EXHIBIT 23

Certificate of Need Data Request – Prince George's Hospital Center

Quality Measures identified as below average on the Maryland Health Care Commission Quality Data Website as of 12/23/14

Metric	Performance Improvement Action Plan	10/1/12-9/30/13 Baseline	10/1/13-9/30/14	10/1/14–12/31/14	12/31/14	Goal
Emergency Room Patients:						
A. How long patients spend in the emergency department before leaving for their hospital room.	1. Ensure the ED flow data abstracted by the Quality management Dept. (QMD) is accurate by conducting an inter-rater reliability study. 2. Establish a multidisciplinary work group with the ED physicians and nursing to identify areas of opportunity and action plans to decrease through-put times. 3. Implement the action plans agreed upon. 4. Establish a report card with key metrics related to ED flow and present/discuss with members of the organizational performance improvement committee each quarter. 5. Modify action plans as needed if results do not improve.	597.63 minutes	630.73 minutes	725.44 minutes	634.89 minutes	**Goal = < 355 min** Hospital Compare Inpatient Preview Report: Third Quarter 2012 through Second Quarter 2013 Discharges
B. How long patients in the emergency department after the doctor decided the patient would stay in the hospital before leaving for their hospital room.		360.76 minutes	387.80 minutes	470.79 minutes	413.31 minutes	**Goal = < 144 min** Hospital Compare Inpatient Preview Report: Third Quarter 2012 through Second Quarter 2013 Discharges
Heart Attack Patients:						
A. Heart attack patients given procedure to open blood vessels within 90 minutes of getting to the hospital.	1. Ensure the heart attack data abstracted by the Quality management Dept. (QMD) is accurate by conducting an inter-rater reliability study. 2. Establish a multidisciplinary work group to identify areas of opportunity and action plans to decrease time taken to open blood vessels. 3. Implement the action plans agreed upon. 4. Establish a report card with key metrics related to this measure and present/discuss with members of the organizational performance improvement committee each quarter. 5. Modify action plans as needed if results do not improve. ***(Eliminated as a Core Measure by MHCC as of 1/1/15)***	56% com-pliance	64%	72.7%	100%	MD: 94% Nat: 96%
B. Heart attack patients given a prescription for a Statin at discharge		96.5% com-pliance	97.9%	98.1%	93.3%	MD: 99% Nat: 98%

Metric	Performance Improvement Action Plan	10/1/12-9/30/13 Baseline	10/1/13-9/30/14	10/1/14–12/31/14	12/31/14	Goal
Heart Failure Patients:						
A. Heart failure patients are given instructions to follow up care before leaving the hospital.	Compliance with this measure improved the year following the baseline data reported. Therefore, an action plan will not be implemented for this measure. ***(Eliminated as a Core Measure by MHCC as of 1/1/14)***	82.25 (per 1,000) com-pliance from 10/1–12/31/12	100%	No data available	No data available	MD: 92% Nat: 95%
B. Heart failure patients receive a test of how well the heart is able to pump blood	1. Ensure the heart failure data abstracted by the Quality management Dept. (QMD) is accurate by conducting an inter-rater reliability study. 2. Establish a multidisciplinary work group to identify areas of opportunity and action plans to increase the number of patients with heart failure who receive a test of how well the heart is able to pump blood. 3. Implement the action plans agreed upon. 4. Establish a report card with key metrics related to this measure and present/discuss with members of the organizational performance improvement committee each quarter. 5. Modify action plans as needed if results do not improve. ***(Eliminated as a Core Measure by MHCC as of 1/1/15)***	98.6% complian ce	98.6%	95%	100%	MD: 99% Nat: 99%
C. Heart failure patients given medicine to make the heart work better.	1. Ensure the heart failure data abstracted by the Quality management Dept. (QMD) is accurate by conducting an inter-rater reliability study. 2. Establish a multidisciplinary work group to identify areas of opportunity and action plans to increase the number of heart failure patients given medicine to make the heart work 3. Implement the action plans agreed upon. 4. Establish a report card with key metrics related to this measure and present/discuss with members of the organizational performance improvement committee each quarter. 5. Modify action plans as needed if results do not improve. ***(Eliminated as a Core Measure by MHCC as of 1/1/14)***	92.03% com-pliance from 10/1–12/31/12	100%	No data available	No data available	MD: 97% Nat: 97%

