improvement in the ability to recruit physicians to serve its service area population.</i>	<i>Maintain/Improve access for its service area population</i>
Dimensions believes Option 5 would significantly PGHC's ability to remain a regional medical center. Score: 10	The fresh start at a new site will significantly improve perception. Score: 10	Dimensions believes Option 5 would significantly improve the ability to recruit physicians. Score: 10	Option 5 would improve access. Adjacent Metro station is an advantage. Score: 10

<i>Enable collaboration with the University of Maryland Medical System and University of Maryland System.</i>	<i>Cost</i>	<i>Site Characteristics including Engineering and Traffic Considerations, Parcel Size, etc.</i>
Option 5 would enable collaboration. Score: 10	Costs would be comparable to building a new facility at a different site. Second least expensive site costs of the new sites. (Only \$225,000 more than the Schwartz property option.) Score: 9	Moderate engineering issues. No traffic issues. Less site development restrictions than Schwartz property option. Score: 9

d. Option 6: Schwartz Property Parcel at Boulevard at the Capital Centre Site

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

The land bay under consideration totals approximately 16 acres of land zoned M-A-C (Major Activity Center). Currently the site is undeveloped. The owner demonstrated a significant amount of entitlement approvals had already been obtained for the site. These approvals would require revisions to accommodate the regional medical center. The site also provides a significant amount of road frontage along a public right-of-way. Pedestrian access from the surrounding area is well developed and includes a pedestrian bridge from the Largo Metro site to the Capital Centre site.

Utilities: Water and sewer are obtained by accessing the existing water and sewer on Lottsford Road. There is no approved WSSC authorization for this site; however, based on observation and discussions with WSSC, there are no significant downstream improvements that appear to be required. Power will be brought to the site by PEPCO with a single feed from

the substation. The substation is powered by two separate feeders, which allows for redundancy in the system. Both gas and telecommunications are located on Lottsford Road and will provide for an easy connection to the site.

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

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

Figure 15
Option 6 Pedestrian Bridge



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

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

Table 43
Estimated Site Costs of Option 6
Schwartz Property

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

**Table44
Dimensions' Ranking of Option 6**

<i>Maintain PGHC's role as a regional medical center</i>	<i>Address public perceptions of PGHC.</i>	<i>Improvement in the ability to recruit physicians to serve its service area population.</i>	<i>Maintain/Improve access for its service area population</i>
Dimensions believes Option 6 would significantly improve PGHC's ability to remain a regional medical center. <i>Score: 10</i>	The fresh start at a new site will significantly improve perception. <i>Score: 10</i>	Dimensions believes Option 6 would significantly improve the ability to recruit physicians. <i>Score: 10</i>	Option 6 would improve Access. Adjacent Metro station is an advantage. <i>Score: 10</i>

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

3. Dimensions' Selection.

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

Once the alternatives were narrowed to the two configurations of parcels of land at the Largo site, the final selection was made based upon assessment of cost, accessibility, and ease of land development. Among the two variations (the Powell Property and the Schwartz Property), the option to combine the approximate 17 acre parcel (portion of the Boulevard at the Capital Centre parcel) with the 8.5 acre Powell parcel was selected as the best option by both Prince George's County and Dimensions. This combined 26 acre parcel will provide more options in developing the medical campus with fewer restrictions.

Table 45: Summary of Dimensions' Ranking Scores

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

4. Laurel Regional Hospital.

In completeness questions posed following the initial CON Application, the MHCC Staff asked Dimensions to explain why consolidating Laurel Regional Hospital (“LRH”) with PGRMC was not presented as part of the options considered for the project. Consolidating LRH with PGRMC would harm the delivery of health care services in the northern portion of Prince George’s County.

LRH is an important health care provider and is the sole acute care provider for northern Prince George’s County. LRH attracts and sustains a provider community of adequate size for that population center and for the underserved Zip Codes nearby. The average hospital acute inpatient census in FY 2014 was 57 (excluding newborns).

Dimensions consistently has sought ways of coordinating services between PGHC and LRH. During the planning process for this project, Dimensions considered ways the two sites could be best used in an effective way. One example of Dimensions’ cost effective coordination of the use of both the PGHC and LRH sites is the relocation in 2011 of the Gladys Spellman chronic care unit from PGHC to the LRH campus. The chronic care unit located there currently adds an additional 18 patients to the facility’s census. The chronic care facility efficiently shares many of the resources available in the acute care hospital.

LRH’s emergency department serves more than 3,000 patients each month. It supports and provides other quality serves including sophisticated wound care with hypobaric therapy. LRH houses the only CARF accredited rehabilitation center between Baltimore and Washington, DC. In the 1990s, Dimensions moved 12 obstetrical beds from PGHC to LRH to better serve the growing needs of the community. The hospitals benefit from greater purchasing power and scale from many support services that have been centralized in the system, including financial services, human resources, professional staff credentialing services, all insurance coverages,

employee benefits, purchasing and materials management. LRH is consistently in the lower half of average costs for its peer group.

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

Through the State of Maryland Capital Budget, the Governor and the General Assembly have supported the role and mission of LRH. The State has appropriated \$15 million dollars in two phases to address capital needs. The Phase I grant of approximately \$5,000,000 was used to replace obsolete building infrastructure, including upgrades to assure that energy and air exchange mechanicals meet modern standards for patient safety and operational efficiency. The Phase II grant of \$10,000,000 will be used for direct patient care unit upgrades and renovations, which are currently in the planning stage. These improvements and a range of services have been approved / implemented by the Dimensions' Board of Directors, which reviewed the need for LRH and affirmed that it continues to serve a vital mission in an otherwise underserved part of Prince George's County.

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

Finally, the plan to improve the Prince George's County health system described in the MOU, commits the State, County, Dimensions, UMMS, and the University System of Maryland to develop ways to enhance the capabilities of LRH as necessary to achieve the full benefits of the collaboration. This is described in sections C.1.a and D.1.b. of the MOU (Exh. 6).

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

Inapplicable.

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

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

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

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

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

Applicant Response:

The proposed site is within a Priority Funding Area. (see **Exhibit 32**).

Standard .04B (6) – Burden of Proof Regarding Need.

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.

Applicant Response:

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

Standard .04B(7) – Construction Cost of Hospital Space.

(a) The cost per square foot of hospital construction projects shall be no greater than the cost of good quality Class A hospital construction given in the Marshall and Swift Valuation Quarterly, updated to the nearest quarter using the Marshall and Swift update multipliers, and adjusted as shown in the Marshall and Swift guide as necessary for terrain of the site, number of levels, geographic locality, and other listed factors.

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

Applicant Response:

PGRMC will be comprised of the hospital building (with a rooftop mechanical penthouse) and a separate building that is the hospital central utility plant (“CUP”) The concourse level is entirely at grade level, except for the area that will house the linear accelerators and related Cancer treatment rooms, which are below ground. Because the majority of the floor is not below ground, Dimensions considered it a normal hospital floor (not a basement), as the MHCC has historically treated such space. The CUP will be connected to the hospital via an underground tunnel. Consequently, Dimensions performed one Marshall Valuation Service (“MVS”) analysis for the Hospital Building, Mechanical Penthouse, and Underground Pedestrian Tunnel (using separate MVS benchmarks) and another separate analysis for the CUP. As shown below, the cost per square foot of the new construction is consistent with the MVS benchmark. A complete MVS analysis is attached as **Exhibit 33**.

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

Type		Hospital
Construction Quality/Class		Good/A
Stories		10
Perimeter		1,438
Average Floor to Floor Height		16.8
Square Feet		697,243
f.1	Average floor Area	69,724
A. Base Costs		
	Basic Structure	\$354.99
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		\$354.99
Adjustment for Departmental Differential Cost Factors		1.01
Adjusted Total Base Cost		\$358.81
B. Additions		
	Elevator (If not in base)	\$0.00
	Other	\$0.00
Subtotal		\$0.00

Total		\$358.81	
C. Multipliers			
Perimeter Multiplier		0.899077654	
	Product	\$322.60	
Height Multiplier		1.11	
	Product	\$358.13	
Multi-story Multiplier		1.035	
	Product	\$370.66	
D. Sprinklers			
	Sprinkler Amount	\$1.95	
Subtotal		\$372.61	
E. Update/Location Multipliers			
Update Multiplier		1.04	12/14
	Product	\$387.52	
Location Multiplier		1.05	10/14
	Product	\$406.89	
Calculated Square Foot Cost Standard		\$406.89	

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

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
ACUTE PATIENT CARE				
ACUTE CARE	90,840	Inpatient Unit	1.06	96,290
INTENSIVE CARE	22,794	Inpatient Unit	1.06	24,162
POST-PARTUM	17,454	Inpatient Unit	1.06	18,501
NEONATAL INTENSIVE CARE UNIT	11,921	Inpatient Unit	1.06	12,636
PEDIATRICS	400	Inpatient Unit	1.06	424
MT. WASHINGTON PEDIATRICS	13,149	Inpatient Unit	1.06	13,938

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
DIAGNOSTICS & TREATMENT				
SURGERY	33,137	Operating Suite, Total	1.59	52,688
CARDIAC CATH LAB	4,676	Operating Suite, Total	1.59	7,435
GI - ENDOSCOPY	1,903	Operating Suite, Total	1.59	3,026
ADULT ED	27,151	Emergency Suite	1.18	32,038
PEDS ED	1,757	Emergency Suite	1.18	2,073
TRAUMA	5,165	Emergency Suite	1.18	6,095
UNIVERSAL CARE / PRE-POST	19,516	Inpatient Unit	1.06	20,687
CLINICAL DECISION UNIT	9,904	Inpatient Unit	1.06	10,498
IMAGING	18,135	Radiology	1.22	22,125
NEUROLOGY/CARDIOLOGY	6,854	Offices	0.96	6,580
LABOR & DELIVERY	14,648	Obstetrical Suite Only	1.44	21,093
C-SECTION	3,735	Operating Suite, Total	1.59	5,939
WOMENS CENTER	10,082	Radiology	1.22	12,300
DOMESTIC VIOLENCE CENTER	2,235	Emergency Suite	1.18	2,637
DIALYSIS	2,344	Laboratories	1.15	2,696
PT/OT	3,461	Physical Medicine	1.09	3,772
RESP THERAPY	1,222	Physical Medicine	1.09	1,332
CLINICAL SUPPORT				
LABORATORY / PATHOLOGY	12,895	Laboratories	1.15	14,829
PHARMACY	5,220	Pharmacy	1.33	6,943
NON CLINICAL SUPPORT				
DIETARY / DINING	13,333	Dietary	1.52	20,266
MATERIALS / BIO MED / EVS	16,176	Storage and Refrigeration	1.6	25,882
CENTRAL STERILE	8,004	Central Sterile Supply	1.54	12,326
FACILITIES & SUPPORT SERVICES	8,545	Offices	0.96	8,203
IT / TELECOM	9,616	Offices	0.96	9,231
OFFICES & EDUCATION				
OFFICE / ADMINISTRATION	21,318	Offices	0.96	20,465
ON CALL	3,643	Offices	0.96	3,497
CONFERENCE CENTER	5,256	Public Space	0.8	4,205
RESIDENT / FACULTY	15,341	Offices	0.96	14,727

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
PUBLIC SPACES	11,630	Public Space	0.8	9,304
CIRCULATION	98,817	Internal Circulation, Corridors	0.6	59,290
MECHANICAL/ELECTRICAL	74,503	Mechanical Equipment and Shops	0.7	52,152
BEHAVIORAL HEALTH				
CLINICAL PROGRAMS	2,580	Outpatient Department	0.99	2,554
ACUTE BEHAVIORAL HEALTH	20,488	Inpatient Unit	1.06	21,717
ASSESSMENT STABILIZATION	3,444	Inpatient Unit	1.06	3,651
AMBULATORY/CANCER CLINICAL PROGRAMS				
MT WASHINGTON OUTPATIENT	1,922	Laboratories	1.15	2,210
CANCER CENTER	12,105	Radiology	1.22	14,768
AMBULATORY CLINICS	11,241	Outpatient Department	0.99	11,129
SHAFTS / EXTERIOR WALL THICKNESS	25,452	Shafts and Exterior wall	0.6	15,271
TOTAL	704,012		1.01075925	711,587

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

Type	Mechanical Penthouse
Construction Quality/Class	Excellent A
Stories	7
Perimeter	484
Average Floor to Floor Height	30.00
Square Feet	6,769
Average floor Area	6,769
A. Base Costs	
Basic Structure	\$87.09
Elimination of HVAC cost for adjustment	0
HVAC Add-on for Mild Climate	0
HVAC Add-on for Extreme Climate	0
Total Base Cost	\$87.09

B. Additions			
	Elevator (If not in base)	\$1.45	
	Other	\$0.00	
Subtotal		\$1.45	
Total		\$88.54	
C. Multipliers			
	Perimeter Multiplier	1.03403372	
	Product	\$91.55	
	Height Multiplier	1.413	
	Product	\$129.36	
	Multi-story Multiplier	1.035	
	Product	\$133.89	
D. Sprinklers			
	Sprinkler Amount	\$4.34	
Subtotal		\$138.23	
E. Update/Location Multipliers			
	Update Multiplier	1.04	12/14
	Product	\$143.76	
	Location Multiplier	1.05	10/14
	Product	\$150.95	
Calculated Square Foot Cost Standard		\$150.95	

III. Pedestrian Tunnel

Type	Underground Pedestrian Tunnel		
Construction Quality/Class		All	
Stories		1	
Perimeter		126	
Average Floor to Floor Height		17.00	
Square Feet		2,617	
	Average floor Area	2,617	
A. Base Costs			
	Basic Structure	\$	493.26
	Elimination of HVAC cost for adjustment		0
	HVAC Add-on for Mild Climate		0
	HVAC Add-on for Extreme Climate		0
Total Base Cost			\$493.26

B. Additions			
	Elevator (If not in base)	\$0.00	
	Other	\$0.00	
Subtotal		\$0.00	
Total		\$493.26	
C. Multipliers			
Perimeter Multiplier		0.97059928	
	Product	\$478.76	
Height Multiplier		1.115	
	Product	\$533.81	
Multi-story Multiplier		1.000	
	Product	\$533.81	
D. Sprinklers			
	Sprinkler Amount	\$5.29	
Subtotal		\$539.11	
E. Update/Location Multipliers			
Update Multiplier		1.04	12/14
	Product	\$560.67	
Location Multiplier		1.05	10/14
	Product	\$588.70	
Calculated Square Foot Cost Standard		\$588.70	

IV. Consolidated MVS Benchmark

Standard	MVS Benchmark	Sq. Ft.	Total Cost Based on MVS
"Tower" Component	\$406.89	697,243	\$283,703,487.72
Tunnel	\$588.70	2,617	\$1,540,639.60
Mechanical Penthouse	\$150.95	6,769	\$1,021,753.57
Consolidated	\$405.11	706,629	\$286,265,880.89

IV. Cost of New Construction

A. Base Calculations	Actual	Per Sq. Foot
Building	\$276,046,707	\$390.65
Fixed Equipment	In Building	\$0.00
Site Preparation	\$16,603,282	\$23.50
Architectural Fees	\$15,676,523	\$22.18
Permits	\$10,590,589	\$14.99
Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	\$318,917,102	\$451.32

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

Canopy	\$3,620,400	Building
Foundation Drainage/Dewatering	\$310,320	Building
LEED Silver Premium	\$11,421,709	Building
Redundant Electric Service	\$2,586,000	Building
Redundant Water Service	\$310,320	Building
Jurisdictional Hook-up Fees	\$517,200	Permits
Premium for Concrete Frame Construction	\$2,161,453	Building
OVHD Bridge	\$1,500,000	Building
Demolition	\$1,034,400	Site
Storm Drains	\$1,551,600	Site
Rough Grading	\$3,620,400	Site
Landscaping	\$930,960	Site
Sediment Control & Stabilization	\$103,440	Site
Roads	\$517,200	Site
Helipad	\$1,551,600	Building
Deep Foundations	\$517,200	Site
Utilities	\$5,792,640	Site
Signs	\$517,200	Building
Pilings	\$517,200	Site
Hillside Foundation	\$1,551,600	Site
Premium for Paying Prevailing Wage	\$25,356,771	Building
Premium for Paying Prevailing Wage	\$46,664	Site
Total Cost Adjustments	\$66,036,277	

Explanation of Extraordinary Costs

- Signs, Canopy, Jurisdictional Hook-up Fees, Impact Fees, Paving and Roads, Storm Drains, Rough Grading, Landscaping, Sediment Control & Stabilization, Demolition, Deep Foundation, Pilings, and Hillside Foundation¹³ – These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A – Good General Hospital per Section 1, page 3 of the Marshall Valuation Service.
- Deep Foundation, Pilings, and Hillside Foundation – These costs are also specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A;
- LEED Silver Premium – Dimensions has included a 4% premium (based on Building Costs only) due to constructing this building to LEED Silver standards. The potential for a 0%-7% premium is recognized by MVS in Section 99, Page 1.
- Redundant Electric and Water Service – As a safety measure, Dimensions is planning to construct redundant electric and water service. This is not a feature of most hospitals.
- Helipad – As the second busiest trauma center in the state, PGRMC will have two rooftop helipads and one area on the ground where a helicopter can land. This is not a feature of most hospitals.
- Foundation Drainage/Dewatering – Since only Normal Site Preparation is included in the benchmark (see Section 1, page 3 of the Marshall Valuation Service), the need for foundation drainage and dewatering is not included.
- Utilities – This project requires the extension of public utilities to the perimeter of the hospital related portion of the site. The \$5,600,000 shown in the MVS analysis represents the cost for the utility company to bring utilities to the property line. The cost of bringing the utilities from the property line to the building is another \$3,000,000. These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A – Good General Hospital per Section 1, page 3 of the Marshall Valuation Service. They are both included in the site preparation costs.
- Premium for Concrete Frame Construction – Concrete frame construction is significantly more costly than steel frame. Only the Premium has been considered an extraordinary cost. Dimensions based the premium on discussions with a contractor. The premium was estimated to be between \$3 and \$4/square foot (not counting the first floor, which is already on a concrete slab). The premium that UMMS used is \$3.10/square foot, based on the following calculation:

¹³ Deep Foundation, Pilings and Hillside Foundation costs are necessary to this project. Soils in the region of the proposed project have a bearing capacity such that shallow foundation systems like spread footings are not practical for large building loads in the range of what is expected for PGRMC. Deep foundations, such as driven or drilled piles or drilled caissons, carry the building weight on deeper soil layers, which are better suited to support these loads reliably. Given the sloping nature of the site, the foundation system will bear at varying elevations and will incorporate a basement retaining wall on one side of the building. This type of hillside foundation system presents the unique structural challenge of resisting unbalanced earth pressures which are addressed in the structural design.

SF	697,243
Premium	\$2,161,453
@	\$3.10/SF

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

- Premium for Paying Prevailing Wage – Because both State and County funds will be used to construct PGRMC, Dimensions’ contractors will have to pay “prevailing” wages, rather than “scale.” Dimensions’ consultant, Andrew Solberg, telephoned Marshall and Swift’s Technical Assistance staff on 9/27/13 and asked John Thompson whether this would constitute a premium over the average cost per square foot presented in the MVS, even when adjusted for update and local multipliers. Mr. Thompson stated that paying prevailing wage would definitely be a premium over the average. He stated that he had previously been an electrician and, on buildings on which he was paid scale, the pay was approximately \$11/hour. However, on projects on which he was paid prevailing wage, he was paid approximately \$32/hour. Dimensions has searched for an average premium that is should use as the basis for its assumption. The Maryland Department of Legislative Services Office of Policy Analysis issued a report on March 25, 2014 that found that in cases of available “side by side” bid comparisons with prevailing wage requirements and without prevailing wage requirements, on average bids with prevailing wages came in at 10% higher.¹⁴ Dimensions assumes the premium will be 10%. Because prevailing wage will have to be paid for both site preparation and construction, Dimensions has applied it to both.
- Capitalized Construction Interest on Extraordinary Costs - \$50,500,000 in capitalized interest shown on the project budget sheet is for the entire costs of the project. However, because Dimensions projects that there will be \$15,100,000 interest earned on the borrowing, Dimensions pro-rated the net capitalized interest (\$35,400,000) between the hospital building and the CUP. The costs associated with this line item also apply to the extraordinary costs. Because the Capitalized Construction Interest only associate with the costs in the “Building” budget line are considered in the MVS analysis, it is appropriate to adjust the cost of each of the above items that are in the Building costs to include the associated capitalized construction interest.
- Architectural and Engineering Fees Related to Extraordinary Costs – A&E Fees are typically a percentage of the total cost of Building and Site Preparation, including extraordinary costs. Consequently, like Capitalized Interest, if the extraordinary costs are removed from the comparison, their related A&E Fees should also be removed. This was accomplished by calculating the percent that the original A&E Fees comprised of the Building and Site Prep costs, multiplying that percentage times the sum of the extraordinary costs, and subtracting that number from the original A&E fees.

¹⁴ Maryland Department of Legislative Services Office of Policy Analysis, Task Force to Study the Applicability of the Maryland Prevailing Wage Law (Annapolis, MD, March 25, 2014), p. 5

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

	Adjusted Project Cost	Per Square Foot
Building	\$226,710,935	\$320.83
Fixed Equipment		\$0.00
Site Preparation	\$419,978	\$0.59
Architectural Fees	\$12,262,669	\$17.35
Permits	\$10,073,389	\$14.26
Subtotal	\$249,466,971	\$353.04
Capitalized Construction Interest	\$36,515,179	\$51.68
Total	\$285,982,150	\$404.71

V. Comparison to the MVS Benchmark

MVS Benchmark	\$405.11
The Project	\$404.71
Difference	-\$0.40

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

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

Type	Hospital
Construction Quality/Class	Good/A
Stories	1
Perimeter	-
Average Floor to Floor Height	22.0
Square Feet	43,199
f.1	Average floor Area
	21,600

A. Base Costs			
	Basic Structure	\$354.99	
	Elimination of HVAC cost for adjustment	0	
	HVAC Add-on for Mild Climate	0	
	HVAC Add-on for Extreme Climate	0	
Total Base Cost		\$354.99	
Adjustment for Departmental Differential Cost Factors		0.70	
Adjusted Total Base Cost		\$248.49	
B. Additions			
	Elevator (If not in base)	\$0.00	
	Other	\$0.00	
Subtotal		\$0.00	
Total		\$248.49	
C. Multipliers			
Perimeter Multiplier		0.931927442	
	Product	\$231.58	
Height Multiplier		1.23	
	Product	\$284.84	
Multi-story Multiplier		1.000	
	Product	\$284.84	
D. Sprinklers			
	Sprinkler Amount	\$3.70	
Subtotal		\$288.54	
E. Update/Location Multipliers			
Update Multiplier		1.04	12/14
	Product	\$300.08	
Location Multiplier		1.05	10/14
	Product	\$315.09	
Calculated Square Foot Cost Benchmark		\$315.09	

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

VII. The Project

A. Base Calculations	Actual	Per Sq. Foot
Building	\$8,697,383	\$201.33
Fixed Equipment		\$0.00
Site Preparation	\$530,668	\$12.28
Architectual Fees	\$501,048	\$11.60
Permits	\$338,493	\$7.84
Subtotal	\$10,067,591	\$233.05

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

B. Extraordinary Cost Adjustments		
	Project Costs	
Premium for Paying Prevailing Wage	\$869,738	Building
Premium for Paying Prevailing Wage	\$53,067	Site
C. Adjusted Project Cost		
		Per Square Foot
Building	\$7,827,644	\$181.20
Fixed Equipment		\$0.00
Site Preparation	\$477,602	\$11.06
Architectual Fees	\$649,819	\$15.04
Permits	\$202,166	\$4.68
Subtotal	\$9,157,232	\$211.98
Capitalized Construction Interest	\$3,173,566	\$73.46
Total	\$13,241,158	\$306.52
	MVS Benchmark	\$315.09
	The Project	\$306.52
	Difference	-\$8.57

Standard .04B(8) – Construction Cost of Non-Hospital Space.

The proposed construction costs of non-hospital space shall be reasonable and in line with current industry cost experience. The projected cost per square foot of non-hospital space shall be compared to the benchmark cost of good quality Class A construction given in the Marshall

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

Inapplicable.

Standard .04B(9) – Inpatient Nursing Unit Space.

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

Applicant Response:

The average square feet/bed of the inpatient nursing units in the proposed facility is under 500 sf/bed, using the definition in the Acute Care Chapter. The average sf/bed varies by the type of nursing unit. The analysis includes one Pediatric bed located in the integrated pediatric Inpatient/Clinical Decision/ED unit. The detailed analyses are included in **Exhibit 34.**

**Table46
PGRMC Inpatient Nursing Unit Space
Average SF/Bed**

UNIT	NSF	Beds	NSF/Bed
MEDICAL/ SURGICAL - LEVEL 9	13,660	34	401.8
MEDICAL/ SURGICAL - LEVEL 8	13,777	33	417.5
MEDICAL/ SURGICAL - LEVEL 7	13,136	33	398.1
INTERMEDIATE CARE - LEVEL 6	15,411	33	467
INTENSIVE CARE - LEVEL 5	14,880	32	465
BEHAVIORAL HEALTH - LEVEL 4	13,039	28	465.7
POST-PARTUM - LEVEL 2	10,690	22	485.9
PEDIATRICS – LEVEL 1	400	1	400

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

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

Applicant Response:

In the most recent ROC (2011), PGHC was identified as being 8.76% above the average of its Peer Group (see Exh. 27).

PGHC Most Recent ROC Performance

<u>Date of ROC</u>	<u>% Below Peer Group</u>
Spring 2011	8.76% Above

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

- 1) Most Maryland hospitals are no longer subject to the Charge per Case (CPC) methodology. They are currently subject to the Global Budget Revenue methodology or the Total Patient Revenue methodology, both of which provide incentives to reduce readmissions.
- 2) The Spring 2011 ROC was published more than three years prior to this modified application.
- 3) The inpatient CPC and outpatient Charge per Visit (CPV) targets were combined in the ROC measurement. The CPV methodology was discontinued after only one year of use. Since 2011, Maryland hospitals have shifted a number of inpatient cases to observation status. Excluding the outpatient CPV from any comparison is incomplete.
- 4) Annual rate updates below expense inflation over a sustained period have reduced operating profits.

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

Standard .04B(11) – Efficiency.

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

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

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

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

Applicant Response:

The replacement facility for PGHC allows for significant operational changes and efficiencies to be incorporated into the plans. The lean concept of “pulling” both services and staff expertise to the patients is aimed to reduce handoffs, transports, and unproductive time, while at the same time improve the quality of patient care. This will lead to a more efficient use of the space, and reduce the time patients spend in the hospital recovering and completing tests and procedures. The effectiveness of lean operations is measured in the value brought to the patient and the ultimate elimination of waste or non-value service.

Dimensions’ new facilities at PGRMC will incorporate the latest in technology to better serve its patients. Wireless communication systems, such as patient and instrument tracking, automations and robotics in such areas as lab and surgery, telemedicine and video conferencing, remote imaging and patient monitoring, are a few of the technologies that will help improve patient flow and cost of care. In addition, the design and systems incorporated into the proposed PGRMC enable sustainable operation of the facility by reducing resources consumed and waste and emissions generated. The combined effect of these measures reduced the financial burden on the facility operators while improving occupant and public health. See **Exhibit 35** for an in depth discussion of how the proposed project meets smart and sustainable growth policies and green design principles.

The plans also create a highly efficient trauma and emergency process, allowing for short distances and a high level of collaboration among the key critical departments. A dedicated trauma size elevator will transport patients from and to a helipad located on the roof of the hospital. The acute care functions that share common processes will be more streamlined and have greater flexibility through more efficient use of staff’s time and technology. Behavioral health patients will be accessed and treated through a stabilization and assessment center where patients can be discharged or admitted to a dedicated behavioral health inpatient unit.

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

Diagnostic and Treatment

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

The surgical area is comprised of rooms for trauma, cardiovascular, orthopedic, and general surgery. Rooms are sized to accommodate all case types and complexities, and share support functions and processes for patient prep and recovery. Adjacent to the operating rooms are the interventional rooms for cardiac cath, electrophysiology, and radiological procedures. Rooms are designed to optimize flexibility.

The radiology department will be centrally located to effectively serve the trauma/emergency area, surgery/cath, and all inpatient and outpatient diagnostic imaging. A

MRI suite will accommodate inpatient, outpatient, and emergency scans. Women's imaging for mammography and bone density will be located on the Concourse Level adjacent to the Women's Center entrance.

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

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

Acute and Critical Care Nursing Units

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

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

Clinical Decision Unit

All procedural functions are organized and located on the first floor with close proximities among the ED, surgery, endoscopy and cardiac cath suites. In close proximity is the Clinical Decision Unit ("CDU"). The CDU provides observational beds for admissions decisions, pre-admit testing, and medical adult observation.

