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August 31, 2016

VIA HAND DELIVERY

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

Re: CON Application - Prince George's Regional Medical Center
As a Replacement and Relocation of Prince George's Hospital Center
No. 13-16-2351

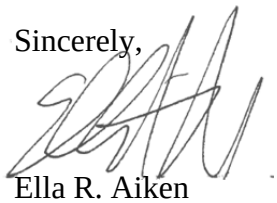
Dear Ms. Potter:

On behalf of Prince George's Regional Medical Center, enclosed are six copies of its Modification in Response to May 17, 2016 Project Status Conference in the above-referenced matter, along with two full-size sets of project drawings. Also enclosed is a CD containing searchable PDFs of the filing, Word versions of the document and available exhibits, and native Excel spreadsheets of the MHCC tables.

I hereby certify that a copy of this submission has also been forwarded to the appropriate local health planning agencies as noted below.

Thank you for your assistance.

Sincerely,



Ella R. Aiken

ERA:blr
Enclosures
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Kevin McDonald, Chief, Certificate of Need
Suellen Wideman, Esq., Assistant Attorney General, Maryland Health Care Commission
Pamela B. Creekmur, Health Officer, Prince George's County
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IN THE MARYLAND HEALTH CARE COMMISSION

Modification in Response to
May 17, 2016 Project Status Conference

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.
August 31, 2016

No. 13-16-2351

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Dimensions Health Corporation *d/b/a* Prince George's Hospital Center and Mount Washington Pediatric Hospital, Inc.
Relocation of a General Acute Care Hospital and a Special Hospital-Pediatric
Matter No. 13-16-2351

Modification in Response to May 17, 2016 Project Status Conference

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Dimensions Health Corporation d/b/a Prince George's Hospital Center ("Dimensions") and Mount Washington Pediatric Hospital, Inc. ("MWPH," together with Dimensions, the "Applicants"), by their undersigned counsel, pursuant to COMAR §10.24.01.08.E(2) and in response to the Reviewer's requests and recommendations at the May 17, 2016 Project Status Conference, (i) make modifications to their Application for a Certificate of Need for the Relocation of a General Acute Care Hospital and a Special Hospital-Pediatric; and (ii) provide the additional information requested.

I. INTRODUCTION

For far too long the health care delivery system in Prince George's County has been inadequate to meet the considerable health care needs of the County's residents. County residents suffer from higher rates of chronic diseases, including diabetes, heart disease, hypertension, asthma, and cancer, than those residing in neighboring jurisdictions. Today, most County residents seek inpatient care outside the County, and they have few local opportunities for primary health care services relative to the residents of neighboring jurisdictions. Prince George's Hospital Center ("PGHC"), originally a County owned and operated hospital, has struggled to address the health care needs of the County, and it has faced its own daunting financial challenges for a number of years.

More than five years ago, the State of Maryland, Prince George's County, Dimensions, the University of Maryland Medical System Corporation ("UMMS"), and the University System of Maryland ("USM") came together to meaningfully address the health care problems of Prince George's County by entering a Memorandum of Understanding dated July 21, 2011, which set

forth a comprehensive plan to strengthen the state of health care in the County, increase access to primary care, and enhance the County's overall health infrastructure.

This proposed project, Prince George's Regional Medical Center ("PGRMC"), is the centerpiece of the collaboration of the State, the County, Dimensions, UMMS, and USM. PGRMC will replace PGHC in a more accessible location, and it will preserve all of the critically important clinical programs provided today at PGHC, including, among many others, a high-quality cardiac surgery program, a Level II regional trauma center, and a neonatal intensive care unit (NICU). However, PGRMC will not merely be the replacement hospital for the aging PGHC. It will serve as the center of a comprehensive strategy to transform the health care delivery system in Prince George's County, including initiatives to expand the ambulatory care network in the County. As explained below, Dimensions, including PGRMC, will become a wholly-owned affiliate of UMMS prior to the opening of PGRMC. Thus, PGRMC will be owned and operated by one of the strongest and highest quality health care systems in the State. Through its medical education programs and its affiliation with UMMS and University of Maryland School of Medicine, PGRMC will be a magnet to recruit and retain needed physicians for the County. At long last, the residents of Prince George's County will have the health care delivery system they need and deserve.

During the May 17, 2016 Project Status Conference, the Reviewer recognized that "a modern hospital is a crucial variable" to developing a "revitalized health care system" in the County. However, the Reviewer also shared concerns about several aspects of the proposed project, as expressed by the Reviewer during the Conference and in a written report issued the same day. This modification is submitted in response to the Reviewer's concerns, most of which were focused on the size and the cost of the proposed project. The Reviewer made a number of modification recommendations and posed several questions, which are restated in the headings below. In a May 26, 2016 letter responding to Dimensions' request for clarification

regarding some of the recommendations, the Reviewer emphasized that the capacity and size recommendations were important but secondary considerations to achieving the recommended cost targets.

While Dimensions does not agree with some of the Reviewer's recommendations, this modification largely complies with the recommendations so that the proposed project may be approved and built as soon as possible. The residents of Prince George's County have waited too long already for a strong, high-quality health care system. Further delay would not be warranted because Dimensions and UMMS are confident that the Reviewer's recommendations compromise neither their ability to serve the health care needs of Prince George's County nor the transformational quality of the proposed project.

Table 83[1], below, summarizes Applicants' responses to the recommendations regarding the size and cost of the proposed project.

Table 83
Summary of Size and Cost Changes

	January 16, 2015 Modified Application (with pre-docketing changes)	**Recommended Modifications, May 17, 2016 Project Status Conference**	**Applicants' Modifications to Project**
Construction Costs Table E, line A.1.b(1)	$284,744,090	$225 million	$225 million
Total Project Cost (excluding land donation)	$639,055,000	$543 million	$543 million
Square Feet per Bed (excluding 27,000 SF for Cancer Center, Res./Fac.)	2,987 sq. feet per bed (per Reviewer's Report)	2,400 sq. feet per bed	2,370 sq. feet per bed
Operating Rooms (OR)	9 ORs plus 1 unfinished	8 ORs	8 ORs

[1] Exhibits and tables are numbered to continue from prior CON application submissions in this review. Table 83 is the first table and Exhibit 62 is the first exhibit referenced in this document.

	January 16, 2015 Modified Application (with pre-docketing changes)	Recommended Modifications, May 17, 2016 Project Status Conference	Applicants' Modifications to Project
ED Treatment Bays	52 Bays	45 Bays	45 Bays
Beds by Service Line (Dimensions only)	MSGA 133 ICU 32 Pysch 28 OB 22 Peds 1 **Total 216**	MSGA 122 ICU Not addressed Pysch Not addressed OB 19 Peds Not addressed **Total 202**	MSGA 122 ICU 32 Pysch 28 OB 22 Peds 1 **Total 205**

II. Revised Form MHCC Tables and Project Drawings

A. MHCC Form Tables

Applicants have modified all form tables, attached as Exhibits 62 and 63, consistent with the project changes described in this submission and based on a revised opening date of July 1, 2020. Exhibit 62 includes the tables for PGRMC, and Exhibit 63 includes the tables for MWPH.

B. Project Drawings

Applicants have revised the project drawings to address the Reviewer's recommendations. Revised project drawings are attached as Exhibit 64.

III. Responses to Recommended Project Modifications and Requests for Information

1. Recommended Changes Regarding Size and Cost

Reduce the size, bed capacity, and other service capacities to reduce the estimated cost of the replacement hospital. The space constructed should be no more than 2,400 gross square feet per bed (exclusive of the space identified by Dimensions for "resident/faculty" space and the cancer center space). The bed capacity of the proposed hospital should be no more than 219 beds (204 general acute care beds and 15 special hospital-pediatric beds). The estimated construction cost of the hospital should be no more than $225 million and the total project cost estimate should be no more than $543 million.

- In reducing the bed capacity of the replacement hospital, reduce MSGA bed capacity by at least 11 beds and obstetric bed capacity by at least three beds.

- In reducing the service capacity of the replacement hospital, reduce the number of finished operating rooms by at least one operating room (OR), eliminate the unfinished OR, and reduce the 10-OR suite to an 8-OR suite.

- In reducing the service capacity of the replacement hospital, reduce the number of Emergency Department treatment spaces to no more than 45 spaces and bring the size of the ED in line with this treatment capacity, consistent with American College of Emergency Physicians (ACEP) guidelines that are incorporated by reference in the SHP.

While Dimensions proposed a reduction in pediatric beds, it is also seeking to add a pediatric clinical decision unit/observation bed capability, as part of its ED, with one licensed bed. PGHC has recently proposed elimination of pediatric services as a distinct inpatient service line specifically recognized by HSCRC in its payment model. Please provide a persuasive justification of the need to have a single licensed pediatric bed for the admission of pediatric patients rather than simply operating the proposed pediatric space as an observation unit without a licensed bed. Consider whether pediatric services should be eliminated as a separate inpatient service, given that, in recent years, PGHC has admitted only a handful of patients under the age of 15.

Applicants' Response

A. Changes to Bed Capacity

Dimensions updated the market analysis that was included in the Modified Application in order to assess the recommended bed capacity reductions. As a result of these updates and the Reviewer's recommendations, Dimensions has reduced the bed capacity of the proposed PGRMC. The reductions to service capacity are summarized in the following table.

Table 83
(excerpt)

	January 16, 2015 Modified Application	**Recommended Modification**	**Applicants' Modifications to Project**
Beds by Service Line (Dimensions only)	MSGA 133 ICU 32 Pysch 28 OB 22 Peds 1 **Total 216**	MSGA 122 ICU Not addressed Pysch Not addressed OB 19 Peds Not addressed **Total 202**	MSGA 122 ICU 32 Pysch 28 OB 22 Peds 1 **Total 205**

Bed Capacity is addressed in greater detail in Exhibit 62, Table A.

(i) MSGA Beds

As stated above, Dimensions' Modified Application, submitted January 16, 2015, justified a need for 133 MSGA beds. Those beds represented need based on demand projections through FY 2022. Since the Reviewer recommended 122 MSGA beds, Dimensions re-examined its need analysis.

The need analysis presented in the Modified Application was based on FY 2013 actual utilization. In re-examining its need analysis, Dimensions used FY 2015 actual utilization as a starting point. In looking at the trends in the PGRMC service area by age cohort, Dimensions recognized utilization rates declining at a faster rate than previously projected.

Table 84
PGRMC Service Area Use Rates
(All Hospitals – MD, DC, and VA)

	FY 2013	FY 2014	FY 2015	FY 2013 - FY 2015 Δ
MSGA 75+	377.60	342.33	338.59	*-10.3%*
Annual Change		*-9.3%*	*-1.1%*	
MSGA 65-74	208.49	191.69	185.16	*-11.2%*
Annual Change		*-8.1%*	*-3.4%*	
MSGA 15-64	60.54	58.33	54.72	*-9.6%*
Annual Change		*-3.7%*	*-6.2%*	

As such, Dimensions assumed this trend will continue throughout the projection period.

Dimensions considered other factors in its further examination of need, the most influential of which was the increased focus placed on potentially avoidable utilization. Since several of the tests under the Maryland All-Payer Model Agreement with the Centers for Medicare & Medicaid Services are tied to quality, per capita healthcare spending, and potentially avoidable utilization, it is reasonable to assume further declines in use rates as the Maryland Health Services Cost Review Commission ("HSCRC") has designed policies around those goals. Dimensions' updated need analysis assumed a targeted use rate for the service area between "moderately-" and "well-managed," as defined by Milliman in a study conducted in 2011 (see Modified CON Application, p. 64). The combined impact of actual utilization trends

from FY 2013 to FY 2015 and further emphasis on potentially avoidable utilization led Dimensions to agree to include 122 MSGA beds in the new hospital as recommended by the Reviewer.

(ii) Obstetric Beds

While the Modified Application justified a need for 22 Obstetrics beds, the Reviewer recommended a reduction to 19 Obstetrics beds. Dimensions reviewed its projections and considered similar factors discussed above in evaluating the need for Obstetric beds.

Dimensions first examined the FY 2013 – FY 2015 use rate trends in the PGRMC service area.

Table 85
PGRMC Service Area Use Rates
(All Hospitals – MD, DC, and VA)

	FY 2013	FY 2014	FY 2015	FY 2013 - FY 2015 Δ
Obstetrics	64.59	64.21	65.42	*1.3%*
Annual Change		*-0.6%*	*1.9%*	

While MSGA use rates in the PGRMC service area declined in the range of 9.6% to 11.2% from FY 2013 – FY 2015, Obstetrics use rates increased. Dimensions recognized that most of the opportunity to reduce potentially avoidable utilization is in MSGA inpatient services, not Obstetrics. Even though the Obstetrics use rate increased historically, Dimensions assumed that there is some limited opportunity to reduce potentially avoidable utilization and that the use rate for Obstetrics would decline modestly by 0.8% from FY 2015 – FY 2023. This decline results in a FY 2023 Obstetrics use rate for the PGRMC service area of 64.88. Assuming a population of 170,626 in PGRMC's Service Area (based on Nielsen projections), this results in 11,070 discharges in the total PGRMC service area. Assuming an Obstetrics market share of 19.0% for PGRMC, as projected in the Modified CON Application (see Modified CON Application, p. 77), 2,100 PGRMC discharges will result in its service area. Based on FY

2015 actual utilization, out of service area discharges for Obstetrics represent an additional 16.1% of service area discharges, resulting in 2,437 total Obstetrics discharges at PGRMC in FY 2023.

PGRMC's Obstetrics average length of stay in FY 2015 was 2.61 days. Dimensions targeted the statewide case mix-adjusted average length of stay in FY 2023, or 2.56 days, representing a decline of 1.8%. This results in 6,247 Obstetrics days at PGRMC. Based on an assumed occupancy rate for Obstetrics of 75%, the projected days justify a need for 23 beds. As such, Dimensions respectfully has decided not to modify its request for 22 Obstetrics beds.

(iii) Other Beds

Dimensions has not made any changes to the remainder of the proposed bed capacity for PGRMC. The decision to keep the proposed Pediatric Bed is discussed on pages 8-10, below. These and other bed needs are presented in Table F1 along with projected inpatient and outpatient utilization.

B. Need for Retaining a Licensed Pediatric Bed[2]

PGHC, with two licensed pediatric beds, is the only facility within its primary service area that has licensed pediatric beds. MedStar's Southern Maryland Hospital is the only other Prince George's County facility that has licensed pediatric beds (4 licensed beds). The other three County hospitals, (Doctors Community Hospital, Laurel Regional Hospital and Fort Washington Medical Center), do not have any licensed pediatric beds, which creates service gaps within certain geographic areas of the County.

Dimensions and its stakeholders feel it is important to maintain inpatient pediatric service for the residents of Prince George's County at PGRMC, which will be more accessible to the

[2] Regarding the designation of inpatient services with the HSCRC, Dimensions has withdrawn its request to the HSCRC that PGHC's pediatric services be eliminated as a distinct inpatient service line. The HSCRC rate structure required Dimensions to maintain a separate unit for this service.

majority of County residents. The need in PGRMC's pediatric service area supports maintaining this service. The current pediatric population (ages 0-14) of the PGRMC primary/secondary service area is estimated to be 168,515, and is projected to increase to 172,034 by 2021.

Table 86
PGRMC Service Area Population, Pediatric 0-14
FY 2016 – FY 2021 Change

Service Area	FY 2016	FY 2021	FY16-FY21 Change
PGRMC Peds Service Area	168,515	172,034	2.1%

Source: Nielsen (2016) Pop-Facts Demographics
Note: PGRMC Peds Service Area as defined in January 16, 2016 Modified Application

For the projected PGRMC pediatric service area during FY 2015, it is estimated that there were approximately 3,198 pediatric inpatient discharges resulting in approximately 15,267 patient days.[3] Based on 85% occupancy, this would equate to a need of 49.2 pediatric beds for the service area, of which these pediatric patients are predominantly being served by out-of-service area hospitals.

Proximity is important, especially in emergent situations. Caring for pediatric patients in a close-to-home setting provides comfort and satisfaction to families. PGHC has a robust Women and Infants Service line, including a Level III NICU. Pediatricians are available in the inpatient setting to care for newborns as well as other types of inpatient pediatric patients. Dimensions wishes to continue to provide safe, appropriate, and effective care to the newborn patients who need either admission or observation in an appropriate, patient friendly environment.

Although many pediatric services are provided primarily on an outpatient basis or in tertiary centers, there remains a need, within the community, to be able to serve the pediatric patient across the continuum of care. The continuum includes the inpatient, observation, and

[3] FY 2015 volumes were based on combining available inpatient dataset from HSCRC inpatient data base, as well as D.C. Hospitals and Virginia hospitals database. Estimated volumes excluded newborn, neonatal, psychiatric, rehabilitation, and obstetrical DRGs.

outpatient settings. The inpatient unit would facilitate a more seamless transition of care as patients move from the emergency department to the inpatient unit to outpatient services. The one-bed unit would also help retain patients in the local community, reducing the number of patients who are currently transferred out of Prince George's County for care.

Maintaining a pediatric service will be a benefit to PGHC's family medicine residency program as well as its plans to attract skilled providers to the County. Residents will be exposed to a wide variety of patients on the unit, which will improve their care delivery skills. Currently, Prince George's County has a shortage of medical practitioners to provide essential services in the community. Thus, the continuation of an inpatient pediatric service would provide an additional aspect of residency training and would enhance Dimensions' ability to attract and retain needed practitioners to the County, which will contribute to community wellness.

Additionally, PGHC has an opportunity to collaborate with both Children's National Medical Center in Washington, D.C. and University of Maryland Children's Hospital in Baltimore to provide additional sub-specialty services as well as telemedicine referral services to prevent some non-severe acute pediatric inpatients from having to be transferred to more distant hospitals. This would prevent a hardship and significant inconvenience for pediatric patients and their families.

Finally, many hospitals are facing decreased pediatric inpatients census and are challenged in developing a care model that meets the basic needs of pediatric patients. Of the 33 hospitals in Maryland with licensed pediatric beds, 14 are licensed for four beds or fewer (FY 2016). Nine of these 33 hospitals have only one or two licensed beds. PGHC falls into this category and, thus, is typical of many other Maryland hospitals. Despite the declining pediatric census, families expect to have basic pediatric services in their community hospitals, with specialized services being offered at larger hospital centers.

C. Changes to Operating Room Capacity

As shown in the revised project drawings, Exhibit 64, Dimensions has accepted the Reviewer's recommended modification and reduced the number of operating rooms to eight.

D. Changes to Emergency Department

As shown in the revised project drawings, Exhibit 64, Dimensions has accepted the Reviewer's recommended modification to the proposed PGRMC Emergency Department, and has revised its plans to include 45 treatment spaces. In connection with accepting the recommendation, Dimensions updated its volume projections consistent with the revised statistical projections set forth in Exhibit 62, Table F. The size of the revised proposed PGRMC Emergency Department, and its inclusion of 45 treatment spaces, is consistent with COMAR 10.24.10, Acute Care Chapter, Project Review Standard .04B(14) and the most recent edition of the American College of Emergency Physicians *Emergency Department Design: A Practical Guide to Planning for the Future,* published April, 2016.

E. Modification to Gross Square Feet per Bed

As shown in Table B, Exhibit 62, and as described in this modification, Dimensions has revised the project to reduce the total gross square feet to 2,370 square feet per bed, exclusive of certain resident education space and certain cancer services space, consistent with the Reviewer's recommendations, and of central utility plant ("CUP") space, consistent with the redesign of the CUP. Dimensions converted the CUP into prefabricated equipment, eliminating the CUP's prior total square footage of 41,244.[4] The treatment of the CUP based on the current design is consistent with the treatment of such space in the CON review of the Holy Cross Germantown Hospital, Docket No. 08-15-2286. Dimensions achieved additional space reductions by removing the interstitial floor that previously housed mechanical equipment,

[4] Under Dimensions' revised plans, the CUP equipment occupies approximately 27,000 square feet.

consolidating MWPH spaces, and eliminating the ambulatory care center, which previously included some space for rate-regulated services. These changes are shown in the revised Project Drawings, Exhibit 64.

As demonstrated in Table 87, below, the project as revised is consistent with COMAR 10.24.10, Acute Care Chapter, Project Review Standard .04B(9) – Inpatient Nursing Unit Space. The space for inpatient nursing units is below 500 square feet per bed.

Table 87
PGRMC Inpatient Nursing Unit Space
Average SF/Bed

ROOM/FUNCTION	NSF	BEDS	SF/BED
MEDICAL/SURGICAL	14,143	34	416.0
MEDICAL/SURGICAL	14,129	33	428.2
MEDICAL/SURGICAL	7,436	17	437.4
INTENSIVE CARE	14,577	32	455.5
INTERMEDIATE CARE	14,974	33	453.8
OB/GYN	10,587	27	392.1
BEHAVIORAL HEALTH	13,039	28	465.7
PEDIATRICS	400	1	400.0

F. Changes in Construction and Project Costs

As demonstrated in Tables D and E, Exhibit 62, Dimensions has revised the project costs by reducing total construction costs and total use of funds. Total construction costs (Table E, Line A.1.b(1)) are reduced by $59,744,090 to $225 million. The total use of funds, excluding the value of the land donation, is reduced by $96,055,000 to $543 million. The reductions made to achieve this result are shown in Table E, which includes a column showing the budget for the January 16, 2015 Modified CON Application, a column with the current budget, and a column showing the variance.

2. Analysis of Potential Size and Cost Reductions

I recommend that the applicants reexamine all aspects of the project in determining the best ways in which to reduce the size and cost of this project. My analysis indicates that attention should be focused on:

The need for a dedicated ambulatory care center and the administrative space it includes. This distinct project component does not appear to be necessary for a hospital of this size.

The need to construct new hospital space for the special hospital unit of Mt. Washington Pediatric Hospital. The applicants should examine and report on the potential of other hospital space alternatives that may already be available for lease in Prince George's County that could serve the purpose of housing this small specialized hospital.

Applicants' Response

A. Ambulatory Care Center and Administrative Space

As shown in the Project Drawings, Exhibit 64, Dimensions eliminated the Ambulatory Care Center from the proposed PGRMC hospital construction project and has moved the administrative space and certain cancer services previously located in that center into the main hospital building. Dimensions is reassessing its ambulatory care plan in light of these changes and will develop a plan that will consider and address what type of ambulatory care services Dimensions may offer on its PGRMC campus in the future. Outside of the scope of this CON project, Dimensions may construct a medical office building that could house non-rate regulated ambulatory services. If Dimensions proceeds with such a project, Dimensions would likely seek a determination of non-coverage of CON review.

B. Analysis of Alternative Hospital Space for MWPH in Prince George's County

MWPH provides essential services to children in the Prince George's County community that are not available in all Maryland hospitals. MWPH's Prince George's inpatient unit provides care for medically complicated infants who are transitioning from Neonatal Intensive Care Units, Pediatric Intensive Care Units, and acute care children's hospitals. In response to the Reviewer's request, MWPH analyzed whether it could continue providing this specialized care in

the community by relocating its existing 15 bed program at PGHC to alternative existing hospital space in Prince George's County. After reviewing alternatives, MWPH feels strongly based on its expertise and history of providing specialized services to compromised infants and children that PGRMC will be the best location in the County for MWPH, and the only location with all of the services on which MWPH relies to support its 15 bed program.

