STATE OF MARYLAND

MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

May 26, 2016

By E-Mail and USPS

Thomas C. Dame, Esquire
Ella R. Aiken, Esquire
Gallagher, Evelius & Jones LLP
218 North Charles Street, Suite 400
Baltimore, Maryland 21201

Re: Clarification re Project Status Conference Recommendations
Dimensions Health Corporation d/b/a Prince George's Hospital Center
Mt. Washington Pediatric Hospital, Inc.
Docket No. 13-16-2351

Dear Mr. Dame and Ms. Aiken:

Thank you for your letter of May 23. I was pleased to learn that the applicants, Dimensions Health Corporation ("Dimensions") d/b/a Prince George's Hospital Center ("PGHC") and Mount Washington Pediatric Hospital, Inc., decided to modify their application as I recommended at the project status conference held on May 17. As I noted then, I believe that a modern medical center is a key element in a strategic plan to improve the health status of the residents of Prince George's County. I will provide the further clarifications that you seek, but also believe it is necessary that I address some apparent misconceptions held by the applicants.

I want to assure you that the applicants are not correct in their conclusion that my "concern about size and cost seems to be that the proposed PGRMC appears not to compare favorably with the recently approved relocation of Washington Adventist Hospital …." As I noted at the project status conference, the critical problem with the proposed Prince George's Regional Medical Center ("PGRMC") is that it is too large. While I found the disparity in the size of the proposed hospital and the recently approved replacement Washington Adventist Hospital to be remarkable, I also explained the basis of my conclusion that the proposed PGRMC is too large and, thus, too costly. As I stated in my document that was distributed at the project status conference:

> I have also examined other new and replacement hospital projects in Maryland developed in the last six years and made comparisons with the proposed project,

adjusting for differences in those projects and the PGHC replacement in order to make the comparisons fair and meaningful.

In my comparison of these fairly recent Commission decisions regarding replacement and new hospital projects, I made appropriate adjustments to get as close as possible to an apples-to-apples comparison. Since every situation is different, arriving at a perfect comparison is not possible. In this case, to make reasonable comparisons, I excluded space that is unique to the proposed Prince George's Regional Medical Center – space related to medical education and space for the cancer center. I also adjusted the square footage figures of the comparison group hospitals where necessary by adding space, e.g., to account for leased space outside the hospital that would continue to be used for hospital functions (Meritus and Western Maryland) or to account for the "missing" central utility plant space at Washington Adventist Hospital.

I will now address your specific questions.

Q1. You recommend that the estimated "construction cost of the hospital" should not exceed $225 million. We assume that the expense items included in "construction cost of the hospital" on Table E (Exhibit 50) are the expenses for "Building" and "Fixed Equipment" (lines A.1.b(1) and(2)). Please confirm that our understanding is correct. Also, if the "Movable Equipment" associated with the CUP is reclassified as "Fixed Equipment," as you suggest, do you expect the amount ($32,496,000) to be included as part of the recommended $225 million budget for the construction cost of the hospital?

My recommended target of $225 million in construction cost is for the building only. Thus, the reclassification of the equipment associated with the Central Utility Plant ("CUP") will not be counted against the construction cost target I have provided.

Q2. As noted above, the projected cost of complying with prevailing wage and Minority Enterprise requirements will be approximately 15% of the construction cost. Given that the WAH project, which you used as a comparison, was not subject to these requirements, would you consider increasing your recommended costs by 15%?

I arrived at the target of $225 million for building construction cost by using Dimensions' estimated construction cost per square foot multiplied by my recommended square footage adjustment. I note that Dimensions' calculation of building construction cost[1] included, as an "extraordinary cost," its estimate of the additional cost of complying with the State's and Prince George's County's prevailing wage requirement.

[1]This was shown in the Marshall Valuation Service cost comparison provided in the January 2015 replacement application.