The CDU (observation unit) is designed to serve those patients who do not require inpatient hospitalization but may require nursing care for several hours or overnight. This 20-bed unit is designed to increase accessibility, operational efficiency, and capacity for the emergency and surgery departments, while also providing space for outpatients and observation status patients requiring up to 24 hours of nursing care. Advances in technology such as minimally invasive procedures are shifting patient census from inpatient to outpatient and reducing recovery time and the need for inpatient admissions. The flexibility of accommodating procedure patients and observation patients reduces the need to duplicate dedicated ED observation and prep recovery or inpatient rooms, which often may not be occupied by an admitted patient.

Women's Services

A Women's Center for maternal diagnostic testing and women's imaging services will be provided. Maternal Child Health Services will be located on Level 2 which will include Triage and Labor, Delivery and Recovery (LDR), normal nursery, and adjacent C-section rooms and post-anesthesia recovery. The neonatology intensive care unit (NICU) will be adjacent to the LDR suite for direct patient access from the delivery rooms. The post-partum unit is located nearby with rooming-in capabilities. The south end of the post-partum patient nursing unit has been designed to allow its use for ante-partum when required.

Acute Behavioral Health

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

Ambulatory and Cancer Center

The outpatient clinics in the Ambulatory Care Center will include clinics designed to assist with the hospital's population health management initiatives. Such ambulatory clinics will include a regional diabetes center, a chronic heart failure clinic, pulmonary disease (COPD) clinic, and a wound care clinic. Physician-based clinics planned include trauma, orthopedics, obstetrics, general surgery, and other subspecialties, designed to provide improved access to subspecialty services for the community. The first floor of the ambulatory care building will be the location of a planned regional cancer center, providing both radiation and medical oncology services, which is planned to be affiliated with a university oncology program.

Ancillary & Support Functions

The ancillary and support functions such as laboratory, pharmacy, materials management, food services, and plant operations are located in a level below the D&T floor. Logistics of transport and supplies have been planned to access the facility through the lower level. This lower level will provide ease of movement without interfering with patient flow, allowing materials and staff to circulate to dedicated service elevators leading to "back of the house" zones on clinical areas. Loading docks are located behind the logistic platform.

Public Lobby

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

FTEs/Unit Volume

Dimensions has built efficiency into its projections. Based on the patient days, shown in Table F1, and FTEs, shown in Table L1, the total staffing for the inpatient nursing units will reduce from 2.59 FTEs/Patient Day to 2.46 FTEs/Patient Day from 2015 to 2022. As presented in Table 47, the staffing becomes more efficient as inpatient volumes grow. The same is true for the staffing of outpatient services.

**Table 47
FTEs / Patient Day – Inpatient Nursing Units
2015 and 2022**

Inpatient Nursing Units	Patient Days 2015	FTEs 2015	FTE per Patient Day	Patient Days 2022	FTEs 2022	FTE per Patient Day
120611000 NURSING E 900 (MS-TELE/ON		63.11			69.94	
120612000 NURSING E 700 (MS-TELE)		30.52			33.82	
120612500 NURSING E-800 (MS-ORTHO/T		58.61			64.95	
120624000 NURSING K400 - PCRU		50.00			55.41	
120660000 NURSING - CCU		23.49			26.03	
120663000 NURSING - ICU/CCC		88.91			98.53	
120640000 NURSING E 600 PEDIATRICS *		8.80			9.75	
120651000 NURSING K 200 - ANTE/POST		48.62			53.88	
120666000 NURSING - PSYCH		36.52			40.47	
Total Inpatient Nursing Units	57,630	408.58	2.59	67,125	452.80	2.46

Standard .04B(12) – Patient Safety.

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

Applicant Response:

Research has shown that the most common and costly medical errors that affect patient safety include:

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

Fortunately, the majority of these medical errors are preventable with proper planning and designing. The proposed project addresses these common medical errors in the following way.

COMMUNICATION ERRORS

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

- The proposed Nursing Unit design is based on Multi-Acuity Universal Care Patient rooms so that the patient is moved as infrequently as possible.
- The plan utilizes multi-disciplinary work spaces and visual connections among staff work areas to promote regular communication and discussion.

- Lean Operational planning has been integrated into the Diagnostic & Treatment platform and Universal Care Unit to reduce the number of patient transfers.

HOSPITAL ACQUIRED INFECTIONS

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

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

PATIENT FALLS

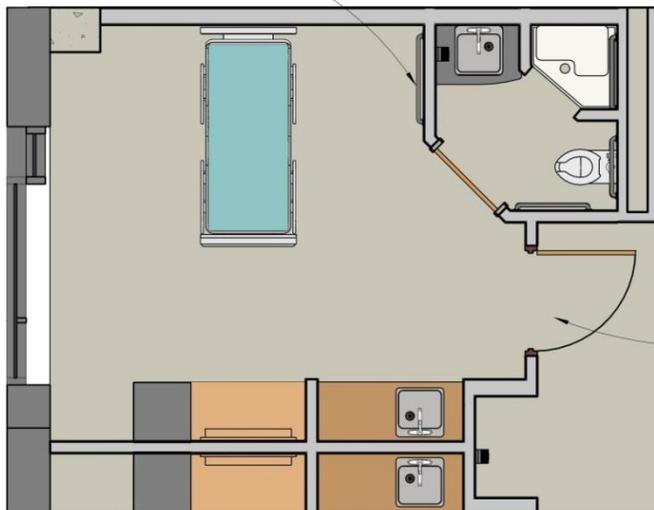
Studies have shown that the majority of patient falls are either toilet related or occur during transitions from beds to chairs. The risk of falls and resulting injury in patient rooms will be reduced as a result of the following design features:

- The Patient Room Toilet is placed close to the patient.
- The Patient has access to a grab-bar from bed to toilet.
- Staff charting areas located at the Patient Room Entry allow direct visualization of the patient by staff.
- The Nursing Unit configuration provides decentralized nursing and clear lines of sight into patient rooms. This will allow greater visibility of the patient that may be attempting to transition from the bed or chair on their own, enable quicker preventative assistance by nursing staff, and in the event of a fall, provide for faster post fall care.

Refer to Figure 16: Patient Room and Figure 17: Sensor Lighted Patient Grab Bar.

Figure 16
PATIENT ROOM

The Toilet is located adjacent to the headwall, and a touch sensitive grab bar lights the path. It also sends a signal to the nurse station.



Workstation location allows for direct visualization of the patient.

Figure 17
SENSOR LIGHTED PATIENT GRAB BAR



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

Bathroom Location and Design

- Easier bathroom transfers result in fewer falls.

Bedside Documentation

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

Nursing Unit Design

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

MEDICATION ERRORS

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

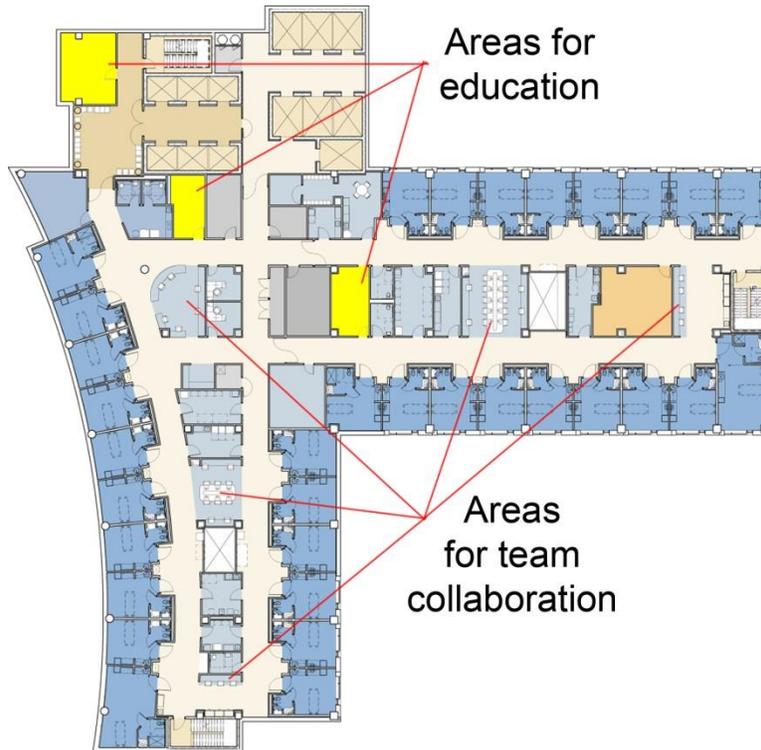
- Eliminates confusion among drug names that sound alike
- Prompts for drug interaction, allergy, or overdose
- Associated with a 55% reduction in prescribing errors

TRANSFERS AND HAND-OFFS

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

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

**Figure 18
NURSING UNIT DESIGN**



Standard .04B(13) – Financial Feasibility.

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

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

(b) Each applicant must document that:

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

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

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the

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

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

Applicant Response:

The proposed project will be financially feasible. The financial feasibility of PGRMC is based on the following assumptions:

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

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

(c) Staffing and overall expense projections that are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by PGHC (Part III COMAR 10.24.01.08G(3)(f) – Table L)

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

Based on these assumptions, PGRMC is projected to experience a positive Excess of Revenue over Expense by its second year of operations.

As Table G shows, PGRMC will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved by 2022.

Consistency with the Maryland All-Payer Model Agreement

The proposed project is consistent with the Maryland All-Payer Model Agreement.

First, it is important to recognize that the All-Payer Model Agreement contemplates reductions in “per capita” growth, not necessarily reductions in total volume. In describing the all-payer ceiling, the All-Payer Model Agreement states:

Over Performance Years 1, 2, and 3, the State must limit the cumulative annual all-payer per capita total hospital revenue growth for Maryland residents, as specified in this Agreement, to less than or equal to the per capita growth ceiling.

* * * * *

For Performance Years 1 through 3, the growth limit is fixed at 3.58 percent per capital per year, which represents Maryland’s per capita gross state product (“GSP”) compound annual growth rate between 2002 – 2012.

All-Payer Model Agreement, pp. 8. Thus, the All-Payer Model Agreement does not preclude growth, but, rather, states growth will be measured on a per capita basis.

The All-Payer Model Agreement aims to reduce the overall cost of healthcare with emphasis on reducing utilization and costs associated with hospital care. The goal is for the State’s inpatient utilization rates, readmission rates, and other hospital utilization benchmarks to be comparable or better than the national averages. The inpatient forecasting model for PGRMC takes into account trends in population health management as well as current national inpatient utilization forecasts.

As presented in the response to COMAR 10.24.10.04B(2) - Identification of Bed Need and Addition of Beds, pp. 49-79, PGHC projects significant per capita reductions in inpatient volumes, as follows:

- 11.2% reduction in MSGA inpatient use rates
- 19.0% reduction in MSGA average length of stay

Consistent with the All-Payer Model Agreement, these assumptions result in a substantial decline in MSGA patient days per capita as shown below. The average 16.4% reduction in patient days per 1000 population for all cohorts is led by the 31.9% reduction in patient days per 1000 population for those over the age of 65. The populations shown below for the years 2012 and 2022 represent the projected PGRMC service area by cohort.

Table 48: Projected Patient Days per Capita for PGHC / PGRMC

Use Rates	MSGA					OB (1)	PSY (1)	Total
	75+	65-74	15-64	0-14	Subtotal			
2012								
Projected Population	34,792	55,106	644,648	168,128	902,674	169,791	670,188	902,674
% of Population	3.9%	6.1%	71.4%	18.6%	100.0%	18.8%	74.2%	100.0%
Discharges	14,061	11,724	41,736	3,376	70,897	11,321	3,689	85,907
Discharge Rate / 1000 Pop	404.1	212.8	64.7	20.1	78.5	66.7	5.5	95.2
ALOS	6.51	6.83	5.40	2.63	5.72	2.78	5.45	5.32
Patient Days	91,591	80,037	225,347	8,890	405,865	31,448	20,094	457,407
Patient Days / 1000 Pop	2,632.5	1,452.4	349.6	52.9	449.6	185.2	30.0	506.7
2022								
Projected Population	51,601	92,052	658,017	173,139	974,809	160,659	737,554	974,809
% of Population	5.3%	9.4%	67.5%	17.8%	100.0%	16.5%	75.7%	100.0%
Discharges	18,526	17,390	37,827	3,477	77,220	10,498	4,060	91,778
Discharge Rate / 1000 Pop	359.0	188.9	57.5	20.1	79.2	65.3	5.5	94.1
ALOS	5.00	5.24	4.47	2.63	4.69	2.65	5.76	4.50
Patient Days	92,558	91,056	169,214	9,156	361,984	27,804	23,386	413,174
Patient Days / 1000 Pop	1,793.7	989.2	257.2	52.9	371.3	173.1	31.7	423.9
2012-2022 % Change								
% of Population	37.3%	54.7%	-5.5%	-4.6%	0.0%	-12.4%	1.9%	0.0%
Discharge Rate / 1000 Pop	-11.2%	-11.2%	-11.2%	0.0%	0.9%	-2.0%	0.0%	-1.1%
ALOS	-23.3%	-23.3%	-17.1%	0.0%	-18.1%	-4.7%	5.7%	-15.4%
Patient Days / 1000 Pop	-31.9%	-31.9%	-26.4%	0.0%	-17.4%	-6.6%	5.8%	-16.4%

The project will not rely on continually growing volume. The projections provided are through FY 2022, when PGRMC is expected to reach its maturity. Dimensions assumes that

volumes will not grow continually after that point. However, the hospital will remain financially viable without growing volumes.

C. Rate Agreement with the Health Services Cost Review Commission

On July 16, 2014, Dimensions entered an Agreement with the Maryland Health Services Cost Review Commission Regarding Global Budget Revenue and Non-Global Budget Revenue (the "2014 HSCRC Agreement") covering the period from July 1, 2013 through June 30, 2014 for Dimensions' hospitals, including PGHC. The agreement renews every year unless cancelled by the HSCRC or Dimensions. A copy of the 2014 HSCRC Agreement is attached as **Exhibit 36**.

Under the GBR, current proposals to achieve revenue growth in relation to volume growth is considered a market share adjustment and is recognized at 50% variability in the year after the growth in volume. An assumption in this CON application is that PGRMC will be able to recognize revenue growth, at 50% variability, but in the year that the volume growth occurs. This will likely require an agreement to adjust PGRMC's GBR at the beginning of each year for the expected volume growth. A reconciliation may then occur on an agreed upon interval to revise the GBR adjustment based on actual volume growth.

The expected growth in revenue at 50% revenue variability while volumes grow at 100 % variability will result in the following:

- Reduction in PGRMC's average charges per discharge over the projection period, thereby improving its price competitiveness
- Generating savings to Medicare
 - Medicare currently pays approximately 75% to 80% of PGHC's rates for services outside the State of Maryland
 - Bringing patients back from DC and Virginia hospitals at 50% of Maryland's hospital rates will result in lower payments by Medicare.

Standard .04B(14) – Emergency Department Treatment Capacity and Space.

(a) An applicant proposing a new or expanded emergency department shall classify service as low range or high range based on the parameters in the most recent edition of *Department Design: A Practical Guide to Planning for the Future* from the American College of Emergency Physicians. The number of emergency department treatment spaces and the departmental space proposed by the applicant shall be consistent with the range set forth in the most recent edition of the American College of Emergency Physicians *Emergency Department Design: A Practical Guide to Planning for the Future*, given the classification of the emergency department as low or high range and the projected emergency department visit volume.

(b) In developing projections of emergency department visit volume, the applicant shall consider, at a minimum:

(i) The existing and projected primary service areas of the hospital, historic trends in emergency department utilization at the hospital, and the number of hospital emergency department service providers in the applicant hospital's primary service areas;

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

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

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

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

Applicant Response:

Dimensions is seeking an expansion from 43 treatment spaces (not including 3 triage rooms), to 52 treatment spaces as shown below. There will be 48 adult treatment spaces and 4 pediatric treatment spaces.

ED Treatment Spaces	Adult		Pediatric	
	Existing	Proposed	Existing	Proposed
General & Fast Track	25	30		4
Resuscitation	4	6		
Trauma	2	4		
Psych	5	7		
Hallway Treatment Spaces	6	0		
Sexual Assault	1	1		
Total Treatment Space	43	48		4

* Numbers do not include Triage Rooms.

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

Prince George’s County has the highest number of uninsured adults of all of the Maryland jurisdictions.

**Table 49
Uninsured Adults by Jurisdiction
2014**

Jurisdiction	Number	Percent of Population
Prince George's	111,245	19.7%
Montgomery	97,298	15.6%
Baltimore City	73,441	18.2%
Baltimore	66,261	13.2%
Anne Arundel	37,302	11.0%

Jurisdiction	Number	Percent of Population
Frederick	17,873	12.1%
Howard	17,819	9.7%
Harford	16,333	10.6%
Washington	12,805	14.7%
Wicomico	10,587	17.3%
Charles	10,281	10.9%
Carroll	9,905	9.7%
Cecil	8,025	12.5%
St. Mary's	7,440	11.2%
Allegany	6,038	14.5%
Calvert	5,291	9.5%
Worcester	4,962	16.6%
Caroline	3,680	18.1%
Queen Anne's	3,559	12.2%
Talbot	3,418	16.0%
Dorchester	3,396	17.1%
Garrett	3,118	17.0%
Somerset	2,250	17.2%
Kent	1,831	16.5%

Source: County Health Rankings & Roadmaps;
<http://www.countyhealthrankings.org/app/maryland/2014/measure/additional/3/data>
 Accessed 1/3/2015

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

Table 50
Uninsured Children by Jurisdiction
2014

Jurisdiction	Number	Percent of Population
Prince George's	13,671	6%
Montgomery	12,969	5%
Baltimore	9,337	5%
Baltimore City	6,496	5%
Anne Arundel	4,706	4%
Howard	3,250	4%
Frederick	2,711	4%
Harford	2,469	4%
Charles	1,718	4%
Washington	1,681	5%
Carroll	1,635	4%

Jurisdiction	Number	Percent of Population
Wicomico	1,336	6%
Cecil	1,292	5%
St. Mary's	1,222	4%
Calvert	898	4%
Worcester	658	7%
Allegany	590	4%
Queen Anne's	579	5%
Caroline	555	6%
Talbot	478	6%
Dorchester	404	5%
Garrett	397	6%
Somerset	270	6%
Kent	250	7%

Source: County Health Rankings & Roadmaps;
<http://www.countyhealthrankings.org/app/maryland/2014/measure/additional/122/data>
 Accessed 1/3/2015

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

Table 51
Medicaid Eligible Residents by Jurisdiction
December 2014

COUNTY	December 2014
Baltimore City	253,869
Prince George's	197,744
Montgomery	163,774
Baltimore County	160,442
Anne Arundel	78,314
Washington	37,126
Harford	37,122
Howard	36,236
Frederick	34,792
Wicomico	29,815
Charles	26,518
Cecil	23,343
Carroll	20,320
St. Mary's	20,240
Allegany	19,817

COUNTY	December 2014
Calvert	13,222
Worcester	11,718
Dorchester	11,680
Caroline	10,371
Queen Anne's	8,107
Garrett	7,845
Somerset	7,810
Talbot	7,536
Kent	4,749
Out of State	905
Unknown	1

Source: <http://www.chpdm-ehealth.org/eligibility/new/index.cfm>
 Accessed 1/3/15

The impact of these populations on ED utilization is well documented. Dimensions has made great efforts to decrease unnecessary ED visits to PGHC. For example, Dimensions annually spends approximately \$15 million in physician subsidy payments to attract and retain physicians to care for the low income and indigent populations in Prince George's County.

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

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

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

and Medical Mall Health Services, the program has reduced overall readmission by 20%. Medical Mall incorporates continuous quality improvement metrics into the program and reports the outcomes to the Delmarva Foundation and to CMS.

Medical Mall calls the program “Health Connect” and it has now been expanded to include other high-risk groups to include the behavioral health population and persons with HIV/AIDS. The Health Connect program uses a modified Coleman model of service delivery to reduce readmissions. The Care Transitions model, developed by Eric Coleman, MD, MPH, is an Agency for Healthcare Research and Quality (AHRQ) evidence-based intervention designed to reduce healthcare costs and readmissions. The intervention is a 4-week intervention that begins prior to the patient’s discharge from the hospital. An advanced practice nurse and community health worker provides a detailed assessment 48 hours prior to discharge. The inpatient assessment includes a medication reconciliation, assessment of the home care environment, and analysis of their ability to self-manage their disease, review of family history of disease, completion of a personal health record, and a review of their discharge disease management plan. After discharge, the Health Connect team makes a second contact with the patient within 72 hours of discharge. This second contact is made by the community health worker and is used to assess if the disease management plan is being adhered to post discharge.

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

PGHC’s ED volume grew 13.1% from FY 2007 through FY 2013, growing from 45,068 visits in 2007 to 50,962 visits in 2013. ($50,962/45,068 = 1.131$) The historical volumes are shown in Table 52.

Table 52
Historical ED Volume
PGHC
1998 – 2013

Year	Total Visits
2007	45,068
2008	42,844
2009	45,561
2010	48,145
2011	49,100
2012	52,506
2013	50,962

Source: PGHC

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

Dimensions has consulted with the Prince George's County Fire/EMS Department to determine the impact of the relocation to Largo on EMS transports to the hospital. According to the EMS Department, the number of transport calls in the new catchment area will be significantly greater than in PGHC's existing catchment Area.

Figure 19 shows the catchment areas for each of the Emergency Departments in Prince George's County and the number of transport calls in each catchment area in 2012. It further shows that there were 21,900 calls from PGHC's catchment area in 2012. The EMS Department anticipates this to change when Dimensions moves to Largo.

Figure 20 shows the revised catchment areas resulting from the relocation of Dimensions to Largo. It shows that the number of transport calls in the PGRMC/Largo catchment area would have been 28,702 in 2012. According to the EMS Department, two thirds of transport calls result in actual transports. Further, while the hospital to which patients are transported may be affected by patient preference, the EMS Department has advised Dimensions to assume that nearly all of the transports in PGHC's catchment area do and will go to PGHC. This means that the existing catchment area resulted in 14,601 transports to PGHC in 2012 and would have resulted in 19,136 transports if Dimensions was already located in Largo.

Figure 19
Existing EMS Catchment Areas

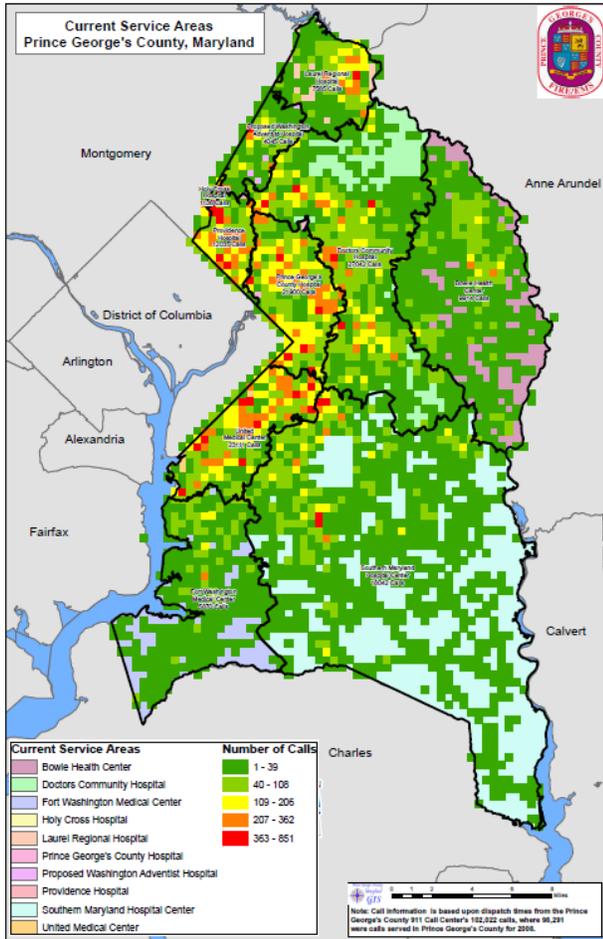
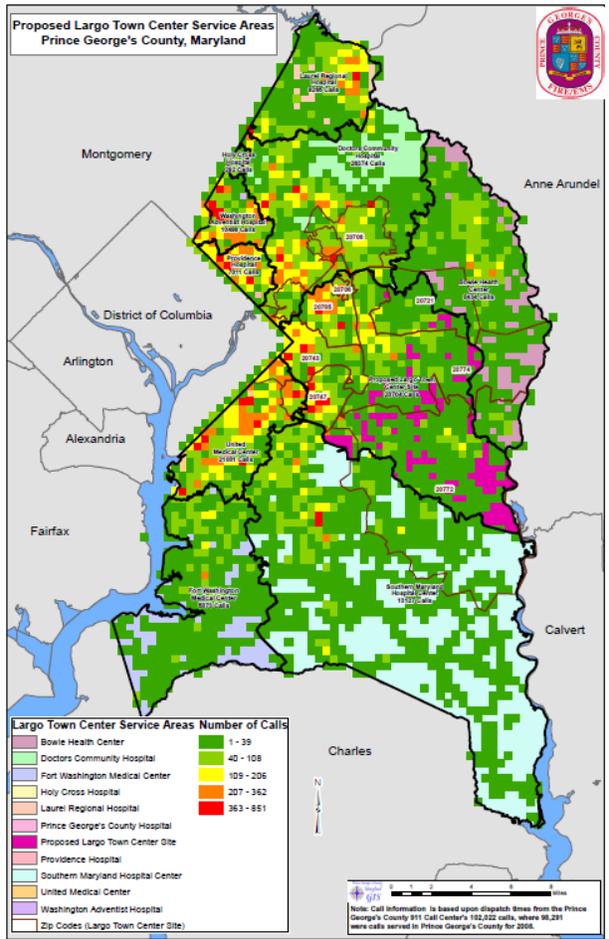


Figure 20
Resultant EMS Catchment Areas



Full page versions of Figures 19 and 20 are attached as **Exhibit 37**.

Because Dimensions does not anticipate that its service area for non-transport ED visits will change, Dimensions assumed that its non-transport ED visits would be affected by population growth. Of course, the estimated 19,136 transport visits in the EMS Largo catchment area would also change as the population in the EMS defined catchment area changes. Including these factors, Dimensions projects that it will see 60,202 ED visits in 2022, as demonstrated below.

**Table 53
Projected PGRMC ED Visits
2022**

Total Population, 2012	1,071,171
ED Visits, 2012	52,309
Transport Calls, 2012	21,900
Call to Transport Conversion	0.6667
Estimated Transports, 2012	14,601
Non-Transport Visits	37,708
Use Rate of Non-Transport Visits/Population	0.0352
Total Population, 2022	1,145,047
Non-Transport Visits 2021	40,308.93
Transport Calls, Largo Catchment Area 2012	28,702
Call to Transport Conversion	0.6667
2012 Transports from Largo Catchment Area	19,136
2012 Pop of Largo Catchment Area	268,663
2022 Pop of Largo Catchment Area	279,300
Pop Ratio 2022/2012	1.04
Projected Transports	19,893
Total Projected Visits	60,202

The proposed ED's size is within the range of the departmental gross square feet ("DGSF") benchmark in the American College of Emergency Physicians ("ACEP") Guide entitled *Emergency Department Design*. On pages 69-71, the Guide presents, in chart form, the factors that should be considered in planning the size of the ED. The information on the proposed PGRMC is presented below. The ACEP Guidelines use "Low Range" and "High Range" thresholds for certain measures to determine the appropriate size for an ED. Criteria 1-11 in Table 54 show the factors that go into determining if an ED should be planned larger or smaller. If the facts for any given hospital under the criteria fall in the "Low Range" category, the ED could be smaller than if the majority falls in the "High Range" Category. Criteria 12 and 13 show the number of DGSF and the number of treatment bays that would be required in both the high and low range categories at various projected ED volumes.

Table 54 shows that, based on the ACEP Guide, an ED at Dimensions projected volumes would require between 29,816 and 40,043 DGSF. Dimensions' ED will be 38,990 DGSF in size, and this includes 3,000 square feet for radiology and 5,165 square feet for trauma. If these areas were not included, PGRMC's ED area would be near the low end of

ACEP Guide’s suggested range of DGSF at Dimensions’ projected volumes. Therefore, Dimensions believes that it is proposing a design that is efficient and not too large.