There are currently four hospitals in the County, other than PGHC: Doctors Community Hospital ("DCH"), Fort Washington Medical Center, Laurel Regional Hospital ("LRH"), and MedStar Southern Maryland Hospital Center ("MedStar"). Dimensions has announced plans to transform Laurel Regional Hospital, and therefore, MWPH cannot rely on having appropriate space and services at LRH when PGHC closes in 2021. Fort Washington Medical Center is a small community hospital with only 34 licensed beds, and has existing physical capacity of an additional 3 beds based on the Annual Report on Selected Maryland General and Special Hospital Services for Fiscal Year 2016. MWPH ruled out these two hospitals from further analysis based on these facts alone.

MedStar is not a viable option for the relocation of MWPH Prince George's County unit because it already faces significant space constraints and a need for modernization. In 2013, MedStar submitted a Certificate of Need application proposing a renovation of its existing facility and an expansion that would add 165,000 square feet of floor area of new construction.[5] The application confirms that the facility faces space constraints throughout:

> The key driver of this project is to create a contemporary facility, accommodating the changing needs of the patient services, improving efficiencies and addressing the significant lack of space in most of the hospital's clinical areas. Many critical clinical services are provided in spaces that are significantly undersized to support contemporary practice for both existing and anticipated community need. The restrictive size of these spaces also presents significant challenges for the

[5] The MedStar CON application may be accessed on the Commission's website at the following link: http://mhcc.maryland.gov/mhcc/Pages/hcfs/hcfs_con/hcfs_con_medstar_southern_maryland.aspx.

> introduction of both established and emerging advances in diagnostic and therapeutic technology. Departmental square footage is well below national benchmarks of similar size and location in many areas, particularly critical care beds, medical/surgical beds, ED, radiology, surgery, administration, central supply and materials management, dietary and cafeteria, lab, and public lobby space. These areas all lack sufficient staff and physician support space, and often lack of space hinders family members from participating in patient care. Space constraints in the Emergency Department, Surgery and Critical Care restrict operational efficiency. Critical care rooms are very dissimilar to each other, contributing to inefficiencies for staff. ICU space shortages impact multiple service lines. The undersized specialty procedure and diagnostic rooms and operating rooms do not support current or future technology. In addition, with a new level of care being provided, more space is needed for the growing number of observation patients.

MedStar Application, Matter No. 13-16-2350, at p. 11. MedStar projects a five-year period between project approval and first use.

MedStar's expansion plans as described in its application do not, of course, contemplate adding additional space to support MWPH. Furthermore, MedStar's application is currently inactive, and a new facility would not be completed before MWPH would be required to leave PGHC. Given the serious space constraints of the current facility, and the uncertain timing (or occurrence) of future renovations, MedStar is not a viable option for the relocation of MWPH.

DCH is not a viable option for MWPH because it lacks services critical to MWPH's ability to safely and efficiently operate its 15-bed facility in Prince George's County. It is critical to MWPH's mission that this unit be located in a hospital that has its own NICU, together with the ancillary services that support that unit. MWPH relies on Dimensions, and would need to rely on any alternative partner, to provide ancillary services to its patients. Such services must be provided by personnel who are specially trained to treat small children. Examples of such services are outlined below.

Respiratory Therapists

MWPH requires respiratory therapists ("RT") who have experience and comfort in treating small children and managing their specialized equipment. A NICU in the same hospital

ensures that the respiratory therapists are familiar with small infants and their small airways. Small infants also require special ventilators which are completely different than those used for older children.

It is not cost effective for MWPH to provide respiratory therapy services to its patients. At the main hospital in Baltimore, each RT FTE bills for about 120,000 relative value unit (RVU) of service per year. At PGHC, a total of 30,000 RVUs were billed during FY 2016. It would not be economical to staff a full-time RT at the Prince George's County unit. But full-time coverage is needed, because services are provided throughout the day and night. This is one of the reasons it makes economic sense to be located within a hospital that can provide the staff that has the knowledge and experience to serve MWPH patients.

Radiology Services

MWPH patients also require radiology services and radiologists accustomed to imaging infants and interpreting their x-rays. Hospitals with NICUs have radiology technicians and radiologists who are familiar with the ability to take X-rays on tiny infants using minimal radiation.

Laboratory services

Laboratory services are also different for young children. The technologists need to be trained and the analyzers need to be designed for very small samples. Lab personnel would need to be familiar with how to obtain blood from small infants to measure blood oxygen and carbon dioxide levels. They also need to be able to measure electrolytes and blood counts from micro samples.

Lastly, all personnel who interact with MWPH's patients must be familiar with diseases that are not seen in hospitals with only a full term newborn nursery. These diseases include respiratory distress syndrome, bronchopulmonary dysplasia, and pulmonary hypertension.

This response supplements MWPH's response to COMAR 10.14.01.08G(3)(c) - 10.24.01.08G(3)(c) – Availability of More Cost-Effective Alternatives, January 16, 2015 Modified Application, pp. 209-210.

3. Requested Analysis of Operational Efficiency and Financial Impact

Provide a complete and detailed analysis of how this project will improve operational efficiency and reduce staffing hours and cost per unit of service, beyond the ratio of nursing FTEs per unit of service in the nursing units included in the CON application. Quantify the financial impact of the projected operational efficiencies.

Applicants' Response

Dimensions has identified several areas for performance improvement opportunities at PGHC in the near term and at PGRMC in the long term that will enable Dimensions to improve its financial performance and ensure financial feasibility following the opening of PGRMC. The five distinct performance improvement opportunities identified are Revenue Cycle, Quality, Utilization, Labor, and Supply Chain and Contracts. Improvements in these areas will offset the loss of subsidies Dimensions has received from the State and County that are projected to end by the third year after PGRMC opens, and will enable Dimensions to absorb the new depreciation and interest expense that will accompany the new facility.

The improvements will begin this year, FY 2017. Dimensions will build on these improvements through its affiliation with UMMS in FY 2018. With the opening of the new hospital, there will be additional operating efficiencies that are enabled by the design of the new facility.

The financial impact of these improvements is shown in Table 88.

Table 88
Cumulative Projected Impact of Performance Improvements
($ in Millions)

	Cumulative Projected Impact of Performance Improvements						
Performance Improvement Category	**FY 2017 Budget**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
PGHC / PGRMC							
Revenue Cycle							
Reduction in Denials	$2.1	$3.6	$3.8	$3.9	$4.4	$4.6	$4.8
Improved Hospital Collections (Bad Debt)	5.0	8.5	8.7	6.8	4.7	4.2	4.2
Increase in DHA Physician Collections	1.4	1.5	1.5	1.5	1.8	2.0	2.2
Subtotal Revenue Cycle	**$8.6**	**$13.6**	**$13.9**	**$12.1**	**$11.0**	**$10.9**	**$11.2**
Quality - Reward / (Penalty)	**$1.9**	**$3.8**	**$7.6**	**$9.2**	**$10.8**	**$12.4**	**$12.4**
Readmissions	($3.7)	($2.2)	$0.0	$0.0	$0.0	$0.0	$0.0
MHAC	($0.5)	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
QBR	$0.1	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Composite Method	$0.0	$0.0	$1.6	$3.2	$4.8	$6.4	$6.4
Total Reward / (Penalty)	($4.1)	($2.2)	$1.6	$3.2	$4.8	$6.4	$6.4
Utilization							
ALOS Reduction Resulting in Lower FTEs and Variable Costs	$0.2	$1.7	$3.1	$3.9	$3.1	$2.9	$2.7
Subtotal Utilization	**$0.2**	**$1.7**	**$3.1**	**$3.9**	**$3.1**	**$2.9**	**$2.7**
Labor							
Reduction in Labor and Premium Pay/Overtime	$3.0	$6.2	$11.2	$13.9	$16.2	$16.6	$17.0
Subtotal Labor	**$3.0**	**$6.2**	**$11.2**	**$13.9**	**$16.2**	**$16.6**	**$17.0**
Supply Chain, Drugs and Contract Services	**$2.0**	**$4.0**	**$6.0**	**$8.0**	**$10.0**	**$10.3**	**$10.5**
Total PGHC / PGRMC	**$15.6**	**$29.4**	**$41.8**	**$47.1**	**$51.1**	**$53.0**	**$53.8**

A full size version of Table 88 is attached as Exhibit 65.

Some of these initiatives have immediate impacts, while others will take longer to improve financial performance. These improvements are achievable, are in-line with industry benchmarks, and will improve the operating margin without compromising the quality and patient satisfaction delivered at PGHC and PGRMC.

Each category of performance improvement is discussed in greater detail below.

A. Improvement Opportunity 1 - Revenue Cycle Improvement

Revenue Cycle enhancements are opportunities to improve revenue deductions for services already being rendered. These opportunities do not increase the amount of gross revenue the hospital receives under the GBR; however, they do improve the net revenue the hospital collects from the services rendered. Dimensions identified three major areas of opportunity that include improved denial management, improved hospital collections on bad debt, and improved physician collections on bad debt.

Denials Management Process Improvement

In FY 2016, PGHC created a task force to explore improving denial management and the operational changes needed to achieve that goal. As demonstrated in the table below, PGHC has historically realized a higher denial percentage than the selected peer groups, which include the average of statewide hospitals, Baltimore City hospitals, and UMMS facilities.

Table 89
Denied Claims Benchmarking

Denials	FY 2013 [1]	FY 2014 [1]	FY 2015 [1]	FY 2016 [2]
PGHC				
Gross Revenue	$249,193	$267,282	$279,091	$237,951
Denials	7,567	9,473	12,827	8,450
% Denials	3.0%	3.5%	4.6%	3.6%
Statewide	1.3%	1.4%	1.8%	1.6%
Baltimore City	1.4%	1.5%	1.9%	1.7%
UMMS Facilities	1.6%	1.6%	1.5%	1.8%

Note [1]: Based on RE schedule from annual filing
Note [2]: Based on unaudited FSA schedules, through April, 2016
Note [3]: Baltimore City Hospitals include UMMC, JHH, JHBMC, Mercy, Midtown, St. Agnes, Harbor, Sinai, Good Samaritan, Union Memorial and Bon Secours)
Note [4]: UMMS Facilities excludes Shock Trauma

The task force identified several operational changes that will lead to improved denial management, including education of staff, adopting Interqual Criteria, and improvement in pre-authorization on weekends. Dimensions engaged a consultant to educate front end clinical staff about the documentation process so that they better understand what documentation to provide to the insurance company to ensure claims are approved. The adoption of Interqual Criteria will also help ensure that cases with a potential denial are reviewed to confirm that all required information is collected and sent with the claim. Dimensions has further identified the opportunity to improve pre-authorization processes to ensure that claims will not be denied.

Dimensions believes that it can reduce denials at PGHC to approximately 2% of total charges. This target is above the peer groups' averages previously identified, but is a

reasonable target to reach within three years. By reducing PGHC's denials from its current run rate in FY 2016 through April of 3.6% to 2.0% by FY 2021, the hospital will experience a bottom line impact of approximately $4.5 million. Dimensions believes it will be able to maintain the lower denials percentage thereafter by continuing the education of staff and implementing the other changes identified.

Improved Bad Debt Collections

Hospital Bad Debt Collections. Dimensions has recognized the opportunity to improve bad debt collections based on benchmarking against other peer groups. Table 90 below provides for the bad debt percentage comparison against the peer group averages, and demonstrates room for improvement at PGHC.

Table 90
Bad Debt Write-Offs Benchmarking

Bad Debt	FY 2013 [1]	FY 2014 [1]	FY 2015 [1]	FY 2016 [2]
PGHC				
Gross Revenue	$249,193	$267,282	$279,091	$237,951
Bad Debt	16,710	19,007	10,715	14,542
% Bad Debt	6.7%	7.1%	3.8%	6.1%
Statewide	3.9%	4.0%	2.7%	3.0%
Baltimore City	3.4%	3.3%	2.0%	2.3%
UMMS Facilities	2.9%	4.1%	2.7%	2.9%

Note [1]: Based on RE schedule from annual filing
Note [2]: Based on unaudited FSA schedules, through April, 2016
Note [3]: Baltimore City Hospitals include UMMC, JHH, JHBMC, Mercy, Midtown, St. Agnes, Harbor, Sinai, Good Samaritan, Union Memorial and Bon Secours)
Note [4]: UMMS Facilities excludes Shock Trauma

Dimensions has identified potential ways to narrow the gap in its bad debt as compared to peer hospitals. First, Dimensions can improve the Medicaid certification process for eligible patients, who are a large population of PGHC's patients. By providing greater assistance to eligible patients who apply for coverage, Dimensions may avoid instances where such patients are instead included as self-pay, which often results in an inability to collect the associated

revenue. Second, Dimensions will work with collection companies to ensure proper adherence to policies, ultimately resulting in greater collection percentages.

PGHC is targeting an improvement of collections over the next several years from the current FY 2016 run rate of 6.1% to 3.1%. Uncompensated care in the state is fully funded through the uncompensated care policy, but there is still an opportunity to improve the hospital's collection percentage and improve the bottom line. The uncompensated care policy will eventually catch up with actual results. However, the entire benefit will not completely disappear because the uncompensated care policy is 50% actual performance for the prior one or two years and 50% a predicted value.

Physician Bad Debt Collections. Dimensions has historically experienced lower collection rates for its PGHC employed physicians than industry standards. The lower collection rates are driven by both the payer mix and a de-centralized approach to the physician groups. Dimensions is projecting to increase physician collections from the current level of 36% of gross revenue to a target of 47% in FY 2023, which will result in a $2.2 million increase in net revenue. Dimensions will achieve this by improving preauthorization practices, identifying insurance on the front end, and centralizing the collection efforts for all employed physician practices. Dimensions will be participating in the Transforming Clinical Practice Initiative, which will provide coaching, resources and tools to help Dimensions practices improve quality of care, and practice performance in preparation for value-based payment models.

B. Improvement Opportunity 2 - HSCRC Quality and Pay for Performance Projection

Dimensions' considerable efforts to address the health disparity and access issues in the County are addressed more fully in the January 16, 2016 Modified CON Application and in response to Section III.4, Population Health Management, below. With the initiatives underway at PGHC and the concerted effort to improve the quality performance from one of the worst

performing hospitals in the State to one of the better performing hospitals, PGHC is projecting to receive a Quality payment reward by FY 2019. Table 91 below shows the projected improvement in quality scores and the corresponding reward for each fiscal year.

Table 91
HSCRC Quality and Pay for Performance Projection

	2017	2018	2019	2020	2021	2022	2023
RRIP	$(3,738,798)	$(2,203,064)	-	-	-	-	-
MHAC	$(550,766)	-	-	-	-	-	-
QBR	$154,214	-	-	-	-	-	-
Composite Method	-	-	$1,608,750	$3,217,500	$4,826,250	$6,435,000	$6,435,000
	$(4,135,350)	$(2,203,064)	$1,608,750	$3,217,500	$4,826,250	$6,435,000	$6,435,000

C. Improvement Opportunity 3 - Utilization Change - ALOS reduction resulting in lower FTEs, variable cost

The average length of stay (ALOS) at PGHC was 5.2 days for FY 2015, and was reduced to 4.9 days for FY 2016. Dimensions projects reducing ALOS to 4.8 days by FY 2021, based on the FY 2015 statewide average at PGHC volumes, and holding it constant thereafter.

Table 92
ALOS Summary by Cohort

	PGHC's ALOS	Statewide Unadjusted ALOS	Statewide ALOS @ PGHC Volumes
Pediatrics (0-15)	3.0	3.7	2.0
MSG (15-64)	5.6	4.2	4.7
MSG (65-74)	6.4	5.0	5.6
MSG (75+)	6.3	5.1	5.5
Psych 18+	6.3	6.1	6.3 (1)
OB	2.6	2.5	2.6
Total	5.2	4.4	4.8

Note (1): The FY 2015 Statewide ALOS at PGHC volumes for Psych 18+ was 7.1 days. As such, PGHC's ALOS of 6.3 days was kept constant in the financial projections.

Assuming 50% expense variability, the projected reduction in ALOS will result in savings of $3.2 million. Dimensions will achieve this savings by reducing salary and benefits costs

associated with the reduction in the ALOS and lower usage of supplies and drugs. Reducing PGHC's ALOS to the statewide ALOS at PGHC's service mix drives down average daily census requiring fewer FTEs. Although supply and drug usage is lower at the end of patient's stay, use reduction will still drive meaningful savings for the hospital. Dimensions projects that approximately 30% of the cumulative performance improvements projected in Table 88 above will be driven by a reduction in costs that are more variable.

D. Improvement Opportunity 4 - Reduction in Labor and Premium Pay / Overtime

Dimensions has designed the proposed PGRMC to operate efficiently. Consistent with the State Health Plan Acute Care Chapter, General Standard .04B(11), Dimensions analyzed changes in operational efficiency and documented that the planning and design of the project took efficiency improvements into account. In addition, PGRMC is designed such that operational efficiency will improve with increases in volume.

Dimensions anticipates achieving operational efficiencies and labor savings via the collective bargaining process. Current labor agreements are scheduled to expire in October 2017. Traditionally, Dimensions Collective Bargaining Agreements ("CBAs") have not exceeded a three-year life. Dimensions anticipates at least two CBA negotiation sessions between 2017 and 2023. Additionally, Dimensions and the union have initiated a CBA negotiated Workforce Transformational Council. In addition to training and development programs, the Workforce Transformational Council will also work to introduce hybrid roles that will lead to operational efficiencies, work to improve quality of care, and assist in transitioning displaced workers impacted by changes in technology.

For a long time, PGHC has experienced significant clinical staff turnover, which led to higher staffing-related costs at PGHC. The components of those higher costs break down into several categories including paying premium rates for agency nurses, paying overtime to employees to ensure coverage and recruiting additional clinical staff. According to the Robert

Wood Johnson Foundation, the cost of replacing a single nurse can range from $22,000 to more than $64,000. In addition to the cost implications, patient satisfaction, treatment outcomes and staff productivity can be equally impacted. With the approaching affiliation with UMMS, the executive team's commitment to build a stronger culture, and the construction of a new, modern hospital, Dimensions believes it will be able to retain its employees and decrease staff turnover.

In FY 2017, Dimensions will initiate a 180 day recruiting plan to help fill 100 vacant positions. Dimensions strongly believes that the upcoming recruitment plan, along with the UMMS affiliation, will allow for the reduction in agency nurses, which accounted for approximately 90 positions at PGHC in FY 2016. The recruitment plan will not only impact the agency positions, but also the amount paid for overtime, since PGHC will have better coverage. Dimensions projects that the financial impact of the recruitment plan will be recognized quickly over the first three years of implementation.

Dimensions is in the process of identifying other opportunities to reduce labor utilization. In comparison to benchmarks of comparable hospitals, Dimensions has identified an opportunity to reduce staff related to support and management functions. By incorporating UMMS' standards for critical departments, Dimensions expects to reduce FTEs by 3.5% through the standardization of Administrative systems, IT systems, Materials Management / Supply Chain, Human Resources and Finance. These improvements will occur over the next several years, but prior to the opening of the new hospital.

Dimensions also expects that the design of the new hospital will drive operational efficiencies in patient care, ancillary and other support functions. As presented in the January 16, 2015 Modified Application, pp. 132-134, the replacement facility will allow for significant operational efficiencies. 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.

Efficiency increases in the new facility will be addressed in several different areas, including improvements in patient flow and staff work-flow directly related to the architectural design and improvements in productivity due to the state-of-the-art building systems and equipment. These efficiencies are summarized below.

Building Design Efficiencies

General Building Efficiencies

- Minimization of public and staff cross-traffic and interaction
- Clear & understandable way finding for patients and visitors along the concourse and up to the patient floors
- Public elevators are conveniently located near the hospital entry. Service elevators are centrally located to the tower and first floor service departments
- Elevator locations, sizes, quantity and speeds are all optimized for the facility, and planned for future growth. Destination control will be employed to increase efficiency and lower operating costs
- Key service departments are located adjacent to loading dock, with close access to service elevators
- Centralized Dialysis
- Consolidated and comprehensive surgery floor with immediate adjacency to Trauma, the ED, and imaging

Emergency Department

- Robust triage area in ED will allow for faster treatment of patients
- Two CTs in ED will reduce wait times, provide redundancy, and minimize the need for transport to Imaging
- Decontamination/isolation rooms with own exterior entrance will facilitate isolating any infectious or contaminated cases from the general patient population
- ASC is separated from the ED, adjacent to the ambulance entry to facilitate police and ambulance drop-offs.

Patient Floors

- Patient rooms are virtually identical from floor to floor for efficiency in nursing and staff
- Decentralized nurse stations locate staff and supplies closer to the patients they serve and improve patient safety and satisfaction
- ICU and IMC floors are nearly identical to allow for flexing the ICU bed needs up or down based on the census
- Co-location of Labor & Delivery, Post-Partum and NICU are ideal for minimization of patient transport, staff travel distance and response time between the various departments

Equipment Efficiencies

- Automated waste, recycling, soiled linen collection and transport
- Pneumatic Tube system throughout facility
- Automated line in the lab
- Patient Beds – DHS currently requires large quantities of specialty rental beds. Appropriate selection of patient beds will significantly decrease the need for rentals (and the associated staff effort required to move the rentals).
- Patient Lifts in every room
- Workstations on Wheels (WOWs) – allows flexibility in charting, and avoids patient room downtime when a computer malfunctions.
- All new equipment will translate into significant decreases in downtime and repairs for several years, compared to the current hospital where nearly all equipment is near end of life.
- Adequate equipment supply will enable staff to spend less time searching. RFID (the “internet of things”) aids in locating critical equipment.
- Par Level Monitoring System in clean rooms reduces need for staff to constantly check stock levels, and significantly reduces outages and overstocking.
- Pharmacy – Automated Picking Robot
- OR Status Tracking
- Appropriately equipped ORs, adequate storage
- Implant tracking system

- CSP – Standardization of instruments, significant decrease in failed packs because of new equipment, decrease in packs prepared outside of facility
- Use of kiosks for registration/check-in

In the spring of 2016, UMMS engaged ADAMS Management Services Corporation, an independent qualified healthcare planner, to conduct a peer review of the plans for PGRMC and provide input regarding the design, planning, and layout and provide insight into how to make it even better.

In a report dated May 5, 2016, Adams concluded that the overall design development plan of PGRMC is inviting, well organized, and efficient, with appropriate separation of flows and paths for the exceptional delivery of healthcare that will be received by patients within its walls. The design is flexible, adaptable, has significant capacity to grow and change, and can evolve with the nuances of the US healthcare delivery system.

Specifically, the report identified the following:

- With the hospital designed around a combined public, patient and staff central elevator cores, the facility is both compact and efficient.
- The CDU is located and planned very well. Its location adjacent to the ER is an effective response to have an alternative environment for multiple care uses. The adjacency to and operational efficiency of Observation beds may be an important key to the successful regional medical center in the future of healthcare reform.
- The design of the nursing units follows the current trend of inpatient bed units evolving into smaller all-private bed units as technology and new models of nursing care are being implemented; and supply management systems strive to be as efficient as possible yet provide stellar quality of care.
- Emergency is located well in the building and on the site. The corner location allows for separation of access and clarity of operational flows. The Pediatric ED is located well within the main ED, accessible to both entry doors and multiple levels of acuity support. Trauma is pulled inside the building closer to the travel paths to Imaging and Surgery.
- The Behavioral Health Clearance Unit is also located well, just off of the Ambulance entry and next to Security.
- Surgery is well thought out and combines all interventional services, a very effective and efficient solution.