Q3. You recommend that the bed capacity of the proposed hospital should not exceed 219 inpatient beds, including 204 general acute care beds and 15 special hospital – pediatric beds. You also recommend that the applicants reduce the MSGA bed count by eleven beds and the obstetric bed count by three beds. However, as shown below, these recommendations result in a bed count of 202 general acute care beds.

	Applicant's CON Proposal	Recommended Reduction	Resulting Bed Count
MSGA	165	-11	154
Obstetrics	22	-3	19
Psychiatric	28	N/A	28
Pediatric	1	N/A	1
TOTALS	216	-14	202

Please clarify the recommended bed count of general acute care beds; it seems the recommendation should be for a reduction of nine, not eleven, MSGA beds, especially since Dimensions intends to eliminate inpatient capacity at Laurel Regional Hospital prior to the opening of the proposed PGRMC.

The reduction that I recommend, 11 MSGA beds and three obstetric beds, is correct. I regret the typographical error. The target total acute care bed capacity should have been stated as no more than 202 acute care beds. Thus, my recommendation is that the bed capacity of the proposed hospital should be no more than 217 beds (202 general acute care beds and 15 special hospital-pediatric beds).

Q4. Table A in the pending application (Exhibit 50) erroneously shows that the proposed facility will include 20 observation beds. In fact, the application and the project drawings describe and depict 24 observation beds: 20 beds in the proposed Clinical Decision Unit and 4 beds within the Pediatric Emergency Department. See Modified Application at pp. 26, 86, and 90. The applicants intend to modify Table A to reflect the additional four beds that were inadvertently omitted in Table A. In light of this correction, will the amount of your recommended project cost increase? If so, what is the revised recommended hospital construction cost and total project cost?

I differentiated the four pediatric observation beds in the Emergency Department from the 20-bed observation unit because these beds are essentially ED treatment spaces (included in the applicant's proposed count of 52 ED treatment spaces) and only have a secondary use as observation beds. Thus, I conclude that the correct bed inventory count for purposes of calculating the new spending target for the project should only include the 20-bed adult observation unit. This means that the full bed inventory count used in

developing my spending targets declines from 239 beds (204 general care beds + 15 special hospital beds + 20 observation beds) to 237 beds (202 general hospital beds + 15 special hospital beds + 20 observation beds). Despite this, I will not make a downward adjustment in the targets outlined in my May 17, 2016 handout because of this small discrepancy. The building construction cost should not exceed $225 million and the total project cost should not exceed $543 million.

I also want to clarify that this total project cost target of $543 million does not include the land valuation that was included in the official project budget estimate, since this is not an expense that the applicant will make for this project, given that the land has been donated to Dimensions.

In closing, I want to emphasize something that I stated at the project status conference. I conclude that meaningful reduction in the amount of building space for the proposed PGRMC and the resulting smaller project expenditure will permit the development of a modern regional medical center in Largo that has the necessary service capacity and an ability to play a major role in supporting and revitalizing the health care system in Prince George's County. I believe that my recommendations will result in a hospital that has a much greater opportunity both to recover from its current unfavorable pricing position and to achieve a stable financial future. While I have outlined bed and other capacity reductions that I believe are reasonable components of a needed reduction in project scope, I note that these are important but secondary considerations if the modified application filed no later than August 31, 2016 achieves a redesign that meets my recommended cost targets.

I want to remind all parties again that this is a contested case and that the *ex parte* prohibitions in the Administrative Procedure Act, Maryland Code Ann., State Gov't §10-219, apply to this proceeding until the Commission issues a final decision.

Sincerely,

Robert E. Moffit
Commissioner/Reviewer

cc: Jonathan Montgomery, Esquire
Peter P. Parvis, Esquire
Jennifer J. Coyne, Esquire
Pamela Creekmur, R.N., Prince George's County Health Officer

Donna Kinzer, Executive Director, HSCRC
Ben Steffen, Executive Director, MHCC
Paul Parker
Kevin McDonald
Suellen Wideman, AAG