Table 54
American College of Emergency Physicians (“ACEP”) Guide
Emergency Department Design
“Low Range” and “High Range” Thresholds
and PGHC Comparison
Emergency Department
At Projected Volume Growth

	Low	High	Existing Hospital	Proposed Hospital
1 ALOS	<2.5 Hours	>3.5 Hours	4.4	3.1
2 Location of Observation Beds	Outside ED	Inside ED	Outside	Outside
3 Time to Admit	<60 Minutes	> 90 Minutes	258	90
4 Turnaround Time Dx Tests	<31 Minutes	> 60 Minutes	Lab - 349 Rad - 318	60
5 % Admitted Patients	< 18%	> 23%	18.00%	18.00%
6 % Nonurgent/%Urgent	>1.1/1	>1/1.1	1/1.4	1/1.4
7 Age of Patient	<20% Age 65+	>25% Age 65+	8.9%	13%
8 Admin/Teaching Space	Minimal	Extensive	Extensive	Extensive
9 Imaging w/n ED	No	Yes	No	Yes
10 Specialty Components	No	Yes	Yes	Yes
11 Flight/Trauma Services	No	Yes	Yes	Yes
Projected DGSF			21,220	38,990
Projected Annual Visits			52,500	60,202
12 DGSF 60,000 Visits	29,750	39,950		
DGSF 70,000 Visits	33,000	44,550		
DGSF Calculated at PGHC Volumes	29,816	40,043		
13 Treatment Bays 60,000 Visits	35	47		
Treatment Bays 70,000 Visits	40	54		
Treatment Bays Calculated at Projected Volumes	35	47		
Proposed Number of Treatment Bays				52

Dimensions recognizes it is asking for more ED bays than the Guide suggests it would need at Dimensions’ projected volumes. However, this includes four Trauma rooms and one Sexual Assault room, each their own separate units. (Both the treatment bays and the departmental square footage are included in the ACEP Guide analysis above.)

Furthermore, Dimensions is proposing to have those bays in a footprint that is within the range of the MHCC’s benchmark for size. Dimensions urges the MHCC to provide flexibility to Dimensions in the way it proposes to use its efficient footprint.

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

Even if, as a result of the Affordable Care Act, the use rates showed a reduction (something that PGRMC is not predicting), the size of the Proposed ED would be reasonable. Table 55 shows the ACEP analysis assuming that the non-transport use rates are reduced by 10%. The proposed number of square feet of the ED of Trauma Unit does exceed the ACEP range. However, if one excludes the 8,165 square feet for radiology and trauma, it is only 9.6% above the imputed Low end of the square footage range for those volumes. (38,990-8,165 = 30,825; 30,825/28,123 = 1.0961)

Table 55
American College of Emergency Physicians (“ACEP”) Guide
Emergency Department Design
“Low Range” and “High Range” Thresholds
and PGHC Comparison
Emergency Department
At a 10% Decline in Non-Transport Use Rates

	Low	High	Existing Hospital	Proposed Hospital
1 ALOS	<2.5 Hours	>3.5 Hours	4.4	3.1
2 Location of Observation Beds	Outside ED	Inside ED	Outside	Outside
3 Time to Admit	<60 Minutes	> 90 Minutes	258	90
4 Turnaround Time Dx Tests	<31 Minutes	> 60 Minutes	Lab - 349 Rad - 318	60
5 % Admitted Patients	< 18%	> 23%	18.00%	18.00%
6 % Nonurgent/%Urgent	>1.1/1	>1/1.1	1/1.4	1/1.4
7 Age of Patient	<20% Age 65+	>25% Age 65+	8.9%	13%
8 Admin/Teaching Space	Minimal	Extensive	Extensive	Extensive
9 Imaging w/n ED	No	Yes	No	Yes
10 Specialty Components	No	Yes	Yes	Yes
11 Flight/Trauma Services	No	Yes	Yes	Yes
Projected DGSF			21,220	38,990
Projected Annual Visits			52,500	56,171
12 DGSF 50,000 Visits	25,500	34,000		
DGSF 60,000 Visits	29,750	39,950		
DGSF Calculated at PGHC Volumes	28,123	37,672		
13 Treatment Bays 50,000 Visits		30	40	
Treatment Bays 60,000 Visits		35	47	
Treatment Bays Calculated at Projected Volumes	33	44		
Proposed Number of Treatment Bays				52

Standard .04B(15) – Emergency Department Expansion.

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

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

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

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

Applicant Response:

Dimensions has taken several steps to make PGHC's ED more efficient and to improve waiting times. Triage innovations include a "pull to full" process to bring arriving patients directly back to beds, as well as a provider in triage during busy hours to assist with early evaluation and order entry. As a result, door to bed times for patients have improved from 75 minutes in February 2013 to 37 minutes in November 2014. Door to provider times have improved from an average of 80 minutes in the first half of 2013 to 53 minutes in the second half of 2014. Overall door to disposition for patients improved from 224 minutes to 208 minutes in that same period and total length of stay a modest decrease from 297 to 293 minutes. This was accomplished by use of an extra provider during high volume hours, revamping of stock medications, and the use of expedited orders. Additionally, the percentage of patients leaving without being triaged or seen improved from an average of 7.23 to 5.22% between the first half of 2013 and second half of 2014.

In addition, please see response to Standard .04B(14) – Emergency Department Treatment Capacity and Space.

Standard .04B(16) – Shell Space.

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

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

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

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

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

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

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

Applicant Response:

There is no shell space built into this project.

COMAR 10.24.12 OB SERVICES CHAPTER
.04 REVIEW STANDARDS

Standard .04B(1) – Need.

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

Applicant Response:

The proposed project shifts the service area for Prince George’s Hospital Center (PGHC) from one based on its current location in Cheverly, MD to Dimensions’ new location based in Largo, MD. The response to COMAR 10.24.10.04B(2) - Identification of Bed Need and Addition of Beds, pp. 49-79, contains a detailed discussion of the methodology used to define the new service area and make projections based on that service area.

As explained above, Dimensions split the historical 2013 inpatient discharge data into six cohorts – MSGA (15-64), MSGA (65-74), MSGA (75+), Obstetrics (OB), Pediatrics (PED), and Psychology (PSY). To determine the Zip Code areas to include in the expected 85% service area for the Largo site, Dimensions used drive times generated by Spatial Insights from Zip Codes in Prince George’s County, and selected surrounding Zip Codes to each Maryland, District of Columbia, and Virginia hospital.

The Maryland Zip Codes were then sorted by proximity to the current PGHC location and the 2013 discharges were summed until they equaled 85% of PGHC’s total 2013 discharges. This was done for each cohort individually. For OB, this occurred with the Zip Codes for which PGHC was the fourth closest hospital and these Zip Codes accounted for 90.8% of PGHC’s 2013 OB discharges. In determining the closest hospital for OB, PGHC was compared only to those hospitals offering OB services. These conditions were then applied to Zip Codes surrounding the future Largo site for PGRMC. Zip Codes for which PGRMC would be the fourth most proximate hospital or closer hospital for OB beds were identified. This was determined by ranking the proximity of all hospitals, excluding the existing PGHC. The results are recorded in Table 56.

**Table 56
Defining PGRMC's Service Area
OB
FY 2013**

Prince George's Hospital Center						
Zip Code	Town	Drive Time	Rank	FY 2013 Discharges	%	Cumulative %
20785	Hyattsville - Landover	5.70	1	244	10.7%	10.7%
20743	Capitol Heights Area	7.70	1	227	9.9%	20.6%
20706	Lanham-Glenarden	9.18	1	176	7.7%	28.3%
20784	Hyattsville - Landover Hills	5.48	1	171	7.5%	35.8%
20747	District Heights - Forestville	12.77	1	168	7.3%	43.1%
20737	Riverdale	4.50	1	125	5.5%	48.6%
20774	Upper Marlboro	16.00	1	81	3.5%	52.1%
20710	Bladensburg	2.62	1	57	2.5%	54.6%
20781	Hyattsville Area	3.88	1	49	2.1%	56.7%
20770	Greenbelt Area	8.15	1	41	1.8%	58.5%
20721	Bowie	15.33	1	32	1.4%	59.9%
20720	Bowie - North	14.88	1	16	0.7%	60.6%
20722	Colmar Manor	4.20	1	12	0.5%	61.1%
20715	Bowie - North	19.58	1	12	0.5%	61.7%
20769	Glenn Dale	14.77	1	7	0.3%	62.0%
20787	Hyattsville	6.23	1	4	0.2%	62.2%
20753	District Heights	12.30	1	-	0.0%	62.2%
20731	Capitol Heights	7.08	1	-	0.0%	62.2%
20791	Capitol Heights	7.03	1	-	0.0%	62.2%
20752	Suitland	11.03	1	-	0.0%	62.2%
20738	Riverdale Park	5.10	1	-	0.0%	62.2%
20797	Southern MD Facility	7.08	1	-	0.0%	62.2%
20718	Bowie	18.53	1	-	0.0%	62.2%
20775	Upper Marlboro	16.30	1	-	0.0%	62.2%
20741	College Park	7.98	1	-	0.0%	62.2%
20703	Lanham-Seabrook	11.55	1	-	0.0%	62.2%
20768	Greenbelt	8.73	1	-	0.0%	62.2%
20771	Greenbelt	10.20	1	-	0.0%	62.2%
20799	Capitol Heights	12.17	1	-	0.0%	62.2%
20792	Upper Marlboro	16.07	1	-	0.0%	62.2%
20748	Temple Hills	15.23	2	124	5.4%	67.6%
20746	Suitland	13.07	2	108	4.7%	72.3%
20772	Upper Marlboro	28.12	2	34	1.5%	73.8%
20735	Clinton	24.43	2	31	1.4%	75.1%
20740	College Park	10.75	2	21	0.9%	76.0%
20712	Mount Rainier	5.93	2	20	0.9%	76.9%
20716	Bowie - South East	19.27	2	19	0.8%	77.8%
20708	South Laurel	16.53	2	18	0.8%	78.5%
20613	Brandywine	36.40	2	8	0.3%	78.9%
20602	Waldorf	39.77	2	5	0.2%	79.1%
20601	Waldorf	35.27	2	5	0.2%	79.3%
20623	Cheltenham	30.73	2	1	0.0%	79.4%
20603	Waldorf	43.12	2	-	0.0%	79.4%
20719	Bowie	19.03	2	-	0.0%	79.4%
20788	Hyattsville	6.32	2	-	0.0%	79.4%
20773	Upper Marlboro	27.07	2	-	0.0%	79.4%
20608	Aquasco	49.70	2	-	0.0%	79.4%
20757	Temple Hills	14.97	2	-	0.0%	79.4%
20709	Laurel	15.30	2	-	0.0%	79.4%
20717	Bowie	20.58	2	-	0.0%	79.4%
20762	Andrews AFB	20.50	2	-	0.0%	79.4%
20653	Lexington Park	94.48	2	-	0.0%	79.4%
20742	College Park	10.03	3	-	0.0%	79.4%
20745	Oxon Hill	17.07	4	111	4.9%	84.2%
20744	Fort Washington	23.53	4	78	3.4%	87.6%
20782	Hyattsville-Chillum	7.97	4	45	2.0%	89.6%
20705	Beltsville	14.58	4	20	0.9%	90.5%
20607	Accokeek	34.63	4	7	0.3%	90.8%
20749	Fort Washington	25.87	4	-	0.0%	90.8%
20704	Beltsville	13.60	4	-	0.0%	90.8%
20725	Laurel	21.13	4	-	0.0%	90.8%
20726	Laurel	19.98	4	-	0.0%	90.8%
Total Discharges in Service Area				2,077		

PGRMC - Largo Location					
Using Ranking as Service Area Cut-Off					
Zip Code	Town	PGHC Drive Time	PGHC Rank	Drive Time	Rank
20785	Hyattsville - Landover	5.7	1	5.5	1
20743	Capitol Heights Area	7.7	1	7.05	1
20784	Hyattsville - Landover Hills	5.48	1	7.58	1
20706	Lanham-Glenarden	9.18	1	7.43	1
20747	District Heights - Forestville	12.77	1	9.3	1
20774	Upper Marlboro	16	1	6.45	1
20770	Greenbelt Area	8.15	1	10.35	1
20721	Bowie	15.33	1	7.85	1
20720	Bowie - North	14.88	1	12.52	1
20716	Bowie - South East	19.27	2	15.37	1
20715	Bowie - North	19.58	1	17.22	1
20769	Glenn Dale	14.77	1	13.42	1
20773	Upper Marlboro	27.07	2	17.25	1
20753	District Heights	12.3	1	9.52	1
20775	Upper Marlboro	16.3	1	6.68	1
20731	Capitol Heights	7.08	1	7.18	1
20791	Capitol Heights	7.03	1	7.55	1
20752	Suitland	11.03	1	12.82	1
20717	Bowie	20.58	2	14.22	1
20797	Southern MD Facility	7.08	1	7.18	1
20799	Capitol Heights	12.17	1	2.35	1
20792	Upper Marlboro	16.07	1	6.45	1
20718	Bowie	18.53	1	16.2	1
20703	Lanham-Seabrook	11.55	1	9.83	1
20768	Greenbelt	8.73	1	10.67	1
20771	Greenbelt	10.2	1	10.65	1
20746	Suitland	13.07	2	13.45	2
20748	Temple Hills	15.23	2	13.87	2
20735	Clinton	24.43	2	18.83	2
20772	Upper Marlboro	28.12	2	18.77	2
20708	South Laurel	16.53	2	18.47	2
20613	Brandywine	36.4	2	30.8	2
20602	Waldorf	39.77	2	34.17	2
20601	Waldorf	35.27	2	29.67	2
20603	Waldorf	43.12	2	37.52	2
20719	Bowie	19.03	2	18.18	2
20623	Cheltenham	30.73	2	21.38	2
20762	Andrews AFB	20.5	2	11.83	2
20608	Aquasco	49.7	2	44.1	2
20757	Temple Hills	14.97	2	14.23	2
20709	Laurel	15.3	2	17.23	2
20653	Lexington Park	94.48	2	88.88	2
20737	Riverdale	4.5	1	10.72	3
20710	Bladensburg	2.62	1	10.7	3
20738	Riverdale Park	5.1	1	11.27	3
20745	Oxon Hill	17.07	4	17.42	4
20744	Fort Washington	23.53	4	24.18	4
20781	Hyattsville Area	3.88	1	12.77	4
20607	Accokeek	34.63	4	35.42	4
20749	Fort Washington	25.87	4	26.6	4
20704	Beltsville	13.6	4	16.08	4
20705	Beltsville	14.58	4	17.07	5
20740	College Park	10.75	2	13.38	5
20722	Colmar Manor	4.2	1	13.32	5
20725	Laurel	21.13	4	23.07	5
20726	Laurel	19.98	4	21.92	5
20787	Hyattsville	6.23	1	13.8	5
20741	College Park	7.98	1	14.05	5
20742	College Park	10.03	3	16.22	6
20782	Hyattsville-Chillum	7.97	4	16.72	7
20712	Mount Rainier	5.93	2	15.05	7
20788	Hyattsville	6.32	2	15.47	7

The change in PGHC's service area to PGRMC's service area results in a 16.5% reduction in the total service area population. Based on PGRMC's future service area, population growth assumptions through 2022 were obtained from Claritas at the six cohort levels (MSG A 15-64, MSG A 65-74, MSG A 75+, OB, PED, PSY). For OB, Dimensions used the population of women age 15-45 which is expected to decline by 5.4% by 2022. In 2012, Dimensions calculated that the use rate for OB admissions was 66.68 per 1,000 women age 15-44. Dimensions expects that this use rate will have declined by 2% to 65.34/1,000 by next year in 2015. Dimensions does not expect any further reductions in this use rate in future

years. The relocation of the hospital to Largo is also expected to have an adverse impact on the expected volume of OB discharges at PGRMC.

Offsetting the reductions driven by population, use rates, and relocation, is the expectation that PGRMC will recapture its historical market share. PGHC experienced market shares of 22% in 2011 and 2012. In 2013, PGHC had a 17.4%% market share in the service area in OB. This is projected to increase to 19.0% by 2022. This increase in market share is expected to offset the expected decline in OB discharges as a result of population and use rate reductions, as well as relocation.

Combined with out-of-service area patients, Dimensions projects that the new facility will admit 2,193 OB patients in 2022. Applying the 2012 Statewide Average Length of Stay for OB (2.65 days) and an assumed 75% occupancy results in the need for 22 beds.

Standard .04(2) – The Maryland Perinatal System Standards.

Each applicant shall demonstrate the ability of the proposed obstetric program and nursery to comply with all essential requirements of the most current version of Maryland's Perinatal System Standards, as defined in the perinatal standards, for either a Level I or Level II perinatal center.

Applicant Response:

PGHC is designated as a Level IIIB Perinatal Referral Center by the Maryland Institute for Emergency Medical Services Systems (“MIEMSS”).

Dimensions resubmitted a re-designation application for the center in May 2013. MIEMSS conducted an initial on-site survey on June 25, 2013 and identified certain concerns and standards that were not met. On August 27, 2013, MIEMSS re-designated PGHC’s Level IIIB Perinatal Referral Center on a one-year provisional basis, followed by four years of probation, which required a Corrective Action Plan.

Dimensions submitted its Corrective Action Plan to address the deficiencies noted in the initial survey, and it filed quarterly reports detailing its progress under the Corrective Plan. MIEMSS conducted a compliance check visit on May 19, 2014 and a one-year re-verification site survey on August 8, 2014.

Following the August 8, 2014 survey, MIEMSS concluded that PGHC improved its perinatal center program and that, based on reviews of records and an onsite tour, NICU and Intermediate Unit at PGHC support the treatment of perinatal patients commensurate with that of a Level IIIB Perinatal Center. On August 26, 2104, MIEMSS informed PGHC that, in light of PGHC’s progress, MIEMSS determined to remove PGHC’s provisional designation and to maintain PGHC’s designation on probation for the remainder of the four-year designation cycle. A copy of the August 26, 2014 letter from MIEMSS is attached as **Exhibit 38**. Dimensions expects that the design of the physical space in the new PGRMC will enhance its ability to comply with the Perinatal System Standards.

Standard .04(3) – Charity Care Policy.

Each hospital shall have a written policy for the provision of charity care for uninsured and under-insured patients to promote access to obstetric services regardless of an individual's ability to pay.

(a) The policy shall include provisions for, at a minimum, the following:

(i) annual notice by a method of dissemination appropriate to the hospital's patient population (for example, radio, television, newspaper);

(ii) posted notices in the admissions office, business office and emergency areas within the hospital;

(iii) individual notice provided to each person who seeks services in the hospital at the time of community outreach efforts, prenatal services, preadmission, or admission, and

(iv) within two business days following a patient's initial request for charity care services, application for medical assistance, or both, the facility must make a determination of probable eligibility.

(b) Public notice and information regarding a hospital's charity care policy shall be in a format understandable by the target population.

Applicant Response:

As explained above, the replacement hospital's charity care policy will be consistent with these requirements. Please see Exh. 20.

Standard .04(4) – Medicaid Access.

Each applicant shall provide a plan describing how the applicant will assure access to hospital obstetric services for Medical Assistance enrollees, including:

(a) an estimate of the number of Medical Assistance enrollees in its primary service area, and the number of physicians that have or will have admitting privileges to provide obstetric or pediatric services for women and infants who participate in the Medical Assistance program.

Applicant Response:

Dimensions provides care to all individuals, regardless of ability to pay or identity of payor. According to Maryland Department of Health and Mental Hygiene's Maryland Medicaid eHealth Statistics, there were an average of 179,359 Medicaid enrollees in Prince George's County in the first four months of FY 2015 (<http://www.chpdm-ehealth.org/mco/mco-enrollment-action.cfm>). The website provides data for each month in the fiscal year. Dimensions averaged the monthly data. It is the policy of Dimensions to accept a patient for Medicaid obstetric services if the patient is a Maryland resident and has a pending Medicaid application filed.

All of the obstetricians with privileges at PGHC participate in the Medical Assistance Program. There are six employed obstetricians and nine private, privileged obstetricians. There are also two employed maternal fetal medicine physicians. All privileged PGHC obstetricians and maternal fetal medicine physicians accept Medicaid patients per the above guidelines.

Standard .04(5) – Staffing.

Each applicant shall provide information on the proposed staffing, associated number and type of FTEs, projected expenses per FTE category and total expenses, for labor and delivery, post partum, nursery services, and other related services, including nurse staffing, non-nurse staffing and physician coverage, at year three and at maximum projected volumes; if applicable, current staffing and expenses should also be included.

Applicant Response:

Table 57: OB Staffing Projections for PGRMC

Employee Category	2014 FTEs by Dept	Change in FTEs			2022 FTEs	Average Salary per FTE (1)	2022 Total Expense
		Volume FTEs	SEIU FTEs	Total			
Labor and Delivery							
CLERICAL SPECIALIST	4.3	0.4	(0.5)	(0.1)	4.2	\$ 49,725	\$ 208,880
NSG ASST DEPT MGR	4.7	0.4	(0.5)	(0.1)	4.6	127,298	584,484
PATIENT CARE TECH	7.1	0.6	(0.8)	(0.2)	6.9	47,242	327,674
REG NURSE, OCFP	1.5	0.1	(0.2)	(0.0)	1.5	122,273	179,174
REGISTERED NURSE	26.2	2.2	(2.7)	(0.5)	23.3	92,338	2,147,894
REGISTERED NURSE II	0.9	0.1	(0.1)	(0.0)	0.9	120,772	106,185
AGENCY RN	0.9	0.1	(0.1)	(0.0)	0.9	151,526	133,224
Subtotal	49.8	4.0	(5.0)	(1.0)	42.2	87,355	3,687,515
Post Partum							
CLERICAL SPECIALIST	6.3	0.6	(0.7)	(0.1)	6.2	49,725	306,034
NEWBORN HEARING TECH	1.0	0.1	(0.1)	(0.0)	1.0	45,487	44,436
NSG ASST DEPT MGR	2.9	0.3	(0.3)	(0.1)	2.8	127,298	360,640
NSG ASST DEPT MGR WE	1.2	0.1	(0.1)	(0.0)	1.2	131,307	153,928
PATIENT CARE TECH	6.3	0.6	(0.7)	(0.1)	6.2	47,242	290,753
REG NURSE, OCFP	1.2	0.1	(0.1)	(0.0)	1.2	122,273	143,340
REGISTERED NURSE	22.3	2.3	(2.8)	(0.6)	24.2	101,846	2,469,380
REGISTERED NURSE II	0.9	0.1	(0.1)	(0.0)	0.9	120,772	106,185
VITAL STATS COORD	2.0	0.2	(0.2)	(0.0)	2.0	58,369	114,042
AGENCY RN	2.0	0.2	(0.2)	(0.0)	2.0	136,373	266,448
Subtotal	46.1	4.4	(5.6)	(1.1)	47.5	89,589	4,255,186
NICU							
CLERICAL SPECIALIST	4.2	0.4	(0.5)	(0.1)	4.1	49,725	204,023
EQUIPMENT TECHNICIAN	1.4	0.1	(0.2)	(0.0)	1.4	37,789	51,683
NSG ASST DEPT MGR	4.1	0.4	(0.5)	(0.1)	4.0	127,298	509,869
NSG ASST DEPT MGR WE	0.6	0.1	(0.1)	(0.0)	0.6	131,307	76,965
REG NURSE, OCFP	1.2	0.1	(0.1)	(0.0)	1.2	142,652	167,229
REGISTERED NURSE	18.0	1.1	(1.4)	(0.3)	12.1	92,441	1,118,442
REGISTERED NURSE III	3.3	0.3	(0.4)	(0.1)	3.2	128,377	414,471
AGENCY RN	2.0	0.2	(0.2)	(0.0)	2.0	151,527	296,055
Subtotal	34.8	2.7	(3.3)	(0.7)	28.5	99,549	2,838,736
Total Salaries	130.7	11.1	(13.9)	(2.8)	118.2	\$ 91,194	\$10,781,436
Benefits (calculated @ 28.9%)							3,115,075
Total Salaries and Benefits							\$13,896,511

Note (1): Average salary per FTE reflects 2014 budget with no inflation

Standard .04(6) – Physical Plant Design and New Technology.

All applicants must describe the features of new construction or renovation that are expected to contribute to improvements in patient safety and/or quality of care, and describe expected benefits.

Applicant Response:

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

The new facility will also implement the design and plan features discussed in response to Standard 10.24.10.04B(12) (Patient Safety), pp. 131-135.

Standard .04(7) Nursery.

An applicant for a new perinatal service shall demonstrate that the level of perinatal care, including newborn nursery services, will be consistent with the needs of the applicant's proposed service area.

Inapplicable.

Standard .04(8) – Community Benefit Plan.

Each applicant proposing to establish a new perinatal service will develop and submit a Community Benefit Plan addressing and quantifying the unmet community needs in obstetric and perinatal care within the applicant's anticipated service area population, This Plan should include an outreach program component, and should provide a detailed description of the manner in which the proposed perinatal service will meet these needs, and the resources required, At a minimum, the Community Benefit Plan must include:

- (a) a needs assessment related to obstetric and nursery services for the proposed program's service area population, including a description of the manner in which the proposed perinatal service will satisfy unmet needs identified in the needs assessment,**
- (b) measurable and time-limited goals and objectives for health status improvements pursuant to which the Plan can be evaluated; and**
- (c) information on the structure, staffing and funding of the Plan;**

(d) documentation of community support and involvement in program planning for the Plan by other agencies, organizations or institutions which will be involved, directly or indirectly, with the Plan;

(e) an implementation scheme for the Community Benefit Plan.

(f) Applicants must commit to implementation of the Community Benefit Plan and continuing commitment to the Plan as a condition of Commission approval, and as an ongoing condition of providing obstetric services.

(g) Applicants must agree to submit an Annual Report to the Commission which will include:

(i) an evaluation of the achievement of the goals and objectives of the Community Benefit Plan; and

(ii) information on staffing levels and the total costs of any programs implemented as part of the Community Benefit Plan.

Inapplicable.

Standard .04(9) – Source of Patients.

An applicant for a new obstetric service shall demonstrate that the majority of its patients will come from its primary service area.

Inapplicable.

Standard .04(10) – Non-metropolitan Jurisdictions.

A proposed obstetrics program in non-metropolitan jurisdictions, as defined in the chapter, shall demonstrate that physicians with admitting privileges to provide obstetric services have offices for patient visits within the primary service area of the hospital.

Inapplicable.

Standard .04(11) – Designated Bed Capacity.

An applicant for a new obstetric service shall designate a number of the beds from within the hospital's licensed acute care beds that will comprise the proposed obstetric program.

Inapplicable.

Standard .04(12) – Minimum Volume.

- (a) An applicant for a new obstetrics program must be able to demonstrate to the Commission's satisfaction that the proposed program can achieve a minimum volume of 1,000 admissions annually in metropolitan jurisdictions, or 500 cases annually in non-metropolitan jurisdictions, within 36 months of initiation of the program.**
- (b) As a condition of approval; the applicant shall accept a requirement that it will lose the obstetric program, and its authority to operate will be revoked, if:
 - (i) it fails to meet the minimum annual volume for any 24 consecutive month period, and**
 - (ii) it fails to provide good cause for its failure to attain the minimum volume, and a feasible corrective action plan for how it will achieve the minimum volume within a two year period.****

Inapplicable.

Standard .04(13) – Impact on the Health Care System.

- (a) An application for a new perinatal program will be approved only if its likely impact on the volumes of obstetric discharges at any existing obstetric program, after the three year start-up period, will not exceed 20 percent of an existing program's current or projected volume.**
- (b) When determining whether to approve an application for an obstetrics program, the Commission will consider whether an existing program's payer mix of obstetrics patients will significantly change as a result of the proposed program, and the existing program will have to care for a disproportionate share of the indigent obstetrics patients in its service area; and**
- (c) When determining whether to approve an application for an obstetrics program the Commission will also consider the impact on a hospital with an existing program that has undertaken a capital expenditure project for which it has pledged pursuant to H-G Article § 19-120(k) not to increase rates for that project, so long as the pledge was based, at least in part, on assumptions about obstetric volumes.**
- (d) The Commission may consider evidence:
 - (i) from an applicant as to why rules (a) through (c) should not apply to the applicant, or;**
 - (ii) from a very low volume program (fewer than 500 annual obstetric discharges) as to why a lower volume impact should apply.****

Inapplicable.

Standard .04(14) – Financial Feasibility.

Hospitals applying for a Level I or II perinatal program must clearly demonstrate that the hospital has the financial and non-financial resources necessary to implement the project, and that the average charge per admission for new perinatal programs will be less than the current statewide average charge for Level I and Level II perinatal programs. When determining whether to approve an application for an obstetric program, the Commission will consider the following:

- (a) the applicant's projected sources of funds to meet the program's total expenses for the first three years of operation,
- (b) the proposed unit rates and/or average charge per case for the perinatal services;
- (c) evidence that the perinatal service will be financially feasible at the projected volumes and at the minimum volume standards in this Plan, and
- (d) the written opinions or recommendations of the HSCRC.

Inapplicable.

Standard .04(15) – Outreach Program.

Each applicant with an existing perinatal service shall document an outreach program for obstetric patients in its service area who may not have adequate prenatal care, and provide hospital services to treat those patients. The program shall address adequate prenatal care, prevention of low birth weight and infant mortality, and shall target the uninsured, under-insured, and indigent patients in the hospital's primary service area, as defined in COMAR 10.24.01.01.B.