- Labor & Delivery, Post-partum and NICU have ideal relationships. The direct link from OB to the Perinatal Diagnostic Center in the adjacent Ambulatory Care Center is ideal.

- Food service and dining is ideally located off of the main entry lobby and has a direct path for patient food to the support elevators.

- The consolidation of "clinical traveler" support/office space near the elevator core throughout the design enables staff with no home on a particular unit to effectively serve multiple units from a central location.

Dimensions expects that all of these design efficiencies will help to reduce labor related costs in the new facility. With the movement of hospital operations from Cheverly to Largo in FY 2021, it is expected that PGRMC will be able to reduce FTEs by 2.1% in the following departments as a result of design efficiencies:

- Nursing
- Emergency Services
- Pharmacy
- Lab
- Environmental Services
- Patient Transport
- Central Sterile Processing
- Maintenance
- Food Services

As presented in Table 93, these design efficiencies are projected to reduce the hospitals' staffing ratio by 0.15 FTEs per Adjusted Average Occupied Bed (AOB) or 2.1%.

Table 93
Projected Reduction in Staffing Ratio
($ in millions)

Statistic	Budget 2017	Impact of Assumptions on Projected 2023				Projected 2023
		Performance Improvements	Building Design Efficiency	Volume Growth (1)	Total	
Adjusted Average Occuped Beds (AOB)	218.2	-	-	16.3	16.3	234.5
% Change in Adjusted AOB	-	-	-	7.5%	7.5%	7.5%
FTEs per Adjusted AOB	7.07	(0.25)	(0.15)	(0.22)	(0.62)	6.45
% Change in FTEs per Adjusted AOB	-	-3.5%	-2.1%	-3.1%	-8.8%	-8.8%
FTEs	1,542.8	(54.5)	(32.5)	56.9	(30.1)	1,512.7
% Change in FTEs	-	-3.5%	-2.1%	3.7%	-1.9%	-

Note (1): FTEs are projected to increase at 50% variability with the increase in Adjusted AOB, thus reducing the ratio of FTEs per Adjusted AOB

Combined with performance improvements and volume growth, the staffing ratio is projected to decline from 7.07 FTEs per Adjusted AOB in 2017 to 6.45 FTEs per Adjusted AOB in 2023.

E. Improvement Opportunity 5 - Supply Chain, Drugs and Contract Service Cost Reductions

Dimensions has identified several opportunities to improve supply chain services and reduce drug costs that will increase operational efficiencies of PGHC. With the strategic and operational support of UMMS, Dimensions believes the projected cost reductions are more conservative, based on internal analyses. One of the largest and most immediate savings will come from the affiliation with UMMS and the associated drug pricing and purchase service arrangements to which PGHC will have access.

Besides buying power, Dimensions has also identified several strategic initiatives to reduce supply chain costs. First, Dimensions will upgrade its IT supply chain platform to ensure more transparency within the organization. Second, Dimensions is reevaluating its procedure standards and the monitoring of supply chain partners. This ensures Dimensions is effectively managing its relationships and ensuring these partners are getting the most return for their investments. Dimensions also identified specific areas of the supply chain that it will focus on, including blood management, non-clinical supply costs, and improvement in single-use clinical device reuse. The combined effect of these initiatives should provide significant savings over the next five years for Dimensions. Some of the initiatives will provide immediate results, while others will take longer to implement.

Dimensions has identified several strategic opportunities that will lead to cost savings at PGHC's pharmacy. Dimensions is trying to maximize the 340B drug pricing benefit, while ensuring compliance with all regulations. In addition to maximizing the benefit of 340B pricing, the pharmacy department is performing a thorough review on all high volume drugs and high cost drugs to see if there is a generic and/or lower cost option available. Two additional strategies that are being implemented at PGHC involve increasing the inventory turnover rate to ensure drugs are not expiring, and improving the tracking of the drug dispensary to minimize lost dosages. The most immediate benefit will come from identifying lower cost drug options, and long range benefits will result from maximizing 340B pricing and improving the pharmacy's supply chain process.

4. Population Health Management Improvements in Prince George's County

I request a full and detailed accounting of the progress made to date in the County in implementing the applicant's collaborative population health management practices, its transition to value-based care, its development of an ambulatory care network and increase in primary care providers, and its establishment of a clinically integrated network. I would like an analysis of the steps that remain to be taken in implementing and funding these plans.

Applicants' Response

I. Introduction

The recent All-Payer Model for Maryland is intended to be a model for achieving the triple aim of (i) lower costs, (ii) better patient experience, and (iii) improved health through transforming care delivery and developing partnerships between hospitals and other providers across the care continuum. Dimensions is fully committed to meeting all three of these goals.

In collaboration with Prince George's County and others, Dimensions is pursuing a number of population health initiatives to improve the health status of County residents. To provide appropriate leadership for these important initiatives, Dimensions recently appointed a new Vice President of Community and Population Health, Tiffany Sullivan, MPH. Ms. Sullivan is charged with leading the development and implementation of Dimensions' population health strategy, through which Dimensions hopes to transform the healthcare delivery system in Prince George's County by making primary care more accessible and available to County residents.

Improvement in population health will not only benefit the health status of County residents, but also their total cost of care. As illustrated in Table 94, the total cost of care (Part A and B cost per Medicare beneficiary) in CY2015 for Prince George's County residents increased by 2.6% compared to Maryland Statewide growth of 2.5% while the Nation grew 1.7%.

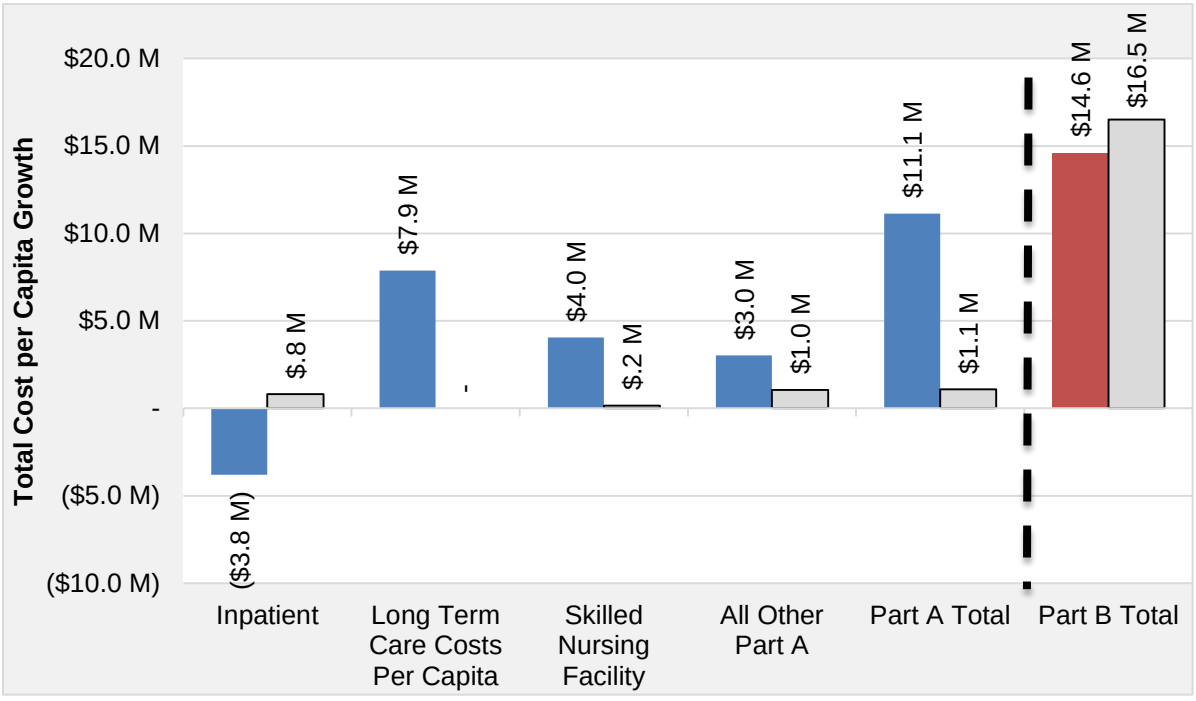
Table 94
Total Cost of Care
Increase CY 2014 to CY 2015
Prince George's County Residents

	Part A	Part B	Total
Prince George's County	2.10%	2.70%	2.60%
Maryland Statewide	1.25%	3.40%	2.50%
Nation	0.20%	3.10%	1.70%

Of the 24 counties in Maryland, change in total cost of care ranged from (4.30%) to 7.90%. Prince George's County ranked 16th out of 24 MD counties. Neighboring Montgomery County had greater growth than Prince George's County, at 3.20%.

Although total cost of care increased in the County, inpatient hospital growth declined from CY2014 to CY2015, as demonstrated in Table 95.

Table 95
Total Cost of Care Growth – Prince George's County
Medicare Cost per Capita Growth by Type
CY 2014 to CY 2015



Source: HSCRC, Medicare FFS - MD Residents from Geographic Variation Report, Prince George's County residents

The largest drivers of the Part A change related to growth in Long Term Care and Skilled Nursing Facility cost. Inpatient Hospital Cost of Care declined from CY 2014 to CY 2015 by $4.6 million while Long term Care and Skilled Nursing Facility Cost of Care increased by almost $12 million. The increase in these costs highlights the need for Hospitals to partner with post-acute providers and develop strong population health initiatives.

II. Summary of Community Health Issues in Prince George's County

The issues to be addressed in Prince George's County are formidable. Over the past several years, four major studies and reports have been completed to evaluate the health status, service capacity, and the community health needs of Prince George's County residents, and to identify the highest priorities for the County. These reports include: (1) a comprehensive Community Health Needs Assessment prepared by the Prince George's County Health Department in collaboration with Dimensions and other County hospitals (Spring 2016) (the "2016 Community Health Needs Assessment"); (2) a report entitled "Transforming Health in Prince George's County, Maryland: A Public Health Impact Study," prepared by the University of Maryland School of Public Health (July, 2012); (3) a report entitled "Assessing Health and Health Care in Prince George's County" prepared by the RAND Corporation for the Prince George's County Council (2009); and (4) a report entitled "Prince George's County Primary Healthcare Strategic Plan," (2014-2015) for which Prince George's County engaged John Snow, Inc., a public health consulting company, to develop a primary care plan for Prince George's County, focusing on a County-led process to improve public health and expand access to high-quality primary care. These studies incorporated extensive reviews of vital statistics, health service utilization, workforce data and socioeconomic indicators. Together, the studies also integrated household surveys and professional roundtables to provide more current and direct input from health professionals and community residents.

The studies consistently reported a number of alarming factors:

A. Morbidity and mortality rates of Prince George's County residents

- County residents experience higher rates of chronic diseases as compared with residents in most neighboring counties and, in several cases, at rates higher than the State averages (diabetes, heart disease, hypertension, asthma and cancer). The Town of Capitol Heights falls into the highest quintile for the age-adjusted rate for heart disease across all the Maryland census tracts. In a County-wide survey, heart disease and diabetes were identified as "urgent health conditions."

- Serious health disparities have been documented for minority populations. The morbidity and mortality rates for chronic diseases among racial and ethnic minority County populations are dramatically higher relative to the white population. For example, emergency department visits by African Americans are more than three times higher for asthma and hypertension, and nearly twice as high for diabetes as the visit rate for whites.

B. Need for behavioral health services

- The behavioral health service category was cited as one of the top health concerns in the PGHC service area. Respondents in the County survey referred to the need to expand mental health and substance abuse services, and clinicians have referred to mental health conditions as being linked to difficulties managing chronic conditions and as a precipitant of admissions. The County convened a County-wide Behavioral Health Workgroup with the intention of creating a collaborative team of hospitals, community organizations, and concerned residents dedicated to developing strategies to address behavioral health in the community. County Health Officer Pamela Creekmur is leading this effort. Dimensions team members are part of this team.

C. Health care workforce capacity

- The County has far fewer primary care providers per capita as compared with surrounding counties and the State. Community assessments consistently report an inadequate supply of primary care physicians, measured by per capita ratio of physicians to population. The 2012 Public Health Impact Study prepared for the County estimated that an additional 61 primary care physicians are needed to meet the minimum recommended ratios. Geographic "pockets" of the County are designated as Medically Underserved Areas, including the Town of Capitol Heights.

- Access to specialists is consistently cited as a problem, with a wide range of specialties identified. The shortage of specialists has made the chronic disease population particularly vulnerable to acute care episodes and high emergency department utilization. There are substantially fewer specialists of all types in Prince George's County as compared with other jurisdictions. Physician manpower reviews that have been prepared confirm markedly lower ratios of specialists in the area.

D. Limited number of service sites/access points

- There are only a small number of federally qualified health centers (FQHCs) in the County and only a small number of safety net clinics/access points across the County.

E. High rate of outmigration

- A sizable number of residents rely on hospitals outside of Prince George's County for care. This reflects the shortage of specialists, PGHC's aged plant, the strength of Baltimore and Washington, DC hospitals, and the negative perception of PGHC. Residents with private insurance are least likely to stay in the County for care, and patients with Medicaid have been more likely to use PGHC.

F. Affordability issues

- The inability to pay for prescriptions has been cited as a serious barrier among the unemployed and the working poor. Clinicians maintain that this issue is directly linked to high rates of emergency department utilization. Patients are relying heavily on emergency departments to fill prescriptions and manage acute problems when prescriptions run out.

- Also of note is that Prince George's County has a very diverse population including a significant population of first generation immigrants. Some of these immigrants are undocumented and pose challenges to post-discharge disposition to other providers for follow-up care.

III. Dimensions' Transition to Value-Based Care

Dimensions is in the process of transitioning from a volume-based reimbursement system to a value-based care delivery model. Operational preparedness initiatives include the following:

- Expanding the primary care network and strengthening relationships with community physicians;

- Developing chronic care programs to manage health status of targeted patient populations;

- Initiating care management programs to reduce unnecessary hospital utilization with emphasis on "high risk" patients;

- Developing specific population health program infrastructure;

- Developing data warehousing assets to improve accessibility of clinical information of patients;

- Identifying patients utilizing emergency department / other hospital services who lack a primary care home and connecting them to a primary care provider;
- Identifying operational efficiency opportunities to improve financial position;
- Developing an education platform to educate community physicians on aspects of the ever-changing value-based reimbursement environment; and
- Identifying/developing an array of community partnerships needed to be successful in transitioning to value-base care.

Some of the value-based care transitioning initiatives and elements needed to be successful in the future are described below.

IV. Prince George's County Initiatives to Expand Primary and Community Care

The Prince George's County Government is taking productive steps to expand primary care in the County. The plan to transform the healthcare delivery system in Prince George's County relies on the collaboration of the parties to the 2011 Memorandum of Understanding (Dimensions, UMMS, USM, the County, and the State) to not only develop a new regional medical center, but to undertake significant efforts outside of hospital services to achieve several community care objectives, including increased access to primary care, increased safety-net clinic capacity that is integrated with overall health care and social services 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 County worked with JSI Inc., with participation from Dimensions, UMMS, and other healthcare providers and community stakeholders, to develop a strategic plan to transform primary healthcare in the County (the "Primary Healthcare Strategic Plan"). The Primary Healthcare Strategic Plan is centered on:

- Increasing patient-centered primary care practices in Health Investment Zones; [6]
- Building capacity of existing primary care practices to operate as patient-centered medical homes ("PCMH");
- Building collaboration among Prince George's County hospitals; and
- Developing workforce to support patient-centered primary care.

In furtherance of the Primary Healthcare Strategic Plan, the County has directly invested more than $2.1 million in three primary care practices serving high need areas and has provided working capital loans to an additional three medical practices in high need areas, and will continue these investments. To incentivize other new primary care practices, the County routinely expedites building permits for all new medical practices by deeming them as priority projects for permitting purposes, and has provided working loans to two patient-centered medical homes. The County Health Department was also successful in its initiative of signing up more than 120,000 Prince Georgians for health insurance under the Affordable Care Act.

Access to primary care has improved in the County through the opening of Federally Qualified Health Centers ("FQHCs"). In 2011, the County only had one FQHC that offered primary care, Greater Baden Medical Center ("GBMC"). GBMC has three locations that support the southern portion of the County. Since 2011, the County has assisted four additional FQHCs to open within the County: The Mary's Center in Adelphi, Maryland, Community Clinic, Inc. in Greenbelt, Maryland, Family Medical and Counseling Services in Capitol Heights, Maryland, and La Clinica del Pueblo in Hyattsville, Maryland.

The County has also increased the number of providers who serve the underserved with the implementation of the Health Enterprise Zone ("HEZ")[7] in Capitol Heights, Zip Code 20743,

[6] Health Investment Zones are geographical areas identified in the County's Primary Care Strategic Plan as areas of high need for additional primary care resources.

which includes the towns of Capitol Heights, Fairmont Heights, Seat Pleasant, and Coral Hills. The population of the HEZ is diverse with more than 95% comprised of racial and ethnic minorities. According to the 2012 Public Health Impact Study, this Zip Code was medically underserved with no board-certified primary care physicians and only one healthcare clinic serving its 38,621 residents.

This creation of the HEZ was jointly funded by the State of Maryland Community Health Resources Commission and the State Department of Health & Mental Hygiene in January 2013, with one of the funding designations awarded to the Prince George's County Health Department. In planning for the work and targeted goals in the HEZ, the County Health Department convened a wide range of community partners and stakeholders to expand the primary resources and recruit primary care providers to establish five PCMHs to serve a minimum of 10,000 residents. The major accomplishments to date include the opening of the four medical practices since 2013: Global Vision Community Health Services; Greater Baden Medical Services' expansion; Gerald Family Care, P.C.; and Family and Medical Counseling Service, Inc. In September 2016, Dimensions and Prince George's County Health Department will open an extended PCMH, Dimensions Specialty Care Center, which will provide specialists and behavioral health services to the HEZ.

Through the HEZ Community Health Worker Program, five full-time Community Health Workers ("CHWs") work in the HEZ to facilitate access to care; connect residents to health insurance registration tools and primary care medical practices; provide assistance and navigation with various social services resources; promote medication adherence and health literacy education resources; and coordinate care to minimize hospital readmissions. The CHW

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[7] The Health Enterprise Zone program is a four year State initiative designed to: (1) reduce disparities among racial and ethnic minority populations and among geographic areas; (2) improve health care access and health outcomes in underserved communities; and (3) reduce health care costs and hospital admissions and re-admissions.

staff use evidence-based pathways and workflows to address social determinants of health, with the ultimate goal of guiding individuals to adopt healthy behaviors that promote, maintain, and improve their quality of life. CHW Program Referrals are initiated by ED case managers, hospital care transition nurses, ambulatory and primary care practices, health department clinics, payers and community non-profit organizations.

The HEZ also includes a Community Care Coordination Team ("CCCT"). The CCCT is a multidisciplinary group of healthcare professionals working together to provide care coordination to high risk patients with frequent hospital readmissions and emergency department visits. The CCCT's mission is to:

1. Assist providers with implementing an evidence-based framework for improving the health outcomes of high risk and at-risk populations in the community;

2. Develop care transition and care coordination protocols, workflows and pathways to guide the Community Health Workers in addressing the social determinants of health of high risk and at-risk Prince George's County residents;

3. Monitor and measure the health outcomes of this population, and to educate and motivate improvements in the healthcare system;

4. Promote provider adoption of innovative health information technology, innovative delivery models, and chronic disease initiatives to reduce hospital re-admissions and non-urgent ED visits.

The CCCT includes a number of representatives of community health providers and advocates, including the County Health Department, Health Enterprise Zone Project Team, PGHC, and other health care providers within the County.

The County is also engaged in other initiatives. As noted above, to build collaboration among Prince George's County hospitals, the County Health Department convened all five of the County's hospitals to complete the first joint Community Health Needs Assessment for Prince George's County, which identified the most critical health needs common to all hospitals (behavioral health and the reduction and / or management of chronic disease).

Further collaboration will occur once the Prince George's Healthcare Alliance, Inc. is established. This organizational structure will be designed to develop a stronger primary care alliance within the County and will promote patient-centered medical homes.

Finally, additional primary care resources have been added to the County through expansion efforts of other private practices and health systems. For example, Kaiser Permanente has advanced initiatives to expand primary care for its clients, as well as increase the number of convenient urgent care centers around the County. More detailed information regarding the County Health Department's initiatives can be reviewed in Exhibit 66.

V. Dimensions' Population Health Initiatives

Dimensions is working to develop leading population health management initiatives in collaboration with community providers and other agencies. The population health plan is in concert with initiatives to develop stronger primary care / ambulatory care network supported by the proposed PGRMC.

As explained in the 2016 Community Health Needs Assessment, social determinants have a significant impact on health outcomes. Social determinants of health are "the structural determinants and conditions in which people are born, grow, live, work and age." They include factors like socioeconomic status, education, the physical environment, employment, and social support networks, as well as access to health care. (Kaiser Family Foundation)

Dimensions believes that its population health vision, strategic objectives, and specific initiatives embodied within its efforts represent a unique opportunity to redesign the way the healthcare ecosystem is structured and rethink the way healthcare is delivered in Prince George's County to include greater focus on social determinants and support for self-managed care. Dimensions' goals for population health are aligned with the principles of the nation's "Triple Aim" vision as well as the State of Maryland's initiatives of reducing unnecessary hospital utilization.

A partnership consisting of the State of Maryland, Prince George's County, UMMS, USM, and Dimensions, initiated a healthcare planning process five 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 Prince George's Hospital Center, with a recommendation that the new regional medical center be affiliated with an academic medical center.

As noted, Dimensions participated in a joint community health needs assessment process, led by the County Health Department, to design and produce the 2016 Community Health Needs Assessment. The stakeholders engaged in a collaborative process to conduct a comprehensive community health needs assessment process in Prince George's County. The process involved the collection and analysis of data (quantitative and qualitative) to ascertain residents' health status, identify trends in health problems, as well as the social and economic determinants impacting the health of Prince George's County residents. The written report of the community health needs assessment process and findings was prepared and presented to the County Health Department and County hospitals. The report included recommendations to address health needs and other areas of concern to the County Health Department and County hospitals, based on the findings. Recommendations include public health policy, processes, programs, and interventions.

The 2016 Community Health Needs Assessment assessed and identified significant community health needs in the County. Although the process encompassed the needs of the

County's hospitals as a whole, it was not a series of hospital-specific needs assessments. The assessment utilized quantitative and qualitative data, as available. The joint assessment provides required data and information for each of the hospitals to use. Each hospital is responsible for using the report to: 1) identify their own geographical priority issues; 2) develop and implement strategies and action plans for each priority issue, and 3) establish accountability to ensure measurable health improvement.

Informed by the recommendations of the 2012 Public Health Impact Study and the 2016 Community Health Needs Assessment, Dimensions will focus on the following strategic objectives over the next three years:

- **Strategic Objective 1:** Using analysis of Dimensions' strengths and opportunities and Community Health Needs Assessment data to determine the need to recruit and place primary care and multiple specialty care physicians and mid-level providers in order to support the development of effective primary and multi-specialty clinics at Dimensions sites to increase access to care.

- **Strategic Objective 2:** Develop effective care continuum models and strategies for preventing Potentially Avoidable Utilizations to reduce readmissions and improve quality of care.