Metric	Performance Improvement Action Plan	10/1/12-9/30/13 Baseline	10/1/13-9/30/14	10/1/14–12/31/14	12/31/14	Goal
Complications:						
A. How often patients die in the hospital because of a serious condition that was not identified and treated *by nursing.*	• Evaluate the current auditing process for deaths within the hospital and include any issues identified in the Senior Patient Safety Committee. • Complete root cause analysis as needed to decrease frequency of patient deaths caused by unexpected serious illness.	84.25%	No data available	No data available	No data available	Data is generated by CMS. More recent data is not available from CMS.
Pneumonia:						
A. Pneumonia patients who had a blood test done when they go to the emergency room before they got antibiotics	1. Ensure the pneumonia data abstracted by the Quality management Dept. (QMD) is accurate by conducting an inter-rater reliability study. 2. Establish a multidisciplinary work group to identify areas of opportunity and action plans to increase the number of pneumonia patients who had a blood test done when they go to the emergency room before they got antibiotics. 3. Implement the action plans agreed upon. 4. Establish a report card with key metrics related to this measure and present/discuss with members of the organizational performance improvement committee each quarter. 5. Modify action plans as needed if results do not improve. ***(Eliminated as a Core Measure by MHCC as of 1/1/14)***	93.65% com-pliance from 10/1–12/31/22	80%	No data available	No data available	MD: 97% Nat: 97%
B. The right antibiotics were given for pneumonia patients	Use the pneumonia work group and method to improve the compliance to use the right antibiotic	94.20% com-pliance	91.9%	92.3%	100%	MD: 97% Nat: 96%
Immunizations						
A. Patients in the hospital who got the flu vaccine	1. The QMD in collaboration with the nursing department staff have begun to monitor all patients who are in the hospital every day to make sure they are offered and given the flu vaccine from October – March. 2. When the immunization has not been offered on the day of admission, the QMD sends correspondence to the nurse leader for each unit with patients who still require the immunization. 3. The nursing leader follows-up and advises their CNO of the completion.	87.03% com-pliance	69.29%	89.03%	96.61%	MD target 100%
B. Patients in the hospital who got the pneumonia vaccine	Use the same method to improve the compliance with the pneumonia vaccine as is used for the influenza vaccine.	82.42% com-pliance	81.41%	N/A	N/A	There is no data in the Hospital Compare website on this measure.

Metric	Performance Improvement Action Plan	10/1/12-9/30/13 Baseline	10/1/13-9/30/14	10/1/14–12/31/14	12/31/14	Goal
Surgical Patient Safety						
A. How often patients die in the hospital because of a serious condition that was not identified or treated.	• Evaluate the current auditing process for deaths within the hospital and include any issues identified in the Senior Patient Safety Committee. • Complete root cause analyses as needed to decrease frequency of Patient deaths caused by unexpected complications from surgery	84.25% com-pliance	No data available	No data available	No data available	Data is generated by CMS. More recent data is not available from CMS.
B. Antibiotics were stopped within 24 hours after surgery	1. Ensure the surgical measure data abstracted by the Quality management Dept. (QMD) is accurate by conducting an inter-rater reliability study. 2. Establish a multidisciplinary work group to identify areas of opportunity and action plans to improve all of the surgical measure outcomes. 3. Implement the action plans agreed upon. 4. Establish a report card with key metrics related to this measure and present/discuss with members of the organizational performance improvement committee each quarter. 5. Modify action plans as needed if results do not improve. ***(Eliminated as a Core Measure by MHCC as of 1/1/14 & 1/1/15)***	89.61% complian ce	87.17%	94.44%	100%	MD: 98% Nat: 99%
C. Surgery patients have their catheter removed within the first or second day after surgery.		92.24% com-pliance	86.36%	88%	100%	
D. Blood sugar level controlled after heart surgery		71.43% com-pliance	100%	100%	100%	
E. Prevent low body temp during and after surgery		96.88% com-pliance	97.82%	N/A	N/A	
F. Medicine to lower blood pressure given		83.33% com-pliance	86.11%	92.85%	100%	MD: 98% Nat: 99%
G. Antibiotics given one hour before surgery		89.16% com-pliance	96.25%	100%	100%	
H. Right antibiotic given		82.93% com-pliance	92.3%	95.45%	100%	
I. Surgery patients prescribed treatment to prevent blood clots at the right time		84.42% com-pliance	94.92%	100%	100%	

Note:

- A number of Core Measures were eliminated by MHCC either in 1/14 or 1/15. PGHC's performance continues to be below expected levels for the organization. PGHC will continue to gather data related to these measures to improve performance. The performance improvement will continue until the Maryland average is reached.
- The goals have been established by the Hospital Compare Report available on the Maryland.Gov website. The is the official US government site for Medicare.