Applicant Response:

As a safety-net hospital, Dimensions is committed to providing care to individuals who have limited or no access to healthcare due to finances, insurance, and/or health status. This care is provided to target populations, such as women in need of obstetric services, to include prenatal and preventative maternal child care. In order to meet these needs, Dimensions collaborates with community partners that serve as referral sources for entry into the hospital and health system which includes Laurel Regional Hospital and Glenridge Medical Center, affiliates of Dimensions. In addition to system members, the Prince George's County Health Department, community health centers, local physicians, social services agencies, and other organizations in the County and surrounding area identify women who need prenatal care, prevention of low birth weight and infant mortality, and uninsured, under-insured, and indigent patients. Women who believe they may be pregnant or in need of obstetric services may also refer themselves. PGHC accommodates referrals for obstetric and gynecologic care for underserved women primarily in Prince George's County from any of these sources.

In addition, PGHC offers community health and wellness programs for the community, including:

- Beautiful Beginnings Tour
- Childbirth Preparation Classes
- Free HIV Testing
- Smoking Cessation
- Support Groups: Alcoholics Anonymous, Preemie Parent, Survivors of Rape/Sexual Assault, WomenHeart

These programs are free to all community members. If a woman in need of OB services is identified as needing prenatal care through one of these programs, she may be referred to an appropriate source for care such as the Health Department or other care providers in the community including PGHC.

In 2011, Dimensions became a part of a joint initiative with the Pregnancy Aid Centers, Inc. ("PAC") to increase prenatal care for women in need. The PAC is a nonsectarian, non-profit, community-based women's health clinic and social service agency operating in Prince George's County. The initiative was established to address the needs of low income and uninsured high-risk pregnant women residing in Prince George's County. Through this collaboration, Dimensions Healthcare Associates ("DHA"), an affiliate of Dimensions Healthcare System, and PAC expanded existing services offered at PAC to better address the disparity in the infant mortality rate among African-Americans and Latinas by improving prenatal health provided African-American and Latina women and adolescents.

The program offers co-management of patient care by a DHA physician and PAC nurse midwife or nurse practitioner. Management consists of determining a care plan for medically high-risk and low-risk maternity patients including referral to PGHC for delivery and surgical services if necessary. High risk patients may also be referred to the Health Department, or other appropriate care providers in the community for health services.

COMAR 10.24.07 - PSYCHIATRIC SERVICES CHAPTER

The current State Health Plan Overview standards and policies and the current standards of the Overview of Acute Care Section in the State Health Plan shall also apply to the Acute Psychiatric Section. In instances of inconsistency between these standards and the (1983-1988) State Health Plan, these standards supersede. The following specific standards are expressly overridden: OAC 4, OAC 5, OAC 11, and OAC 15, a, b, and c.

Standard AP Ia.

The projected maximum bed need for child, adolescent, and adult acute psychiatric beds is calculated using the Commission's statewide child, adolescent, and adult acute psychiatric bed need projection methodologies specified in this section of the State Health Plan. Applicants for Certificates of Need must state how many child, adolescent, and adult acute psychiatric beds they are applying for in each of the following categories: net acute psychiatric bed need, and/or state hospital conversion bed need.

Inapplicable. PGHC does not provide child and adolescent psychiatry, nor will PGRMC.

Standard AP Ib.

A Certificate of Need applicant must document that it has complied with any delicensing requirements in the State Health Plan or in the Hospital Capacity Plan before its application will be considered.

Inapplicable. There are no delicensing requirements in the State Health Plan, the hospital capacity plan regulations no longer exist, and there are no existing beds to delicense.

Standard AP Ic.

The Commission will not docket a Certificate of Need application for the "state hospital conversion bed need" as defined, unless the applicant documents written agreements with the Mental Hygiene Administration. The written agreements between the applicant and the Mental Hygiene Administration will specify:

(i) the applicant's agreement to screen, evaluate, diagnose and treat patients who would otherwise be admitted to state psychiatric hospitals. These patients will include: the uninsured and underinsured, involuntary, Medicaid and Medicare recipients;

(ii) that an equal or greater number of operating beds in state facilities which would have served acute psychiatric patients residing in the jurisdiction of the applicant hospital will be closed and delicensed, when the beds for the former state patients become operational;

(iii) that all patients seeking admission to the applicant's facility will be admitted to the applicant's facility and not be transferred to the state

psychiatric hospital unless the applicant documents that the patient cannot be treated in its facility; and

(iv) that the applicant and the Mental Hygiene (MHA) Administration will be responsible for assuring financial viability of the services, including the payment of bad debt by DHMH as specified in the written agreement between MHA and the applicant.

Inapplicable.

Standard AP 1d.

Preference will be given to Certificate of Need applicants applying for the "net adjusted acute psychiatric bed need", as defined, who sign a written agreement with the Mental Hygiene Administration as described in part (i) and (iii) of Standard AP 1c.

Inapplicable.

Standard AP 2a.

All acute general hospitals with psychiatric units must have written procedures for providing psychiatric emergency inpatient treatment 24 hours a day, 7 days a week with no special limitation for weekends or late night shifts.

Applicant Response:

PGHC has written procedures for providing psychiatric emergency inpatient treatment 24 hours a day, 7 days a week, with no special limitation for weekends or late night shifts. As part of a hospital that will be operating 24/7, the adult acute inpatient psychiatric unit has appropriate staffing at all times. A licensed psychiatrist and a licensed psychiatric crisis clinician are on call at all times, 24/7. The replacement facility will have similar procedures and staffing as well.

Standard AP 2b.

Any acute general hospital containing an identifiable psychiatric unit must be an emergency facility, designated by the Department of Health and Mental Hygiene to perform evaluations of persons believed to have a mental disorder and brought in on emergency petition.

Applicant Response:

The Emergency Department at PGHC is designated by the Director of the Department of Health and Mental Hygiene to perform evaluations of persons believed to have a mental disorder and brought in on emergency petition. Dimensions expects that the ED at the replacement facility will serve this function as well.

PGHC Behavioral Health Services, Assessment and Stabilization Center is a comprehensive, hospital based psychiatric service separate from the Hospital's main ED. After psychiatric patients are medically cleared in the main ED, they are transferred to the Assessment and Stabilization Center to obtain the clinical assessment, evaluation, medical activities and interventions necessary to stabilize their psychiatric or co-occurring psychiatric and substance use. Resolution of conditions or behaviors are criteria for discharge readiness and/or transfer to an inpatient unit to ensure patient's clinical management and resolution of the specific behaviors or conditions that precipitated hospitalization. Included within the Assessment and Stabilization Center (ASC) are 23 Hour Observation Beds.

ASC operates 24/7 with appropriate staffing at all time. Registered Nurses, Crisis Counselors are on site 24/7 and licensed psychiatrists are on site and on-call at all times, as well as other medical and surgical specialist. The replacement facility will continue this service.

Standard AP 2c.

Acute general hospitals with psychiatric units must have emergency holding bed capabilities and a seclusion room.

Applicant Response:

While Dimensions attempts to avoid using seclusion, there are two "seclusion rooms" on the current unit which are generally used for other purposes. The replacement facility will include one inpatient seclusion room and will meet the standard.

Standard AP 3a.

Inpatient acute psychiatric programs must provide an array of services. At a minimum, these specialized services must include: chemotherapy, individual psychotherapy, group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies.

Applicant Response:

The inpatient acute psychiatric program at PGRMC will include an array of services, including individual psychotherapy, group therapy, family meetings and education, social services, and Art Therapy and Addiction Counseling. When promoting these services, PGRMC will have access to models from other inpatient adult psychiatric programs, as well as other best practices in the mental health field. PGRMC will not have a child or adolescent inpatient unit.

The full range of psychological therapies will be provided by staff dedicated to the unit, to include licensed therapists, psychiatry nurses, and other staff specially trained in providing care to psychiatric inpatients. Additional treatment, such as physical therapy, respiratory therapy, and medical intervention will be provided by departments that serve the entire campus. Case Management will be stationed on the inpatient unit as part of the dedicated licensed staff.

In the current facility, if an adult, acute psychiatric inpatient on the unit requires chemotherapy prior to discharge, the patient is transferred to a specialty unit within PGHC. A chemo-certified nurse administers the drugs to the psychiatric inpatient. PGRMC will follow this same procedure.

Standard AP 3b.

In addition to the services mandated in Standard 3a., inpatient child and adolescent acute psychiatric services must be provided by a multidisciplinary treatment team which provides services that address daily living skills, psychoeducational and/or vocational development, opportunity to develop interpersonal skills within a group setting, restoration of family functioning and any other specialized areas that the individualized diagnostic and treatment process reveals is indicated for the patient and family. Applicants for a Certificate of Need for child and/or adolescent acute psychiatric beds must document that they will provide a separate physical environment consistent with the treatment needs of each age group.

Inapplicable. Inpatient child and adolescent services will not be provided at the new hospital.

Standard AP 3c.

All acute general hospitals must provide psychiatric consultation services either directly or through contractual arrangements.

Applicant Response:

Dimensions has licensed psychiatric physicians available on staff and through contractual arrangements 24/7. They provide psychiatric services to include but not be limited to:

- Psychiatric crisis management (i.e., arrange psychiatric admissions to the unit or transfers to an appropriate facility)
- Psychosocial crisis assessments
- Psychiatric referrals
- Individual and group therapy are provided on the psychiatric unit

A Maryland licensed psychiatrist is the medical director for the adult acute inpatient psychiatric unit at PGHC. The Medical Director assures consultative services are available, as required, throughout the campus either directly or through those contracts.

The replacement facility will follow these same practices.

Standard AP 4a.

A Certificate of Need for child, adolescent or adult acute psychiatric beds shall be issued separately for each age category. Conversion of psychiatric beds from one of these services to another shall require a separate Certificate of Need.

Inapplicable. This is not a conversion project.

Standard AP 4b.

Certificate of Need applicants proposing to provide two or more age specific acute psychiatric services must provide that physical separations and clinical/programmatic distinctions are made between the patient groups.

Inapplicable. Inpatient psychiatric services will only be provided to adults.

Standard AP 5.

Once a patient has requested admission to an acute psychiatric inpatient facility, the following services must be made available:

- i. intake screening and admission;**
 - ii. arrangements for transfer to a more appropriate facility for care if medically indicated; or**
 - iii. necessary evaluation to define the patient's psychiatric problem and/or emergency treatment.**
-

Applicant Response:

PGHC utilizes policies and procedures for these services, and will continue to utilize them, as well as modify them as appropriate, for the adult acute inpatient unit at the new facility.

As key components of a comprehensive voluntary/involuntary adult psychiatric service, all services required by this standard will be provided on the inpatient unit and Assessment and Stabilization Center at PGRMC for patients who arrive with a psychiatric primary diagnosis. At the current PGHC facility, those patients are triaged by an ED nurse and assessed by an emergency physician to rule out a medical primary diagnosis. If assessed with a medical primary diagnosis or requiring emergency medical treatment, the patient is treated in the ED, admitted to inpatient care, or transferred to an appropriate facility for medical care upon orders of the ED physician. If assessed with a psychiatric primary diagnosis, the patient is transferred to Behavioral Health Services, Assessment and Stabilization Center for a psychiatric evaluation to define the patient's psychiatric problem. If the patient requests admission to a psychiatric inpatient unit, the ASC Clinicians obtain insurance authorization and contact hospitals with the appropriate type of psychiatric beds. Once a bed is identified, and the outside facility agrees to accept the patient, the ASC Clinician arranges transportation. The ASC RN completes required paperwork for transfer and provides an original set and copies to the ambulance crew that arrives to transfer the patient to the psychiatric facility.

Patients admitted to PGHC inpatient unit are escorted to the unit by ASC staff. Until a bed is found, the patient is held in ASC until transferred or stabilized and cleared for release by the consulting psychiatrist.

Standard AP 6.

All hospitals providing care in designated psychiatric units must have separate written quality assurance programs, program evaluations and treatment protocols for special populations including: children,

adolescents, patients with secondary diagnosis of substance abuse, and geriatric patients, either through direct treatment or referral.

Applicant Response:

Dimensions meets this standard for patients who require short-term inpatient care and outpatient services, and will continue to meet this standard at the new PGRMC facility. Inpatient services will include voluntary and involuntary admissions,

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

PGHC's general adult psychiatric unit's Scope of Service document is included as **Exhibit 39**. This document includes a generalized service scope of the inpatient psychiatric unit, staffing positions / qualifications, general admission criteria, and some information on some quality initiatives.

As a member of the Dimensions network, PGRMC will have access to quality assurance programs, program evaluations and treatment protocols for adult acute inpatient psychiatric populations, which it can replicate with appropriate modifications at the new facility.

Standard AP 7.

An acute general or private psychiatric hospital applying for a Certificate of Need for new or expanded acute psychiatric services may not deny admission to a designated psychiatric unit solely on the basis of the patient's legal status rather than clinical criteria.

Applicant Response:

Admission to PGHC's adult acute psychiatric unit or any other unit of the hospital is not denied based on a patient's legal status, nor will this occur at the replacement facility.

Standard AP 8.

All acute general hospitals and private freestanding psychiatric hospitals must provide a percentage of uncompensated care for acute psychiatric patients which is equal to the average level of uncompensated care provided by all acute general hospitals located in the health service area where the hospital is located, based on data available from the Health Services Cost Review Commission for the most recent 12 month period.

Applicant Response:

Based on FY2014 data, PGHC's percentage of self-pay patients for acute psychiatric patients was 14.8%. For patients residing within the Prince George's County service area, PGHC's percentage of self-pay patients for acute psychiatric patients was 15.3%. Based on information obtained from SMA Informatics Patient Care Analyst Reports, Southern Maryland Hospital Center's percentage of self-pay acute psychiatric patients from Prince George's County was 13.3%, and Laurel Regional Hospital's percentage of self-pay acute psychiatric patients from Prince George's County was 17.8%. These three hospitals are licensed to provide acute psychiatric services within Prince George's County.

In FY2014, PGHC reviewed inpatient psychiatric accounts and determined that 124 patients received \$490,530 in charity care write-offs in accordance with hospital policy. The average charity care allowance was \$3,660. Dimensions could not determine actual charity care write-offs specific to acute psychiatric inpatient services of other hospitals.¹⁵

Standard AP 9.

If there are no child acute psychiatric beds available within a 45 minute travel time under normal road conditions, then an acute child psychiatric patient may be admitted, if appropriate, to a general pediatric bed. These hospitals must develop appropriate treatment protocols to ensure a therapeutically safe environment for those child psychiatric patients treated in general pediatric beds.

Applicant Response:

Inapplicable. Child and acute psychiatric beds are available within a 45 minute travel time under normal road conditions at Potomac Ridge in Rockville and Washington Adventist Hospital in Takoma Park.

¹⁵ Sources of information: internal financial data from Dimensions; and SMA Informatics Patient Care Analyst Reports - FY2014 (APR-DRGs 750-760).

Standard AP 10.

Expansion of existing adult acute psychiatric bed capacity will not be approved in any hospital that has a psychiatric unit that does not meet the following occupancy standards for two consecutive years prior to formal submission of the application.

Inapplicable. Dimensions does not seek to expand existing capacity.

Standard AP 11.

Private psychiatric hospitals applying for a Certificate of Need for acute psychiatric beds must document that the age-adjusted average total cost for an acute (< 30 days) psychiatric admission is no more than the age-adjusted average total cost per acute psychiatric admission in acute general psychiatric units in the local health planning area.

Applicant Response:

Inapplicable. The new hospital will not be a psychiatric hospital.

Standard AP 12a.

Acute inpatient psychiatric services must be under the clinical supervision of a qualified psychiatrist.

Applicant Response:

The Medical Director of the inpatient unit is a qualified psychiatrist, as will be the Medical Director of the inpatient unit at the new facility.

Standard AP 12b.

Staffing of acute psychiatric programs should include therapists for patients without a private therapist and aftercare coordinators to facilitate referrals and further treatment. Staffing should cover a seven day per week treatment program.

Applicant Response:

Dimensions' acute inpatient psychiatric program meets this standard through direct employment of and contractual arrangements with Maryland licensed therapists, counselors, and RNS. The staff is available 7/24.

Standard AP 12c.

Child and/or adolescent acute psychiatric units must include staff who have experience and training in child and/or adolescent acute psychiatric care, respectively.

Applicant Response:

Inapplicable. This project does not involve child or adolescent inpatient care.

Standard AP 13.

Facilities providing acute psychiatric care shall have written policies governing discharge planning and referrals between the program and a full range of other services including inpatient, outpatient, long-term care, aftercare treatment programs, and alternative treatment programs. These policies shall be available for review by appropriate licensing and certifying bodies.

Applicant Response:

Dimensions has written discharge planning policies and works with psychiatric experts to assure and meet this standard for the adult acute inpatient psychiatric unit, building upon the referral arrangement and community networks originated by Prince George's Hospital Behavioral Health Services to provide seamless transition of patients to a full range of other services once discharged.

Dimensions' referral relationships include inpatient, outpatient, long-term care, aftercare treatment programs, and alternative treatment programs. These are available for review by appropriate licensing and certifying bodies.

Standard AP 14.

Certificate of Need applications for either new or expanded programs must include letters of acknowledgement from all of the following:

- i. the local and state mental health advisory council(s);**
- ii. the local community mental health center(s);**
- iii. the Department of Health and Mental Hygiene; and**
- iv. the city/county mental health department(s).**

Letters from other consumer organizations are encouraged.

Applicant Response:

Inapplicable. Dimensions is not seeking an approval for either a new or expanded program.

COMAR 10.24.11. GENERAL SURGICAL SERVICES

.05A. GENERAL STANDARDS.

Standard .05A(1) – Information Regarding Charges.

Information regarding charges for surgical services shall be available to the public. A hospital or an ambulatory surgical facility shall provide to the public, upon inquiry or as required by applicable regulations or law, information concerning charges for the full range of surgical services provided.

Applicant Response:

Please see the response to COMAR 10.24.10.04A-Standard .04A (1) – Information Regarding Charges.

Standard .05A(2) – Charity Care Policy.

(a) Each hospital and ambulatory surgical facility shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide ambulatory surgical services on a charitable basis to qualified indigent persons consistent with this policy. The policy shall have the following provisions:

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

(ii) **Notice of Charity Care Policy.** Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the surgical facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's arrival for surgery, facilities should address any financial concerns of patients, and individual notice regarding the facility's charity care policy shall be provided.

(iii) **Criteria for Eligibility.** Hospitals shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. ASFs, at a minimum, must include the following eligibility criteria in charity care policies. Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge. At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial

assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of ASFs described in these regulations.

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

(c) A proposal to establish or expand an ASF for which third party reimbursement is available, shall commit to provide charitable surgical services to indigent patients that are equivalent to at least the average amount of charity care provided by ASFs in the most recent year reported, measured as a percentage of total operating expenses. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If an existing ASF has not met the expected level of charity care for the two most recent years reported to MHCC, the applicant shall demonstrate that the historic level of charity care was appropriate to the needs of the service area population.

(d) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a Certificate of Need for a surgical facility project, shall commit to provide charitable services to indigent patients. Charitable services may be surgical or nonsurgical and may include charitable programs that subsidize health plan coverage. At a minimum, the amount of charitable services provided as a percentage of total operating expenses for the health maintenance organization will be equivalent to the average amount of charity care provided statewide by ASFs, measured as a percentage of total ASF expenses, in the most recent year reported. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If the health maintenance organization's track record is not consistent with the expected level for the population in the proposed service area, the applicant shall demonstrate that the historic level of charity care was appropriate to the needs of the population in the proposed service area.

Applicant Response:

Please see the response to COMAR 10.24.10.04A-Standard .04A(2) – Charity Care Policy.

Standard .05A(3) – Quality of Care.

A facility providing surgical services shall provide high quality care.

(a) An existing hospital or ambulatory surgical facility shall document that it is licensed, in good standing, by the Maryland Department of Health and Mental Hygiene.

(b) A hospital shall document that it is accredited by the Joint Commission.

(c) An existing ambulatory surgical facility shall document that it is:

(i) In compliance with the conditions of participation of the Medicare and Medicaid programs; and

(ii) Accredited by the Joint Commission, the Accreditation Association for Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, or another accreditation agency recognized by the Centers for Medicare and Medicaid as acceptable for obtaining Medicare certification.

(d) A person proposing the development of an ambulatory surgical facility shall demonstrate that the proposed facility will:

(i) Meet or exceed the minimum requirements for licensure in Maryland in the areas of administration, personnel, surgical services provision, anesthesia services provision, emergency services, hospitalization, pharmaceutical services, laboratory and radiologic services, medical records, and physical environment.

(ii) Obtain accreditation by the Joint Commission, the Accreditation Association for Ambulatory Health Care, or the American Association for Accreditation of Ambulatory Surgery Facilities within two years of initiating service at the facility or voluntarily suspend operation of the facility.

Applicant Response:

Please see the response to COMAR 10.24.10.04A-Standard .04A (3) – Quality of Care.

Standard .05A(4) – Transfer Agreements.

(a) Each ASF and hospital shall have written transfer and referral agreements with hospitals capable of managing cases that exceed the capabilities of the ASF or hospital.

(b) Written transfer agreements between hospitals shall comply with the Department of Health and Mental Hygiene regulations implementing the requirements of Health-General Article §19-308.2.

(c) Each ASF shall have procedures for emergency transfer to a hospital that meet or exceed the minimum requirements in COMAR 10.05.05.09.

Applicant Response:

Please see **Exhibit 40**, which includes copies of Dimensions' transfer agreements.

COMAR 10.24.11. GENERAL SURGICAL SERVICES

.05B. Project Review Standards.

Standard .05B(1) – Service Area.

An applicant proposing to establish a new hospital providing surgical services or a new ambulatory surgical facility shall identify its projected service area. An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall document its existing service area, based on the origin of patients served.

Applicant Response:

Dimensions expects the service area for surgery will be the same as its MSGA Service area.

Standard .05B(2) – Need- Minimum Utilization for Establishment of a New or Replacement Facility.

An applicant proposing to establish or replace a hospital or ambulatory surgical facility shall demonstrate the need for the number of operating rooms proposed for the facility. This need demonstration shall utilize the operating room capacity assumptions and other guidance included in Regulation .06 of this Chapter. This needs assessment shall demonstrate that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the initiation of surgical services at the proposed facility.

(a) An applicant proposing the establishment or replacement of a hospital shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for inpatient and outpatient surgical procedures by the new or replacement hospital's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed new or replacement hospital by surgical specialty or operating room category; and

(iii) In the case of a replacement hospital project involving relocation to a new site, an analysis of how surgical case volume is likely to change as a result of changes in the surgical practitioners using the hospital.

(b) An applicant proposing the establishment of a new ambulatory surgical facility shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for outpatient surgical procedures by the proposed facility's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed facility by surgical specialty or, if approved by Commission staff, another set of categories; and

(iii) Documentation of the current surgical caseload of each physician likely to perform surgery at the proposed facility.

Applicant Response:

PGHC currently has ten operating rooms and proposes to maintain ten operating rooms at the new facility. PGHC's OR configuration includes one dedicated Trauma OR, two dedicated Cardiac Surgery ORs (one for surgery and one for backup, which is standard among hospitals with Cardiac Surgery programs), and seven ORs for non-Cardiac or Trauma cases. Table 58 shows the OR volumes for 2008-2013.

**Table 58
Historical OR Volumes
PGHC
2008-2013**

	Cases					Minutes				
	Inpatient				Outpatient	Inpatient				Outpatient
	Total	Cardiac	Trauma	Non-Cardiac or Trauma		Total	Cardiac	Trauma	Non-Cardiac or Trauma	
FY: 2008	2,917	54	114	2,749	1,805	304,674	19,865	14,859	269,950	121,734
FY: 2009	2,863	31	97	2,735	1,933	289,576	8,835	12,659	268,082	128,478
FY: 2010	2,731	27	101	2,603	1,781	277,843	8,150	12,571	257,122	117,692
FY: 2011	2,577	39	87	2,451	1,826	274,154	11,340	11,327	251,487	116,652
FY: 2012	2,614	8	84	2,522	1,824	286,725	2,323	10,338	274,064	123,328
FY: 2013	2,434	22	91	2,321	2,063	303,751	7,143	11,824	284,784	154,261

Source: PGHC, Volumes include only OR Cases, excluding endoscopies, cystoscopies, C-sections, and other procedure room cases.

Table 59 shows the historical and average minutes per case at PGHC:

**Table 59
Historical OR Minutes per Case
PGHC
2008-2013**

	Inpt. Non-Cardiac or Trauma Minutes/Case	Outpt. Minutes/Case
FY: 2008	98.22	67.44
FY: 2009	98.03	66.45
FY: 2010	98.77	66.09
FY: 2011	102.61	63.87
FY: 2012	108.67	67.62
FY: 2013	122.69	74.76
Average	104.83	67.71

Dimensions recognizes that volumes have declined, as have admissions in general, as PGHC's physical plant has aged and the hospital has not had the capacity to compete with other hospitals with more modern operating room suites. Also, several Dimensions surgeons

have recently retired, and it has been difficult to recruit new surgeons to replace them because of the hospital's physical plant and the hospital's unclear future over the last ten years. However, Dimensions believes that its volumes will grow in the future, as hospital volumes grow. (See the discussion of projected MSGA volumes.) Dimensions has initiated the recruitment of several surgeons to replace those who have retired. In addition, Dimensions will work with local referring physicians to recapture patients who have been traveling into Washington, D.C. for surgery.

Just as it currently has three ORs to accommodate its trauma and cardiac surgery programs, Dimensions proposes three ORs for these programs in the new facility. Dimensions projects future need for its non-cardiac or trauma ORs based on the projected growth in MSGA admissions from 2012-2021. Dimensions has used the average number of minutes per case between 2008 and 2013 and has used 25 minutes per case for cleanup time. These projections are shown below. The result is that Dimensions will require 6.23 ORs for non-Cardiac or trauma cases. When the Cardiac and trauma ORs are included, Dimensions is proposing to maintain the ten ORs that it currently uses.

2012 MSGA Admissions	7,502
Non-Cardiac or Trauma OR Cases/Admissions, 2012	0.34
Projected MSGA Admissions, 2021	10,726
Projected Inpatient Non-Cardiac or Trauma OR Cases 2021	3,606
Ratio Outpatient/Non-Cardiac or Trauma Inpatient OR Cases, 2012	0.72
Projected Outpatient Cases, 2021	2,608
Avg. Inpatient Non-Cardiac or Trauma Minutes/Case	104.83
Avg. Outpatient Minutes/Case	67.71
Projected Inpatient Non-Cardiac or Trauma Minutes, 2021	378,010
Projected Outpatient Minutes, 2021	176,547
Subtotal	554,556
Cleanup Minutes/Case	25
Projected Cleanup Minutes	155,334
Total Minutes, 2021	709,890
Optimal Capacity/OR in Minutes	114,000
Needed Non-Cardiac or Trauma ORs 2021	6.23

Note Regarding Methodology of Above Analysis

Because Dimensions is proposing to relocate the hospital and operating rooms, it is not possible to perform a direct population based analysis of surgical cases, as Dimensions does not have data on all of the surgical cases performed on residents in the new service area in order to calculate surgical use rates. Furthermore, identifying cases that should be counted in the use rates based on HSCRC data (which would be necessary to identify all cases at all hospitals by Zip Code of residence) is a difficult undertaking because these data do not distinguish whether inpatients with an OR charge were treated in an OR or in a procedure room.

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

However, the need projection methodology included above is population-based for the following reasons:

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

Standard .05B(3) – Need - Minimum Utilization for Expansion of An Existing Facility.

An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall:

(a) Demonstrate the need for each proposed additional operating room, utilizing the operating room capacity assumptions and other guidance included at Regulation .06 of this Chapter;

(b) Demonstrate that its existing operating rooms were utilized at optimal capacity in the most recent 12-month period for which data has been reported to the Health Services Cost Review Commission or to the Maryland Health Care Commission; and

(c) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the completion of the additional operating room capacity. The needs assessment shall include the following:

(i) Historic trends in the use of surgical facilities at the existing facility;

(ii) Operating room time required for surgical cases historically provided at the facility by surgical specialty or operating room category; and

(iii) Projected cases to be performed in each proposed additional operating room.

Not applicable. Dimensions will not increase the number of ORs.

Standard .05B(4) – Design Requirements.

Floor plans submitted by an applicant must be consistent with the current FGI Guidelines.

(a) A hospital shall meet the requirements in Section 2.2 of the FGI Guidelines.

(b) An ASF shall meet the requirements in Section 3.7 of the FGI Guidelines.

(c) Design features of a hospital or ASF that are at variance with the current FGI Guidelines shall be justified. The Commission may consider the opinion of staff at the Facility Guidelines Institute, which publishes the FGI Guidelines, to help determine whether the proposed variance is acceptable.