- **Strategic Objective 3:** Identify community partners equipped to help expand current programs or develop supportive programs for behavioral health, chronic disease self-management, and diabetes prevention to improve disease management and prevent complications.

- **Strategic Objective 4:** Develop a strategy for improved transitional care support for patients at risk for readmission who are being transferred to post-acute care sites (PACS).

- **Strategic Objective 5:** Develop an integrated corporate, departmental and IT population health management infrastructure to support clinical decision making, clinical integration and access to health information for community providers, and provide linkages of clinical and financial data in order to reduce unnecessary admissions/hospital utilization, while promoting utilization of primary care and ambulatory services, in coordination with other healthcare initiatives to improve overall community health status.

- **Strategic Objective 6:** Collaborate with community based organizations and healthcare providers to develop a formal structure of integrated network of community providers and institutions (e.g., FQHCs, Health Department, post-acute care facilities, and other agencies) to improve access and coordination of care.

VI. Expansion of Primary Care / Ambulatory Care Network

As a key strategy to improve community health, Dimensions is highly focused on building and maintaining a strong primary care and ambulatory care network. Within the ambulatory care network, Dimensions has an objective to also address community mental health concerns, particularly chronic mental health disease management.

A. Local access to primary care and specialists

In response to the community health needs described above, Dimensions has developed new practice sites in the community and has positioned additional specialists in County clinics and FQHCs to provide specialty support.

The Family Health and Wellness Centers of Dimensions Healthcare System provide comprehensive quality healthcare services in the areas of dental care, women's health, men's health, and family medicine (including pediatric health). The mission of the Family Health and Wellness Centers is to meet the needs of Prince George's County residents by providing greater access to primary care, when and where it is needed.

The Family Health and Wellness Centers, staffed and operated through Dimensions Healthcare Associates, employ more than 22 physicians, a dentist, ten nurse midwives, a nurse practitioner, and a physician assistant. There are currently 34 clinical and administrative support staff that have grown from providing 11,000 patient visits in 2013 to more than 19,000 patient visits in 2015. The sites are strategically located in four County locations that are accessible to the most vulnerable residents. A fifth site in the HEZ in Capitol Heights in partnership with the County Health Department will open in the fall of 2016. This fifth site will provide access to specialty care physicians. Specialty care services will also be provided at the Gerald Family Care location, via a new telehealth program. A brief description of the five sites follows.

Cheverly Family Health and Wellness Center Cheverly MD	Suitland Family Health and Wellness Center Suitland MD	Laurel Family Health and Wellness Center Laurel MD	Senior Health Center Brentwood, Maryland	Health Enterprise Zone (Scheduled to Open 9/2016)
• Primary Care • OB/GYN • Internal Medicine Residency Program • Family Medicine Residency Program • Ortho/Trauma/General Surgery Follow up • Same Day Urgent • Open Monday-Friday 9 am -5 pm	• Primary Care • Dental • OB/GYN • Open Monday - Friday 9 am - 5 pm • Extended hours on Thursday evenings	• Primary Care • Pulmonology • OB/GYN • Pain Management • Open Monday-Friday, 9 am until 5 pm	• Primary Care • Open 1.5 days per week	• Partnership with Prince George's County Health Department • Specialty Care-Infection Disease, Pulmonology, Behavioral Health • Projected to be open Monday-Friday 9 am – 5pm

The Family Health and Wellness Centers use the "Four Pillars of Ambulatory Care Management," a management model focused on transforming care by achieving "The Ideal Patient and Family Experience" in an academic healthcare center setting by delivering consistent, reliable, and excellent clinical and service outcomes. The model builds upon best practices from around the nation and models that incorporate Medical Group Management Association ("MGMA") standards. The Four Pillars focus areas for management are described in Exhibit 67.

Dimensions approved funding for Fiscal Year 2017 to create an ambulatory case management team to assist with care transitions. The team will consist of a Director for Ambulatory Care Coordination, a Social Work Case Manager, a Community Health Worker, a Health Educator, and a part-time Ambulatory Medical Director. With the exception of the Social Work Case Manager, these are all new positions within Dimensions, demonstrating its commitment to ensuring that patients successfully transition through the care continuum. The ambulatory team will coordinate with Dimensions internal case management teams to ensure patients' hand offs are complete. The ambulatory case management team will also work with outpatient providers to implement chronic care manager and other care coordination solutions in the ambulatory setting.

The ambulatory landscape continues to change and evolve as healthcare moves from volume to value-based care. The highest risk patients are managing multiple chronic conditions including congestive heart failure, congestive obstructive pulmonary disease, hypertension, and Type 2 diabetes. Dimensions ambulatory care network must develop its medical team in order to provide the care that is best for patients. The current plans are to:

- Provide patients with increased access to specialty care in the ambulatory setting in order to successfully manage chronic conditions. Plans are underway to recruit and hire in the following specialty areas: pulmonology, endocrinology, cardiology, expanded gynecology services, and orthopedics.
- Implement care planning teams for patients managing chronic conditions.
- Improve management of patients with chronic conditions by providing training to the medical staff on Chronic Care Management.
- Increase patient encounters for Family Medicine residents.
- Utilize the Chesapeake Regional Information System for Patients ("CRISP") encounter notification system to follow up with patients who have had an emergency department visit or inpatient stay.
- Improve physician education offerings to include information on patient engagement and activation.
- Implement a patient satisfaction tool for the ambulatory centers.

Integrate behavioral health into primary care sites (this initiative is beginning).

B. Residency Programs

Two residency programs are housed in the Cheverly Family Health and Wellness site, Internal Medicine and Family Medicine:

- The Internal Medicine Residency Program provides intensive exposure to the practice of internal medicine and prepares graduates for a wide variety of careers in medicine. The Department of Medicine at PGHC offers a three-year program in internal medicine and currently has 42 residents in the program. The Categorical Program provides core clinical training in internal medicine and meets the requirements of the American Board of Internal Medicine ("ABIM"). The department also provides training for interns completing a preliminary year before moving on to other specialties.

- The Family Medicine Residency Program, which has 12 residents, aims to develop outstanding family physicians capable of providing comprehensive and compassionate primary care in a variety of settings. In addition, Dimensions' goal is to develop physicians who effectively communicate with patients, other health care professionals, and the families of patients. Family Medicine Residents provide care throughout the community including the Pregnancy Aid Center ("PAC"). The PAC provides obstetrics care to low-income and uninsured women in Prince George's County.

Both residency programs are committed to recruiting, enrolling, and supporting a diverse group of residents who reflect the ethnic and cultural diversity of our community and the patients served at Dimensions.

C. Physician recruitment

Dimensions is active in recruiting both primary and specialty care providers. Dimensions seeks to improve access to specialty providers in primary care sites in selected areas of the County. Hiring and recruiting are underway in a number of specialties, including Internal Medicine, OB/GYN, chronic disease specialties (Endocrinology, Pulmonary Medicine, etc.), Orthopedics, Cardiovascular surgeons, and Neuroscience Specialties (Neurologist, Neurosurgeon).

VII. Other Active Programmatic Initiatives

In addition to its core clinical programs, Dimensions has implemented several other population health initiatives, including programs aimed at reducing non-acute emergency department utilization, reducing readmissions and improving the health status of the community. Dimensions has designed efforts in response to local community health needs assessments, County Health Department priorities, and internal analyses that profile utilization patterns at PGHC. Several of these new initiatives have been implemented through partnerships with other providers, and several programs have begun to demonstrate meaningful reductions in hospital utilization. Selected programs are highlighted below:

A. Initiatives for "High Utilizers."

In partnership with the Prince George's County Health Department, Dimensions identified emergency department and hospital high utilizers. Patients were enrolled in a care management program intended to reduce hospital utilization. There were 57 patients identified and utilization was tracked for July to December of 2014 and calendar year 2015. During the 6-month time period, these patients experienced reduced hospitalizations of 22% and reduced readmissions of 33%. Emergency department support for high utilizers includes a team of professionals who identify "high users" in the emergency department and provides case management for these people.

B. Primary Care Physician Program.

Emergency department patients without a primary care physician are connected to local primary care resources. Patients without a primary care physician are connected to one of the Family Wellness Centers (Cheverly or Suitland location) to obtain a follow-up visit and be assigned a primary care provider. Assistance is also provided to enroll patients without existent coverage in a health insurance plan. Also, during the period FY 2016 – FY 2020, Dimensions has committed to recruiting 14 primary care physicians to address the current shortage in Prince George's County. These physicians may be hired or placed in an existing community primary care office.

C. Telehealth Pilot Program.

Dimensions has completed a successful telehealth pilot with nursing homes. The overall purpose and goal of the project was to reduce hospital admission and 30-day readmissions for patients in comprehensive care facilities ("CCFs") by: (1) improving care transitions for Medicare, Medicaid and dually eligible patients who were admitted to the hospital and transferred to the CCFs or who are at risk for readmission to the hospital from the CCFs; and (2) reducing unnecessary emergency department visits for Medicare, Medicaid and dually eligible

residents of the CCFs. The Dimensions project involved two telehealth interventions. The first intervention was a post-discharge e-visit between the CCF and Dimensions hospitals (PGHC and LRH) to track a patient's status during the first 30 days of discharge. The second intervention was a pre-transfer e-visit between the CCF and Dimensions hospitals' emergency departments to determine if emergency transfer is necessary or provide support to the CCF to avoid emergency transfer. The pilot was successful in reducing the hospital admission and 30-day readmission rate for the sample of CCF residents who participated in the study. The results of the pilot study results are summarized in Exhibit 68.

The success of this pilot has also positioned Dimensions as an attractive partner for other telehealth projects. Dimensions is now partnering with Gerald Family Care, a patient-centered medical home network providing family practice services to Prince George's County, to implement an 18-month pilot telehealth program funded by the Maryland Health Care Commission to increase patient access to specialty care in Prince George's County through the use of telehealth. This project will improve access to specialists in psychiatry, cardiology, pulmonary medicine, and gastroenterology. This project is designed to reduce the time primary care physicians and patients have to wait for specialty consultations. This is especially a value-added service for those patients within this practice area that have less socioeconomic means and may have transportation issues in getting to a specialty practice location. Another goal is to promote uptake of behavioral health services in a population where seeking behavioral health treatment is stigmatized. Core Measures to determine success of this telehealth project are described below:

Core Measures:
Reduction in the wait time for specialty appointment
Increase in the proportion of patients screening positive for depression who access behavioral health services
Over 60% of patients will score an average of 4.0 out of 5 or more on the patient satisfaction survey
Reduction in ED visits associated with gastroenterologic, neurologic, dermatologic, cardiologic, pulmonary related and/or behavioral health conditions
Percent change in 30-day readmission for all patients discharged from Hospital to Gerald Family Care

D. Community Partnerships

Partnerships and innovation are critical components of population health management. Dimensions is a member of Totally Linking Care In Maryland, LLC ("TLC-MD"). This new collaborative is effectively positioning itself to operate as a regional delivery system (and possibly a broader accountable care entity); PGHC represents one of the hospital members in this delivery system. The Coalition includes Doctors Community Hospital, Dimensions, Fort Washington Medical Center, Calvert Memorial Hospital, MedChi, the Southern Maryland ACO, the Area Agency on Aging, the Prince George's County Health Department and many smaller health care, religious and non-profit partners. At this stage, the Coalition will focus on identifying "super-utilizing patients" and delivering the "right services" that directly address patient needs, minimize hospital utilization and reduce complications. The Coalition will use this experience to further develop a regional model for more broadly improving population health. As part of this initiative, the Coalition will work with community physicians to determine the level of electronic health record/health information exchange that can be productive for patient management. Dimensions is also partnering with the March of Dimes to provide prenatal care, preconception, interconception and postpartum care through the deployment of the March of Dimes Mama and Baby Mobile Health Center, hereafter referred to as the Bus. The overarching goal of this partnership is to render high quality care to underserved women and their children under the age of two that reside in the target communities. The mobile health service will be jointly administered by the Dimensions Departments of Community, Population Health and OB/GYN.

VIII. Future Population Health Efforts and Initiatives

Consistent with the 2016 Community Health Needs Assessment and the 2012 Public Health Impact Study, Dimensions is continuing to develop programs and initiatives to improve the population health in the service areas of its hospitals.

A. Behavioral Health Integration at Cheverly Health and Wellness Center

Between the high prevalence of mental health diagnoses among primary care patients, compounded by the high prevalence of mental health diagnoses among the low-income and uninsured, Dimensions and its providers find themselves spending large amounts of time and money diagnosing and trying to manage mental and behavioral health conditions in systems not necessarily designed to help patients successfully manage chronic mental illness, *i.e.* the emergency department or inpatient setting. Like Type 2 diabetes or hypertension, mental illness is a chronic condition that can be managed in the outpatient setting. Dimensions will improve outpatient offerings in order to provide residents of Prince George's County with viable options for managing behavioral health issues. Reducing readmissions and avoidable utilization due to chronic disease is critical to the overall success of the system.

Dimensions is in the early stages of integrating behavioral health into its primary care sites. The implementation strategy is summarized in Exhibit 69.

B. Clinically Integrated Network

Developing a platform for collaborative alignment between Dimensions and its employed and independent physicians is an opportunity to meet the needs of payors, employers, and patients within the present healthcare environment. The overall goal of clinical integration is to improve quality and efficiency through the use of evidence-based protocols, quality measures and care coordination.

Dimensions is currently assessing a plan to develop a formalized Clinically Integrated Network ("CIN"), which would allow Dimensions and its physicians to not only legally joint contract, but to also proactively drive healthcare delivery in the local market. Dimensions is working with Valence Health, a national consulting firm with experience in developing CINs. Valence Health has recently completed a Feasibility Assessment for Dimensions, which is now assessing the implementation plan.

Dimensions' objectives in the formation of a CIN are:

- Develop an FTC-compliant CIN; including an engaged physician network, infrastructure and quality measures;
- Drive clinical alignment and integration with Dimensions and its affiliated physicians; and
- Prepare and transition the newly created CIN into day-to-day operations to address strategic and operational considerations.

Dimensions' strategy is to build clinical, financial, operational, and technical capabilities that will position it to be successful in a range of value-based contracting and delivery roles. Developing the CIN infrastructure and capabilities will benefit Dimensions across its lines of business with commercial payors and lay the groundwork for other value-based payor strategies.

C. Other Future Initiatives

Key elements of population health management include patient engagement and community integration. Dimensions is developing additional community initiatives that will achieve the following objectives, among others:

- Map services to population need;
- Overcome non-clinical barriers to maximize health outcomes;
- Integrate patient's values into the care plan; and
- Use community stakeholders to connect patients with high-value resources.

In order to build connections across the care continuum, Dimensions has plans underway to:

- Engage experienced community partners to implement Transitional Care Management services for patients at risk for readmission.
- Partner with adult day care centers to provide access to day care services for patients who lack a caregiver during the day.
- Improve the patient transition process. A leading factor in improving the overall patient experience and preventing readmissions is ensuring that patients make a safe transition out of the hospital. Dimensions is working to streamline processes related to timely discharge phone calls by working with an experienced vendor to provide this service.

- Integrate chronic disease clinics into ambulatory care sites.

5. Information Regarding Charges: COMAR 10.24.10, General Standard (1)

Recommended Project Modification: Provide an updated Representative List of Services and Charges that is readily available in printed form and on the hospital's web site.

Applicants' Response

Exhibit 70 is the Representative List of Services and Estimated Charges for common inpatient and outpatient procedures at PGHC, updated as of July 25, 2016. PGHC's website has been updated to reflect these average charges of the most common inpatient discharges and procedures. Also, the website links to the Representative List and the financial application are working properly.

6. Construction Cost of Hospital Space: COMAR 10.24.10, Project Review Standard .04B(7)

Recommended Project Modification: Clarify the accuracy of the CUP equipment classification.

Applicants' Response

In the May 17, 2016 Project Status Conference Report, the Reviewer made an assumption that all $32,496,000 of equipment for the Central Utility Plant ("CUP") should be reclassified from "movable equipment" to "fixed equipment." Project Status Report at 6. Dimensions has made this change in the revised Project Budget (Table E, Exhibit 62).

In addition, Dimensions has revised its Marshall and Swift Valuation analysis, attached as Exhibit 71**.** This replaces the analysis previously submitted in response to Project Review Standard .04B(7) – Construction of Hospital Space, Modified Application, pp. 117-129. As demonstrated in the revised analysis, the adjusted PGRMC project cost per square foot is $408.40, which is below the MVS benchmark of $423.02.

7. Governance, Management, and Project Sponsorship

The history of PGHC has been one of long-standing managerial and financial difficulties. One of the key objectives of UMMS' involvement is to assure a turnaround and put the institution on a path toward permanent progress. Please provide detailed plans for incorporating the Dimensions system into UMMS. Please provide a full and detailed accounting of the governance, management, and project sponsorship responsibilities of UMMS in light of actions taken by the Maryland General Assembly and the Governor in 2016.

Applicants' Response

Enacted in 2016, Chapter 13 of the 2016 Laws of Maryland (SB 324 – Prince George's County Regional Medical Center Act of 2016) ("Chapter 13") requires the State of Maryland to provide additional funding totaling $170.5 million to support the transition of PGRMC from Dimensions to its operation as a participating institution of UMMS, including $115.5 million in capital funds for the construction of PGRMC. Also, the statute requires Prince George's County to contribute $263 million in funds. The State's obligation to provide funding is contingent on UMMS becoming the sole corporate member of Dimensions, and UMMS assuming responsibility for the governance of Dimensions.

Consistent with the funding contingency, UMMS will become the sole corporate member of Dimensions and will assume responsibility for the governance of Dimensions, which is expected to occur within approximately three or four months following the Commission's approval of the CON for replacement and relocation of PGHC. The PGRMC partners – Prince George's County, Dimensions, and UMMS – have entered into a new Memorandum of Understanding, dated August 30, 2016 (the "2016 MOU"). A copy of the 2016 MOU is attached as Exhibit 72. The 2016 MOU addresses the governance and management of Dimensions as well as the disposition of the County-owned health care facility assets.

The parties expect that Dimensions will remain as the sponsor of the PGRMC project and will be the licensee of the proposed facility. However, Dimensions itself will be owned by UMMS and will be subject to governance oversight by UMMS. In light of the funding

contingencies of Chapter 13, Dimensions acknowledges that the affiliation transaction must occur in order for the project to be viable with the proposed sources of funding.

A. Governance and Management

Regarding governance and management of Dimensions, the 2016 MOU parties have agreed that Dimensions will be governed directly by a local board. This structure is similar to other UMMS affiliations, such as the University of Maryland Upper Chesapeake Health and the University of Maryland Shore Regional Health. In each case, UMMS or a subsidiary of UMMS holds the corporate membership of the local affiliate entity. In general, the UMMS affiliations involve a local board of directors as well as local leadership staff, including a president / CEO who is responsible for managing the local hospital or health system. Typically, the decision-making authority of the local board and staff leadership is subject to the oversight of the UMMS board of directors and leadership, including rights expressly reserved to UMMS. The affiliation of Dimensions with UMMS will be similar to these other UMMS affiliation relationships.

1. The Interim Board of Directors.

Under the terms of the 2016 MOU, an interim seven member board of directors will serve between the date UMMS becomes the sole corporate member of Dimensions and December 31, 2018. The interim board will be comprised of specified members, including Bradford Seamon (as Chairman), the County's Health Officer, the Liaison to the County Board of Health, and four members appointed by UMMS (designated in the 2016 MOU as the UMMS President and Chief Executive Officer, the Executive Vice President and Chief Financial Officer, John Ashworth, and Stephen Bartlett, MD).[8] Also, the County Executive and the County Council may each appoint a non-voting interim board member. The actions and decisions of the

[8] Mr. Ashworth and Dr. Bartlett were elected to the Dimensions board as public directors in June 2016, and they were also appointed to the Executive Committee of Dimensions' Board. Appropriate steps have been taken to avoid conflicts of interest for these members.

interim board will be subject to UMMS' reserve and initiation rights as contained in the Dimensions and UMMS bylaws and articles.

2. The Permanent Board of Directors.

Beginning on January 1, 2019, a permanent board comprised of 21 members will govern Dimensions. : The permanent board of directors will include: (1) the Liaison to the Prince George's County Board of Health; (2) the County's Health Officer; (3) four members appointed by UMMS; and (4) 15 other members who will be residents of Prince George's County and Southern Maryland (Calvert, Charles, and St. Mary's Counties).[9] Two-thirds of the members must be residents of Prince George's County, and no member may be an elected official at any level of government. The actions and decisions of the permanent board will be subject to UMMS' reserve and initiation rights as contained in the Dimensions and UMMS bylaws and articles.

Each health care facility will have an advisory board comprised of seven members to be selected by the Dimensions board.

3. President and Chief Executive Officer

The UMMS President and Chief Executive Officer will hold the authority to appoint and remove the Dimensions President and Chief Executive Officer. However, until the earlier of June 30, 2022 or the end of the fiscal year in which the County ceases to provide operating funds to Dimensions, the UMMS President and Chief Executive Officer must consult with the County Executive and the Chairperson of the County Council before taking these actions. These individuals cannot veto or override the final decision of the UMMS President and Chief Executive Officer.

[9] Until the earlier of June 30, 2022 or the end of the fiscal year in which the County ceases to provide operating funds to Dimensions, the permanent board will include one member who has been recommended by the County Executive, subject to approval by UMMS.

B. The Disposition of Property

Regarding the disposition of the health facility assets, the County has agreed to terminate the existing leases and transfer the health facility assets to either Dimensions or UMMS under the following conditions: (1) the Commission approves the CON for the replacement and relocation of PGHC; (2) the HSCRC approves a funding plan supporting the project; (3) UMMS becomes the sole corporate owner of Dimensions; and (4) if any property transferred ceases to be used for a health care purpose within ten years after the transfer date, the property will revert to the County.

IV. The Modified Project is Financially Feasible.

Dimensions is working with the HSCRC to develop a funding option to help support the construction of PGRMC. Dimensions entered into a GBR arrangement with the HSCRC in FY 2014. GBR is a tool that can allow for redistribution of revenues within a system. Thus, funds can be available within the existing GBR system to help fund the PGRMC project. Dimensions believes that it has submitted all of the information necessary for the HSCRC to evaluate funding options. Dimensions expects that the HSCRC will supplement the memo it provided to the Reviewer on October 23, 2015 concerning the financial feasibility of the proposed project.

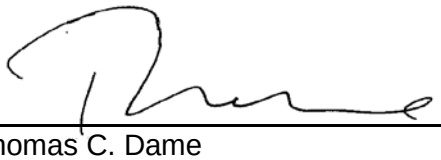
Since its submission of the Modified Application, Dimensions has updated its PGRMC financial projections to reflect the changes discussed herein, including:

- Actual FY 2015 and projected FY 2016 operating performance and utilization
- FY 2017 Dimensions approved operating budget and utilization
- Reduced project size and cost
- Reduced bond issuance and interest costs
- Redistribution of Dimensions GBR within the existing GBR system to help fund the PGRMC project
- Removal of capital related rate increase.

- Improvements to quality scores impacting approved revenue
- Updated shared savings and demographic adjustments impacting revenue
- Revised opening date of PGRMC and extension of projections through FY 2023
- Updated operating efficiencies, as described in Section II.[3].

While these are the most significant changes between the Modified Application and this submission, see Exhibit 62 for a full listing of assumptions built into the financial projection. As presented in that exhibit, the modified project is financially feasible as it generates positive operating margins in each year.

Respectfully submitted,



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218 North Charles Street, Suite 400
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(410) 727-7702

Attorneys for Dimensions Health Corporation d/b/a Prince George's Hospital Center and Mt. Washington Pediatric Hospital, Inc.

Dated: August 31, 2016

TABLE OF EXHIBITS

Exhibit	Description
62	Revised MHCC Tables – PGRMC
63	Revised MHCC Tables – MWPH
64	Revised Project Drawings
65	Full size version of Table 88
66	Summary of Prince George's County initiatives to expand primary care
67	Summary of "Four Pillars" of Ambulatory Care Management
68	Pilot Study results
69	Summary of implementation strategy
70	Representative List of Services and Estimated Charges for common inpatient and outpatient procedures at PGHC
71	Revised Marshall and Swift Valuation analysis
72	August 30, 2016 Memorandum of Understanding

TABLE OF TABLES

Table	Description
83	Summary of Size and Cost Changes
84	PGRMC Service Area Use Rates--MSGA (All Hospitals – MD, DC, and VA)
85	PGRMC Service Area Use Rates--Obstetrics (All Hospitals – MD, DC, and VA)
86	PGRMC Service Area Population, Pediatric 0-14 (FY 2016 – FY 2021 Change)
87	PGRMC Inpatient Nursing Space – Average SF / Bed
88	Cumulative Projected Impact of Performance Improvements
89	Denied Claims Benchmarking
90	Bad Debt Write-Offs Benchmarking
91	HSCRC Quality and Pay for Performance Projection
92	ALOS Summary by Cohort
93	Projected Reduction in Staffing Ratio
94	Total Cost of Care Growth – Increase CY 2014 to CY 2015 – Prince George's County Residents
95	Total Cost of Care Growth – Prince George's County – Medicare Cost per Capita by Type – CY 2014 to CY 2015

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Modification in Response to May 17, 2016 Project Status Conference and its exhibits are true and correct to the best of my knowledge, information, and belief.

8/5/16
Date

Sherry Perkins
Executive Vice President and
Chief Operating Officer
Dimensions Healthcare System

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Modification in Response to May 17, 2016 Project Status Conference and its exhibits are true and correct to the best of my knowledge, information, and belief.

8/12/16
Date

Jeffrey L. Johnson, MBA, FACHE
Senior Vice President, Strategic
Planning & Business Development
Dimensions Healthcare System

#481237
013346-0001

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Modification in Response to May 17, 2016 Project Status Conference and its exhibits are true and correct to the best of my knowledge, information, and belief.

8/16/16
Date

Darryl Mealy
Vice President of Construction and Facilities Planning
University of Maryland Medical System

#586195
013346-0001

I hereby declare and affirm under the penalties of perjury that the facts stated in Co Applicants' Modification in Response to May 17, 2016 Project Status Conference and its exhibits are true and correct to the best of my knowledge, information, and belief.

8/12/16
Date

Mary Miller
Vice President, Finance and Business Development
Mt. Washington Pediatric Hospital

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Modification in Response to May 17, 2016 Project Status Conference and its exhibits are true and correct to the best of my knowledge, information, and belief.

August 3, 2016
Date

Craig Moskowitz
Wilmot Sanz, Inc.

#516937
013346-0001

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Modification in Response to May 17, 2016 Project Status Conference and its exhibits are true and correct to the best of my knowledge, information, and belief.

August 03, 2016.
Date

Michael Stitcher
Managing Director
Berkeley Research Group

#545530
013346-0001

I hereby declare and affirm under the penalties of perjury that the facts stated in Co-Applicants' Modification in Response to May 17, 2016 Project Status Conference and its exhibits are true and correct to the best of my knowledge, information, and belief.

8/3/16
Date

Andrew L. Solberg
A.L.S. Healthcare Consultant Services

#481240
013346-0001

EXHIBIT 62

Name of Applicant:	Dimensions Health Corporation d/b/a Prince George's Hospital Center and Mount Washington Pediatric Hospital, Inc.
Date of Submission:	31-Aug-16

Applicants should follow additional instructions included at the top of each of the following worksheets. Please ensure all green fields (see above) are filled.

Table Number	Table Title	Instructions
Table A	**Physical Bed Capacity Before and After Project**	All applicants whose project impacts any nursing unit, regardless of project type or scope, must complete Table A.
Table B	**Departmental Gross Square Feet**	All applicants, regardless of project type or scope, must complete Table B for all departments and functional areas affected by the proposed project.
Table C	**Construction Characteristics**	All applicants proposing new construction or renovation must complete Table C.
Table D	**Site and Offsite Costs Included and Excluded in Marshall Valuation Costs**	All applicants proposing new construction or renovation must complete Table D.
Table E	**Project Budget**	All applicants, regardless of project type or scope, must complete Table E.
Table F	**Statistical Projections - Entire Facility**	Existing facility applicants must complete Table F. All applicants who complete this table must also complete Tables G and H.
Table G	**Revenues & Expenses, Uninflated - Entire Facility**	Existing facility applicants must complete Table G. The projected revenues and expenses in Table G should be consistent with the volume projections in Table F.
Table H	**Revenues & Expenses, Inflated - Entire Facility**	Existing facility applicants must complete Table H. The projected revenues and expenses in H should be consistent with the projections in Tables F and G.
Table I	**Statistical Projections - New Facility or Service**	Applicants who propose to establish a new facility, existing facility applicants who propose a new service, and applicants who are directed by MHCC staff must complete Table I. All applicants who complete this table must also complete Tables J and K.
Table J	**Revenues & Expenses, Uninflated - New Facility or Service**	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant who completes a Table I must complete Table J. The projected revenues and expenses in Table J should be consistent with the volume projections in Table I.
Table K	**Revenues & Expenses, Inflated - New Facility or Service**	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant that completes a Table I must complete Table K. The projected revenues and expenses in Table K should be consistent with the projections in Tables I and J.
Table L	**Manpower**	All applicants, regardless of project type or scope, must complete Table L.

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

INSTRUCTION : Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project in accordance with the definition of physical capacity noted below. Applicants should add columns and recalculate formulas to address rooms with 3 and 4 bed capacity. See additional instruction in the column to the right of the table.
NOTE: Physical capacity is the total number of beds that could be physically set up in space without significant renovations. This should be the maximum operating capacity under normal, non-emergency circumstances and is a physical count of bed capacity, rather than a measure of staffing capacity. A room with two headwalls and two sets of gasses should be counted as having capacity for two beds, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough from a square footage perspective to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain no headwalls or a single headwall, but are normally used to accommodate one or more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms should be counted as they are currently used.

Before the Project							After Project Completion						
Hospital Service	Location (Floor/Wing)*	Licensed Beds: 7/1/2013	Based on Physical Capacity				Hospital Service	Location (Floor/Wing)*	Based on Physical Capacity			
			Room Count			Bed Count			Room Count			Bed Count
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity
ACUTE CARE							**ACUTE CARE**					
General Medical/Surgical*					0	0	**General Medical/Surgical***				0	0
Med Surg Oncology	E900	24	10	16	26	42	Med/Surg - GYN	3	5	0	5	5
Med Surg Trauma	E800	24	9	17	26	43	Med/Surg	6	33	0	33	33
General Medical/Surgical	E700	24	10	16	26	42	Med/Surg	7	33	0	33	33
PCRU Extended	E500	12	3	7	10	17	Med/Surg	8	17	0	17	17
Post Coronary Recovery Unit	E400	24	4	11	15	26	Med/Surg	9	34	0	34	34
SUBTOTAL Gen. Med/Surg*		**108**	**36**	**67**	**103**	**170**	**SUBTOTAL Gen. Med/Surg***		**122**	**0**	**122**	**122**
ICU/CCU	300	**24**	24	0	24	24	**ICU/CCU**	5	32	0	32	32
CCU	K400	**10**	10	0	10	10			0	0	0	0
Other *(Specify/add rows as needed)*		**0**	0	0	0	0			0	0	0	0
TOTAL MSGA		**142**	**70**	**67**	**137**	**204**	**TOTAL MSGA**		**154**	**0**	**154**	**154**
Obstetrics	K300	**18**	21	0	21	21	**Obstetrics**	3	22	0	22	22
Obstetrics	K200	**18**	21	0	21	21				0	0	0
Pediatrics	E600	**8**	0	6	6	12	**Pediatrics**	2	1	0	1	1
Psychiatric	E400	**28**	0	18	18	38	**Psychiatric**	4	28	0	28	28
TOTAL ACUTE		**214**	**112**	**91**	**203**	**296**	**TOTAL ACUTE**		**205**	**0**	**205**	**205**
NON-ACUTE CARE							**NON-ACUTE CARE**					
Dedicated Observation**		**0**	0	**0**	0	0	**Dedicated Observation****	2	20	0	20	20
Rehabilitation (MWPH)		**15**	15	**0**	15	15	**Rehabilitation (MWPH)**	8	15	0	15	15
Comprehensive Care		**0**	0	**0**	0	0	**Comprehensive Care**		0	0	0	0
Other *(Specify/add rows as needed)*		**0**	0	**0**	0	0	**Other** *(Specify/add rows as needed)*		0	0	0	0
TOTAL NON-ACUTE		**15**	**15**	**0**	**15**	**15**	**TOTAL NON-ACUTE**		**35**	**0**	**35**	**35**
HOSPITAL TOTAL		**229**	**127**	**91**	**218**	**311**	**HOSPITAL TOTAL**		**240**	**0**	**240**	**240**

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

INSTRUCTION: Add or delete rows if necessary. See additional instruction in the column to the right of the table.

DEPARTMENT/FUNCTIONAL AREA	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
					0
ACUTE PATIENT CARE					0
ACUTE CARE INPT. UNITS	59,850	82,492			82,492
INTENSIVE CARE	21,913	22,980			22,980
POST-PARTUM	28,764	18,526			18,526
NEONATAL INTENSIVE CARE UNIT	2,272	11,479			11,479
PEDIATRICS	5,773	400			400
MT. WASHINGTON PEDIATRICS	8,197	10,392			10,392
					0
DIAGNOSTICS & TREATMENT					0
SURGERY	18,894	34,626			34,626
CARDIAC CATH LAB	3,939	5,533			5,533
GI - ENDOSCOPY	5,398	2,735			2,735
ADULT ED	15,024	27,361			27,361
PEDS ED		1,840			1,840
TRAUMA	859	6,093			6,093
UNIVERSAL CARE / PRE-POST	10,507	19,273			19,273
CLINICAL DECISION UNIT	1,397	9,955			9,955
					0
IMAGING	17,854	18,217			18,217
NEUROLOGY/CARDIOLOGY	1,363	4,758			4,758
LABOR & DELIVERY	7,248	13,682			13,682
C-SECTION	1,129	3,950			3,950
WOMEN'S CENTER	5,540	0			0
DOMESTIC VIOLENCE CENTER	1,187	2,012			2,012
DIALYSIS	1,166	2,377			2,377
PT/OT	3,905	4,610			4,610
RESP THERAPY	1,932	1,062			1,062
					0
CLINICAL SUPPORT					0
LABORATORY / PATHOLOGY	13,593	14,956			14,956
PHARMACY	2,293	9,642			9,642
					0
NON CLINICAL SUPPORT					0
DIETARY / DINING	13,791	15,782			15,782
MATERIALS / BIO MED / EVS	9,271	20,032			20,032
CENTRAL STERILE	6,806	9,771			9,771
FACILITIES & SUPPORT SERVICES	28,972	5,720			5,720
IT / TELECOM	10,406	5,322			5,322
REGISTRATION		1,464			1,464
HEALTH INFORMATION MANAGEMENT		2,075			2,075
					0
OFFICES & EDUCATION					0
OFFICE / ADMINISTRATION	31,298	6,534			6,534
ON CALL	4,838	4,773			4,773
CONFERENCE CENTER	6,967	4,632			4,632
RESIDENT / FACULTY	7,577	17,938			17,938
					0
PUBLIC SPACES	39,186	11,728			11,728
CIRCULATION	102,527	87,142			87,142
					0
MECHANICAL/ELECTRICAL	15,558	14,609			14,609
					0
BEHAVIORAL HEALTH					0
CLINICAL PROGRAMS	2,292	2,430			2,430
ACUTE BEHAVIORAL HEALTH	15,905	20,646			20,646
ASSESSMENT STABILIZATION	3,031	3,605			3,605
					0
AMBULATORY/CANCER CLINICAL PROGRAMS					0
MT WASHINGTON OUTPATIENT	1,344	0			0
CANCER CENTER		12,000			12,000
AMBULATORY CLINICS	7,443				0
					0
SHAFTS / EXTERIOR WALL THICKNESS	31,848	20,541			20,541
					0
Total	579,057	595,695			595,695

TABLE C. CONSTRUCTION CHARACTERISTICS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garages, medical office buildings, or energy plants), complete an additional Table C for each structure.

	NEW CONSTRUCTION	RENOVATION
BASE BUILDING CHARACTERISTICS	**Check if applicable**	
Class of Construction (for renovations the class of the building being renovated)*		
Class A	☑	☐
Class B	☐	☐
Class C	☐	☐
Class D	☐	☐
Type of Construction/Renovation*		
Low	☐	☐
Average	☐	☐
Good	☑	☐
Excellent	☐	☐
Number of Stories		

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
First Floor	151,926	
Second Floor	165,896	
Third Floor	64,701	
Fourth Floor	49,120	
Fifth Floor	30,666	
Sixth Floor	30,666	
Seventh Floor	30,666	
Eighth Floor	30,666	
Ninth Floor	30,666	
Tenth Floor	5,456	
Eleventh Floor	4,007	
Penthouse	1,259	
Total Square Footage	595,695	
Average Square Feet	**49,641**	
Perimeter in Linear Feet	**Linear Feet**	
First Floor	2,377	
Second Floor	1,979	
Third Floor	1,550	
Fourth Floor	1,389	
Fifth Floor	947	
Sixth Floor	937	
Seventh Floor	937	
Eighth Floor	937	
Ninth Floor	937	
Tenth Floor	456	
Eleventh Floor	349	
Penthouse	145	
Total Linear Feet	**12,940**	
Average Linear Feet	**1,078**	
Wall Height (floor to eaves)	**Feet**	
First Floor	16	
Second Floor	17	
Third Floor	14	
Fourth Floor	14	
Fifth Floor	14	
Sixth Floor	14	
Seventh Floor	14	
Eighth Floor	14	
Ninth Floor	22	
Tenth Floor	14	
Eleventh Floor	19	
Penthouse	12	
Average Wall Height		

OTHER COMPONENTS		
Elevators	**List Number**	
Passenger	6	
Freight	9	
Sprinklers	**Square Feet Covered**	
Wet System	595,695	
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project	VAV / REHEAT	
Type of Exterior Walls for proposed project	PRECAST CONCRETE AND NATURAL STONE WITH GLASS CURTAINWALL	

TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garages, medical office buildings, or energy plants), complete an additional Table D for each structure.

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
SITE PREPARATION COSTS		
Total Site Preparation	$23,833,950	
Utilities from Structure to Lot Line		
Subtotal included in Marshall Valuation Costs	**$6,587,574**	
Site Demolition Costs	**$1,034,400**	
Storm Drains	**$1,551,600**	
Rough Grading	**$3,620,400**	
Hillside Foundation	**$1,551,600**	
Paving		
Exterior Signs		
Landscaping	$930,960	
Walls		
Yard Lighting		
Other *(Specify/add rows if needed:*		
Sediment Control & Stabilization	$103,440	
Deep Foundations	$517,200	
Pilings	$517,200	
Premium for Paying Prevailing Wage	$724,871	
Premium for Minority Business Enterprise Requirement	$384,866	
Subtotal On-Site excluded from Marshall Valuation Costs	**$10,936,536**	
OFFSITE COSTS		
Roads	$517,200	
Utilities	$5,792,640	
Jurisdictional Hook-up Fees		
Other *(Specify/add rows if needed)*		
Subtotal Off-Site excluded from Marshall Valuation Costs	**$6,309,840**	
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$17,246,376**	**$0**
BUILDING COSTS		
Total Building Costs	**$225,000,000**	
Subtotal included in Marshall Valuation Costs	**$173,194,880**	
Exterior Signs	$517,200	
Canopy	$3,620,400	
Foundation Drainage/Dewatering	$250,000	
LEED Silver Premium	$11,392,052	
Redundant Electric Service	$2,586,000	
Redundant Water Service	$310,320	
Premium for Concrete Frame Construction	$1,729,453	
Underground Bridge	$1,500,000	
Helipad	$1,551,600	
Premium for Paying Prevailing Wage	$19,232,575	
Premium for Minority Business Enterprise Requirement	$9,115,520	
Subtotal Building Costs excluded from Marshall Valuation Costs	$51,805,120	
PERMITS COSTS		
Jurisdictional Hook-up Fees	$517,200	
FIXED EQUIPMENT COSTS		
Premium for Paying Prevailing Wage	$3,596,735	
Premium for Minority Business Enterprise Requirement	$1,798,368	

TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$74,963,799**	**$0**

TABLE E. PROJECT BUDGET

INSTRUCTION : Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application. See additional instruction in the column to the right of the table.

NOTE : Inflation should only be included in the Inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.a as a use of funds and on line B.8 as a source of funds

			Modified Application Exhibit 50, March 13, 2015	Revised Budget August 30, 2016	Variance
A.	**USES OF FUNDS**				
1.	**CAPITAL COSTS**				
b.	**New Construction**				
(1)	Building		$284,744,090	$225,000,000	-$59,744,090
(2)	Fixed Equipment		$0	$35,967,350	$35,967,350
(3)	Site and Infrastructure		$17,133,951	$23,833,950	$6,699,999
(4)	Architect/Engineering Fees		$16,177,571	$15,177,571	-$1,000,000
(5)	Permits (Building, Utilities, Etc.)		$10,929,082	$10,088,060	-$841,022
	SUBTOTAL		**$328,984,694**	**$310,066,931**	**-$18,917,763**
c.	**Renovations**				
(1)	Building		$0	$0	$0
(2)	Fixed Equipment (not included in construction)		$0	$0	$0
(3)	Architect/Engineering Fees		$0	$0	$0
(4)	Permits (Building, Utilities, Etc.)		$0	$0	$0
	SUBTOTAL		**$0**	**$0**	**$0**
d.	**Other Capital Costs**				
(1)	Movable Equipment		$158,916,566	$118,724,774	-$40,191,792
(2)	Contingency Allowance		$30,000,000	$27,544,547	-$2,455,453
(3)	Gross interest during construction period		$39,762,000	$22,900,000	-$16,862,000
(4)	Other (Specify) UMMS PM, Builder's Risk, Commissioning/Testing, Warehousing, Testing, Traffic Study, Davis Langdon, CM Pricing, Scheduling, Helipad, Survey, Risk Assessment, Code, review, ICRA, MET Testing, Curtainwall Testing, Legal, Office Consolidation, Enabling, Equipment Planning, IT Design, Offsite Improvements, IT Design, Original site leave behind		$20,079,220	$19,329,220	-$750,000
	SUBTOTAL		***$248,757,786***	**$188,498,540**	**-$60,259,246**
	TOTAL CURRENT CAPITAL COSTS		**$577,742,480**	**$498,565,471**	**-$79,177,009**
e.	**Inflation Allowance**		$25,824,520	$17,173,011	-$8,651,509
	TOTAL CAPITAL COSTS		**$603,567,000**	**$515,738,482**	**-$87,828,518**
2.	**Financing Cost and Other Cash Requirements**				
a.	**Loan Placement Fees**		**$4,131,000**	$2,500,000	-$1,631,000
b.	**Bond Discount**		**$0**	$0	$0
c.	**Legal Fees**		**$1,000,000**	$927,115	-$72,885
d.	**Non-Legal Consultant Fees**		**$900,000**	$834,403	-$65,597
e.	**Liquidation of Existing Debt**		**$0**	$0	$0
f.	**Debt Service Reserve Fund**		**$14,775,000**	$8,500,000	-$6,275,000
g.	**Other (Specify)RPAI, Gold's Gym**		**$14,500,000**	$14,500,000	$0
	SUBTOTAL		***$35,306,000***	**$27,261,518**	**-$8,044,482**
3.	**Working Capital Startup Costs**		$0	$0	$0
	TOTAL PROJECT COSTS (as defined by Commissioner Moffit on 5/26/16)		**$638,873,000**	**$543,000,000**	**-$95,873,000**
a.	**Land Purchase**		$12,350,000	$12,350,000	$0
	TOTAL USES OF FUNDS		***$651,223,000***	***$555,350,000***	***-$95,873,000***
B.	**SOURCES OF FUNDS**				
1.	**Cash**		$0	$0	$0
2.	**Philanthropy (to date and expected)**		$0	$0	$0
3.	**Authorized Bonds**		$206,760,000	$117,809,717	-$88,950,283
4.	**Interest Income from bond proceeds listed in #3**		$16,113,000	$9,190,283	-$6,922,717
5.	**Mortgage**		$0	$0	$0
6.	**Working Capital Loans**		$0	$0	$0
7.	**Grants or Appropriations**				
a.	**Federal**		$0	$0	$0
b.	**State**		$208,000,000	$208,000,000	$0
c.	**Local**		$208,000,000	$208,000,000	$0
8.	**Other *(rounding)***		$12,350,000	$12,350,000	$0
	TOTAL SOURCES OF FUNDS		***$651,223,000***	***$555,350,000***	***-$95,873,000***
Annual Lease Costs (if applicable)					
1.	**Land**		$0		
2.	**Building**		$0		
3.	**Major Movable Equipment**		$0		
4.	**Minor Movable Equipment**		$0		
5.	**Other *(Specify/add rows if needed)***		$0		

TABLE F1 . STATISTICAL PROJECTIONS - ENTIRE FACILITY - DIMENSIONS

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
1. DISCHARGES (excludes newborn)										
a. General Medical/Surgical*	6,004	6,568	7,204	7,107	7,205	7,340	7,492	7,667	7,843	8,018
b. ICU/CCU (Admissions)	1,521	1,436	1,575	1,554	1,575	1,605	1,638	1,676	1,715	1,753
Total MSGA	**7,525**	**8,004**	**8,779**	**8,661**	**8,780**	**8,945**	**9,130**	**9,344**	**9,558**	**9,771**
c. Pediatric	29	0	1	1	1	1	1	10	19	27
d. Obstetric	2,283	2,525	2,252	2,331	2,331	2,331	2,331	2,366	2,401	2,437
e. Acute Psychiatric	1,468	1,415	1,274	1,424	1,424	1,424	1,424	1,465	1,506	1,548
Total Acute	***11,305***	***11,944***	***12,306***	***12,417***	***12,536***	***12,701***	***12,886***	***13,185***	***13,484***	***13,783***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL DISCHARGES	***11,305***	***11,944***	***12,306***	***12,417***	***12,536***	***12,701***	***12,886***	***13,185***	***13,484***	***13,783***
2. PATIENT DAYS										
a. General Medical/Surgical*	32,720	35,141	33,855	36,738	36,240	36,149	36,459	37,685	38,430	39,432
b. ICU/CCU	10,970	11,929	13,083	9,253	9,127	9,104	9,182	9,884	10,080	10,343
Total MSGA	**43,690**	**47,070**	**46,938**	**45,991**	**45,367**	**45,253**	**45,641**	**47,569**	**48,511**	**49,775**
c. Pediatric	35	0	4	4	4	3	3	22	39	55
d. Obstetric	5,829	6,462	5,823	6,014	6,002	5,990	5,978	6,063	6,156	6,247
e. Acute Psychiatric	8,264	8,640	8,050	8,999	8,999	8,999	8,999	9,259	9,519	9,779
Total Acute	***57,818***	***62,172***	***60,815***	***61,008***	***60,372***	***60,245***	***60,622***	***62,913***	***64,224***	***65,855***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS	***57,818***	***62,172***	***60,815***	***61,008***	***60,372***	***60,245***	***60,622***	***62,913***	***64,224***	***65,855***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*	5.4	5.4	4.7	5.2	5.0	4.9	4.9	4.9	4.9	4.9
b. ICU/CCU	7.2	8.3	8.3	6.0	5.8	5.7	5.6	5.9	5.9	5.9
Total MSGA	**5.8**	**5.9**	**5.3**	**5.3**	**5.2**	**5.1**	**5.0**	**5.1**	**5.1**	**5.1**
c. Pediatric	1.2	NA	2.9	2.7	2.6	2.4	2.3	2.2	2.1	2.0
d. Obstetric	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6
e. Acute Psychiatric	5.6	6.1	6.3	6.3	6.3	6.3	6.3	6.3	6.3	6.3
Total Acute	**5.1**	**5.2**	**4.9**	**4.9**	**4.8**	**4.7**	**4.7**	**4.8**	**4.8**	**4.8**
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL AVERAGE LENGTH OF STAY	**5.1**	**5.2**	**4.9**	**4.9**	**4.8**	**4.7**	**4.7**	**4.8**	**4.8**	**4.8**