Applicant Response:

Please see **Exhibit 41**, which is a letter from the Architectural firm Wilmot Sanz attesting that the surgical suite meets FGI Guidelines.

Standard .05B(5) – Support Services.

Each applicant shall agree to provide as needed, either directly or through contractual agreements, laboratory, radiology, and pathology services.

Applicant Response:

The current hospital, PGHC, provides laboratory, radiology, and pathology services on-site. The same will be true at the new PGRMC.

Standard .05B(6) – Patient Safety.

The design of surgical facilities or changes to existing surgical facilities shall include features that enhance and improve patient safety. An applicant shall:

(a) Document the manner in which the planning of the project took patient safety into account; and

(b) Provide an analysis of patient safety features included in the design of proposed new, replacement, or renovated surgical facilities.

Applicant Response:

The operating rooms in the proposed PGRMC facility will be larger than the rooms in the current PGHC, and each will be equipped with video equipment (and boom technology throughout the suite), which will facilitate safe conditions and standardization. In the new design, monitoring equipment will be located within the OR for proper access and visibility by both the RN and anesthesiologist. The surgical suite will provide the correct ratio and location of prep and recovery areas to improve patient flow and the appropriate level of nursing care.

The new facility will also implement the design and plan features discussed in response to Standard 10.24.10.04B(12) (Patient Safety), pp. 131-135.

Standard .05B(7) – Construction Costs.

The cost of constructing surgical facilities shall be reasonable and consistent with current industry cost experience.

(a) Hospital projects.

(i) The projected cost per square foot of a hospital construction or renovation project that includes surgical facilities shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors.

(ii) If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include:

1. The amount of the projected construction cost and associated capitalized construction cost that exceeds the Marshall Valuation Service® benchmark; and

2. Those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

(b) Ambulatory Surgical Facilities.

(i) The projected cost per square foot of an ambulatory surgical facility construction or renovation project shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors.

(ii) If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost by 15% or more, then the applicant's project shall not be approved unless the applicant demonstrates the reasonableness of the construction costs. Additional independent construction cost estimates or information on the actual cost of recently constructed surgical facilities similar to the proposed facility

may be provided to support an applicant's analysis of the reasonableness of the construction costs.

Applicant Response:

Please see the response to COMAR 10.24.10.04B-Standard .04B(7) – Construction Cost of Hospital Space.

Standard .05B(8) – Financial Feasibility.

A surgical facility project shall be financially feasible. Financial projections filed as part of an application that includes the establishment or expansion of surgical facilities and services shall be accompanied by a statement containing each assumption used to develop the projections.

(a) An applicant shall document that:

(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the likely service area population of the facility;

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

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

(iv) The facility will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years of initiating operations.

(b) A project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project may be approved upon demonstration that overall facility financial performance will be positive and that the services will benefit the facility's primary service area population.

Applicant Response:

Please see the response to COMAR 10.24.10.04B(13) - Financial Feasibility.

Standard .05B(9) – Preference in Comparative Reviews.

In the case of a comparative review of CON applications to establish an ambulatory surgical facility or provide surgical services, preference will be given to a project that commits to serve a larger proportion of charity care

and Medicaid patients. Applicants' commitment to provide charity care will be evaluated based on their past record of providing such care and their proposed outreach strategies for meeting their projected levels of charity care.

Inapplicable.

CARDIAC SURGERY SERVICES

The relocation of PGHC to PGRMC does not involve creating a new cardiac surgery service as one exists at the current PGHC facility. Nevertheless, because MHCC Staff posed several completeness questions following the initial CON Application concerning cardiac surgery at the new location, Dimensions has included a discussion of its Cardiac Surgery services and voluntarily addressed the specific State Health Plan provisions referred to in those earlier completeness questions.

* * * * *

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

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

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

Market and Operational Assessments

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

Based upon the planning process and the market and operational assessments summarized below, Dimensions decided to proceed with the revitalization of its cardiovascular program, including cardiac surgery. Dimensions developed a Strategic Cardiovascular Business Plan to revitalize the entire cardiovascular service line, with a specific focus on cardiac surgery. The plan establishes strategies for Dimensions, including PGHC, LRH, and Bowie Health Center, for a five year period, 2013 – 2017. The Dimensions' Board of Directors approved the plan in January 2013. The Executive Summary of Dimensions' Cardiovascular Program Strategic Business Plan and the Market Assessment associated with the Business Plan are attached, collectively, as Exh. 26.

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

Cardiovascular Business Plan’s Market Assessment.

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

- Prince George’s County has a higher cardiovascular morbidity and mortality rate, as well as a shortage of approximately 66 primary care physicians. By improving access to care, more cardiovascular disease will be detected and interventional care (PCI and cardiac surgery) will be needed.
- The 45 years of age and older population is expected to grow approximately 8% between 2011 and 2016, comparable to State and national rates. The 65 and over is expected to increase significantly by 22.9%, which is higher than the estimated growth rate of 17.7% for Maryland residents. These aging factors indicate an increase in cardiac surgery volume potential.
- Each year between FY 2010 and FY 2012, approximately 500 or more cardiac surgery cases were performed on Prince George’s residents. Of those, approximately 60% were performed in D.C. and Virginia hospitals. By implementing appropriate strategies to rebuild confidence among cardiologists and the community, Dimensions has the opportunity to recapture a portion of cases out-migrating to D.C. and Virginia hospitals.

**Table 60:
Cardiac Surgery Cases
Prince George’s County Residents**

<u>Location</u>	<u>FY 2010</u>	<u>FY 2011</u>	<u>FY 2012</u>
D.C. Hospitals			
Washington Hospital Center	244	244	236
George Washington University Hospital	27	19	12
Howard University Hospital	5	-	-
Childrens Hospital NMC	36	40	42
Total D.C. Hospitals	<u>312</u>	<u>303</u>	<u>290</u>
Virginia Hospitals	<u>20</u>	<u>12</u>	<u>17</u>
Total Cardiac Surgery Patients in Prince George’s County	<u>556</u>	<u>543</u>	<u>498</u>

- The utilization of PCI and cardiac surgery among Prince George’s residents is lower than national utilization rates. The lower utilization rates may be attributed in part to limited access to care based on the shortage of needed primary care physicians in the County, possibly causing an under-diagnosing of cardiovascular disease and the need for procedural intervention.

CABG rates have been in decline as other treatment methodologies have emerged. The decline in CABG and PCI utilization rates were considered and discussed extensively with cardiac surgeons, as well as cardiologists. Some believe that the decrease in total procedures may level off due to continued growth in the 45 and older age cohort, especially the 65 and older population. The projected five-year growth rate in Prince George’s County of people aged

65 and older is estimated to increase by 22.9% between 2011 and 2016, which is higher than national and state growth projections of 15.9 % and 17.7%, respectively.

In addition to the aging factor, Prince George’s County has a significantly high death rate due to heart disease, *i.e.*, 224.2 per 100,000 people versus a rate of 194.0 for the state of Maryland and 130.2 for Montgomery County, as reported in Table 1 in the University of Maryland School of Public Health’s report, *Transforming Health in Prince George’s County, Maryland: A Public Health Impact Study, July 2012* (Exh. 7). By focusing efforts on reducing deaths due to heart disease, it is realistic to assume cardiac procedure volumes will increase.

In sum, Prince George’s County is under served, utilization rates are low for cardiac surgery, and volumes are projected to increase as the cardiovascular needs of the community are further addressed. Dimensions calculated cardiovascular utilization rates as set forth below:

**Table 61: Comparison of Cardiovascular Use Rate Calculations
(Per 1,000 Population)**

PROCEDURE / SOURCE	Claritas 2011 Estimates Prince George's County (Note1)	Nat'l Hospital Discharge Summary Report 2010 (Nat'l Rate) (Note 2)	AHA 2012 Report (2009 Data) Nat'l Rate (Note 3)	Prince George's County Actual Experience Rate 2010	Use Rate Applied to 2016 Pop. Proj. Prince George's County
PCI	2.69	2.02	2.44	1.72	1.99
Cardiac Surgery (Note 4)	1.02	1.09	1.25	0.64	.87

Note 1: For cardiovascular volume forecasting, PGHC worked with Haber Consulting Services and the University of Maryland Medical System, relying upon Nielsen iXPRESS® planning software system. The iXPRESS system has a population demographic component and a healthcare utilization rate component with regional variations in utilization forecasting. The population projections draw demographic data from Claritas, a service of The Nielsen Company and a leading provider of demographic data. Healthcare utilization data is derived from several national data sources administered by the National Center For Health Statistics (NCHS). These data sources include the National Ambulatory Medical Care Survey (NAMCS), National Hospital Ambulatory Medical Care Survey (NHAMCS), National Hospital Discharge Survey (NHDS), National Survey of Ambulatory Surgery (NSAS), and National Health Interview Survey (NHIS). An overview of the Nielsen iXPRESS’s methodology is attached as **Exhibit 42**.

Note 2: The report represents 2010 data obtained by Haber Consulting. It was published on the CDC website on August 28, 2012 according to original internet search for the data.

Note 3: The 2012 AHA report is reporting 2009 data derived from the National Hospital Discharge Survey summary/National Center for Health Statistics, 2009 and obtained by Haber Consulting. Estimates are based on a sample of inpatient records from short-stay hospitals in the United States.

Note 4: Cardiac surgery includes CABG, Valves and “other” major cardiothoracic procedures.

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

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

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

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

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

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

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

Progress on Enhancement Initiatives

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

1. Cardiovascular Program Leadership Enhancement

- A contract with the cardiac surgery practice of the clinical affiliate of the University of Maryland School of Medicine ("UMSOM") was recently entered to provide 1.2 FTE cardiac surgeon services at PGHC for administrative and clinical services. Under this contract, the UMSOM Cardiac Division Chief functions as the Senior Administrative Medical Director of Cardiac Services at PGHC. In addition, UMSOM is providing a full-time cardiac surgeon to function as Chief of Cardiac Surgery at PGHC. A well-respected and established cardiac surgeon, Dr. Jamie Brown, was recruited specifically for PGHC. UMSOM and UMMC have worked with the PGHC team on training and modifying clinical protocols/processes to complete a "Readiness Plan" for the surgery team. The team completed their work in July, 2014, completing its improvement initiatives.
- PGHC hired a new Chief of Critical Care with extensive cardiac surgery experience to enhance post-surgical care. An additional intensivist is being

recruited to help medically manage the coronary care unit, step-down, and telemetry unit patients.

- PGHC engaged a Cardiovascular Service Line consultant/administrator to facilitate program enhancement initiatives.
- PGHC created a CV service line team with meetings every two weeks to improve operational processes and enhance patient care.
- The cardiac surgery specific nurse practitioners and physician assistants have been hired or contracted and they have completed additional training. Coverage on a 24/7 basis on-site is being provided.
- An experienced cardiovascular surgery physician assistant has been recruited for the operating room and to assist with intra-operative and post-surgical patient care.
- A CV clinical nurse specialist has been hired to focus on process improvement with nursing staff and physicians to enhance patient care at PGHC.
- Other key clinical leadership changes at PGHC that will indirectly enhance the future success of the cardiac surgery program include:
 - A new Chief Nursing Officer;
 - A new Chief of Emergency Services, PGHC, LRH, and BHC (UMSOM affiliated);
 - A new Chief of Trauma; and
 - A new Chief of Anesthesiology

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

- UMMC has assisted PGHC in developing a training program for cardiac nurses, cardiac nurse practitioners, physician assistants and the cardiovascular surgery operating room team. The training program includes the PGHC CV surgery team “shadowing “ at UMMC, the UMMC team observing PGHC’s team, sharing clinical protocols, staff competencies, and other valuable information with PGHC.
- PGHC has contracted with UMMC for cardiac surgery perfusion services.

3. PGHC has contracted with UMSOM Anesthesiology practice to provide services and coverage for cardiac surgery cases, so to rebuild confidence among local cardiologists and the community.

An additional key component of success is to enhance communication and collaboration among the cardiovascular physicians and PGHC administration. Additional initiatives to rebuilding relationships among cardiologists and the community include:

CARDIOLOGISTS

- Both formal and informal grassroots marketing activities have been implemented to inform cardiologists of changes in the cardiac surgery program. For example, one-on-one meetings will be convened to discuss

(a) qualifications of new surgeon/chief of cardiac surgery; (b) the cardiologist's preference of post-patient care involvement; and (c) level of satisfaction. Also, Dr. Jamie Brown has written to cardiologists and other physicians to inform them of the new developments in the cardiac surgery program at PGHC. A copy of Dr. Brown's letter is attached as **Exhibit 43**.

- The chief of cardiac surgery personally calls the referring cardiologist after each consult and surgery to discuss referred patient.
- PGHC will create a collaborative Heart Team among cardiac surgery and the cardiologists to review quality of service provided and appropriateness of care.
- The cardiologists, along with the chief of cardiac surgery, participate on PGHC CV service line steering committees to enhance collaboration and communication.
- Grand rounds on cardiac surgery cases and medical staff CME programs will be conducted. The cardiac surgeon will conduct 3-4 continuing education classes for the cardiologists. Topics will be based on preferences of the cardiologists, as well as need determined by the chief of cardiac surgery.
- Performance dashboards for the CV program will be shared with the cardiologists.
- The CV Service Line administrator personally meets individually with the cardiologists on a regular basis to review changes and discuss any concerns.

COMMUNITY

- Dimensions and PGHC are in the process of finalizing a "grassroots" cardiovascular specific marketing plan to focus on education about cardiovascular disease signs and symptoms, when and how to access care, treatment options, and rehabilitation services. A CV specific speaker's bureau will be established and offered to community organizations such as churches, senior centers, Lions Club and others. During these events, information about PGHC's cardiovascular program and physicians will be mentioned and handout material will be provided.
- A formal "closed loop" cardiovascular screening program is in development in collaboration with physicians. Closed loop program refers to ensuring appropriate follow-up with individuals identified to be at high risk.
- Dimensions/PGHC will continue to collaborate with Prince George's Health Department, University of Maryland Medical System, and other organizations to address the shortage of primary care physicians in the county, as well as improving cardiovascular and coronary heart disease mortality rates.
- Dimensions will also collaborate with local cardiologists to improve access to cardiology care via various strategies such as physician recruitment, outreach clinic development and expansion to new sites in the county.
- Dimensions will evaluate need and opportunities to have cardiologists as well as cardiovascular surgeons see and follow-up patient visits at designated primary care clinics in Prince George's County.

- As the program matures and results are documented, a traditional marketing plan will be developed to promote the program to the community.
4. Capital Investment in cardiac surgery
- The estimated total capital requirements to enhance the program, as identified in the Business and Operational Enhancement Plan, and further enhancements from the UMSOM cardiac surgery team is \$2.2 million dollars. To date, approximately \$1.5 million in capital improvements have been made, as outlined below:
- Replacement heart and lung machines (2)
 - Replacement intra aorta balloon pumps (2)
 - Replacement TEE probe and ultrasound unit
 - Replacement OR table (2)
 - Replacement OR lighting
 - Replacement defibrillator
 - Fluid warmer / blanket (4)
 - Replacement cell saver machines (4)
 - ECMO and microplegia equipment
 - Replacement Slush machine (2)
 - STS software
 - Rotem Lab testing System
 - Endovascular harvest equipment
 - Cerebral monitoring equipment
 - Transport monitoring upgrade
 - Wireless telemetry upgrade
 - Furnishings
5. Increase in cardiac nurse to patient staffing ratios and established a universal bed patient care model in the ICU.

Administrative and Operating Costs

The cardiac surgery program is a Dimensions' program, and costs associated with the program will be managed by Dimensions. However, Dimensions is currently working very closely with the University of Maryland Medical System and University of Maryland School of Medicine in developing and maintaining an effective, high-quality cardiac surgery program at PGHC.

Dimensions has contracted with the University of Maryland School of Medicine (Faculty Practice Inc. / University of Maryland Surgical Associates, P.A.) to provide cardio-thoracic surgeon resources for the cardiac surgery program. A full-time cardio-thoracic (CT) surgeon has been recently recruited for Dimensions and began performing cases at PGHC in July 2014. This cardiac surgeon also serves as Medical Director/Chief of Cardiac Surgery for the cardiac surgery program and is involved in quality assurance initiatives. Three other cardio-thoracic surgeons from UMSOM have obtained privileges at PGHC to provide additional coverage. In addition, the Division Chief of Cardiac Surgery at UMSOM is contracted by Dimensions to function as Senior Administrator of Cardiac Surgery at PGHC.

Dimensions is contracted with the UMMC for training and other consultative services related to clinical staff training, pre and post-surgical care protocols, and other support services related to the cardiac surgery program at Dimensions. UMMC shared cardiac surgery care

plans and training opportunities for PGHC nursing and physician extenders. The PGHC cardiac surgery operating team has also been trained at UMMC with the UMMC cardiac surgery team. Dimensions also has contracted with UMMC for management of perfusion services PGHC.

Responses to Specific Questions Posed by MHCC Staff in Completeness Questions:

Consistent with the Quality Review Program standards in COMAR 10.24.17.06B(2), please document that Prince George's Hospital Center (PGHC) has utilization and peer review and control programs for cardiac surgery and percutaneous coronary intervention (PCI) with regularly scheduled conferences.

Quality Review of Cardiac Surgery Procedures

All cardiovascular surgery procedures are reviewed at PGHC's monthly Surgery Department peer review meeting; the meeting includes cardiovascular surgeons. Providers are monitored for practices that are not compliant with standards in COMAR 10.24.17.06B. If as a result of this review, there are concerns or questions, a letter is sent to the provider asking him or her to respond in writing to the questions or concerns. The provider is also given the option of responding in person before the committee or he or she may be asked by the committee to appear in person. If the committee is satisfied with the provider's response, no further discussion is necessary. If the Committee is not satisfied with the provider's response or still has any concerns about the case, it is referred to the Medical Staff Oversight Committee, which reviews the case and makes recommendations to the Medical Executive Committee (MEC). The MEC determines the nature of disciplinary action. All recommendations and reports are then sent to the Hospital Board for final approval.

All cases of concern are also reviewed by the Hospital Quality Oversight Committee, which is chaired by the Vice President of Medical Affairs. If deemed appropriate, providers will be asked to appear before this committee as well. Once the Quality Oversight Committee completes its review, it can close the case or refer it to MEC for further review or disciplinary action. The MEC will then send its recommendations to the Quality and Professional Affairs Committee, a sub-committee of the Hospital Board. All recommendations and reports are then sent to the Hospital Board for final approval. All letters of concern and disciplinary actions are noted in the provider's file.

Quality Overview for Percutaneous Coronary Intervention (PCI)

All Percutaneous Coronary Intervention Procedures are reviewed by peers of the interventional cardiologist. This quality review includes review of the chart, images taken during the procedure, and type of treatment. If there are any concerns, the procedure is then referred to the hospital's Quality Department to be reviewed in the Cath Lab Peer Review meeting. This group may ask questions, voice concerns, teach, and recommend possible other treatment modalities. Providers are monitored for practices that are not compliant with standards in COMAR 10.24.17.06B. If standards are not met, this committee will decide the next steps for addressing the noncompliance. The procedure may then be referred to the Medical Staff Quality Oversight for further action.

PGHC has a Cath Lab Peer Review Committee, comprised of the following:

- Chief Medical Officer
- Chief of Cardiology
- Medical Director of Cardiac Catheterization Laboratory

- Medical Director of Emergency Department
- Vice President of Medical Affairs
- Intervention Cardiologist Prince George's Hospital Center
- Quality Data Resource

The Peer Review Committee is a subcommittee of the Medical Staff Quality Oversight and reports to Medical Executive Committee. That committee reports to Quality and Professional Affairs of the Board and the final report is made to the Hospital Board. Cath Lab Peer Review meetings are held monthly.

Also, PGHC is a participant of the National Cardiac Data Registry (NCDR). Data is entered for Cardiac Catheterizations and Percutaneous Coronary Interventions. The outcome reports from the Registry are used as quality benchmarks for the care of patients undergoing cardiac angiography and interventions.

Additionally, please provide a copy of:

- a) The protocols governing the referral, admission, and discharge of cardiac surgery patients;**
- b) The established list of indications and contraindications to govern patient selection for cardiac surgery; and**
- c) The established guidelines governing the admission of cardiac surgery patients to the intensive care, coronary care and progressive care units, and for discharge from these units.**

Protocols Governing the Referral, Admission, and Discharge of Cardiac Surgery Patients

The protocol governing the referral process of patients is that the on-call cardiovascular surgeon will see any patient needing cardiovascular services anywhere in the hospital. He or she will also answer any calls regarding the potential transfer of cardiovascular patients from an outside facility to our facility. Once accepted for admission, consulting physicians are contacted, an evaluation is performed, and options for care are discussed first with the team, and then with the patient. Options may include: (1) prepare for PCI; (2) prepare for surgery; (3) transfer to a tertiary facility; (4) transfer to a different service within the hospital; or (5) discharge to home.

If the patient is determined to be more appropriate for PCI, the Cardiac Cath Service is immediately consulted, and the process for that service is then initiated. If the patient is deemed inappropriate for treatment at PGHC (in need of a higher level of care), the appropriate facility is contacted immediately. Transfer agreements are already in place with the appropriate facilities. If the patient is deemed to need services within PGHC other than Cardiology or Surgery, the appropriate service is contacted. Finally, if the patient is determined to be appropriate for discharge, follow-up plans are made prior to discharge.

PGHC's clinicians follow established clinical care protocols (clinical pathways) for cardiac care patients. The Cardiac Surgery Clinical Pathway is a care plan for patients that includes care processes related to medications, other treatments/tests/procedures, patient physical activity (pre/post-surgery), consults, patient nutrition, and overall patient monitoring/assessment. A copy of PGHC's Clinical Pathway for Cardiac Surgery is attached as **Exhibit 44**.

Indications and Contraindications to Govern Patient Selection for Cardiac Surgery

Dimensions developed the following list of indications and contraindications concerning patient selection for cardiac surgery at PGHC. Although this list was recently compiled in connection with a completeness question following the initial application, the substantive material contained in the list has been communicated regularly to physicians through peer review processes, lectures, and continuing medical education sessions.

Indications for Cardiac Surgery

- Coronary Artery Disease (CAD)
 - 3 vessels CAD with symptoms.
 - 3 vessel CAD with reduced Ventricular function
 - 2 vessel Coronary artery disease involving the anterior descending artery with symptoms.
 - 2 vessel Coronary artery disease involving the anterior descending artery with reduced ventricular function.
 - Failed Angioplasty
 - Acute MI < 6 hours
 - Congenital anatomy leading to risk of sudden death.
 - Single vessel CAD involving the proximal anterior descending artery in a diabetic patient
 - Coronary artery aneurysm with symptoms
- Aortic Valve Disease
 - Severe aortic stenosis with symptoms
 - Severe aortic stenosis with reduced ventricular function
 - Severe aortic stenosis with history of sudden death
 - Aortic Valve insufficiency with symptoms
 - Aortic Valve insufficiency with dilated ventricle or reduced ventricular function
- Mitral Valve Disease
 - Mitral stenosis with symptoms
 - Severe Mitral stenosis the intracardiac clot
 - Mitral regurgitation with symptoms
 - Mitral regurgitation with dilated ventricle or reduced ventricular function
- Aortic Disease
 - Aortic aneurysm with symptoms
 - Aortic aneurysm size greater than 5.5 cm
 - Aortic dissection- Ascending
 - Aortic dissection with ischemic syndrome
- Heart Failure
 - Congestive heart failure which has failed medical therapy
 - Congestive heart failure due to repairable structural heart disease
- Intracardiac Mass including
 - Tumor
 - Clot
 - Infection

Contraindications for Cardiac Surgery

- A life expectancy of less than one year by clear documentation;
- Closed chest massage for an extended period of time and no signs of life;
- Severe irreversible multiple organ failure.

PGHC's program for educating patients about treatment options for heart disease [COMAR 10.24.17.06B(2)(c)]

PGHC has sponsored a number of community outreach health education and screening programs related to cardiovascular disease including:

- Women Heart -heart Seminar every month along with Doctor's Community Hospital
- Health Fairs
- Blood Pressure screening
- Speaker's Bureau
- Heart Health Seminars

PGHC's cardiac surgery nurse practitioner provides pre- and post-op education for heart surgery patients and PCI patients. Case management and bedside nurses also provide education regarding treatment options for heart disease.

The Cardiac Rehabilitation Program educates and discusses treatment options for patients with heart disease. Both individual and group education is conducted on a variety of topics including treatment options, exercise, diet and education, smoking cessation and other lifestyle modification classes.

The mechanisms that PGHC has in place to monitor long term outcomes of discharged cardiac surgery patients [COMAR 10.24.17.06B(2)(g)]

Currently, cardiac surgery patients are monitored by PGHC's Cardiac Rehabilitation program nurses. A 30-day, 60-day and 90-day follow-up assessment is conducted. The assessment includes measurement of activity, adherence to nutrition guidelines for cardiac patients, psycho-social stress evaluation, and cardiac knowledge. In addition, the cardiac surgery advance practice provider team (NP/Pas) conducts follow-up phone calls post discharge at least weekly and will see patients as frequently as needed, and then monthly until the patient is released back to their cardiologists and cardiac rehabilitation.

PGHC's existing cardiovascular disease prevention and early diagnosis program that provides for outreach to the minority and indigent population in the hospital's service area [COMAR 10.24.17.06(B)(11)]. Please discuss the effectiveness of these strategies in achieving outreach to the minority and indigent populations with cardiovascular diseases

Dimensions is proud of PGHC's long-standing role in addressing racial, ethnic, and socio-economic disparities in Prince George's County. Historically, PGHC has served the largest percentage of Medicaid and Self-Pay patients of any hospital in the county. Dimensions' outpatient network including 120,000 per year emergency visits in our three Dimensions'

facilities, another 50,000 visits to Dimensions' general medicine and OB clinic at Glenridge (including cardiology service), physician offices at Bowie Health Campus and Laurel, Rachel Pemberton Senior Health Center in Brentwood, Suitland Family Health and Wellness Center, physician and nurse practitioner and midwife services at the Greater Baden and Community Care, Inc. federally qualified health centers, and collaboration with the County Health Department to serve high risk and undocumented women. All of these sites, with the exception of Bowie and Laurel, are serving the higher risk "inside the beltway" communities that are largely characterized by their more severe economic challenges and related poor health status.

PGHC has provided up to \$24,000,000 per year in unreimbursed physician subsidies to enable physicians to care for the low income and minority residents of the County.

In 2012, Dimensions co-sponsored the study by the University of Maryland School of Public Health ("UMSPH"), entitled *Transforming Health in Prince George's County, Maryland: A Public Health Impact Study* (see Exh. 7) which identified the major barriers to care in Prince George's County and established a framework for addressing them.

PGHC takes a multi-disciplinary approach to addressing the disparities of care in heart disease and other health indicators.

A. Infrastructure

PGHC recognizes that there must be adequate physician access for underserved populations in order to provide primary prevention, patient education, early detection, primary care, and an entree to specialty services when needed. To this end, as stated previously, PGHC provides physician subsidies to keep physicians serving the otherwise underserved residents of Prince George's County. The physicians which PGHC subsidizes include 11 Internists, 22 Cardiologists, 26 OB-GYN physicians, and 62 other specialists.

In addition, PGHC is a participant in the Partnership to Improve Primary Care, which is planning to attract an additional 60 or more primary care physicians to Prince George's County.

B. Partnerships

PGHC recognizes that it cannot address the disparities alone. Consequently, PGHC partners with the Prince George's County Health Department, community groups, churches, schools, associations such as the American Heart Association, businesses, other hospitals, and the University of Maryland School of Public Health to provide education, reach underserved patients, identify residents in need, and strategize for attempting to provide effective outreach to both.

C. Programs

PGHC offers a variety of programs, such as:

Community Programs

- Childbirth Education Classes
- Diabetes Management Program
- HeartSaver First Aid/CPR
- Maternity Center Tours
- Smoking Cessation Program

Support Groups

- Alcoholics Anonymous (AA)
- Al-Anon
- Bipolar Support Group

- Nar-Anon
- Narcotics Anonymous (NA)
- Rehabilitation Sharing Group (strokes and longtime illness)

In addition, PGHC participates in health fairs, patient education sessions at churches and other community gathering places, blood pressure screenings, and other programs in the community.

In all of these efforts (physicians, partnerships, and programs), disease prevention and early diagnosis are important objectives. If someone is identified as being in need, he or she is encouraged and enabled to receive the care that they need. For example, if someone is participating in a smoking cessation program, and mentions that a loved one is “not well,” he or she is encouraged to bring that person along so that he or she can have a blood pressure screening or receive the kind of care that is required.

More than 70% of the residents of Prince George’s County are African American, Indian, or Asian. Seventeen percent of the County population are Latino. The focus of PGHC’s community programs is on the lower income portions of the County population.

Since the initial *Impact Study*, PGHC has continued to collaborate with the UMSPH in an effort to improve PGHC’s outreach efforts. In June 2013, the UMSPH issued *Community Health Needs Assessment—Prince George’s Hospital Center* (see **Exhibit 45**). This study included focus groups that involved community leaders from the following entities:

- Casa San Bernardo, Inc./St. Bernard Clairvaux Church
- Dimensions Health System Senior Health Center
- Greater Baden Medical Services
- Prince George’s County Chamber of Commerce
- Prince George’s County Council
- Prince George’s County Health Department, Office of the Health Officer
- Support Our Seniors

Building on this study, Dimensions developed a *Community Health Needs Assessment Implementation Strategy Plan, Fiscal Year 2014-2016* (see **Exhibit 46**) to guide the expansion of its outreach efforts.

PGHC chose three areas of concentration (Diabetes, Heart Disease, and Pregnancy and Childbirth Complications). The Diabetes and Heart Disease initiatives are shown below.

Focus Area: Diabetes

Goal I: Improve the availability of diabetes self-management education and services to the community.

Strategies:

- Enhance screenings and information offered at community health events.
- Increase frequency of education and information offerings to area churches, senior centers, and activity centers.
- Continue to offer quarterly on-site free information sessions to community to provide access to resources that are usable by residents with diabetes/pre-diabetes.

Goal II: Engage and partner with community physicians to increase awareness of diabetes services and education availability.

Strategies:

- Create an engagement process inclusive of information package to inform and educate community physicians about diabetes services.
- Distribute program description and promotional materials to physician offices and patients with face-to-face visits to physician/practice administrator.

Goal III: Advance quality and continuity of diabetic care through formation of outpatient care teams and group visits.

Strategies:

- Increase the accurate/adequate coordination of care post ED visit.
- Streamline follow up appointments into outpatient clinics to improve continuity of care.
- Form outpatient care teams to include MD, RN, nutrition and diabetes educator, case manager, podiatrist and wound care RN when needed.
- Educate patients about group visits and coordinate care with outpatient care team to conduct visits.

Goal IV. Promote diabetes literacy – particularly focusing on prevention of diabetes.

Strategies:

- Partner with community partners to create diabetes awareness and education for all ages, focusing on prevention, in local libraries, other public buildings. Advertise via posters newspaper, radio, etc.
- Partner with school system to incorporate nutrition and exercise education into school curriculum via newsletters, health fairs at schools, PTA meetings, and Board of Education.

Focus Area: Heart Disease

Goal I: Educate women on how uncontrolled high blood pressure can lead to cardiovascular disease

Strategies:

- Participate in health fairs at community centers and faith based organizations providing blood pressure screening, educate women on understanding their “Numbers”. Discuss signs & symptoms of stroke.
- Provide Blood Pressure information that explains how uncontrolled blood pressure relates to women’s heart disease in key areas like clinical waiting rooms at PGHC. (Information from Women Heart, Go Red, American Heart Association)
- Clinical staff from PGHC and Doctor’s Community Hospital (DCH) currently partner with Women Heart, The National Coalition for Women with Heart Disease. The meetings will continue to be held monthly alternating the location between PGHC and DCH. Participants are women heart attack survivors and their support system, speakers and clinical staff.

Goal II: Education on recognition of symptoms and risk factors of heart disease in women.

Strategies:

- Organize a women's clinic at PGHC that will provide screening services for heart disease. Clinic will be held quarterly.
 1. Educate women with results of screening
 2. Provide onsite educational support for abnormal clinical values
 3. Provide proper referrals (diabetes, nutritionist, cardiology listing, local exercise programs)
 4. Provide educational material on Women and Heart Disease
 5. Provide education on smoking cessation and its effect on heart disease and stroke.
- Refer to different educational websites: American Heart Association, Go Red, Women Heart, Sister to Sister, Center for Disease Control, Healthy Hearts.

Goal III: Increase exercise & diet awareness, education and opportunities for women.

Strategies:

- Encourage Heart Healthy Diets and Exercise at participating Health Fairs; provide information about heart healthy foods and recipes.
- Provide websites encouraging Health Heart diets to hospital staff and community fairs (Womenshealth.gov, American Heart Association)
- Partner with Diabetes Center at PGHC for information and nutritional consultation to distribute to women with diabetes.
- Contact community-based exercise programs and provide information at clinic and health fairs.
- Continue to follow up with patients in PGHC Cardiac Rehab.
- Provide opportunities for staff exercise or gym at PGHC.
- Provide nutritional information for foods served in hospital cafeteria.

Please note that these initiatives are in addition to the outreach and community health education programs that PGHC already provides or participates in.

One could question the effectiveness of any hospital outreach program since there is still too much obesity, too much diabetes, too much heart disease, in spite of outreach efforts. There are still disparities of care, and PGHC believes that the rate of cardiac surgery among residents of Prince George's County is lower than national rates would indicate.

However, notwithstanding these issues, PGHC reaches many residents who would not otherwise receive care. PGHC's role in providing health education, preventive services, primary care, early detection, hospitalization, rehabilitation, and follow-up to Prince George's County's most challenging populations has been recognized in the *Impact Study*, the MOU, and elsewhere. PGHC is constantly striving to improve its services to its service area in collaboration with the Prince George's County Health Department, community groups, churches, schools, physicians, and the UMSPH.

As an existing cardiac surgery program, PGHC should be reviewing morbidity and mortality rates and other indicators of patient outcomes, and compliance with established processes of care as compared with regional or national averages [See COMAR 10.24. 17.06B(2)(e)]. Please describe PGHC's history of participation in the Society for Thoracic Surgeons (STS) cardiac surgery registry during the last five years and provide the STS Coronary Artery Bypass Graft Composite Scores reported by STS for the PGHC cardiac surgery program for any reporting period during the last five years. Please identify the reporting period for each reported composite score]

The overall quality assurance program for cardiac surgery includes the following components:

- Under the guidance and direction of the new Cardiac Surgery Medical Director / Chief of Cardiac Surgery, the Cardiac Surgery Quality Committee has been restructured. The new committee is named the Continuous Quality Improvement Committee, and it meets at least every two weeks. Membership is multi-disciplinary with representation from each clinical area involved in the delivery of cardiac surgery services. The Committee reviews each case for process concerns and clinical outcome performance.
- A Cardiac Surgery Clinical Performance Dashboard has recently been developed and will be reviewed monthly.
- Multi-disciplinary team conducts daily patient rounds to ensure effective communication and plans for care.
- Patient and family members are surveyed post discharge to evaluate satisfaction with care provided and overall experience and determine if any corrections are needed. Responses to date have been extremely positive.
- A multi-disciplinary Cardiac Service Line meeting with administrative and clinical leadership is held every two weeks to address operational, financial, and strategic issues.
- PGHC participates in the Maryland Cardiac Surgery Quality Initiative, an inclusive, non-profit consortium of the State's cardiac surgery practices for sharing and standardizing best practices and improving patient care. Dr. Brown was recently elected as Chairman of the organization.
- On-going staff training is conducted for the operating room staff and nursing units.
- A universal bed concept was created in the ICU to ensure highly skilled critical care nursing coverage. Staffing ratios are adjusted as patient status changes from ICU to telemetry.
- The surgeon and cardiac surgery NP/PA see the patient within 1-2 weeks post hospital discharge and they see the patient as determined necessary until the patient is referred back to the cardiologists. The PA is also in frequent contact with the patient between

visits via telephone. The patient and family are given 24/7 telephone access to the cardiac surgery PA.

Quality measures, morbidity and mortality and outcomes of cardiac surgery patients are continuously assessed. At PGHC's monthly peer review meeting, all cardiac surgery cases are reviewed. Any deviation from pre-op, intra-op, or post-op care protocols or expectations is discussed.

PGHC completed an agreement with the Society of Thoracic Surgeons ("STS") in May 2014 and also contracted with AXIS, an approved STS software vendor. A STS data coordinator was hired and software / AXIS training was recently completed. In addition, the data coordinator has participated in several data manager training seminars and received one-on-one training from the UMMC STS data manager. In accordance with the regulatory changes in the State Health Plan, data has been collected on all cases since July 2014. The first submission of outcomes data will be submitted in February, 2015, allowing for sufficient number of cases to be harvested and reported on.

10.24.01.08G(3)(b). Need.

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

INSTRUCTIONS: Please identify the need that will be addressed by the proposed project, quantifying the need, to the extent possible, for each facility and service capacity proposed for development, relocation, or renovation in the project. The analysis of need for the project should be population-based, applying utilization rates based on historic trends and expected future changes to those trends. This need analysis should be aimed at demonstrating needs of the population served or to be served by the hospital. The existing and/or intended service area population of the applicant should be clearly defined.

Fully address the way in which the proposed project is consistent with each applicable need standard or need projection methodology in the State Health Plan.

If the project involves modernization of an existing facility through renovation and/or expansion, provide a detailed explanation of why such modernization is needed by the service area population of the hospital. Identify and discuss relevant building or life safety code issues, age of physical plant issues, or standard of care issues that support the need for the proposed modernization.

Please assure that all sources of information used in the need analysis are identified. Fully explain all assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), the relevant population considered in the analysis, and the service capacity of buildings and equipment included in the project, with information that supports the validity of these assumptions.

Explain how the applicant considered the unmet needs of the population to be served in arriving at a determination that the proposed project is needed. Detail the applicant's consideration of the provision of services in non-hospital settings and/or through population-based health activities in determining the need for the project.

Complete the Statistical Projections (Tables F and I, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package.

Applicant Response:

PRINCE GEORGE'S HOSPITAL CENTER

MSGA Bed Need

Please see the response to COMAR 10.24.12 – Acute Care Chapter, Standard .04B(2) – Identification of Bed Need and Addition of Beds.

Obstetrical Bed Need

Please see the response to COMAR 10.24.12 - OB Services Chapter, Standard 04.1 – Need.

Psychiatry Bed Need

The proposed project shifts the service area for Prince George's Hospital Center (PGHC) from one based on its current location in Cheverly, MD to its new location based in Largo, MD. The response to COMAR 10.24.10.04B(2) - Identification of Bed Need and Addition of Beds, pp. 49-79 contains a detailed discussion of the methodology used to define the new service area and make projections based on that service area.

As explained above, Dimensions split the historical 2013 inpatient discharge data into six cohorts – MSGA (15-64), MSGA (65-74), MSGA (75+), Obstetrics (OB), Pediatrics (PED), and Psychology (PSY). To determine the Zip Code areas to include in the expected 85% service area for the Largo site, Dimensions used drive times generated by Spatial Insights from Zip Codes in Prince George's County, and selected surrounding Zip Codes to each Maryland, District of Columbia, and Virginia hospital.

The Maryland Zip Codes were then sorted by proximity to the current PGHC location and the 2013 discharges were summed until they equaled 85% of PGHC's total 2013 discharges. This was done for each cohort individually. For Psych, this occurred with the Zip Codes for which PGHC was the eighth closest hospital and these Zip Codes accounted for 85.7% of PGHC's 2013 Psych discharges. In determining the closest hospital for, Zip Codes for which PGRMC would be the eighth most proximate hospital or closer hospital for Psych beds were identified. This was determined by ranking the proximity of all hospitals, excluding the existing PGHC. The results are recorded in Table 62.

**Table 62
Defining PGRMC's Service Area
PSY 18+
FY 2013**

Prince George's Hospital Center							PGCRMC - Largo Location Using Ranking as Service Area Cut-Off					
Zip Code	Town	Drive Time	Rank	FY 2013 Discharges	%	Cumulative %	Zip Code	Town	PGHC Drive Time	PGHC Rank	Drive Time	Rank
20785	Hyattsville - Landover	5.70	1	171	12.6%	12.6%	20743	Capitol Heights Area	7.7	1	7.05	1
20743	Capitol Heights Area	7.70	1	115	8.5%	21.0%	20785	Hyattsville - Landover	5.7	1	5.5	1
20747	District Heights - Forestville	12.77	1	80	5.9%	26.9%	20774	Upper Marlboro	16	2	6.45	1
20737	Riverdale	4.50	1	48	3.5%	30.5%	20747	District Heights - Forestville	12.77	1	9.3	1
20710	Bladensburg	2.62	1	28	1.9%	32.4%	20721	Bowie	15.33	2	7.65	1
20781	Hyattsville Area	3.88	1	19	1.4%	33.8%	20716	Bowie - South East	19.27	3	15.37	1
20722	Colmar Manor	4.20	1	10	0.7%	34.5%	20791	Capitol Heights	7.03	1	7.55	1
20731	Capitol Heights	7.08	1	1	0.1%	34.6%	20731	Capitol Heights	7.08	1	7.18	1
20791	Capitol Heights	7.03	1	-	0.0%	34.6%	20773	Upper Marlboro	27.07	3	17.25	1
20787	Hyattsville	6.23	1	-	0.0%	34.6%	20753	District Heights	12.3	1	9.52	1
20753	District Heights	12.30	1	-	0.0%	34.6%	20775	Upper Marlboro	16.3	2	6.68	1
20752	Suitland	11.03	1	-	0.0%	34.6%	20752	Suitland	11.03	1	12.62	1
20736	Riverdale Park	5.10	1	-	0.0%	34.6%	20717	Bowie	20.58	3	14.22	1
20797	Southern MD Facility	7.08	1	-	0.0%	34.6%	20797	Southern MD Facility	7.08	1	7.18	1
20774	Upper Marlboro	16.00	2	98	7.2%	41.8%	20799	Capitol Heights	12.17	2	2.35	1
20706	Lanham-Glenarden	9.18	2	77	5.7%	47.5%	20792	Upper Marlboro	16.07	2	6.45	1
20784	Hyattsville - Landover Hills	5.48	2	71	5.2%	52.7%	20706	Lanham-Glenarden	9.18	2	7.43	2
20746	Suitland	13.07	2	37	2.7%	55.4%	20784	Hyattsville - Landover Hills	5.48	2	7.58	2
20770	Greenbelt Area	8.15	2	28	2.1%	57.5%	20772	Upper Marlboro	28.12	3	8.77	2
20721	Bowie	15.33	2	27	2.0%	59.5%	20746	Suitland	13.07	2	13.45	2
20715	Bowie - North	19.58	2	22	1.6%	61.1%	20770	Greenbelt Area	8.15	2	10.35	2
20712	Mount Rainier	5.93	2	14	1.0%	62.1%	20715	Bowie - North	19.58	2	17.22	2
20720	Bowie - North	14.88	2	11	0.8%	62.9%	20720	Bowie - North	14.88	2	12.52	2
20769	Glenn Dale	14.77	2	9	0.7%	63.6%	20769	Glenn Dale	14.77	2	13.42	2
20741	College Park	7.98	2	1	0.1%	63.6%	20703	Lanham-Seabrook	11.55	2	9.83	2
20775	Upper Marlboro	16.07	2	1	0.1%	63.7%	20623	Cheltenham	30.73	4	21.38	2
20703	Lanham-Seabrook	11.55	2	-	0.0%	63.7%	20718	Bowie	18.53	2	16.2	2
20718	Bowie	18.53	2	-	0.0%	63.7%	20762	Andrews AFB	20.5	3	11.83	2
20775	Upper Marlboro	16.30	2	-	0.0%	63.7%	20768	Greenbelt	8.73	2	10.67	2
20788	Hyattsville	6.32	2	-	0.0%	63.7%	20771	Greenbelt	10.2	2	10.65	2
20768	Greenbelt	8.73	2	-	0.0%	63.7%	20748	Temple Hills	15.23	3	13.87	3
20771	Greenbelt	10.20	2	-	0.0%	63.7%	20735	Clinton	24.43	3	18.83	3
20799	Capitol Heights	12.17	2	-	0.0%	63.7%	20708	South Laurel	16.53	3	18.47	3
20748	Temple Hills	15.23	3	38	2.8%	66.5%	20602	Waldorf	39.77	3	34.47	3
20772	Upper Marlboro	28.12	3	32	2.4%	68.9%	20613	Brandywine	36.4	3	30.8	3
20716	Bowie - South East	19.27	3	22	1.6%	70.5%	20603	Waldorf	43.12	3	37.52	3
20735	Clinton	24.43	3	21	1.5%	72.0%	20608	Aquasco	49.7	3	44.1	3
20740	College Park	10.75	3	17	1.3%	73.3%	20757	Temple Hills	14.97	3	14.23	3
20708	South Laurel	16.53	3	9	0.7%	74.0%	20601	Waldorf	35.27	3	29.67	3
20613	Brandywine	36.40	3	2	0.1%	74.1%	20719	Bowie	19.03	3	18.18	3
20603	Waldorf	43.12	3	1	0.1%	74.2%	20709	Laurel	15.3	3	17.23	3
20762	Andrews AFB	20.50	3	1	0.1%	74.2%	20737	Riverdale	4.5	1	10.72	4
20602	Waldorf	39.77	3	-	0.0%	74.2%	20710	Bladensburg	2.62	1	10.7	4
20608	Aquasco	49.70	3	-	0.0%	74.2%	20738	Riverdale Park	5.1	1	11.27	4
20757	Temple Hills	14.97	3	-	0.0%	74.2%	20704	Beltsville	13.6	5	16.08	5
20601	Waldorf	35.27	3	-	0.0%	74.2%	20745	Oxon Hill	17.07	6	17.42	6
20773	Upper Marlboro	27.07	3	-	0.0%	74.2%	20744	Fort Washington	23.53	6	24.18	6
20719	Bowie	19.03	3	-	0.0%	74.2%	20740	College Park	10.75	3	13.38	6
20709	Laurel	15.30	3	-	0.0%	74.2%	20781	Hyattsville Area	3.88	1	12.77	6
20717	Bowie	20.58	3	-	0.0%	74.2%	20705	Beltsville	14.58	5	17.07	6
20782	Hyattsville-Chillum	7.97	4	25	1.8%	76.1%	20607	Accokeek	34.63	6	35.42	6
20623	Cheltenham	30.73	4	1	0.1%	76.2%	20653	Lexington Park	94.48	6	88.88	6
20742	College Park	10.03	4	-	0.0%	76.2%	20725	Laurel	21.13	5	23.07	6
20705	Beltsville	14.58	5	11	0.8%	77.0%	20749	Fort Washington	25.87	6	26.6	6
20704	Beltsville	13.60	5	-	0.0%	77.0%	20726	Laurel	19.98	5	21.92	6
20725	Laurel	21.13	5	-	0.0%	77.0%	20707	Laurel	21.85	6	23.78	7
20726	Laurel	19.98	5	-	0.0%	77.0%	20722	Colmar Manor	4.2	1	13.32	7
20745	Oxon Hill	17.07	6	35	2.6%	79.5%	20787	Hyattsville	6.23	1	13.8	7
20783	Hyattsville-Adelphi	12.22	6	28	2.1%	81.6%	20741	College Park	7.98	2	14.05	7
20707	Laurel	21.85	6	17	1.3%	82.9%	20742	College Park	10.03	4	16.22	8
20744	Fort Washington	23.53	6	16	1.2%	84.0%	20782	Hyattsville-Chillum	7.97	4	16.72	8
20912	Takoma Park	12.89	6	6	0.4%	84.5%	20748	Mount Rainier	5.93	2	15.35	9
20607	Accokeek	34.63	6	3	0.2%	84.7%	20788	Hyattsville	6.32	2	15.47	9
20653	Lexington Park	94.48	6	-	0.0%	84.7%	20903	Silver Spring-Hillandale	14.55	9	18.68	10
20749	Fort Washington	25.87	6	-	0.0%	84.7%	20904	Silver Spring-Colesville	19.45	8	21.93	10
20904	Silver Spring-Colesville	19.45	8	14	1.0%	85.7%	20783	Hyattsville-Adelphi	12.22	6	19.3	11
Total Discharges in Service Area				1,165								

The change in PGHC's service area centered around Cheverly to PGRMC's service area centered around Largo results in a 16.5% reduction in the total service area population. Based on PGRMC's future service area, population growth assumptions through 2022 were obtained from Claritas at the six cohort levels (MSG A 15-64, MSG A 65-74, MSG A 75+, OB, PED, PSY). For Psychiatric, Dimensions used the population 18 and older which is expected to increase 10% by 2022.

Dimensions calculated that the use rate for Psychiatry admissions was 5.50 per 1,000 population in 2012. Dimensions did not adjust this use rate for future years. The relocation of the hospital to Largo is not expected to have a material impact on the expected volume of Psych discharges at PGRMC and PGRMC is expected to maintain its historical market share of 29%.

When out of area patients are accounted for, Dimensions projects that the new facility will admit 1,375 Psych patients in 2022. Applying the Statewide Average Length of Stay for Psychiatry of 5.76 days and an assumed occupancy of 85% results in a need for 25.53 (or 26) beds.

Though the projected average daily census shows a need for 26 beds at 85% occupancy, Dimensions would like to maintain the current licensure level of 28 beds. Dimensions has studied the distribution of census and the number of days that each census occurred. These are shown in Table 63.

**Table 63
Distribution of Census
PGHC
2012 and 2013**

	2012	2013
Days with 1 census	0	0
Days with 8 census	0	1
Days with 9 census	0	0
Days with 10 census	1	1
Days with 11 census	2	2
Days with 12 census	2	5
Days with 13 census	9	5
Days with 14 census	13	13
Days with 15 census	10	7
Days with 16 census	20	27
Days with 17 census	22	23
Days with 18 census	28	28
Days with 19 census	34	34
Days with 20 census	39	43
Days with 21 census	33	37
Days with 22 census	30	41
Days with 23 census	32	40
Days with 24 census	26	15
Days with 25 census	20	15
Days with 26 census	21	7
Days with 27 census	11	11
Days with 28 census	10	2
Days with 29 census	1	3
Days with 30 census	1	4
Days with 31 census	1	1

Source: PGHC

As the data shows, PGHC had a total of nearly two weeks per year in which the census exceeded 27 beds. This causes significant backup in the ED and in “observation.” The lack of availability of psychiatry beds is a chronic problem state wide, to the extent that MIEMSS has proposed a reporting device whereby hospitals with Psychiatry Units will post their census to a central reporting center which will be accessible to other hospitals. This could add to the PGHC census. For all of these reasons, Dimensions is proposing to maintain its current licensed capacity of 28 beds.

Emergency Department

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

Operating Rooms

Please see the response to COMAR 10.24.11: General Surgical Services, Standard (2) Need- Minimum Utilization for Establishment of a New or Replacement Facility.

MOUNT WASHINGTON PEDIATRIC HOSPITAL

MWPH proposes to relocate its 15 beds from the current PGHC to the new PGRMC facility in order to continue to provide specialty pediatric services to this population in Prince George’s County.

When the beds were originally located to PGHC, it was anticipated that most patients would be referred from PGHC, including those who previously were being referred for care to Washington, D. C. Instead, the MWPH unit at PGHC has become a statewide resource. Referral sources have defined MWPH’s service area, rather than simply location. Table 64 shows the number of referrals to the MWPH unit at PGHC by referral source for the last five years. Over the past five years about 6% of admissions to the MWPH unit have come from PGHC. About 33% have come from Johns Hopkins Hospital and another 11% have come from Johns Hopkins Bayview Medical Center. Another 8% have come from Children’s National Medical Center in Washington, DC.

**Table 64
Admissions by Referral Source
MWPH at PGHC**

Referring Hospital	FY09	FY10	FY11	FY12	FY13	FY14	Total	Total %
AAMC					12	6	18	3%
BAYVIEW	16	8	14	13	10	6	67	11%
BWMC				3	2	7	12	2%
CHILDRENS	9	11	16	13			49	8%
CNMC				3	26	31	60	10%
FRANKLIN					1		1	0%
GEORGETOWN	1	1	4	3	7	2	18	3%
HARBOR			1			2	3	1%
HCH					5	2	7	1%
HOWARD			3		3		6	1%
JHH	40	35	26	36	33	25	195	33%
JHHOP				1			1	0%
MERCY				1			1	0%
OTHER	5	15	10	14	4	2	50	8%
PGHC	8	14	6	3	2	4	37	6%
SOUTH MD			2	2		1	5	1%
ST AGNES				1	1		2	0%
UMMS	6	9	5	7	19	13	59	10%
TOTAL	85	93	87	100	125	101	591	100%

Patients coming to MWPB's unit at PGHC reside in many areas of the State. Table 65 shows the Zip Codes providing the top 61 percent of admissions.

Table 65
Admissions by Zip Code
MWPB at PGHC
FY 2014

Zip Code	Admissions	%	Cum. %
20774	6	6%	6%
20735	5	5%	11%
20737	5	5%	16%
20783	4	4%	20%
20784	4	4%	24%
20678	3	3%	27%
20706	3	3%	30%
20744	3	3%	33%
21629	3	3%	36%
20601	2	2%	38%
20634	2	2%	40%
20636	2	2%	42%
20659	2	2%	44%
20685	2	2%	46%
20715	2	2%	48%
20720	2	2%	50%
20746	2	2%	51%
20772	2	2%	53%
20785	2	2%	55%
21061	2	2%	57%
21804	2	2%	59%
21865	2	2%	61%
39 Others	39	39%	100%
Grand Total	101		

Because MWPB is a statewide resource, it is using the statewide pediatric population as the base of its projections. MWPB used only the MDP population for age 0-4, as MWPB at PGHC seldom has any patients older than four years old.

MWPB then developed a use rate for 2012, 2013 and 2014. For 2015, MWPB used the average of the 2013 and 2014 use rates. For 2016 through 2025, MWPB used the average of 2013 and 2014. MWPB did this because MWPB believes that using the 2014 use rate would not adequately account for three factors:

1. Currently, some parents choose to use MWPB in Baltimore or Children's National Medical Center in Washington, D.C., rather than have their children admitted to MWPB

at PGHC. MWPH believes that its relocation to a new facility will cause parents to more readily admit their children to the unit.

2. As population health management takes effect, acute care facilities that refer to MWPH will increase their referrals in order to reduce their own utilization.
3. With a stronger UMMS relationship, referrals from other UMMS hospitals' NICUs to MWPH will increase.

MWPH believes that this approach is conservative because the 2015-2021 use rate is lower than the 2013 actual use rate.

The MWPH at PGHC Average Length of Stay ("ALOS") varies considerably year by year, depending on MWPH's clinical patient mix. With so few admissions, several long-staying patients have a significant impact on ALOS.

For 2014, MWPH used the average ALOS of the five-year period. Thereafter, MWPH added a quarter of a day to the ALOS each year. MWPH believes that, as acute care facilities attempt to reduce their utilization, they will discharge patients to MWPH sooner, usually resulting in a somewhat longer ALOS at the MWPH unit at PGHC.

**Table 66
ALOS
MWPH at PGHC**

	FY09	FY10	FY11	FY12	FY13	FY14	Average
ALOS	31.8	25.6	27.2	21.3	23.4	24.1	25.57

MWPH assumed a 65% occupancy percentage, which is the occupancy percentage identified in the State Health Plan for acute pediatric units sized between 7 and 24 beds.

These assumptions result in a need for 14.1 beds in 2025, as shown below. Hence, MWPH is requesting approval for the relocation of the 15 beds that it currently has licensed to the new facility.

**Table 67
Projected Bed Need
MWPH at PGHC**

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
MD. Pop													
Age 0-4	370,624	372,691	374,770	376,743	378,727	380,721	382,725	384,740	385,850	386,962	388,078	389,198	390,320
Admissions	125	102											
Use Rate/1,000													
Projected Admissions	0.337	0.274	0.305	0.305	0.305	0.305	0.305	0.305	0.305	0.305	0.305	0.305	0.305
Projected Admissions			114	115	116	116	117	118	118	118	119	119	119
ALOS	23.4	24.1	25.7	25.9	26.2	26.4	26.7	26.9	27.2	27.4	27.7	27.9	28.2
Patient Days	2,923	2,459	2,927	2,981	3,036	3,065	3,121	3,177	3,207	3,236	3,293	3,323	3,353
ADC	8.0	6.7	8.0	8.2	8.3	8.4	8.6	8.7	8.8	8.9	9.0	9.1	9.2
Bed Need at 65% Occupancy:	12.3	10.4	12.3	12.6	12.8	12.9	13.2	13.4	13.5	13.6	13.9	14.0	14.1

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the proposed project. The applicant should identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including:

- a) the alternative of the services being provided through existing facilities;
- b) or through population-health initiatives that would avoid or lessen hospital admissions.

Describe the hospital's population health initiatives and explain how the projections and proposed capacities take these initiatives into account.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development costs to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective method to reach stated goal(s) and objective(s) or the most effective solution to the identified problem(s) for the level of costs required to implement the project, when compared to the effectiveness and costs of alternatives, including the alternative of providing the service through existing facilities, including outpatient facilities or population-based planning activities or resources that may lessen hospital admissions, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Applicant Response:

Dimensions

See response to COMAR 10.24.10.04B(5) – Cost-Effectiveness, above.