TABLE F1 . STATISTICAL PROJECTIONS - ENTIRE FACILITY - DIMENSIONS

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*	108	107	135	135	135	135	135	122	122	122
b. ICU/CCU	34	34	34	34	34	34	34	32	32	32
Total MSGA	**142**	**141**	**169**	**169**	**169**	**169**	**169**	**154**	**154**	**154**
c. Pediatric	8	8	2	2	2	2	2	1	1	1
d. Obstetric	36	38	38	34	34	34	34	22	22	22
e. Acute Psychiatric	28	28	28	28	28	28	28	28	28	28
Total Acute	***214***	***215***	***237***	***233***	***233***	***233***	***233***	***205***	***205***	***205***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL LICENSED BEDS	***214***	***215***	***237***	***233***	***233***	***233***	***233***	***205***	***205***	***205***
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. General Medical/Surgical*	83.0%	90.0%	68.5%	74.6%	73.5%	73.4%	73.8%	84.6%	86.3%	88.6%
b. ICU/CCU	88.4%	96.1%	105.1%	74.6%	73.5%	73.4%	73.8%	84.6%	86.3%	88.6%
Total MSGA	**84.3%**	**91.5%**	**75.9%**	**74.6%**	**73.5%**	**73.4%**	**73.8%**	**84.6%**	**86.3%**	**88.6%**
c. Pediatric	1.2%	0.0%	0.5%	0.5%	0.5%	0.5%	0.4%	6.1%	10.7%	15.0%
d. Obstetric	44.4%	46.6%	41.9%	48.5%	48.4%	48.3%	48.0%	75.5%	76.7%	77.8%
e. Acute Psychiatric	80.9%	84.5%	78.6%	88.1%	88.1%	88.1%	87.8%	90.6%	93.1%	95.7%
Total Acute	**74.0%**	**79.2%**	**70.1%**	**71.7%**	**71.0%**	**70.8%**	**71.1%**	**84.1%**	**85.8%**	**88.0%**
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL OCCUPANCY %	**74.0%**	**79.2%**	**70.3%**	**71.5%**	**71.0%**	**70.8%**	**71.3%**	**83.9%**	**85.8%**	**88.0%**
6. OUTPATIENT VISITS										
a. Emergency Department (IP and OP)	50,229	49,756	50,651	51,563	52,491	53,435	54,397	55,376	56,372	57,387
b. Same-day Surgery	1,807	2,335	2,004	2,036	2,056	2,083	2,113	2,198	2,283	2,368
c. Laboratory										
d. Imaging										
e. Other - Psych. Day & Night	2,303	1,850	1,834	1,834	1,852	1,876	1,904	1,948	1,992	2,036
e. Other - Clinic	697	193	191	191	193	196	199	203	208	212
TOTAL OUTPATIENT VISITS	***55,036***	***54,134***	***54,680***	***55,625***	***56,592***	***57,590***	***58,612***	***59,725***	***60,855***	***62,004***
7. OBSERVATIONS**										
a. Number of Patients	4,292	4,363	3,814	3,781	3,817	3,867	3,924	4,015	4,106	4,197
b. Hours	130,072	113,507	104,435	113,224	114,312	115,811	117,498	120,225	122,953	125,680

TABLE G1. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - DIMENSIONS

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Act / Proj	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
1. REVENUE										
a. Inpatient Services	$ 188,441	$ 204,926	$ 214,979	$ 222,540	$ 226,310	$ 255,249	$ 259,910	$ 267,284	$ 272,985	$ 277,463
b. Outpatient Services	$ 76,379	$ 74,139	$ 71,689	$ 68,597	$ 69,846	$ 78,963	$ 80,493	$ 80,250	$ 81,694	$ 82,776
Gross Patient Service Revenues	***$ 264,820***	***$ 279,066***	***$ 286,668***	***$ 291,136***	***$ 296,157***	***$ 334,211***	***$ 340,403***	***$ 347,534***	***$ 354,679***	***$ 360,239***
c. Allowance For Bad Debt	$ 28,269	$ 10,715	$ 17,855	$ 17,950	$ 10,856	$ 10,580	$ 10,776	$ 11,002	$ 11,228	$ 11,404
d. Contractual Allowance	$ 30,070	$ 39,039	$ 33,161	$ 28,455	$ 28,946	$ 32,665	$ 33,270	$ 33,967	$ 34,665	$ 35,209
e. Charity Care	$ 13,185	$ 15,079	$ 10,680	$ 11,584	$ 11,784	$ 13,298	$ 13,545	$ 13,828	$ 14,113	$ 14,334
e. Uncompensated Care Receipts	$ (17,044)	$ (23,547)	$ (25,008)	$ (14,500)	$ (15,231)	$ (15,513)	$ (13,673)	$ (11,787)	$ (11,586)	$ (11,768)
Net Patient Services Revenue	***$ 210,340***	***$ 237,780***	***$ 249,980***	***$ 247,647***	***$ 259,803***	***$ 293,181***	***$ 296,485***	***$ 300,524***	***$ 306,259***	***$ 311,060***
f. Other Operating Revenues - State Support	$ 10,000	$ 10,772	$ -	$ 11,466	$ 22,932	$ 13,469	$ 13,406	$ 4,447	$ 4,427	$ -
f. Other Operating Revenues - County Support	$ 12,165	$ 6,959	$ 6,668	$ 6,736	$ 6,736	$ 8,593	$ 8,553	$ 4,447	$ 4,427	$ -
f. Other Operating Revenues	$ 6,092	$ 8,680	$ 6,320	$ 6,847	$ 6,847	$ 5,805	$ 5,805	$ 5,805	$ 5,805	$ 5,805
NET OPERATING REVENUE	***$ 238,597***	***$ 264,191***	***$ 262,967***	***$ 272,696***	***$ 296,318***	***$ 321,048***	***$ 324,249***	***$ 315,224***	***$ 320,919***	***$ 316,865***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 133,828	$ 134,820	$ 135,011	$ 135,823	$ 131,325	$ 125,506	$ 123,932	$ 124,665	$ 125,990	$ 127,633
b. Contractual Services	$ 35,391	$ 35,310	$ 38,608	$ 36,214	$ 36,260	$ 36,348	$ 35,438	$ 35,835	$ 36,278	$ 36,717
c. Interest on Current Debt	$ 970	$ 114	$ 88	$ 92	$ 92	$ 92	$ 92			
d. Interest on Project Debt								$ 9,469	$ 9,158	$ 8,833
e. Current Depreciation	$ 7,893	$ 8,186	$ 8,355	$ 8,158	$ 9,587	$ 11,060	$ 12,489			
f. Project Depreciation								$ 23,811	$ 24,311	$ 24,954
g. Current Amortization	$ -									
h. Project Amortization								$ 79	$ 79	$ 79
i. Supplies	$ 31,619	$ 36,787	$ 39,331	$ 38,704	$ 37,951	$ 37,562	$ 37,584	$ 37,361	$ 37,709	$ 38,237
j. Other Expenses - Physician/Ambulatory Development Support	$ 28,326	$ 28,547	$ 33,226	$ 39,353	$ 62,934	$ 87,773	$ 87,471	$ 57,463	$ 57,941	$ 48,421
j. Other Expenses - Transition Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,200	$ 800	$ -	$ -
j. Other Expenses - UMMS Overhead Allocation	$ -	$ -	$ -	$ -	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000
j. Other Expenses - Utilities	$ 2,932	$ 2,738	$ 4,310	$ 3,083	$ 3,004	$ 2,927	$ 2,849	$ 2,798	$ 2,833	$ 2,867
TOTAL OPERATING EXPENSES	**$ 240,958**	**$ 246,501**	**$ 258,929**	**$ 261,427**	**$ 284,153**	**$ 304,268**	**$ 305,055**	**$ 295,281**	**$ 297,297**	**$ 290,741**
3. INCOME										
a. Income From Operation	**$ (2,361)**	**$ 17,690**	**$ 4,038**	**$ 11,269**	**$ 12,165**	**$ 16,780**	**$ 19,194**	**$ 19,943**	**$ 23,622**	**$ 26,124**
b. Non-Operating Income	$ 24	$ 6	$ 19	$ 11	$ 11	$ 11	$ 11	$ 11	$ 11	$ 11
SUBTOTAL	***$ (2,337)***	***$ 17,696***	***$ 4,056***	***$ 11,280***	***$ 12,176***	***$ 16,791***	***$ 19,205***	***$ 19,954***	***$ 23,633***	***$ 26,135***
c. Income Taxes										
NET INCOME (LOSS)	***$ (2,337)***	***$ 17,696***	***$ 4,056***	***$ 11,280***	***$ 12,176***	***$ 16,791***	***$ 19,205***	***$ 19,954***	***$ 23,633***	***$ 26,135***

TABLE G1. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - DIMENSIONS

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Act / Proj	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	25.5%	28.1%	28.1%	28.1%	28.1%	28.1%	28.1%	29.0%	29.3%	29.7%
2) Medicaid	36.5%	41.6%	41.6%	41.6%	41.6%	41.6%	41.6%	39.9%	39.3%	38.6%
3) Blue Cross	9.9%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	8.6%	8.5%	8.4%
4) Commercial Insurance	16.0%	14.3%	14.3%	14.3%	14.3%	14.3%	14.3%	15.7%	16.3%	16.8%
5) Self-pay	10.8%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	5.7%	5.6%	5.5%
6) Other	1.3%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.0%	1.0%	1.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days										
1) Medicare	25.9%	27.4%	27.4%	27.4%	27.4%	27.4%	27.4%	27.9%	28.5%	29.0%
2) Medicaid	41.6%	43.3%	43.3%	43.3%	43.3%	43.3%	43.3%	42.1%	41.1%	40.1%
3) Blue Cross	9.0%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%	7.9%	7.7%	7.5%
4) Commercial Insurance	10.8%	10.5%	10.5%	10.5%	10.5%	10.5%	10.5%	11.5%	12.5%	13.4%
5) Self-pay	11.8%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	9.8%	9.5%	9.3%
6) Other	1.0%	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Prince George's Hospital Center & Prince George's Regional Medical Center
Key Financial Projection Assumptions - Uninflated

1) Basis of Projection	Based on the FY 2017 budget with adjustments identified below
2) Volumes	
– Inpatient Discharges	
➢ Interim Period (FY2017-FY2020)	Average annual increase of 1% per year from 12,306 in FY2016 to 12,886 in FY2020 driven by the execution of Dimension's Cardiovascular Business Plan.
➢ New Hospital (FY2021-FY2023)	
• MSGA	7.0% increase from FY2021 to FY2023 driven by growth in population, relocation, and recapture of market share
• Peds	Immaterial change in projected admissions due to limited population growth and no assumed change in use rates
• Psychiatry	9% increase from FY2021 to FY2023 driven by growth in population and increase in historical use rates
• Obstetrics	5% increase from FY2021 to FY2023 driven by growth in relocation and recapture of market share
– Inpatient Average Length of Stay	
➢ MSGA	To achieve Statewide historical averages, Ages 15-64 will decrease by 15% to 4.75, while Ages 65-74 and Ages 75+ will decrease by 12% and 13% to 5.62 and 5.45, respectivley, by FY2023
➢ Peds	To achieve Statewide historical average, PEDS will decrease to 2.00 days by FY2023
➢ Psychiatry	Remains constant at 6.32 days from FY2015
➢ Obstetrics	To achieve Statewide historical average, OB will decrease by 2% to 2.56 days by FY2023
– Outpatient Visits, including Observation	Increases by the same percentage as the annual increase in total inpatient discharges
3) Patient Revenue	
– Gross Charges	
➢ Annual Update Factor	0.0% annual increase
➢ Population Adjustment	0.58% annual increase
➢ Market Share Adjustment	
• Interim Period (FY2018-FY2020)	50% variability with projected growth in volumes related to the Cardiovascular Business Plan. Revenue is recognized in the year after volume growth.
• New Hospital (FY2021-FY2023)	50% variability with projected growth in volumes related to recaptured market share. **Revenue is recognized immediately / in the year of volume growth.**
➢ Retention of Revenue within DHS	$30M redistribution of Dimensions existing GBR in 2019 to help fund investments in IT infrastructure, population health efforts, physician recruitment, and future capital costs at PGRMC's new facility
➢ Case Mix	No governor on changes in case mix
– Revenue Deductions	
➢ Contractual Allowances	Remains constant at 9.77%
➢ Charity Care	Remains constant at 3.98%
➢ Allowance for Bad Debt	Declines by 3.0% of gross revenue due to improved collections
➢ UCC Pool Payment	Declines by 1.7% of gross revenue due to lower projected UCC policy results
4) Other Revenue	
– State Grant	$11M in 2017, $22M in 2018 due to expected receipt of 2016's state grant in 2018, $13M in 2019 and 2020, and $4M in 2021 and 2022
– County Grant	$7M in 2017-2018, increasing to $8M in 2019-2020, and then decreasing to $4M in 2021-2022
– McGruder Grant	Approximately $1M per year through 2018 and $0 thereafter
– Physician Billing and Other Revenue	0.0% increase per year
5) Non-Operating Revenue	0.0% increase per year

Prince George's Hospital Center & Prince George's Regional Medical Center
Key Financial Projection Assumptions - Uninflated

6) Expenses	
– Operating Expense Drivers	
➢ Salaries	Based on FTEs which includes a reduction of 87 FTEs based on comparison to a Peer Group
➢ Benefits	Reflects 24% of salaries as included in 2017 budget
➢ Other Operating Expenses	Reflects changes in adjusted admissions
– Inflation	
➢ Operating Exp, excl Phys Fees	0.0% increase per year
➢ Physician Fees	0.0% increase per year
– Expense Variability	50% throughout projection period
– Performance Improvements	$53M cumulative performance improvements identified related to revenue cycle, quality, utilization, labor, and supply chain
– Physician / Ambulatory Development Support	Includes physician fees for hospital based services, subsidy of physcian practice losses and $10M to $50M of annual investment in physicians and ambulatory platform development beginning in FY2018
– Transition Costs	$3M of costs spread between 2020 and 2021 associated with transition of campuses from Cheverly to Largo
– UMMS Overhead Allocation	$3M overhead allocated to PGRMC, starting in FY 2018
– Rental Space	40,000 sq. ft. of space is expected to be leased for Dimensions' corporate offices at $25 per sq.ft. effective the opening of the new building
– Interest Expense	
➢ Interim Period (FY2017-FY2020)	Magruder Trust Mortgage and capital lease obligations
➢ New Hospital (FY2021-FY2023)	$158.8M bond issuance at 5.5% over 30 years, with $117.8M related to the new Hospital and $41.0M related to the new Ambulatory Care Center (ACC)
➢ Line of Credit (FY2021-FY2023)	$28.5M loan required at opening of new hospital to fund 80 days of cash on hand at DHS in FY 2021 with 3.0% interest. Will be paid off over five years.
– Depreciation and Amortization	
➢ Interim Period (FY2017-FY2020)	Reflects FY2017 budget plus depreciation on $10M of annual routine capital expenditures with average lives of 7 years
➢ New Hospital (FY2021-FY2023)	Reflects depreciation on new hosptial facility with average useful life of 24 years plus depreciation on annual routine capital expenditures with average lives of 7 years
7) Routine Capital Expenditures	
– Interim Period (FY2017-FY2020)	$10M per year
– New Hospital (FY2021-FY2023)	$5M in 2021, $8.5M in 2022, and $13M in 2023
8) Debt	
– New Hospital Construction	$117.8M bond issuance in June 2017 at 5.5% over 30 years. Interest expense during construction will be capitalized. Principal payments will begin upon the new hospital's commencement of operations in FY 2021
– New Ambulatory Care Center Construction (ACC)	$41.0M bond issuance in June 2017 at 5.5% over 30 years. Interest expense during construction will be capitalized. Principal payments will begin upon the new ACC's commencement of operations in FY 2021
– Line of Credit	$28.5M loan required at opening of new hospital to fund 80 days of cash on hand at DHS in FY 2021 with 3.0% interest. Will be paid off over five years.

TABLE H1. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - DIMENSIONS

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Act / Proj	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
1. REVENUE										
a. Inpatient Services	$ 188,441	$ 204,926	$ 214,979	$ 222,540	$ 230,168	$ 263,213	$ 272,654	$ 283,965	$ 294,605	$ 304,262
b. Outpatient Services	$ 76,379	$ 74,139	$ 71,689	$ 68,597	$ 70,887	$ 81,053	$ 83,813	$ 85,722	$ 88,612	$ 91,199
Gross Patient Service Revenues	***$ 264,820***	***$ 279,066***	***$ 286,668***	***$ 291,136***	***$ 301,054***	***$ 344,266***	***$ 356,467***	***$ 369,688***	***$ 383,217***	***$ 395,461***
c. Allowance For Bad Debt	$ 28,269	$ 10,715	$ 17,855	$ 17,950	$ 11,035	$ 10,898	$ 11,284	$ 11,703	$ 12,131	$ 12,519
d. Contractual Allowance	$ 30,070	$ 39,039	$ 33,161	$ 28,455	$ 29,424	$ 33,648	$ 34,840	$ 36,132	$ 37,454	$ 38,651
e. Charity Care	$ 13,185	$ 15,079	$ 10,680	$ 11,584	$ 11,979	$ 13,698	$ 14,184	$ 14,710	$ 15,248	$ 15,735
e. Uncompensated Care Receipts	$ (17,044)	$ (23,547)	$ (25,008)	$ (14,500)	$ (15,483)	$ (15,979)	$ (14,318)	$ (12,538)	$ (12,518)	$ (12,918)
Net Patient Services Revenue	***$ 210,340***	***$ 237,780***	***$ 249,980***	***$ 247,647***	***$ 264,099***	***$ 302,002***	***$ 310,476***	***$ 319,681***	***$ 330,901***	***$ 341,474***
f. Other Operating Revenues - State Support	$ 10,000	$ 10,772	$ -	$ 11,466	$ 22,932	$ 13,413	$ 13,347	$ 4,426	$ 4,404	$ -
f. Other Operating Revenues - County Support	$ 12,165	$ 6,959	$ 6,668	$ 6,736	$ 6,736	$ 8,557	$ 8,515	$ 4,426	$ 4,404	$ -
f. Other Operating Revenues	$ 6,092	$ 8,680	$ 6,320	$ 6,847	$ 6,992	$ 6,099	$ 6,252	$ 6,408	$ 6,568	$ 6,732
NET OPERATING REVENUE	***$ 238,597***	***$ 264,191***	***$ 262,967***	***$ 272,696***	***$ 300,759***	***$ 330,071***	***$ 338,589***	***$ 334,941***	***$ 346,278***	***$ 348,206***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 133,828	$ 134,820	$ 135,011	$ 135,823	$ 134,894	$ 132,665	$ 135,157	$ 137,905	$ 142,848	$ 148,323
b. Contractual Services	$ 35,391	$ 35,310	$ 38,608	$ 36,214	$ 37,191	$ 38,265	$ 38,389	$ 39,936	$ 41,549	$ 43,210
c. Interest on Current Debt	$ 970	$ 114	$ 88	$ 92	$ 92	$ 92	$ 92			
d. Interest on Project Debt								$ 9,469	$ 9,158	$ 8,833
e. Current Depreciation	$ 7,893	$ 8,186	$ 8,355	$ 8,158	$ 9,587	$ 11,060	$ 12,489			
f. Project Depreciation								$ 23,811	$ 24,311	$ 24,954
g. Current Amortization	$ -									
h. Project Amortization								$ 79	$ 79	$ 79
i. Supplies	$ 31,619	$ 36,787	$ 39,331	$ 38,704	$ 39,200	$ 40,173	$ 41,690	$ 42,775	$ 44,406	$ 46,277
j. Other Expenses - Physician/Ambulatory Development Support	$ 28,326	$ 28,547	$ 33,226	$ 39,353	$ 64,793	$ 92,188	$ 93,829	$ 66,048	$ 68,856	$ 61,772
j. Other Expenses - Transition Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,400	$ 800	$ -	$ -
j. Other Expenses - UMMS Overhead Allocation	$ -	$ -	$ -	$ -	$ 3,000	$ 3,075	$ 3,152	$ 3,231	$ 3,311	$ 3,394
j. Other Expenses - Utilities	$ 2,932	$ 2,738	$ 4,310	$ 3,083	$ 3,083	$ 3,085	$ 3,090	$ 3,132	$ 3,259	$ 3,391
TOTAL OPERATING EXPENSES	**$ 240,958**	**$ 246,501**	**$ 258,929**	**$ 261,427**	**$ 291,839**	**$ 320,602**	**$ 330,287**	**$ 327,185**	**$ 337,778**	**$ 340,233**
3. INCOME										
a. Income From Operation	**$ (2,361)**	**$ 17,690**	**$ 4,038**	**$ 11,269**	**$ 8,921**	**$ 9,468**	**$ 8,302**	**$ 7,756**	**$ 8,499**	**$ 7,973**
b. Non-Operating Income	$ 24	$ 6	$ 19	$ 11	$ 11	$ 11	$ 11	$ 12	$ 12	$ 12
SUBTOTAL	***$ (2,337)***	***$ 17,696***	***$ 4,056***	***$ 11,280***	***$ 8,932***	***$ 9,480***	***$ 8,313***	***$ 7,767***	***$ 8,511***	***$ 7,986***
c. Income Taxes										
NET INCOME (LOSS)	***$ (2,337)***	***$ 17,696***	***$ 4,056***	***$ 11,280***	***$ 8,932***	***$ 9,480***	***$ 8,313***	***$ 7,767***	***$ 8,511***	***$ 7,986***

TABLE H1. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - DIMENSIONS

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Act / Proj	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	25.5%	28.1%	28.1%	28.1%	28.1%	28.1%	28.1%	29.0%	29.3%	29.7%
2) Medicaid	36.5%	41.6%	41.6%	41.6%	41.6%	41.6%	41.6%	39.9%	39.3%	38.6%
3) Blue Cross	9.9%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	8.6%	8.5%	8.4%
4) Commercial Insurance	16.0%	14.3%	14.3%	14.3%	14.3%	14.3%	14.3%	15.7%	16.3%	16.8%
5) Self-pay	10.8%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	5.7%	5.6%	5.5%
6) Other	1.3%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.0%	1.0%	1.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days										
1) Medicare	25.9%	27.4%	27.4%	27.4%	27.4%	27.4%	27.4%	27.9%	28.5%	29.0%
2) Medicaid	41.6%	43.3%	43.3%	43.3%	43.3%	43.3%	43.3%	42.1%	41.1%	40.0%
3) Blue Cross	9.0%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%	7.9%	7.7%	7.5%
4) Commercial Insurance	10.8%	10.5%	10.5%	10.5%	10.5%	10.5%	10.5%	11.6%	12.5%	13.5%
5) Self-pay	11.8%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	9.8%	9.5%	9.3%
6) Other	1.0%	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Prince George's Hospital Center & Prince George's Regional Medical Center
Key Financial Projection Assumptions - Inflated

1) Basis of Projection	Based on the FY 2017 budget with adjustments identified below
2) Volumes	
– Inpatient Discharges	
➢ Interim Period (FY2017-FY2020)	Average annual increase of 1% per year from 12,306 in FY2016 to 12,886 in FY2020 driven by the execution of Dimension's Cardiovascular Business Plan.
➢ New Hospital (FY2021-FY2023)	
• MSGA	7.0% increase from FY2021 to FY2023 driven by growth in population, relocation, and recapture of market share
• Peds	Immaterial change in projected admissions due to limited population growth and no assumed change in use rates
• Psychiatry	9% increase from FY2021 to FY2023 driven by growth in population and increase in historical use rates
• Obstetrics	5% increase from FY2021 to FY2023 driven by growth in relocation and recapture of market share
– Inpatient Average Length of Stay	
➢ MSGA	To achieve Statewide historical averages, Ages 15-64 will decrease by 15% to 4.75, while Ages 65-74 and Ages 75+ will decrease by 12% and 13% to 5.62 and 5.45, respectivley, by FY2023
➢ Peds	To achieve Statewide historical average, PEDS will decrease to 2.00 days by FY2023
➢ Psychiatry	Remains constant at 6.32 days from FY2015
➢ Obstetrics	To achieve Statewide historical average, OB will decrease by 2% to 2.56 days by FY2023
– Outpatient Visits, including Observation	Increases by the same percentage as the annual increase in total inpatient discharges
3) Patient Revenue	
– Gross Charges	
➢ Annual Update Factor	1.68% annual increase (2.42% update factor, less 0.74% shared savings)
➢ Population Adjustment	0.58% annual increase
➢ Market Share Adjustment	
• Interim Period (FY2018-FY2020)	50% variability with projected growth in volumes related to the Cardiovascular Business Plan. Revenue is recognized in the year after volume growth.
• New Hospital (FY2021-FY2023)	50% variability with projected growth in volumes related to recaptured market share. **Revenue is recognized immediately / in the year of volume growth.**
➢ Retention of Revenue within DHS GBR	$30M redistribution of Dimensions existing GBR in 2019 to help fund investments in IT infrastructure, population health efforts, physician recruitment, and future capital costs at PGRMC's new facility
➢ Case Mix	No governor on changes in case mix
– Revenue Deductions	
➢ Contractual Allowances	Remains constant at 9.77%
➢ Charity Care	Remains constant at 3.98%
➢ Allowance for Bad Debt	Declines by 3.0% of gross revenue due to improved collections
➢ UCC Pool Payment	Declines by 1.7% of gross revenue due to lower projected UCC policy results
4) Other Revenue	
– State Grant	$11M in 2017, $22M in 2018 due to expected receipt of 2016's state grant in 2018, $13M in 2019 and 2020, and $4M in 2021 and 2022
– County Grant	$7M in 2017-2018, increasing to $8M in 2019-2020, and then decreasing to $4M in 2021-2022
– McGruder Grant	Approximately $1M per year through 2018 and $0 thereafter
– Physician Billing and Other Revenue	2.5% increase per year
5) Non-Operating Revenue	2.5% increase per year

Prince George's Hospital Center & Prince George's Regional Medical Center
Key Financial Projection Assumptions - Inflated

6) Expenses	
– Operating Expense Drivers	
➢ Salaries	Based on FTEs which includes a reduction of 87 FTEs based on comparison to a Peer Group
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7) Routine Capital Expenditures	
– Interim Period (FY2017-FY2020)	$10M per year
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8) Debt	
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– Line of Credit	$28.5M loan required at opening of new hospital to fund 80 days of cash on hand at DHS in FY 2021 with 3.0% interest. Will be paid off over five years.

TABLE L1. MANPOWER INFORMATION - DIMENSIONS

INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables G and J. See additional instruction in the column to the right of the table.

	CURRENT ENTIRE FACILITY - FY201			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) (1)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) (2)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) * - FY2023		
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table J)*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G)*
Administration ***(List general categories, add rows if needed)***												
120854000 PHYSICIAN ASSISTANTS	15.0	$ 128,034	$ 1,925,893	-	$ -	-	(2.2)	$ 128,034	(284,033)	12.8	$ 128,034	$ 1,641,860
120901000 EXECUTIVE OFFICES	4.8	178,532	856,956	-	-	-	(0.7)	178,532	(126,385)	4.1	178,532	730,571
120910000 COMMUNICATIONS	11.8	34,659	410,476	-	-	-	(1.7)	34,659	(60,538)	10.1	34,659	349,938
Total - Executive Office/Administration	31.7	100,783	3,193,325	-	-	-	(4.7)	100,783	(470,956)	27.0	100,783	2,722,369
							-			-		
120999000 CORPORATE ALLOCATION	207.7	82,205	17,070,823	-	-	-	(30.6)	82,205	(2,517,628)	177.0	82,205	14,553,194
Corporate Allocations/Overhead - Direct & Indirect	207.7	82,205	17,070,823	-	-	-	(30.6)	82,205	(2,517,628)	177.0	82,205	14,553,194
							-					
120903000 REGISTRATION	23.0	40,031	920,718	-	-	-	(3.4)	40,031	(135,789)	19.6	40,031	784,929
Total - Fiscal Services	23.0	40,031	920,718	-	-	-	(3.4)	40,031	(135,789)	19.6	40,031	784,929
							-					
120855000 INTERNAL MEDICINE	45.4	58,092	2,635,718	-	-	-	(6.7)	58,092	(388,719)	38.7	58,092	2,246,999
120856000 MEDICAL AFFAIRS OFFICE	9.6	82,867	799,240	-	-	-	(1.4)	82,867	(117,873)	8.2	82,867	681,367
120975000 CASE MANAGEMENT	28.3	85,827	2,426,698	-	-	-	(4.2)	85,827	(357,893)	24.1	85,827	2,068,805
Total - Medical Affairs	83.3	70,376	5,861,656	-	-	-	(12.3)	70,376	(864,485)	71.0	70,376	4,997,171
							-					
120603000 INFECTION CONTROL	2.8	105,368	291,840	-	-	-	(0.4)	105,368	(43,041)	2.4	105,368	248,799
120852000 CLINICAL DOCUMENTATION	6.5	93,707	612,716	-	-	-	(1.0)	93,707	(90,364)	5.6	93,707	522,351
120982000 ONE CALL REFERRAL	6.4	40,028	256,942	-	-	-	(0.9)	40,028	(37,894)	5.5	40,028	219,048
120859000 QUALITY IMPROVEMENT	8.4	91,922	769,548	-	-	-	(1.2)	91,922	(113,494)	7.1	91,922	656,054
Total - Quality Affairs	24.1	80,129	1,931,046	-	-	-	(3.6)	80,129	(284,793)	20.5	80,129	1,646,253
Total Administration	369.7	78,373	28,977,568	-	-	-	(54.5)	78,373	(4,273,651)	315.2	78,373	24,703,917
Direct Care Staff ***(List general categories, add rows if needed)***												
120600000 NURSING ADMINISTRATION	10.0	79,368	793,551	0.4	79,368	29,666	(0.2)	79,368	(13,448)	10.2	79,368	809,768
120600200 INPATIENT OPERATIONS	7.5	108,401	817,941	0.3	108,401	30,577	(0.1)	108,401	(13,862)	7.7	108,401	834,656
120601000 ON CALL FLOAT POOL	2.4	77,700	189,357	0.1	77,700	7,079	(0.0)	77,700	(3,209)	2.5	77,700	193,227
120928000 CLINICAL EDUCATION	8.4	91,571	771,001	0.3	91,571	28,823	(0.1)	91,571	(13,066)	8.6	91,571	786,757
120845000 GRADUATE MEDICAL EDUCATION	2.1	76,731	164,206	0.1	76,731	6,139	(0.0)	76,731	(2,783)	2.2	76,731	167,561
120603500 PATIENT TRANSPORT	14.0	23,677	332,031	0.5	23,677	12,412	(0.2)	23,677	(5,627)	14.3	23,677	338,817
120611000 NURSING E 900 (MS-TELE/ON	61.5	65,869	4,051,594	2.3	65,869	151,463	(1.0)	65,869	(68,663)	62.8	65,869	4,134,393
120612000 NURSING E 700 (MS-TELE)	36.9	68,943	2,541,605	1.4	68,943	95,014	(0.6)	68,943	(43,073)	37.6	68,943	2,593,546
120612500 NURSING E-800 (MS-ORTHO/T	59.6	64,730	3,857,189	2.2	64,730	144,195	(1.0)	64,730	(65,368)	60.8	64,730	3,936,016
120624000 NURSING K400 - PCRU	67.2	65,803	4,420,896	2.5	65,803	165,268	(1.1)	65,803	(74,922)	68.6	65,803	4,511,243
120651000 NURSING K 200 - ANTE/POST	47.2	74,122	3,498,934	1.8	74,122	130,802	(0.8)	74,122	(59,297)	48.2	74,122	3,570,439
120660000 NURSING - CCU	26.9	77,409	2,079,850	1.0	77,409	77,752	(0.5)	77,409	(35,248)	27.4	77,409	2,122,354
120663000 NURSING - ICU/CCC	98.9	75,910	7,510,456	3.7	75,910	280,767	(1.7)	75,910	(127,281)	101.0	75,910	7,663,942
120666000 NURSING - PSYCH	47.6	73,673	3,504,027	1.8	73,673	130,993	(0.8)	73,673	(59,383)	48.5	73,673	3,575,637
120672000 NURSING - NICU	28.6	82,875	2,372,902	1.1	82,875	88,707	(0.5)	82,875	(40,214)	29.2	82,875	2,421,395
120701000 OPERATING ROOM	44.7	77,757	3,472,974	1.7	77,757	129,832	(0.8)	77,757	(58,857)	45.6	77,757	3,543,948
120704000 POST ANESTHESIA CARE UNIT	15.8	90,891	1,432,233	0.6	90,891	53,542	(0.3)	90,891	(24,272)	16.1	90,891	1,461,502
120706000 SAME DAY SURGERY	6.2	68,468	425,439	0.2	68,468	15,904	(0.1)	68,468	(7,210)	6.3	68,468	434,134
120707000 TRANSCARE	2.5	86,978	214,928	0.1	86,978	8,035	(0.0)	86,978	(3,642)	2.5	86,978	219,320
120708000 LABOR AND DELIVERY	46.2	75,195	3,472,059	1.7	75,195	129,798	(0.8)	75,195	(58,842)	47.1	75,195	3,543,015
120718000 CENTRAL STERILE PROCESSIN	11.3	37,233	421,290	0.4	37,233	15,749	(0.2)	37,233	(7,140)	11.5	37,233	429,900
120724000 ANESTHESIOLOGY	3.2	49,182	159,759	0.1	49,182	5,972	(0.1)	49,182	(2,707)	3.3	49,182	163,024
120725000 HEMODIALYSIS	7.9	87,439	689,913	0.3	87,439	25,791	(0.1)	87,439	(11,692)	8.1	87,439	704,012
120744000 CARDIOLOGY	6.1	80,472	494,070	0.2	80,472	18,470	(0.1)	80,472	(8,373)	6.3	80,472	504,167
120746000 CARDIAC CATH LAB	12.4	101,024	1,256,689	0.5	101,024	46,979	(0.2)	101,024	(21,297)	12.7	101,024	1,282,371
120763100 CARDIAC REHAB	2.7	86,727	229,888	0.1	86,727	8,594	(0.0)	86,727	(3,896)	2.7	86,727	234,587
120770000 PSYCH-PARTIAL HOSPITALIZA	2.2	71,064	157,516	0.1	71,064	5,889	(0.0)	71,064	(2,669)	2.3	71,064	160,735
120771100 SMOKING CESSATION	1.3	59,819	77,778	0.0	59,819	2,908	(0.0)	59,819	(1,318)	1.3	59,819	79,368
120772000 EMERGENCY PSYCH SERVICE-E	14.2	73,931	1,046,317	0.5	73,931	39,115	(0.2)	73,931	(17,732)	14.4	73,931	1,067,700
120775000 HIV GRANTS	1.1	57,742	64,688	0.0	57,742	2,418	(0.0)	57,742	(1,096)	1.1	57,742	66,010
120781000 PERINATAL DIAGNOSTIC CTR	4.3	70,522	305,164	0.2	70,522	11,408	(0.1)	70,522	(5,172)	4.4	70,522	311,400
120783200 SPECIAL PROCEDURES	4.9	65,446	320,753	0.2	65,446	11,991	(0.1)	65,446	(5,436)	5.0	65,446	327,308

Job Category	CURRENT ENTIRE FACILITY - FY201			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) (1)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) (2)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) * - FY2023		
	Current Year FTEs	Average Salary per FTE	Current Year Total Cost	FTEs	Average Salary per FTE	Total Cost *(should be consistent with projections in Table J)*	FTEs	Average Salary per FTE	Total Cost	FTEs	Average Salary per FTE	Total Cost *(should be consistent with projections in Table G)*
120743000 CARDIAC PROGRAM	2.7	75,188	200,529	0.1	75,188	7,496	(0.0)	75,188	(3,398)	2.7	75,188	204,627
120844000 CARDIAC SERVICES	0.1	69,917	6,284	0.0	69,917	235	(0.0)	69,917	(106)	0.1	69,917	6,412
120926000 CUSTOMER SERVICE	0.9	66,188	62,090	0.0	66,188	2,321	(0.0)	66,188	(1,052)	1.0	66,188	63,359
Total - Nursing	709.6	72,458	51,415,899	26.5	72,458	1,922,105	(12.0)	72,458	(871,354)	724.1	72,458	52,466,651
120710000 PHARMACY	39.4	96,790	3,811,231	1.5	96,790	142,477	(0.7)	96,790	(64,590)	40.2	96,790	3,889,119
120719000 PATHOLOGY ADMINISTRATION	48.4	67,817	3,282,446	1.8	67,817	122,709	(0.8)	67,817	(55,628)	49.4	67,817	3,349,527
120722000 ANGIOGRAPHY	2.6	75,380	193,329	0.1	75,380	7,227	(0.0)	75,380	(3,276)	2.6	75,380	197,280
120728000 RADIOLOGY	29.8	67,442	2,008,413	1.1	67,442	75,081	(0.5)	67,442	(34,037)	30.4	67,442	2,049,458
120729000 ULTRASOUND	9.0	91,169	820,850	0.3	91,169	30,686	(0.2)	91,169	(13,911)	9.2	91,169	837,625
120730000 CAT SCAN	8.2	87,760	720,781	0.3	87,760	26,945	(0.1)	87,760	(12,215)	8.4	87,760	735,511
120853000 FAMILY MEDICINE PROGRAM	9.1	50,118	455,294	0.3	50,118	17,020	(0.2)	50,118	(7,716)	9.3	50,118	464,598
120732000 NUCLEAR MEDICINE	3.1	93,120	290,235	0.1	93,120	10,850	(0.1)	93,120	(4,919)	3.2	93,120	296,166
120745000 PULMONARY FUNCTION	1.0	84,532	83,437	0.0	84,532	3,119	(0.0)	84,532	(1,414)	1.0	84,532	85,142
120748000 ELECTROENCEPHALOGRAPHY	1.1	61,122	64,322	0.0	61,122	2,405	(0.0)	61,122	(1,090)	1.1	61,122	65,636
120752000 RESPIRATORY THERAPY	30.5	77,864	2,375,682	1.1	77,864	88,811	(0.5)	77,864	(40,261)	31.1	77,864	2,424,232
120760000 PHYSICAL MEDICINE	9.3	72,664	672,540	0.3	72,664	25,142	(0.2)	72,664	(11,398)	9.4	72,664	686,284
120761000 OCCUPATIONAL THERAPY	3.8	92,654	354,159	0.1	92,654	13,240	(0.1)	92,654	(6,002)	3.9	92,654	361,396
120762000 SPEECH THERAPY	2.2	86,763	193,349	0.1	86,763	7,228	(0.0)	86,763	(3,277)	2.3	86,763	197,300
Total - Ambulatory Care & Ancillary Services	197.4	77,641	15,326,068	7.4	77,641	572,942	(3.3)	77,641	(259,734)	201.4	77,641	15,639,276
120769000 SEXUAL ASSAULT CENTER	8.6	63,525	543,735	0.3	63,525	20,327	(0.1)	63,525	(9,215)	8.7	63,525	554,847
120774000 EMERGENCY SERVICES	86.4	74,363	6,424,852	3.2	74,363	240,183	(1.5)	74,363	(108,883)	88.2	74,363	6,556,153
120835000 TRAUMA	6.6	74,049	491,396	0.2	74,049	18,370	(0.1)	74,049	(8,328)	6.8	74,049	501,438
Total - Emergency Services	101.6	73,430	7,459,983	3.8	73,430	278,880	(1.7)	73,430	(126,426)	103.7	73,430	7,612,437
Cancer Center	-	-	-	-	-	-	-	-	-	-	-	-
Total - New Departments	-	-	-	-	-	-	-	-	-	-	-	-
Total Direct Care	1,008.6	73,570	74,201,950	37.7	73,570	2,773,927	(17.1)	73,570	(1,257,513)	1,029.2	73,570	75,718,364
Support Staff *(List general categories, add rows if needed)*												
120930000 FOOD SERVICES	58.8	31,711	1,864,540	2.2	31,711	69,703	(1.0)	31,711	(31,599)	60.0	31,711	1,902,645
120940000 ENVIRONMENTAL SERVICES	81.2	34,165	2,772,781	3.0	34,165	103,656	(1.4)	34,165	(46,991)	82.8	34,165	2,829,446
120964000 MAINTENANCE	22.0	61,558	1,354,061	0.8	61,558	50,620	(0.4)	61,558	(22,948)	22.4	61,558	1,381,733
120976000 PROTECTIVE SERVICES	2.5	102,195	257,468	0.1	102,195	9,625	(0.0)	102,195	(4,363)	2.6	102,195	262,730
Total - Support Services	164.5	37,993	6,248,851	6.1	37,993	233,604	(2.8)	37,993	(105,900)	167.8	37,993	6,376,554
Total Support	164.5	37,993	6,248,851	6.1	37,993	233,604	(2.8)	37,993	(105,900)	167.8	37,993	6,376,554
REGULAR EMPLOYEES TOTAL SALARIES	**1,542.8**	**$ 70,929**	**$ 109,428,369**	**43.9**	**$ 68,582**	**$ 3,007,531**	**(74.4)**	**$ 75,757**	**($ 5,637,065)**	**1,512.2**	**$ 70,623**	**$ 106,798,835**
REDUCTION IN PREMIUM & OVERTIME $ PER FTE @ % OF SALARIES AND BENEFITS		0.0%	0								-3.7%	(3,968,396)
BENEFITS @ % of SALARIES		24.1%	26,394,489								24.1%	24,803,046
TOTAL COST			**$ 135,822,858**									**$ 127,633,484**

* The projected FTEs and cost for the entire facility should equal the current number of FTEs and cost plus changes in FTEs and cost related to the proposed project plus other expected changes in staffing.

Note (1): Includes growth of 76 FTEs related to the projected increase in volumes less 32 FTEs related to the new building design efficiencies

Note (2): Includes reductions of 20 FTEs related to a projected decline in Average Length of Stay and 54 FTEs related to management performance improvements

EXHIBIT 63

Name of Applicant:	Dimensions Health Corporation d/b/a Prince George's Hospital Center and Mount Washington Pediatric Hospital, Inc.
Date of Submission:	8/31/2016

Applicants should follow additional instructions included at the top of each of the following worksheets. Please ensure all green fields (see above) are filled.

Table Number	Table Title	Instructions
Table A	**Physical Bed Capacity Before and After Project**	All applicants whose project impacts any nursing unit, regardless of project type or scope, must complete Table A.
Table B	**Departmental Gross Square Feet**	All applicants, regardless of project type or scope, must complete Table B for all departments and functional areas affected by the proposed project.
Table C	**Construction Characteristics**	All applicants proposing new construction or renovation must complete Table C.
Table D	**Site and Offsite Costs Included and Excluded in Marshall Valuation Costs**	All applicants proposing new construction or renovation must complete Table D.
Table E	**Project Budget**	All applicants, regardless of project type or scope, must complete Table E.
Table F	**Statistical Projections - Entire Facility**	Existing facility applicants must complete Table F. All applicants who complete this table must also complete Tables G and H.
Table G	**Revenues & Expenses, Uninflated - Entire Facility**	Existing facility applicants must complete Table G. The projected revenues and expenses in Table G should be consistent with the volume projections in Table F.
Table H	**Revenues & Expenses, Inflated - Entire Facility**	Existing facility applicants must complete Table H. The projected revenues and expenses in H should be consistent with the projections in Tables F and G.
Table I	**Statistical Projections - New Facility or Service**	Applicants who propose to establish a new facility, existing facility applicants who propose a new service, and applicants who are directed by MHCC staff must complete Table I. All applicants who complete this table must also complete Tables J and K.
Table J	**Revenues & Expenses, Uninflated - New Facility or Service**	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant who completes a Table I must complete Table J. The projected revenues and expenses in Table J should be consistent with the volume projections in Table I.
Table K	**Revenues & Expenses, Inflated - New Facility or Service**	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant that completes a Table I must complete Table K. The projected revenues and expenses in Table K should be consistent with the projections in Tables I and J.
Table L	**Work Force Information**	All applicants, regardless of project type or scope, must complete Table L.