MWPH

MWPH believes that the continuation of its relationship with Dimensions is the most cost effective alternative. Closure of the unit was never a serious or prudent consideration, as closure would reduce access for families across the State. MWPH recognized early in the planning process that it would not make sense to seek to lease space at any alternative facility.

MWPH has a nearly twenty-year relationship with Dimensions which has been very successful. Furthermore, MWPH is owned jointly by University of Maryland Medical System and Johns Hopkins Health System, and, as Dimensions collaborates more closely with UMMS, the relationship will improve, as medical staff, nursing staff, and other components of care

become integrated. Dimensions is also proposing an enhanced relationship with Children's National Medical Center ("CNMC") in Washington, D.C. CNMC is both a competitor to MWPH and a significant referral source. MWPH looks forward to increased coordination with CNMC.

Furthermore, as discussed under 10.24.01.08G(3)(d)-Viability of the Proposal, the MWPH unit at PGHC helps to contribute to MWPH's overall financial health.

In addition, MWPH is a lower-cost alternative for inpatient care. Most of the patients referred to the Prince George's County unit of MWPH are transferred from the referring hospitals' Neonatal Intensive Care Units. These children are not "graduates" of the NICUs, but, rather, "NICU upperclassmen" who would have spent more time in the NICU, were they not transferred to MWPH's unit. The HSCRC Revenue and Volumes Report for FY 2013 demonstrates that MWPH is considerably less costly per patient day than continuing to care for these patients in the NICU. Table 68 shows the number of patient days in the NICU cost center at the four largest Maryland referral sources to MWPH, their Inpatient Revenue for that cost center, and the average revenue per day (average room rates). This is compared to the Pediatric and Pediatric Step Down Cost Centers at MWPH (also, room rates). The average revenue per day at MWPH is lower than at any of the referring hospitals.

Table 68
Number of Patient Days in the NICU Cost Center, NICU Inpatient Revenue,
And Average Revenue per Day
Selected Hospitals-FY 2013

Hospital	Center	Patient Days	Inpt Revenue	Revenue/Day
Bayview	NICU	5,557	\$7,165,025	\$1,289
Hopkins Hospital	NICU	14,893	\$25,903,499	\$1,739
University of MD	NICU	13,834	\$21,650,197	\$1,565
Prince George's	NICU	3,620	\$5,522,008	\$1,525
MWPH	PED and Pediatric Step Down	22,045	\$23,874,910	\$1,083

Source: HSCRC Revenue and Volumes Report for FY 2013, downloaded from its website
<http://www.hscrc.state.md.us/documents/Hospitals/ReportsFinancial/FinancialData/RevenueVolumeSummary/hscrc-fy-2013.xlsx>
 accessed 11/6/14

10.24.01.08G(3)(d). Viability of the Proposal.

The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

- Complete applicable Revenues & Expenses (Tables G, H, J and K as applicable), and the Work Force information (Table L) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable.
- Describe and document relevant community support for the proposed project.
- Identify the performance requirements applicable to the proposed project and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, contracting and obtaining and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame.
- Audited financial statements for the past two years should be provided by all applicant entities and parent companies.

Applicant Response:

Dimensions

Community Support

The collaboration of the MOU partners over the past few years is a tremendous show of support for Dimensions' role as a regional medical center and for this project. The relocation of Dimensions also has enormous public and community support. Exh. 28 includes more than 250 letters of support, including statements of support from: Senate President Thomas "Mike" Miller, Speaker Michael E. Busch, the entire Prince George's Delegation of the Maryland House of Delegates, numerous State Senators and Delegates, Prince George's County Executive Rushern L. Baker III, the Prince George's County Council, the Charles County Commissioners, Dr. William E. Kirwan (Chancellor of the University System of Maryland), Dr. Wallace D. Loh (President of the University of Maryland), Dr. Jay A. Perman (President of the University of Maryland, Baltimore), Dr. Charlene M. Dukes (President of Prince George's Community College), numerous health care providers, business and religious leaders, and many others.

Financial Support

Both the State of Maryland and Prince George's County have demonstrated financial commitment for the RMC, showing their support for Dimensions' role in the community and for the project. Funding for the Project Costs is comprised of the following:

- Prince George's County will contribute:
 - \$208 million at the time of construction in 2016
 - Donated land for the project
- The State of Maryland has been asked to provide grants totaling \$208 million over five years beginning in 2014. Based on discussions with the State, the following assumptions related to a capital funding schedule are being utilized for project funding assumptions
 - \$20M in 2014, \$15M in 2015, \$40M in 2016, \$35M in 2017, and \$90M paid at the end of the 5 years. Commitments have been acquired for the amounts in 2014 and 2015.
 - The signatories to the MOU will meet with State legislators to ask that an additional \$8,000,000 in funding be placed in the State's Capital Budget to achieve the original capital funding amount agreed to be committed by Prince George's County and the State (\$208,000,000 each).
 - If the additional \$8,000,000 is not funded by the State, then the \$8,000,000 shortfall in funds will be acquired either through a Prince George's County community capital campaign program and/or if necessary, additional borrowing for funds (issuance of long-term debt).
- A long-term bond issuance of \$206.7M to be paid back over 30 years
 - Annual interest expense of 5.5% on the outstanding balance
 - Interest during construction will be capitalized
 - Principal payments will begin upon the new hospital's commencement of operations in July 2019

As part of a full rate application to be filed with the Health Services Cost Review Commission ("HSCRC"), Dimensions is requesting an increase in rates equal to approximately 50% of the increase in capital costs (depreciation and interest) associated with the proposed project.

The total cost of the project is \$651.2 million of which \$588.6 million are depreciable assets. \$206.7 million of the depreciable assets will be funded with proceeds from the issuance of tax exempt bonds. With 66% of the project costs funded with equity contributions, there is a limited amount of debt and associated interest expense. Total depreciation and interest expense (i.e., capital costs) related to the project are projected to equal \$36.6M in the first full year of operation of the facility.

	Projected Capital Costs (\$ in millions)
Depreciation	\$ 25.2
Interest	11.4
Total	\$ 36.6
% of Capital to Included in Revenue	50%
Capital Related Revenue Increase	\$ 18.2

Applying Dimensions' mark-up of 1.182 to the capital to be included in rates results in an estimate of gross revenue related to the project of \$21,487,000 which is expected to equate to a 7.0% increase on the 2019 projected HSCRC rates.

Audited Financial Statements are included in **Exhibit 47**. They can also be found online at www.dimensionshealth.com. Exh. 1, MHCC Tables G & H, includes statements of assumptions.

MWPH

MWPH's MHCC Table J2, Revenue & Expenses, Uninflated – New Facility or Service – MWPH, and MHCC Table K2 Revenue & Expenses, Inflated – New Facility or Service - show that the MWPH unit at PGHC is financially solid when corporate overhead is not allocated to the unit. When corporate overhead is allocated to the unit, MWPH at PGHC shows a financial loss. However, the critical point is that the positive net revenue at the PGHC MWPH unit contributes to MWPH's overall financial viability. The corporate overhead that is allocated to the PGHC unit would not be eliminated if the unit was closed. Consequently, the PGHC unit contributes to MWPH's overall bottom line.

As MWPH is in leased space and is not responsible for any debt, this project will not impact charges. MWPH recognizes that rent will increase, as reflected in Exh. 1, MHCC Tables, Table G2, Revenue & Expenses, Uninflated – Entire Facility - MWPH, Table H2, Revenue & Expenses, Uninflated – MWPH.

Audited Financial Statements for MWPH are included in **Exhibit 48**. Exh. 1, MHCC Tables G & H, includes statements of assumptions.

10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.

An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

INSTRUCTIONS: List all of the Certificates of Need that have been issued to the applicant or related entities, affiliates, or subsidiaries since 2000, including their terms and conditions, and any changes to approved CONs that were approved. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

Applicant Response:

Dimensions

Dimensions has received approval for one CON project since 1990:

- In 1996, Dimensions received a CON (Docket #96-16-1901) for the establishment of an 18 bed Neonatal Intensive Care Unit (NICU). The project was completed and service opened. Dimensions completed work for the CON and has complied with all conditions.

MWPH

MWPH has received approval for two CON projects since 1990:

- On February 18, 1994, MWPH was issued an Emergency CON (Docket #94-24-1741) to move 27 specialty pediatric beds from Lutheran Hospital to Montebello Rehabilitation Hospital due to a facility emergency. As a condition to granting the Emergency CON, MWPH was to complete a Certificate of Need application on or before March 18, 1994. MWPH submitted a timely application to relocate the 27 specialty pediatric beds to Harbor Hospital Center. MWPH withdrew that application before decision due to decreasing occupancy. Thus, the conditions of the emergency CON were satisfied.
- On October 8, 1996, MWPH was issued a CON (Docket #96-24-1966) to move 15 specialty pediatric beds to Prince George's Hospital Center facility. The project was completed. MWPH completed work for this CON and has complied with all conditions.

Copies of the applicable CON Orders are attached as **Exhibit 49**.

10.24.01.08G(3)(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.

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project:

- a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project;
 - b) On access to health care services for the service area population that will be served by the project. (state and support the assumptions used in this analysis of the impact on access)
 - c) On costs to the health care delivery system.
-

Applicant Response:

Dimensions

Dimensions has projected the impact on other facilities by using the methodology used by the MHCC in Commissioner Barbara McLean's proposed decision on the CON application for the relocation of Washington Adventist Hospital (Docket No. 09-15-2295) (see Proposed Decision, pp. 157-162). In addition, Dimensions has reflected the recapture of some market share that it has lost over the past decade in service lines that were affected by the loss of physicians.

The objective of the new hospital is to be a regional medical center for all of Prince George's County and the Southern Maryland region, with a focus on providing and growing tertiary and secondary specialty care in trauma, cardiovascular, neonatal, cancer, and subspecialty medical and surgical services. Emphasis will also be placed on Obstetrics and Orthopedics. PGRMC is one component of a new health system supported by a stronger primary care, specialty care, and ambulatory care network.

The business goal for PGRMC is to target and attract back residents currently utilizing hospital services in D.C. and Virginia. Approximately 2/3's of the incremental volume growth from market share recapture is projected to come from D.C. and Virginia hospitals with a focus on capturing volumes related to service lines of cardiovascular, cancer, neurosurgery, and medical/surgical subspecialty care.

A study by University of Maryland School of Public Health (Transforming Health In Prince George's County, Maryland: A Public Health Impact Study), as well as patient utilization characteristics help support the incremental growth projections. Community feedback from the University of Maryland School of Public Health (UMSPH) Study: *Interviews & Survey Findings Illustrate Residents Will Return To Prince George's County To Use New Hospital Facility* include:

- New hospital can demonstrate high quality care;
 - New RMC will be academically affiliated with UMMS and UMB
 - Quality improvement initiative now underway in partnership with UMMS
- Increased access to clinicians;
 - Working with UMMS and UMB to expand access to specialists
 - Working with County to improve access of primary care / development of ambulatory care network
 - New leadership in place to improve service quality of clinical staff
 - Initiatives underway to strengthen relationships with community physicians
- Patients Insurance accepts new RMC as a provider;
 - Efforts are underway to improve operational efficiencies so to position new RMC as charge/price competitive

UMSPH Survey results indicated that 55.1% of those surveyed were very likely to use a new state-of-the-art hospital facility while 37.1% reported they would likely use the new facility. Inpatient data indicates that residents within PGHC's primary and secondary service area are trending coming back to the County for hospital care.

- *FY 2001: Approximately 32.5% inpatient discharges of PGHC's PSA/SSA residents were from D.C. and Virginia hospitals.*
- *FY 2008: Approximately 28.0% inpatient discharges of PGHC's PSA/SSA residents were from D.C. and Virginia hospitals.*
- *FY 2012: Approximately 26.6% inpatient discharges of PGHC's PSA/SSA residents were from D.C. and Virginia hospitals.*

In FY2012, Prince George's County residents represented approximately 97,809 inpatient discharges. Of those, approximately 26,125 (or 26.7%) of discharges came from D.C. and Virginia hospitals. PGRMC's volume projections present a market share recapture of approximately 3,282 discharges by the year 2022. Of that, approximately 2/3's or 2,210 of those discharges are targeted to come from D.C. and Virginia hospitals. This represents a market share decline of only 2.2 percentile points (26.7% to 24.5%) for D.C. and Virginia hospitals of the Prince George's County market.

The rationale supporting 2/3 of market share recapture coming from D.C./Virginia hospitals considers the following:

- Business objective of PGRMC is to focus more on tertiary and secondary care for the inpatient component of care delivery.
- Significant D.C. / Virginia hospital volume within the top 10 Maryland Zip Codes of PGHC, where approximately 30% of all discharges from these 10 ZIP Codes come from D.C. / Virginia hospitals.

Table 69 represents a selection of tertiary and secondary level MS-DRGs to illustrate that WHC, GTUH, and GWUH have a higher percentage of tertiary/secondary level of discharges than community hospitals, which are the type of patients the PGRMC will be

targeting. Please note that this table does not represent all of the cases to be captured by PGRMC.

**Table 69
Tertiary and Secondary Level MS-DRGs, Selection
FY2013**

Selected Hospitals	Tertiary & Secondary Acute Cases of Prince George's County Residents Based on Listing of 161 MS-DRGs*	Total Hospital Cases of Prince George's County Residents	Percent of Highly Acute Cases of Prince George's County Residents
Selected DC Hospitals:			
Washington Hospital Center	1,536	9,206	16.7%
Georgetown University Hospital	468	2,542	18.4%
George Washington University Hospital	230	2,048	11.2%
Howard University Hospital	94	824	11.4%
Providence Hospital	376	3,614	10.4%
Sibley Memorial Hospital	88	730	12.1%
Selected Maryland Hospitals:			
Doctors Community Hospital	497	9,653	5.1%
Southern Maryland Hospital Center	1,021	11,705	8.7%
Washington Adventist Hospital	759	6,177	12.3%
Prince George's Hospital Center	1,115	10,571	10.5%

* Listing of 161 MS-DRGs includes DRGs related to cardiac surgery/interventions, cancer, neurosurgery, and other types of highly acute cases.

The rationale supporting an estimate of 2/3 of market share recapture coming from D.C./Virginia hospitals also considers:

- PGHC's Emergency Department transfers of patients to be admitted to other facilities for higher level of care indicate that there is a strong preference among physicians/patients towards Washington Hospital Center for adult care. One can assume that patients presenting to physician offices needing hospital care will have similar preferences. Other hospitals with volume of note include University of Maryland Medical Center and Holy Cross Hospital.
- The recruitment of subspecialty physicians to increase access of such specialty services within Prince George's County will prevent patients from having to travel to Washington D.C. for subspecialty care.
- Physicians on staff prefer to have patients be taken care of locally versus going to out-of-area hospitals:
 - Physicians wish to keep their connectivity with their patients
 - Physicians prefer to refer to local specialists so they can receive real-time information regarding referred patients
 - Patients / families prefer treatment locally versus traveling assuming local access to specialists

For these reasons, the following allocations were used to determine the source of the recaptured discharges.

**Table 70
Market Share Recapture**

	Market Share Recapture Discharges	Allocation of Recaptured Discharges			Discharge Recapture		
		Out of State	MD	Total	Out of State	MD	Total
MSGA Adult / Pediatric Discharges	2,988	68%	32%	100%	2,034	954	2,988
Obstetrics	294	60%	40%	100%	176	118	294
Psychiatry	-	50%	50%	100%	-	-	-
Total	3,282	67%	33%	100%	2,210	1,072	3,282

The allocation of MSGA discharges, by age cohort, is expected to change from 2013 to 2022 with different assumptions regarding population growth. The 2022 allocation of MSGA discharges, pre-recapture, is applied to the 2022 MSGA discharges, post-recapture, to determine the allocation of MSGA recaptured discharges, by age cohort.

**Table 71
MSGA Recaptured Discharges, by Cohort
FY 2022**

Age Cohort	FY 2013		FY 2022 - Pre-Recapture		Recapture	
	Discharges	%	Discharges	%	Discharges	%
MSGA 75+	977	18.5%	1,439	23.3%	696	23.3%
MSGA 65-74	851	16.1%	1,372	22.2%	664	22.2%
MSGA 15-64	3,438	65.0%	3,347	54.2%	1,619	54.2%
PEDS	20	0.4%	19	0.3%	9	0.3%
Total	5,286	100.0%	6,177	100.0%	2,988	100.0%

Applying the allocation of MSGA discharges from In and Out-of State, to the allocation of recaptured MSGA discharges, by age cohort, results in the following split of recaptured MSGA discharges by age cohort and from In and Out-of-State

**Table 72
MSGA Discharges, by Age Cohort
In and Out-of-State**

Age Cohort	Recaptured Discharges					
	Out-of-State		In-State		Total	
	Discharges	%	Discharges	%	Discharges	%
MSGA 75+	474	23.3%	222	23.3%	696	23.3%
MSGA 65-74	452	22.2%	212	22.2%	664	22.2%
MSGA 15-64	1,102	54.2%	517	54.2%	1,619	54.2%
PEDS	6	0.3%	3	0.3%	9	0.3%
Total	2,034	100.0%	954	100.0%	2,988	100.0%

Applying the allocation of MSGA discharges, by age cohort and from In and Out-of-State, to the allocation of discharges by Service Line results in the following split of recaptured MSGA discharges by Service Line.

Table 73
MSGA Discharges, by Service Line

	Out of State Recapture Allocation by Cohort					Maryland Recapture Allocation by Cohort				
	MSGA	MSGA 65-	MSGA 15-	PEDS	Total	MSGA	MSGA 65-	MSGA 15-	PEDS	Total
	75+	74	64			75+	74	64		
Burn	-	-	-	-	-	0	0	1	0	2
Dental / Oral	-	-	-	-	-	3	3	7	0	12
Cardiac Arrhythmia	12	12	28	0	52	4	4	9	0	17
Cardiac Surgery	27	26	64	0	118	7	7	16	0	29
Cardiology	26	25	61	0	112	26	25	61	0	112
Interventional Cardiology	22	21	52	0	96	12	11	27	0	50
Vascular	13	12	30	0	55	7	6	15	0	28
Vascular Surgery	23	22	54	0	100	8	7	18	0	33
Gastroenterology	19	18	44	0	82	10	9	23	0	42
Gynecology	9	9	21	0	40	5	5	11	0	20
HIV	3	3	7	0	13	2	1	4	0	7
Medical Oncology/ Hematology	62	59	144	1	265	15	15	36	0	66
Medicine	45	43	104	1	192	11	11	26	0	48
Nephrology	14	13	32	0	60	3	3	8	0	15
Neurology	37	35	85	0	158	19	18	44	0	81
Neuro Surgery	6	6	15	0	27	2	2	5	0	9
Ophthalmology	2	2	4	0	7	2	2	4	0	7
Orthopedics	59	57	138	1	255	31	29	71	0	132
Otolaryngology	3	3	7	0	13	2	1	4	0	7
Respiratory	28	26	64	0	118	14	14	33	0	61
Spine-Back/Neck Procedures	9	8	20	0	37	4	4	10	0	19
Substance Abuse	-	-	-	-	-	4	4	10	0	19
Surgery	34	33	80	0	147	15	14	34	0	63
Transplant	0	0	0	0	0	0	0	0	0	0
Trauma	2	2	5	0	8	8	8	18	0	34
Urology	18	17	42	0	77	9	9	21	0	40
Total	474	452	1,102	6	2,034	222	212	517	3	954
	23.3%	22.2%	54.2%	0.3%	100.0%	23.3%	22.2%	54.2%	0.3%	100.0%

With the projection of recaptured discharges split between In and Out of State, the impact was allocated to other hospitals based on their FY2013 proximity adjusted market share by zip code within each Cohort. The example that follows is an excerpt of the In-State MSGA 15-64 Cohort, which required an allocation of 517 discharges, between Maryland hospitals.

Table 74
Allocation of Recaptured Discharges between Maryland Hospitals
In-State MSGA 15-64, Excerpt

	Total	20743	20785	20774	20747	20721	20716	20773	20753	20775
Current Maryland Hosp Discharges	28,641	1,565	1,546	1,319	1,429	667	619	10	9	12
Current DC Hosp Discharges	9,847	712	522	415	634	239	120	-	4	-
Current VA Hosp Discharges	1,433	51	44	57	76	26	23	4	-	-
	39,921									
Incremental MD Discharge Recapture	517	28	28	24	26	12	11	0	0	0
Revised MD Hosp Discharges	28,641	1,565	1,546	1,319	1,429	667	619	10	9	12
Revised DC Hosp Discharges	9,847	712	522	415	634	239	120	-	4	-
Revised VA Hosp Discharges	1,433	51	44	57	76	26	23	4	-	-
	39,921									

	Pre-Recapture Market Share								
	20743	20785	20774	20747	20721	20716	20773	20753	20775
Prince George's Regional Medical Center	22.1%	24.0%	19.1%	18.9%	18.8%	17.4%	22.9%	21.7%	18.6%
Doctor's Community Hospital	19.9%	25.6%	20.8%	10.2%	16.9%	12.6%	0.0%	0.0%	14.6%
Southern Maryland Hospital Center	11.9%	2.3%	3.7%	22.3%	1.4%	1.7%	7.7%	39.2%	7.3%
Washington Adventist Hospital	1.1%	3.9%	1.6%	1.3%	2.6%	1.3%	0.0%	0.0%	0.0%
Laurel Regional Hospital	0.7%	1.0%	1.7%	1.1%	1.6%	2.9%	0.0%	0.0%	0.0%
Johns Hopkins Hospital	1.1%	0.9%	2.8%	1.1%	3.2%	3.9%	0.0%	0.0%	7.3%
University of Maryland Medical Center	1.4%	2.5%	2.4%	1.0%	2.5%	2.1%	0.0%	0.0%	0.0%
Holy Cross Hospital	3.5%	5.3%	4.9%	4.0%	5.0%	5.3%	7.7%	0.0%	7.3%
Howard County General Hospital	0.2%	0.1%	0.2%	0.1%	0.4%	0.3%	0.0%	0.0%	0.0%
Fort Washington Medical Center	0.7%	0.2%	0.4%	2.1%	0.1%	0.1%	0.0%	0.0%	0.0%
Anne Arundel Medical Center	1.1%	2.1%	8.9%	1.0%	11.1%	24.7%	23.1%	0.0%	36.5%
Suburban Hospital	0.9%	0.8%	1.0%	0.9%	1.2%	0.8%	7.7%	0.0%	0.0%
Shady Grove Hospital	0.2%	0.4%	0.2%	0.2%	0.3%	0.4%	0.0%	0.0%	0.0%
Montgomery General Hospital	0.0%	0.0%	0.1%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%
Other MD Hospitals	2.5%	3.8%	5.9%	2.3%	6.5%	7.7%	0.0%	7.7%	8.3%
Total MD Hospitals	67.2%	73.2%	73.7%	66.8%	71.6%	81.2%	69.2%	68.6%	100.0%
Washington Hospital Center	14.7%	12.2%	9.2%	13.8%	9.5%	8.0%	0.0%	15.7%	0.0%
Children's National Medical Center	2.1%	1.0%	2.0%	1.9%	1.9%	1.0%	0.0%	0.0%	0.0%
Providence Hospital	2.1%	2.6%	2.3%	1.9%	3.6%	1.0%	0.0%	0.0%	0.0%
Georgetown University Hospital	2.8%	1.9%	4.0%	4.1%	3.6%	2.6%	0.0%	0.0%	0.0%
George Washington University Hospital	5.2%	4.2%	2.7%	3.9%	3.8%	1.0%	0.0%	15.7%	0.0%
Other DC Hospitals	3.6%	2.8%	2.9%	4.1%	3.2%	2.1%	0.0%	0.0%	0.0%
Total DC Hospitals	30.6%	24.7%	23.2%	29.6%	25.6%	15.8%	0.0%	31.4%	0.0%
Inova Fairfax Hospital	0.5%	0.6%	1.1%	0.7%	0.6%	0.5%	30.8%	0.0%	0.0%
Inova Alexandria Hospital	0.6%	0.5%	0.6%	0.7%	0.5%	0.8%	0.0%	0.0%	0.0%
Virginia Hospital Center - Arlington	0.6%	0.4%	0.4%	0.9%	0.9%	1.3%	0.0%	0.0%	0.0%
Inova Mount Vernon Hospital	0.1%	0.2%	0.5%	0.3%	0.2%	0.0%	0.0%	0.0%	0.0%
Inova Fair Oaks Hospital	0.0%	0.2%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%
Other VA Hospitals	0.4%	0.1%	0.5%	0.8%	0.5%	0.3%	0.0%	0.0%	0.0%
Total VA Hospitals	2.2%	2.1%	3.2%	3.6%	2.8%	3.0%	30.8%	0.0%	0.0%
MD/DC/VA Hospitals Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

	Post-Capture Market Share									
	20743	20785	20774	20747	20721	20716	20773	20753	20775	
Prince George's Regional Medical Center	23.4%	25.4%	20.5%	20.1%	20.1%	19.0%	24.2%	23.0%	20.5%	
Doctor's Community Hospital	19.3%	24.9%	20.2%	9.9%	16.4%	12.3%	0.0%	0.0%	14.3%	
Southern Maryland Hospital Center	11.5%	2.2%	3.6%	21.7%	1.4%	1.7%	7.5%	38.2%	7.1%	
Washington Adventist Hospital	1.1%	3.8%	1.6%	1.2%	2.5%	1.3%	0.0%	0.0%	0.0%	
Laurel Regional Hospital	0.7%	1.0%	1.6%	1.0%	1.6%	2.8%	0.0%	0.0%	0.0%	
Johns Hopkins Hospital	1.0%	0.9%	2.7%	1.1%	3.1%	3.8%	0.0%	0.0%	7.1%	
University of Maryland Medical Center	1.4%	2.4%	2.3%	1.0%	2.4%	2.0%	0.0%	0.0%	0.0%	
Holy Cross Hospital	3.4%	5.2%	4.8%	3.9%	4.9%	5.2%	7.5%	0.0%	7.1%	
Howard County General Hospital	0.2%	0.1%	0.2%	0.1%	0.4%	0.3%	0.0%	0.0%	0.0%	
Fort Washington Medical Center	0.7%	0.2%	0.4%	2.0%	0.1%	0.1%	0.0%	0.0%	0.0%	
Anne Arundel Medical Center	1.0%	2.1%	8.6%	1.0%	10.8%	24.1%	22.5%	0.0%	35.7%	
Suburban Hospital	0.9%	0.8%	1.0%	0.9%	1.1%	0.8%	7.5%	0.0%	0.0%	
Shady Grove Hospital	0.2%	0.4%	0.2%	0.2%	0.3%	0.4%	0.0%	0.0%	0.0%	
Montgomery General Hospital	0.0%	0.0%	0.1%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	
Other MD Hospitals	2.4%	3.7%	5.8%	2.3%	6.4%	7.6%	0.0%	7.5%	8.1%	
Total MD Hospitals	67.2%	73.2%	73.7%	66.8%	71.6%	81.2%	69.2%	68.6%	100.0%	
Washington Hospital Center	14.7%	12.2%	9.2%	13.8%	9.5%	8.0%	0.0%	15.7%	0.0%	
Children's National Medical Center	2.1%	1.0%	2.0%	1.9%	1.9%	1.0%	0.0%	0.0%	0.0%	
Providence Hospital	2.1%	2.6%	2.3%	1.9%	3.6%	1.0%	0.0%	0.0%	0.0%	
Georgetown University Hospital	2.8%	1.9%	4.0%	4.1%	3.6%	2.6%	0.0%	0.0%	0.0%	
George Washington University Hospital	5.2%	4.2%	2.7%	3.9%	3.8%	1.0%	0.0%	15.7%	0.0%	
Other DC Hospitals	3.6%	2.8%	2.9%	4.1%	3.2%	2.1%	0.0%	0.0%	0.0%	
Total DC Hospitals	30.6%	24.7%	23.2%	29.6%	25.6%	15.8%	0.0%	31.4%	0.0%	
Inova Fairfax Hospital	0.5%	0.6%	1.1%	0.7%	0.6%	0.5%	30.8%	0.0%	0.0%	
Inova Alexandria Hospital	0.6%	0.5%	0.6%	0.7%	0.5%	0.8%	0.0%	0.0%	0.0%	
Virginia Hospital Center - Arlington	0.6%	0.4%	0.4%	0.9%	0.9%	1.3%	0.0%	0.0%	0.0%	
Inova Mount Vernon Hospital	0.1%	0.2%	0.5%	0.3%	0.2%	0.0%	0.0%	0.0%	0.0%	
Inova Fair Oaks Hospital	0.0%	0.2%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	
Other VA Hospitals	0.4%	0.1%	0.5%	0.8%	0.5%	0.3%	0.0%	0.0%	0.0%	
Total VA Hospitals	2.2%	2.1%	3.2%	3.6%	2.8%	3.0%	30.8%	0.0%	0.0%	
MD/DC/VA Hospitals Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Total	20743	20785	20774	20747	20721	20716	20773	20753	20775
RECAPTURE IMPACT										
Prince George's Regional Medical Center	517	28	28	24	26	12	11	0	0	0
Doctor's Community Hospital	(120)	(12)	(15)	(9)	(5)	(4)	(2)	-	-	(0)
Southern Maryland Hospital Center	(103)	(7)	(1)	(2)	(12)	(0)	(0)	(0)	(0)	(0)
Washington Adventist Hospital	(34)	(1)	(2)	(1)	(1)	(1)	(0)	-	-	-
Laurel Regional Hospital	(28)	(0)	(1)	(1)	(1)	(0)	(1)	-	-	-
Johns Hopkins Hospital	(20)	(1)	(1)	(1)	(1)	(1)	(1)	-	-	(0)
University of Maryland Medical Center	(16)	(1)	(1)	(1)	(1)	(1)	(0)	-	-	-
Holy Cross Hospital	(43)	(2)	(3)	(2)	(2)	(1)	(1)	(0)	-	(0)
Howard County General Hospital	(7)	(0)	(0)	(0)	(0)	(0)	(0)	-	-	-
Fort Washington Medical Center	(17)	(0)	(0)	(0)	(1)	(0)	(0)	-	-	-
Anne Arundel Medical Center	(31)	(1)	(1)	(4)	(1)	(3)	(4)	(0)	-	(0)
Suburban Hospital	(9)	(1)	(0)	(0)	(0)	(0)	(0)	(0)	-	-
Shady Grove Hospital	(3)	(0)	(0)	(0)	(0)	(0)	(0)	-	-	-
Montgomery General Hospital	(2)	-	(0)	(0)	(0)	-	-	-	-	-
Other MD Hospitals	(85)	(2)	(2)	(3)	(1)	(1)	(1)	-	(0)	(0)
Total MD Hospitals	-	-	-	-	-	-	-	-	-	-
Washington Hospital Center	-	-	-	-	-	-	-	-	-	-
Children's National Medical Center	-	-	-	-	-	-	-	-	-	-
Providence Hospital	-	-	-	-	-	-	-	-	-	-
Georgetown University Hospital	-	-	-	-	-	-	-	-	-	-
George Washington University Hospital	-	-	-	-	-	-	-	-	-	-
Other DC Hospitals	-	-	-	-	-	-	-	-	-	-
Total DC Hospitals	-	-	-	-	-	-	-	-	-	-
Inova Fairfax Hospital	-	-	-	-	-	-	-	-	-	-
Inova Alexandria Hospital	-	-	-	-	-	-	-	-	-	-
Virginia Hospital Center - Arlington	-	-	-	-	-	-	-	-	-	-
Inova Mount Vernon Hospital	-	-	-	-	-	-	-	-	-	-
Inova Fair Oaks Hospital	-	-	-	-	-	-	-	-	-	-
Other VA Hospitals	-	-	-	-	-	-	-	-	-	-
Total VA Hospitals	-	-	-	-	-	-	-	-	-	-
MD/DC/VA Hospitals Total	-	-	-	-	-	-	-	-	-	-

The following example shows the Out-of-State MSGA 15-64 spread, which consisted of 1,102 discharges.

Table 75
Recaptured Discharges, MSGA 15-64
Out-of-State

	<u>Total</u>	<u>20743</u>	<u>20785</u>	<u>20774</u>	<u>20747</u>	<u>20721</u>	<u>20716</u>	<u>20773</u>	<u>20753</u>	<u>20775</u>
Current Maryland Hosp Discharges	28,641	1,565	1,546	1,319	1,429	667	619	10	9	12
Current DC Hosp Discharges	9,847	712	522	415	634	239	120	-	4	-
Current VA Hosp Discharges	1,433	51	44	57	76	26	23	4	-	-
	39,921									
Incremental DC/VA Discharge Recapture	1,102	75	55	46	69	26	14	0	0	-
Revised MD Hosp Discharges	29,743	1,640	1,602	1,365	1,499	693	633	10	9	12
Revised DC Hosp Discharges	8,885	642	471	374	572	215	109	-	4	-
Revised VA Hosp Discharges	1,293	46	40	51	69	23	21	4	-	-
	39,921									

	Pre-Recapture Market Share								
	<u>20743</u>	<u>20785</u>	<u>20774</u>	<u>20747</u>	<u>20721</u>	<u>20716</u>	<u>20773</u>	<u>20753</u>	<u>20775</u>
Prince George's Regional Medical Center	22.1%	24.0%	19.1%	18.9%	18.8%	17.4%	22.9%	21.7%	18.6%
Doctor's Community Hospital	19.9%	25.6%	20.8%	10.2%	16.9%	12.6%	0.0%	0.0%	14.6%
Southern Maryland Hospital Center	11.9%	2.3%	3.7%	22.3%	1.4%	1.7%	7.7%	39.2%	7.3%
Washington Adventist Hospital	1.1%	3.9%	1.6%	1.3%	2.6%	1.3%	0.0%	0.0%	0.0%
Laurel Regional Hospital	0.7%	1.0%	1.7%	1.1%	1.6%	2.9%	0.0%	0.0%	0.0%
Johns Hopkins Hospital	1.1%	0.9%	2.8%	1.1%	3.2%	3.9%	0.0%	0.0%	7.3%
University of Maryland Medical Center	1.4%	2.5%	2.4%	1.0%	2.5%	2.1%	0.0%	0.0%	0.0%
Holy Cross Hospital	3.5%	5.3%	4.9%	4.0%	5.0%	5.3%	7.7%	0.0%	7.3%
Howard County General Hospital	0.2%	0.1%	0.2%	0.1%	0.4%	0.3%	0.0%	0.0%	0.0%
Fort Washington Medical Center	0.7%	0.2%	0.4%	2.1%	0.1%	0.1%	0.0%	0.0%	0.0%
Anne Arundel Medical Center	1.1%	2.1%	8.9%	1.0%	11.1%	24.7%	23.1%	0.0%	36.5%
Suburban Hospital	0.9%	0.8%	1.0%	0.9%	1.2%	0.8%	7.7%	0.0%	0.0%
Shady Grove Hospital	0.2%	0.4%	0.2%	0.2%	0.3%	0.4%	0.0%	0.0%	0.0%
Montgomery General Hospital	0.0%	0.0%	0.1%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%
Other MD Hospitals	2.5%	3.8%	5.9%	2.3%	6.5%	7.7%	0.0%	7.7%	8.3%
Total MD Hospitals	67.2%	73.2%	73.7%	66.8%	71.6%	81.2%	69.2%	68.6%	100.0%
Washington Hospital Center	14.7%	12.2%	9.2%	13.8%	9.5%	8.0%	0.0%	15.7%	0.0%
Children's National Medical Center	2.1%	1.0%	2.0%	1.9%	1.9%	1.0%	0.0%	0.0%	0.0%
Providence Hospital	2.1%	2.6%	2.3%	1.9%	3.6%	1.0%	0.0%	0.0%	0.0%
Georgetown University Hospital	2.8%	1.9%	4.0%	4.1%	3.6%	2.6%	0.0%	0.0%	0.0%
George Washington University Hospital	5.2%	4.2%	2.7%	3.9%	3.8%	1.0%	0.0%	15.7%	0.0%
Other DC Hospitals	3.6%	2.8%	2.9%	4.1%	3.2%	2.1%	0.0%	0.0%	0.0%
Total DC Hospitals	30.6%	24.7%	23.2%	29.6%	25.6%	15.8%	0.0%	31.4%	0.0%
Inova Fairfax Hospital	0.5%	0.6%	1.1%	0.7%	0.6%	0.5%	30.8%	0.0%	0.0%
Inova Alexandria Hospital	0.6%	0.5%	0.6%	0.7%	0.5%	0.8%	0.0%	0.0%	0.0%
Virginia Hospital Center - Arlington	0.6%	0.4%	0.4%	0.9%	0.9%	1.3%	0.0%	0.0%	0.0%
Inova Mount Vernon Hospital	0.1%	0.2%	0.5%	0.3%	0.2%	0.0%	0.0%	0.0%	0.0%
Inova Fair Oaks Hospital	0.0%	0.2%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%
Other VA Hospitals	0.4%	0.1%	0.5%	0.8%	0.5%	0.3%	0.0%	0.0%	0.0%
Total VA Hospitals	2.2%	2.1%	3.2%	3.6%	2.8%	3.0%	30.8%	0.0%	0.0%
MD/DC/VA Hospitals Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

	Post-Recapture Market Share									
	20743	20785	20774	20747	20721	20716	20773	20753	20775	
Prince George's Regional Medical Center	25.5%	26.8%	21.9%	22.3%	21.7%	19.4%	26.1%	24.9%	18.6%	
Doctor's Community Hospital	19.9%	25.6%	20.8%	10.2%	16.9%	12.6%	0.0%	0.0%	14.6%	
Southern Maryland Hospital Center	11.9%	2.3%	3.7%	22.3%	1.4%	1.7%	7.7%	39.2%	7.3%	
Washington Adventist Hospital	1.1%	3.9%	1.6%	1.3%	2.6%	1.3%	0.0%	0.0%	0.0%	
Laurel Regional Hospital	0.7%	1.0%	1.7%	1.1%	1.6%	2.9%	0.0%	0.0%	0.0%	
Johns Hopkins Hospital	1.1%	0.9%	2.8%	1.1%	3.2%	3.9%	0.0%	0.0%	7.3%	
University of Maryland Medical Center	1.4%	2.5%	2.4%	1.0%	2.5%	2.1%	0.0%	0.0%	0.0%	
Holy Cross Hospital	3.5%	5.3%	4.9%	4.0%	5.0%	5.3%	7.7%	0.0%	7.3%	
Howard County General Hospital	0.2%	0.1%	0.2%	0.1%	0.4%	0.3%	0.0%	0.0%	0.0%	
Fort Washington Medical Center	0.7%	0.2%	0.4%	2.1%	0.1%	0.1%	0.0%	0.0%	0.0%	
Anne Arundel Medical Center	1.1%	2.1%	8.9%	1.0%	11.1%	24.7%	23.1%	0.0%	36.5%	
Suburban Hospital	0.9%	0.8%	1.0%	0.9%	1.2%	0.8%	7.7%	0.0%	0.0%	
Shady Grove Hospital	0.2%	0.4%	0.2%	0.2%	0.3%	0.4%	0.0%	0.0%	0.0%	
Montgomery General Hospital	0.0%	0.0%	0.1%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	
Other MD Hospitals	2.5%	3.8%	5.9%	2.3%	6.5%	7.7%	0.0%	7.7%	8.3%	
Total MD Hospitals	70.6%	76.0%	76.4%	70.2%	74.5%	83.1%	72.3%	71.8%	100.0%	
Washington Hospital Center	13.2%	10.9%	8.2%	12.4%	8.5%	7.1%	0.0%	14.1%	0.0%	
Children's National Medical Center	1.8%	0.9%	1.8%	1.7%	1.7%	0.9%	0.0%	0.0%	0.0%	
Providence Hospital	1.9%	2.3%	2.1%	1.7%	3.2%	0.9%	0.0%	0.0%	0.0%	
Georgetown University Hospital	2.5%	1.7%	3.6%	3.7%	3.2%	2.3%	0.0%	0.0%	0.0%	
George Washington University Hospital	4.6%	3.7%	2.4%	3.5%	3.4%	0.9%	0.0%	14.1%	0.0%	
Other DC Hospitals	3.2%	2.5%	2.6%	3.7%	2.9%	1.9%	0.0%	0.0%	0.0%	
Total DC Hospitals	27.4%	22.2%	20.8%	26.6%	23.0%	14.2%	0.0%	28.2%	0.0%	
Inova Fairfax Hospital	0.5%	0.5%	1.0%	0.7%	0.6%	0.5%	27.7%	0.0%	0.0%	
Inova Alexandria Hospital	0.5%	0.5%	0.5%	0.7%	0.5%	0.7%	0.0%	0.0%	0.0%	
Virginia Hospital Center - Arlington	0.5%	0.3%	0.4%	0.8%	0.8%	1.2%	0.0%	0.0%	0.0%	
Inova Mount Vernon Hospital	0.1%	0.2%	0.5%	0.3%	0.2%	0.0%	0.0%	0.0%	0.0%	
Inova Fair Oaks Hospital	0.0%	0.2%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	
Other VA Hospitals	0.3%	0.1%	0.5%	0.7%	0.5%	0.2%	0.0%	0.0%	0.0%	
Total VA Hospitals	2.0%	1.9%	2.9%	3.2%	2.5%	2.7%	27.7%	0.0%	0.0%	
MD/DC/VA Hospitals Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Total	20743	20785	20774	20747	20721	20716	20773	20753	20775
RECAPTURE IMPACT										
Prince George's Regional Medical Center	1,102	75	55	46	69	26	14	0	0	-
Doctor's Community Hospital	-	-	-	-	-	-	-	-	-	-
Southern Maryland Hospital Center	-	-	-	-	-	-	-	-	-	-
Washington Adventist Hospital	-	-	-	-	-	-	-	-	-	-
Laurel Regional Hospital	-	-	-	-	-	-	-	-	-	-
Johns Hopkins Hospital	-	-	-	-	-	-	-	-	-	-
University of Maryland Medical Center	-	-	-	-	-	-	-	-	-	-
Holy Cross Hospital	-	-	-	-	-	-	-	-	-	-
Howard County General Hospital	-	-	-	-	-	-	-	-	-	-
Fort Washington Medical Center	-	-	-	-	-	-	-	-	-	-
Anne Arundel Medical Center	-	-	-	-	-	-	-	-	-	-
Suburban Hospital	-	-	-	-	-	-	-	-	-	-
Shady Grove Hospital	-	-	-	-	-	-	-	-	-	-
Montgomery General Hospital	-	-	-	-	-	-	-	-	-	-
Other MD Hospitals	-	-	-	-	-	-	-	-	-	-
Total MD Hospitals	1,102	75	55	46	69	26	14	0	0	-
Washington Hospital Center	(450)	(34)	(25)	(16)	(29)	(9)	(6)	-	(0)	-
Children's National Medical Center	(55)	(5)	(2)	(4)	(4)	(2)	(1)	-	-	-
Providence Hospital	(73)	(5)	(5)	(4)	(4)	(3)	(1)	-	-	-
Georgetown University Hospital	(159)	(6)	(4)	(7)	(9)	(3)	(2)	-	-	-
George Washington University Hospital	(120)	(12)	(9)	(5)	(8)	(3)	(1)	-	(0)	-
Other DC Hospitals	(106)	(8)	(6)	(5)	(9)	(3)	(2)	-	-	-
Total DC Hospitals	(962)	(70)	(51)	(41)	(62)	(23)	(12)	-	(0)	-
Inova Fairfax Hospital	(37)	(1)	(1)	(2)	(2)	(1)	(0)	(0)	-	-
Inova Alexandria Hospital	(31)	(1)	(1)	(1)	(2)	(0)	(1)	-	-	-
Virginia Hospital Center - Arlington	(30)	(1)	(1)	(1)	(2)	(1)	(1)	-	-	-
Inova Mount Vernon Hospital	(16)	(0)	(0)	(1)	(1)	(0)	-	-	-	-
Inova Fair Oaks Hospital	(7)	(0)	(0)	(0)	(0)	-	(0)	-	-	-
Other VA Hospitals	(18)	(1)	(0)	(1)	(2)	(0)	(0)	-	-	-
Total VA Hospitals	(140)	(5)	(4)	(6)	(7)	(3)	(2)	(0)	-	-
MD/DC/VA Hospitals Total	-	-	-	-	-	-	-	-	-	-

Combining the impact of changes in population, use rates, relocation, and recapture, the 8,319 discharges experienced in FY2013 by PGHC in its service area are expected to grow to 12,335 by FY2022 in PGRMC's service area.

- 512 of the growth in discharges is related to population growth, net of use rate reductions
- 222 of the growth in discharges is related to the relocation of the hospital
- 3,282 of the growth in discharges relate to the recapture of market share

A summary of the impact that the population growth, net of use rate reductions, as well as relocation and recapture of market share by PGRMC is expected to have on other hospitals serving the residents of Prince George's County is presented below.

Table 76
Impact of Population Growth & Relocation and Recapture of Market Share

Hospital	FY13 Largo Service Area Discharges	Population/Use Rate Adjustment	FY22 Largo Service Area Discharges (pre-relocation)	Relocation/Methodology Adjustment, Including Proximity Adj.	FY22 Largo Service Area Discharges (post-relocation)	Additional Recapture Adjustment	FY22 Largo Service Area Discharges (post-relocation, post-recapture)	Total Change
Prince George's Regional Medical Center	8,319	512	8,831	222	9,053	3,282	12,335	4,016
Doctor's Community Hospital	9,552	1,314	10,866	117	10,983	(224)	10,759	1,207
Southern Maryland Hospital Center	12,127	1,543	13,670	(309)	13,361	(234)	13,127	1,000
Washington Adventist Hospital	3,509	409	3,918	189	4,108	(70)	4,038	529
Laurel Regional Hospital	3,326	258	3,584	10	3,594	(58)	3,536	210
Johns Hopkins Hospital	1,503	64	1,567	(30)	1,537	(28)	1,509	6
University of Maryland Medical Center	1,117	52	1,169	(9)	1,160	(23)	1,137	20
Holy Cross Hospital	5,535	287	5,822	49	5,871	(114)	5,757	222
Howard County General Hospital	701	44	745	(5)	741	(13)	728	27
Fort Washington Medical Center	1,784	311	2,095	4	2,099	(37)	2,062	278
Anne Arundel Medical Center	4,335	508	4,843	(333)	4,510	(87)	4,423	88
Suburban Hospital	762	102	864	(4)	860	(16)	844	82
Shady Grove Hospital	311	14	325	0	325	(6)	319	8
Montgomery General Hospital	185	12	197	(1)	196	(3)	193	8
Other MD Hospitals	8,445	741	9,186	0	9,186	(159)	9,027	582
Total MD Hospitals	61,511	6,173	67,684	(101)	67,583	2,210	69,793	8,282
Total MD Hospitals (Excluding PGRMC)	53,192	5,661	58,853	(322)	58,530	(1,072)	57,458	4,266
Washington Hospital Center	8,642	909	9,551	23	9,574	(1,017)	8,557	(85)
Children's National Medical Center	3,506	(232)	3,274	6	3,280	(61)	3,219	(287)
Providence Hospital	1,786	104	1,890	107	1,997	(198)	1,799	13
Georgetown University Hospital	2,684	218	2,902	(54)	2,849	(295)	2,554	(130)
George Washington University Hospital	1,896	79	1,975	14	1,989	(199)	1,790	(106)
Other DC Hospitals	1,774	57	1,831	0	1,831	(178)	1,653	(121)
Total DC Hospitals	20,288	1,135	21,423	97	21,520	(1,947)	19,572	(716)
Inova Fairfax Hospital	639	16	655	(1)	654	(61)	593	(46)
Inova Alexandria Hospital	604	13	617	5	622	(61)	561	(43)
Virginia Hospital Center - Arlington	541	25	566	0	567	(56)	511	(30)
Inova Mount Vernon Hospital	315	48	363	(0)	363	(38)	324	9
Inova Fair Oaks Hospital	81	1	82	0	82	(9)	73	(8)
Other VA Hospitals	358	31	389	0	389	(38)	352	(6)
Total VA Hospitals	2,538	134	2,672	4	2,676	(263)	2,414	(124)
Total	84,337	7,442	91,778	(0)	91,778	0	91,778	0

Table 77 shows a summary of the impact that PGRMC's market share recapture of 3,282 discharges is expected to have on other hospitals, by state.

Table 77
PGRMC Market Share Recapture Impact on Other Hospitals
2022

Estimated Impact on Maryland Hospital Discharges			Estimated Impact on Non-Maryland Hospital Discharges		
Hospital	Change in Discharges	2013 Discharges	Hospital	Change in Discharges	2013 Discharges
Southern Maryland Hospital Center	(234)	12,127	Washington Hospital Center	(1,017)	8,642
Doctor's Community Hospital	(224)	9,552	Georgetown University Hospital	(295)	2,684
Holy Cross Hospital	(114)	5,535	George Washington University Hospital	(199)	1,896
Anne Arundel Medical Center	(87)	4,335	Providence Hospital	(198)	1,786
Washington Adventist Hospital	(70)	3,509	Children's National Medical Center	(61)	3,506
Laurel Regional Hospital	(58)	3,326	Other DC Hospitals	(178)	1,774
Fort Washington Medical Center	(37)	1,784	Recapture Impact on DC Hospitals	(1,947)	
Johns Hopkins Hospital	(28)	1,503	Inova Fairfax Hospital	(61)	639
University of Maryland Medical Center	(23)	1,117	Inova Alexandria Hospital	(61)	604
Suburban Hospital	(16)	762	Virginia Hospital Center - Arlington	(56)	541
Howard County General Hospital	(13)	701	Inova Mount Vernon Hospital	(38)	315
Shady Grove Hospital	(6)	311	Inova Fair Oaks Hospital	(9)	81
Montgomery General Hospital	(3)	185	Other VA Hospitals	(38)	358
Other MD Hospitals	(159)		Recapture Impact on VA Hospitals	(263)	
Recapture Impact on MD Hospitals	(1,072)		Total Impact on Non-MD Hospitals	(2,210)	

Impact on Maryland Hospitals

As the inpatient utilization of Maryland hospitals is reduced, the inpatient revenue at these hospitals will be proportionately reduced. This reduction in revenue is expected to be limited to a 50% reduction in each hospital's GBR or TPR revenue in relation to the specific service line that is affected. This reduction is expected to occur in the year following the change in volumes as a market share adjustment

Any reduction in volumes and related revenue at Maryland hospitals is expected to be partially offset by a reduction in variable expenses. Applying an assumption of 50% variability of expenses with changes in volumes suggests that for every 1% reduction in volumes, the 0.5% reduction in revenue will be offset by a 0.5% reduction in variable expenses.

Impact on Out of State Hospitals and Medicare

As demonstrated in Table 77, 1,947 admissions are projected to be recaptured from the District of Columbia and 263 from Virginia. Applying Dimensions' approved FY 2013 charge per case of \$14,029 would result in gross revenue of approximately \$31 million in current dollars. Outside of Maryland, hospitals negotiate their own rates with payers, thus we are not able to estimate the current net patient revenue associated with specific hospitals in the District of Columbia or Virginia.

Medicare would pay more in Maryland than it would under the national payment system (PPS and OPPS). While no recent computations have been developed, based on analyses done a few years ago, the Medicare inpatient payment difference was approximately 21%.

Although payment levels outside the State of Maryland are difficult to estimate, Dimensions has analyzed both AHA published national payment levels as well as previous studies prepared in the State of Maryland comparing regulated vs. national payment levels. Commercial payers nationally (and assumed to be the same in the District) pay approximately 135% of cost. In Maryland, under the HSCRC, Dimensions estimates that commercial payers pay between 110% and 115% of costs. Under these assumptions, commercial payers are likely paying 20% less in Maryland.

Impact on Other Providers and the Health Care System

The proposed project will have positive effects on the health care system as a whole.

- The project will address and resolve considerable deficiencies in the current site. (See Project Description)
- Dimensions believes that the project will assist Dimensions in recruiting and retaining physicians, which is a challenge in PGHC's current service area.
- The existing PGHC has 73 semi-private rooms. (See Exh. 1, MHCC Table A, Physical Bed Chart) The new PGRMC will have all private rooms, which will produce higher occupancy rates than are achievable with semi-private rooms. Private rooms also enhance patient satisfaction and family involvement, reduce the risk of infection, and reduce the need for transfers due to patient incompatibility.

Impact on Costs

Under the PGRMC's Global Budget Revenue, revenue is relatively fixed. The expected growth in volumes from 2020 to 2022 will drive a reduction in unit costs and related HSCRC unit rates.

MWPH

As discussed previously, the MWPH unit at PGHC is a statewide resource. MWPH's patients live in all regions of Maryland. MWPG at PGHC provides a more geographically proximate alternative for patients' families than being admitted to MWPH in Baltimore City and PGHC improves access for many of these families.

AFFIRMATIONS

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Modified CON Application and its exhibits are true and correct to the best of my knowledge, information, and belief.

12/31/2014

Date

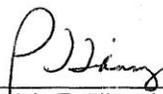
K. Singh Taneja

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

#481235
013346-0001

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Modified CON Application and its exhibits are true and correct to the best of my knowledge, information, and belief.

1/5/2015
Date

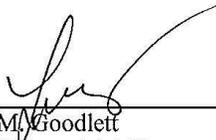


Patricia T. Tihansky
Director, Strategic Planning & Analysis
Dimensions Health Corporation

#481233
013346-0001

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Modified CON Application and its exhibits are true and correct to the best of my knowledge, information, and belief.

1/5/15
Date



Lisa M. Goodlett
Chief Financial Officer
Dimensions Health Corporation

#481236
013346-0001

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Modified CON Application and its exhibits are true and correct to the best of my knowledge, information, and belief.

1/5/14

Date

Mary Miller

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

#480776

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Modified CON Application and its exhibits are true and correct to the best of my knowledge, information, and belief.

January 5, 2015

Date



Craig Moskowitz
Wilmot Sanz, Inc.

#516937
013346-0001



January 7, 2015

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Prince George's Hospital Center
CON Application for a Replacement Hospital

To whom it may concern:

I hereby declare and affirm under the penalties of perjury that the facts stated in the portions of Co-Applicants' Modified CON Application and its exhibits specified below are true and correct to the best of my knowledge, information, and belief:

1. Discussion of HOK Benchmarks related to the Proposed Project Size and Relevant Benchmark Comparisons (Exhibit to Project Description);
2. Existing Facility Assessment contained in the Response to Standard .04B(5) (Cost-Effectiveness);
3. The Concept Plan for Option 2 in the Response to Standard .04B(5) (Cost-Effectiveness);
4. The Design Team Recommendation as to Current PGHC Site Options in the Response to Standard .04B(5) (Cost-Effectiveness); and
5. Response to Standard .04B(12) (Patient Safety).

If you have any questions, you may contact me directly.

Regards,

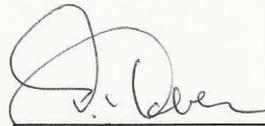
HOK

A handwritten signature in black ink, appearing to read 'Raymond A. Moldenhauer', with a long horizontal flourish extending to the right.

Raymond A. Moldenhauer, AIA
Regional Leader, Healthcare

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Modified CON Application and its exhibits are true and correct to the best of my knowledge, information, and belief.

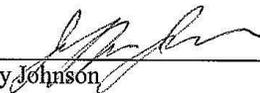
1/6/15
Date


Terri Haber
Cardiovascular Program Development
Consultant
Haber Consulting, LLC

#486238
013346-0001

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Modified CON Application and its exhibits are true and correct to the best of my knowledge, information, and belief.

11/7/15
Date



Jeffrey Johnson
Consultant

#481237
013346-0001

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Modified CON Application and its exhibits are true and correct to the best of my knowledge, information, and belief.

11/1/15
Date


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

#481240
013346-0001

TABLE OF EXHIBITS

Exhibit	<u>Description</u>
1	MHCC Tables
2	Project Drawings
3	"The Hospital Prince George's Deserves," <i>Washington Post</i> Editorial, August 25, 2013
4	Zip Codes within PGHC's current primary and secondary service
5	Summary of the Challenges and Deficits of Current PGHC Facility
6	Memorandum of Understanding dated 7/21/11 among Dimensions, Prince George's County, University of Maryland Medical System Corporation, University System of Maryland, and the State of Maryland
7	"Transforming Health in Prince George's County, Maryland: A Public Health Impact Study" (2012)
8	The University of Maryland Medical System
9	Projected Primary and Secondary Service Area for New PGRMC for MSGA Patients
10	CR-92-2014 designating Largo Town Center Metro Development District
11	MWPH: History and Relationship with PGHC
12	Supplemental Statement Regarding Project Size and Cost with Exhibits
13	Prince George's County Zoning Code—Division 3—Uses Permitted
14	Prince George's County approved capital improvement program FY2014-FY2019
15	Maryland FY2014 & FY2015 capital budgets and five-year capital improvement programs (excerpts)
16	Report on Fiscal 2015 State Operating Budget (excerpt)
17	Policy for Provision of Information to the Public Concerning Charges
18	List of Representative Services and Charges from Hospital Website
19	Financial Assistance Policy
20	Photograph of Hospital's notice of charity care
21	Newspaper Ad copy for Charity Care Policy
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23	Quality Measures Identified as Below Average on MHCC Quality Care Data Website as of 12/23/14
24	Freeway 2012 documentation
25	Sg2 Analytics Frequently Asked Questions
26	Cardiovascular Services Business Plan Executive Summary and Market Assessment
27	Reasonableness of Charges Report (Spring 2011)
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44	Clinical Pathway for Cardiac Surgery
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