TABLE F2. STATISTICAL PROJECTIONS - ENTIRE FACILITY - MWPH

INSTRUCTION : Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23
1. DISCHARGES										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	797	813	761	806	809	815	822	827	832	837
d. Obstetric										
e. Acute Psychiatric										
Total Acute	***797***	***813***	***761***	***806***	***809***	***815***	***822***	***827***	***832***	***837***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL DISCHARGES	***797***	***813***	***761***	***806***	***809***	***815***	***822***	***827***	***832***	***837***
2. PATIENT DAYS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	22,230	23,733	22,347	23,153	23,442	23,808	24,210	24,548	24,891	25,229
d. Obstetric										
e. Acute Psychiatric										
Total Acute	***22,230***	***23,733***	***22,347***	***23,153***	***23,442***	***23,808***	***24,210***	***24,548***	***24,891***	***25,229***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS	***22,230***	***23,733***	***22,347***	***23,153***	***23,442***	***23,808***	***24,210***	***24,548***	***24,891***	***25,229***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Pediatric	27.9	29.2	29.4	28.7	29.0	29.2	29.4	29.7	29.9	30.2
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	27.9	29.2	29.4	28.7	29.0	29.2	29.4	29.7	29.9	30.2

TABLE F2. STATISTICAL PROJECTIONS - ENTIRE FACILITY - MWPH

INSTRUCTION : Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	27.9	29.2	29.4	28.7	29.0	29.2	29.4	29.7	29.9	30.2
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	102	102	102	102	102	102	102	102	102	102
d. Obstetric										
e. Acute Psychiatric										
Total Acute	***102***	***102***	***102***	***102***	***102***	***102***	***102***	***102***	***102***	***102***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL LICENSED BEDS	***102***	***102***	***102***	***102***	***102***	***102***	***102***	***102***	***102***	***102***
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
c. Pediatric	59.7%	63.7%	60.0%	62.2%	63.0%	63.9%	65.0%	65.9%	66.9%	67.8%
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	**59.7%**	**63.7%**	**60.0%**	**62.2%**	**63.0%**	**63.9%**	**65.0%**	**65.9%**	**66.9%**	**67.8%**
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**59.7%**	**63.7%**	**60.0%**	**62.2%**	**63.0%**	**63.9%**	**65.0%**	**65.9%**	**66.9%**	**67.8%**

TABLE F2. STATISTICAL PROJECTIONS - ENTIRE FACILITY - MWPH

INSTRUCTION : Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23
6. OUTPATIENT VISITS										
a. Emergency Department										
b. Same-day Surgery										
c. Laboratory										
d. Imaging										
e. Other (Specify/add rows of needed)	40,641	43,623	47,683	49,039	50,412	51,825	53,281	56,148	59,060	60,651
TOTAL OUTPATIENT VISITS	***40,641***	***43,623***	***47,683***	***49,039***	***50,412***	***51,825***	***53,281***	***56,148***	***59,060***	***60,651***
7. OBSERVATIONS**										
a. Number of Patients										
b. Hours										

* Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a medical practitioner; may or may not be provided in a distinct area of the hospital.

TABLE G2. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - MWPH

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23
1. REVENUE										
a. Inpatient Services	$ 47,087	$ 47,607	$ 45,005	$ 46,629	$ 47,209	$ 47,947	$ 48,756	$ 49,438	$ 50,128	$ 50,808
b. Outpatient Services	$ 13,822	$ 14,901	$ 15,708	$ 16,154	$ 16,606	$ 17,072	$ 17,552	$ 18,496	$ 19,455	$ 19,979
Gross Patient Service Revenues	***$ 60,909***	***$ 62,508***	***$ 60,712***	***$ 62,783***	***$ 63,816***	***$ 65,019***	***$ 66,307***	***$ 67,934***	***$ 69,583***	***$ 70,787***
c. Allowance For Bad Debt	$ 589	$ 603	$ 568	$ 588	$ 596	$ 605	$ 615	$ 624	$ 632	$ 641
d. Contractual Allowance	$ 4,002	$ 3,940	$ 4,016	$ 4,161	$ 4,213	$ 4,279	$ 4,351	$ 4,412	$ 4,473	$ 4,534
e. Charity Care										
Net Patient Services Revenue	***$ 56,318***	***$ 57,965***	***$ 56,128***	***$ 58,034***	***$ 59,007***	***$ 60,136***	***$ 61,342***	***$ 62,898***	***$ 64,478***	***$ 65,613***
f. Other Operating Revenues (Specify/add rows if needed)	$ 750	$ 1,165	$ 870	$ 773	$ 773	$ 773	$ 773	$ 773	$ 773	$ 773
NET OPERATING REVENUE	***$ 57,068***	***$ 59,130***	***$ 56,998***	***$ 58,807***	***$ 59,780***	***$ 60,909***	***$ 62,115***	***$ 63,671***	***$ 65,251***	***$ 66,386***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 39,117	$ 36,178	$ 36,776	$ 37,403	$ 37,711	$ 38,066	$ 38,444	$ 38,915	$ 39,388	$ 39,728
b. Contractual Services	$ 5,596	$ 5,703	$ 5,823	$ 5,922	$ 5,971	$ 6,027	$ 6,087	$ 6,162	$ 6,237	$ 6,290
c. Interest on Current Debt	**$ 151**	**$ 80**	**$ 80**	**$ 81**	**$ 82**	**$ 83**	**$ 84**	**$ 85**	**$ 86**	**$ 86**
d. Interest on Project Debt			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
e. Current Depreciation	$ 2,381	$ 2,834	$ 3,070	$ 3,122	$ 3,148	$ 3,178	$ 3,209	$ 3,249	$ 3,288	$ 3,316
f. Project Depreciation				$ -	$ -	$ -	$ -	$ -	$ -	$ -
g. Current Amortization			***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
h. Project Amortization			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
i. Supplies	$ 5,748	$ 6,296	$ 5,499	$ 5,593	$ 5,639	$ 5,692	$ 5,748	$ 5,819	$ 5,889	$ 5,940
j. Other Expenses (Specify/add rows if needed)	$ 2,322	$ 2,729	$ 2,765	$ 2,812	$ 2,835	$ 2,862	$ 2,963	$ 2,999	$ 3,036	$ 3,062
TOTAL OPERATING EXPENSES	**$ 55,315**	**$ 53,820**	**$ 54,013**	**$ 54,934**	**$ 55,386**	**$ 55,908**	**$ 56,535**	**$ 57,228**	**$ 57,923**	**$ 58,424**

TABLE G2. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - MWPH

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23
3. INCOME										
a. Income From Operation	**$ 1,753**	**$ 5,310**	**$ 2,985**	**$ 3,872**	**$ 4,394**	**$ 5,000**	**$ 5,580**	**$ 6,443**	**$ 7,328**	**$ 7,962**
b. Non-Operating Income	$ 1,082	$ 4	$ 5	$ 1,455	$ 1,746	$ 2,095	$ 2,514	$ 3,017	$ 3,621	$ 4,345
SUBTOTAL	***$ 2,835***	***$ 5,314***	***$ 2,990***	***$ 5,327***	***$ 6,140***	***$ 7,096***	***$ 8,094***	***$ 9,461***	***$ 10,948***	***$ 12,306***
c. Income Taxes										
NET INCOME (LOSS)	***$ 2,835***	***$ 5,314***	***$ 2,990***	***$ 5,327***	***$ 6,140***	***$ 7,096***	***$ 8,094***	***$ 9,461***	***$ 10,948***	***$ 12,306***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	0.3%	0.3%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
2) Medicaid	70.8%	70.8%	73.6%	73.6%	73.6%	73.6%	73.6%	73.6%	73.6%	73.6%
3) Blue Cross	14.8%	14.8%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%
4) Commercial Insurance	6.6%	6.6%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%
5) Self-pay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
6) Other	7.4%	7.4%	5.4%	5.4%	5.4%	5.4%	5.4%	5.4%	5.4%	5.4%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days										
1) Medicare	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2) Medicaid	78.3%	79.0%	79.3%	79.3%	79.3%	79.3%	79.3%	79.3%	79.3%	79.3%
3) Blue Cross	10.7%	9.9%	9.4%	9.4%	9.4%	9.4%	9.4%	9.4%	9.4%	9.4%
4) Commercial Insurance	4.8%	4.7%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%
5) Self-pay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
6) Other	6.0%	6.3%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE H2. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - MWPH

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23
1. REVENUE										
a. Inpatient Services	$ 47,087	$ 47,607	$ 45,005	$ 47,584	$ 49,165	$ 50,957	$ 52,878	$ 54,717	$ 56,619	$ 58,563
b. Outpatient Services	$ 13,822	$ 14,901	$ 15,708	$ 16,485	$ 17,294	$ 18,144	$ 19,036	$ 20,471	$ 21,974	$ 23,029
Gross Patient Service Revenues	***$ 60,909***	***$ 62,508***	***$ 60,712***	***$ 64,070***	***$ 66,459***	***$ 69,100***	***$ 71,914***	***$ 75,188***	***$ 78,593***	***$ 81,592***
c. Allowance For Bad Debt	$ 589	$ 603	$ 568	$ 641	$ 665	$ 691	$ 719	$ 752	$ 786	$ 816
d. Contractual Allowance	$ 4,002	$ 3,940	$ 4,016	$ 4,238	$ 4,396	$ 4,571	$ 4,757	$ 4,974	$ 5,199	$ 5,397
e. Charity Care										
Net Patient Services Revenue	***$ 56,318***	***$ 57,965***	***$ 56,128***	***$ 59,191***	***$ 61,398***	***$ 63,838***	***$ 66,438***	***$ 69,463***	***$ 72,608***	***$ 75,379***
f. Other Operating Revenues (Specify/add rows if needed)	$ 750	$ 1,165	$ 870	$ 789	$ 789	$ 789	$ 789	$ 789	$ 789	$ 789
NET OPERATING REVENUE	***$ 57,068***	***$ 59,130***	***$ 56,998***	***$ 59,980***	***$ 62,187***	***$ 64,627***	***$ 67,227***	***$ 70,252***	***$ 73,397***	***$ 76,168***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 39,117	$ 36,178	$ 36,776	$ 38,338	$ 39,620	$ 40,993	$ 42,434	$ 44,029	$ 45,677	$ 47,224
b. Contractual Services	$ 5,596	$ 5,703	$ 5,823	$ 6,070	$ 6,273	$ 6,491	$ 6,719	$ 6,971	$ 7,232	$ 7,477
c. Interest on Current Debt	**$ 151**	**$ 80**	**$ 80**	**$ 83**	**$ 86**	**$ 89**	**$ 92**	**$ 96**	**$ 99**	**$ 103**
d. Interest on Project Debt		$ -	$ -							
e. Current Depreciation	$ 2,381	$ 2,834	$ 3,070	$ 3,122	$ 3,148	$ 3,178	$ 3,209	$ 3,249	$ 3,288	$ 3,316
f. Project Depreciation		$ -	$ -							
g. Current Amortization		***$ -***	***$ -***							
h. Project Amortization		$ -	$ -							
i. Supplies	$ 5,748	$ 6,296	$ 5,499	$ 5,733	$ 5,924	$ 6,130	$ 6,345	$ 6,583	$ 6,830	$ 7,061
j. Other Expenses (Specify/add rows if needed)	$ 2,322	$ 2,729	$ 2,765	$ 2,882	$ 2,979	$ 3,082	$ 3,274	$ 3,397	$ 3,525	$ 3,644
TOTAL OPERATING EXPENSES	**$ 55,315**	**$ 53,820**	**$ 54,013**	**$ 56,229**	**$ 58,031**	**$ 59,963**	**$ 62,074**	**$ 64,325**	**$ 66,652**	**$ 68,826**

TABLE H2. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - MWPH

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23
3. INCOME										
a. Income From Operation	**$ 1,753**	**$ 5,310**	**$ 2,985**	**$ 3,750**	**$ 4,157**	**$ 4,665**	**$ 5,152**	**$ 5,926**	**$ 6,745**	**$ 7,341**
b. Non-Operating Income	$ 1,082	$ 4	$ 5	$ 1,455	$ 1,746	$ 2,095	$ 2,514	$ 3,017	$ 3,621	$ 4,345
SUBTOTAL	***$ 2,835***	***$ 5,314***	***$ 2,990***	***$ 5,205***	***$ 5,903***	***$ 6,760***	***$ 7,667***	***$ 8,944***	***$ 10,366***	***$ 11,686***
c. Income Taxes										
NET INCOME (LOSS)	***$ 2,835***	***$ 5,314***	***$ 2,990***	***$ 5,205***	***$ 5,903***	***$ 6,760***	***$ 7,667***	***$ 8,944***	***$ 10,366***	***$ 11,686***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	0.3%	0.3%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
2) Medicaid	70.8%	70.8%	73.6%	73.6%	73.6%	73.6%	73.6%	73.6%	73.6%	73.6%
3) Blue Cross	14.8%	14.8%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%
4) Commercial Insurance	6.6%	6.6%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%
5) Self-pay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
6) Other	7.4%	7.4%	5.4%	5.4%	5.4%	5.4%	5.4%	5.4%	5.4%	5.4%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2) Medicaid	78.3%	79.0%	79.3%	79.3%	79.3%	79.3%	79.3%	79.3%	79.3%	79.3%
3) Blue Cross	10.7%	9.9%	9.4%	9.4%	9.4%	9.4%	9.4%	9.4%	9.4%	9.4%
4) Commercial Insurance	4.8%	4.7%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%
5) Self-pay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
6) Other	6.0%	6.3%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE - MWPH

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23
1. DISCHARGES										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA				**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	102	116	111	117	117	120	123	126	129	132
d. Obstetric										
e. Acute Psychiatric										
Total Acute	***102***	***116***	***111***	***117***	***117***	***120***	***123***	***126***	***129***	***132***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL DISCHARGES	***102***	***116***	***111***	***117***	***117***	***120***	***123***	***126***	***129***	***132***
2. PATIENT DAYS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	2,459	2,775	2,395	2,759	2,786	2,889	2,995	3,098	3,204	3,303
d. Obstetric										
e. Acute Psychiatric										
Total Acute	***2,459***	***2,775***	***2,395***	***2,759***	***2,786***	***2,889***	***2,995***	***3,098***	***3,204***	***3,303***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS	***2,459***	***2,775***	***2,395***	***2,759***	***2,786***	***2,889***	***2,995***	***3,098***	***3,204***	***3,303***
3. AVERAGE LENGTH OF STAY										
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Pediatric	24.1	23.9	21.6	23.6	23.8	24.1	24.3	24.6	24.8	25.1
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	24.1	23.9	21.6	23.6	23.8	24.1	24.3	24.6	24.8	25.1

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE - MWPH

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	24.1	23.9	21.6	23.6	23.8	24.1	24.3	24.6	24.8	25.1
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA				**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric	15	15	15	15	15	15	15	15	15	15
d. Obstetric										
e. Acute Psychiatric										
Total Acute	***15***	***15***	***15***	***15***	***15***	***15***	***15***	***15***	***15***	***15***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL LICENSED BEDS	***15***	***15***	***15***	***15***	***15***	***15***	***15***	***15***	***15***	***15***
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
c. Pediatric	44.9%	50.7%	43.7%	50.4%	50.9%	52.8%	54.7%	56.6%	58.5%	60.3%
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	**44.9%**	**50.7%**	**43.7%**	**50.4%**	**50.9%**	**52.8%**	**54.7%**	**56.6%**	**58.5%**	**60.3%**
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**44.9%**	**50.7%**	**43.7%**	**50.4%**	**50.9%**	**52.8%**	**54.7%**	**56.6%**	**58.5%**	**60.3%**

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE - MWPH

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23
6. OUTPATIENT VISITS										
a. Emergency Department										
b. Same-day Surgery										
c. Laboratory										
d. Imaging										
e. Other (Specify/add rows of needed)	3,501	3,194	3,271	3,295	3,295	3,295	3,295	4,663	6,030	6,030
TOTAL OUTPATIENT VISITS	***3,501***	***3,194***	***3,271***	***3,295***	***3,295***	***3,295***	***3,295***	***4,663***	***6,030***	***6,030***
7. OBSERVATIONS**										
a. Number of Patients										
b. Hours										

*Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a medical practitioner; may or may not be provided in a distinct area of the hospital.

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE - MWPH

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23
1. REVENUE										
a. Inpatient Services	$ 3,960	$ 4,302	$ 3,713	$ 4,277	$ 4,319	$ 4,478	$ 4,643	$ 4,802	$ 4,966	$ 5,121
b. Outpatient Services	$ 1,199	$ 1,497	$ 865	$ 865	$ 865	$ 865	$ 865	$ 1,224	$ 1,583	$ 1,583
Gross Patient Service Revenues	***$ 5,159***	***$ 5,799***	***$ 4,578***	***$ 5,142***	***$ 5,184***	***$ 5,343***	***$ 5,508***	***$ 6,026***	***$ 6,549***	***$ 6,704***
c. Allowance For Bad Debt	$ 52	$ 58	$ 46	$ 51	$ 52	$ 53	$ 55	$ 60	$ 65	$ 67
d. Contractual Allowance	$ 335	$ 377	$ 298	$ 334	$ 337	$ 347	$ 358	$ 392	$ 426	$ 436
e. Charity Care										
Net Patient Services Revenue	***$ 4,772***	***$ 5,364***	***$ 4,235***	***$ 4,757***	***$ 4,795***	***$ 4,942***	***$ 5,095***	***$ 5,574***	***$ 6,058***	***$ 6,201***
f. Other Operating Revenues (Specify)	$ 168	$ 168	$ 168	$ 168	$ 168	$ 168	$ 168	$ 168	$ 168	$ 168
NET OPERATING REVENUE	***$ 4,940***	***$ 5,532***	***$ 4,403***	***$ 4,925***	***$ 4,963***	***$ 5,110***	***$ 5,263***	***$ 5,742***	***$ 6,226***	***$ 6,369***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 3,640	$ 3,776	$ 3,379	$ 3,466	$ 3,553	$ 3,640	$ 3,728	$ 4,037	$ 4,347	$ 4,435
b. Contractual Services	$ 107	$ 318	$ 151	$ 168	$ 170	$ 174	$ 178	$ 209	$ 236	$ 241
c. Interest on Current Debt										
d. Interest on Project Debt										
e. Current Depreciation										
f. Project Depreciation										
g. Current Amortization										
h. Project Amortization										
i. Supplies	$ 957	$ 850	$ 500	$ 557	$ 561	$ 576	$ 590	$ 692	$ 781	$ 796
j. Other Expenses (Specify)	$ 120	$ 177	$ 252	$ 281	$ 283	$ 291	$ 297	$ 421	$ 476	$ 485
TOTAL OPERATING EXPENSES	**$ 4,824**	**$ 5,121**	**$ 4,282**	**$ 4,472**	**$ 4,567**	**$ 4,682**	**$ 4,793**	**$ 5,360**	**$ 5,840**	**$ 5,957**
3. INCOME										
a. Income From Operation	**$ 116**	**$ 411**	**$ 121**	**$ 452**	**$ 396**	**$ 429**	**$ 470**	**$ 382**	**$ 386**	**$ 412**
b. Non-Operating Income										
SUBTOTAL	***$ 116***	***$ 411***	***$ 121***	***$ 452***	***$ 396***	***$ 429***	***$ 470***	***$ 382***	***$ 386***	***$ 412***
c. Income Taxes										
NET INCOME (LOSS)	***$ 116***	***$ 411***	***$ 121***	***$ 452***	***$ 396***	***$ 429***	***$ 470***	***$ 382***	***$ 386***	***$ 412***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE - MWPH

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	0.4%	0.4%	0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
2) Medicaid	79.9%	79.9%	85%	84.7%	84.7%	84.7%	84.7%	84.7%	84.7%	84.7%
3) Blue Cross	11.1%	11.1%	7%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%
4) Commercial Insurance	3.7%	3.7%	4%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
5) Self-pay	0.0%	0.0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
6) Other	4.9%	4.9%	5%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2) Medicaid	84.9%	84.9%	85.3%	85.3%	85.3%	85.3%	85.3%	85.3%	85.3%	85.3%
3) Blue Cross	8.2%	8.2%	5.7%	5.7%	5.7%	5.7%	5.7%	5.7%	5.7%	5.7%
4) Commercial Insurance	6.3%	6.3%	5.1%	5.1%	5.1%	5.1%	5.1%	5.1%	5.1%	5.1%
5) Self-pay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
6) Other	0.6%	0.6%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE - MWPH

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23
1. REVENUE										
a. Inpatient Services	$ 3,960	$ 4,302	$ 3,713	$ 4,365	$ 4,497	$ 4,759	$ 5,036	$ 5,315	$ 5,609	$ 5,902
b. Outpatient Services	$ 1,199	$ 1,497	$ 865	$ 883	$ 901	$ 919	$ 938	$ 1,355	$ 1,788	$ 1,825
Gross Patient Service Revenues	***$ 5,159***	***$ 5,799***	***$ 4,578***	***$ 5,248***	***$ 5,398***	***$ 5,679***	***$ 5,974***	***$ 6,670***	***$ 7,397***	***$ 7,727***
c. Allowance For Bad Debt	$ 52	$ 58	$ 46	$ 52	$ 54	$ 57	$ 60	$ 67	$ 74	$ 77
d. Contractual Allowance	$ 335	$ 377	$ 298	$ 341	$ 351	$ 369	$ 388	$ 434	$ 481	$ 502
e. Charity Care	$ -									
Net Patient Services Revenue	***$ 4,772***	***$ 5,364***	***$ 4,235***	***$ 4,854***	***$ 4,993***	***$ 5,253***	***$ 5,526***	***$ 6,170***	***$ 6,843***	***$ 7,148***
f. Other Operating Revenues (Specify/add rows of needed)	$ 168	$ 168	$ 168	$ 168	$ 168	$ 168	$ 168	$ 168	$ 168	$ 168
NET OPERATING REVENUE	***$ 4,940***	***$ 5,532***	***$ 4,403***	***$ 5,022***	***$ 5,161***	***$ 5,421***	***$ 5,694***	***$ 6,338***	***$ 7,011***	***$ 7,316***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 3,640	$ 3,776	$ 3,379	$ 3,553	$ 3,733	$ 3,920	$ 4,115	$ 4,568	$ 5,042	$ 5,271
b. Contractual Services	$ 107	$ 318	$ 151	$ 173	$ 178	$ 188	$ 197	$ 237	$ 274	$ 286
c. Interest on Current Debt	$ -									
d. Interest on Project Debt	$ -									
e. Current Depreciation	$ -									
f. Project Depreciation	$ -									
g. Current Amortization	$ -									
h. Project Amortization	$ -									
i. Supplies	$ 957	$ 850	$ 500	$ 571	$ 589	$ 621	$ 651	$ 783	$ 906	$ 947
j. Other Expenses (Specify/add rows of needed)	$ 120	$ 177	$ 252	$ 288	$ 297	$ 313	$ 328	$ 477	$ 552	$ 577
TOTAL OPERATING EXPENSES	***$ 4,824***	***$ 5,121***	***$ 4,282***	***$ 4,584***	***$ 4,798***	***$ 5,042***	***$ 5,290***	***$ 6,064***	***$ 6,773***	***$ 7,081***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE - MWPH

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23
3. INCOME										
a. Income From Operation	**$ 116**	**$ 411**	**$ 121**	**$ 438**	**$ 363**	**$ 379**	**$ 403**	**$ 273**	**$ 238**	**$ 235**
b. Non-Operating Income										
SUBTOTAL	***$ 116***	***$ 411***	***$ 121***	***$ 438***	***$ 363***	***$ 379***	***$ 403***	***$ 273***	***$ 238***	***$ 235***
c. Income Taxes										
NET INCOME (LOSS)	***$ 116***	***$ 411***	***$ 121***	***$ 438***	***$ 363***	***$ 379***	***$ 403***	***$ 273***	***$ 238***	***$ 235***
4. PATIENT MIX										
1) Medicare	0.4%	0.4%	0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
2) Medicaid	79.9%	79.9%	85%	84.7%	84.7%	84.7%	84.7%	84.7%	84.7%	84.7%
3) Blue Cross	11.1%	11.1%	7%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%
4) Commercial Insurance	3.7%	3.7%	4%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
5) Self-pay	0.0%	0.0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
6) Other	4.9%	4.9%	5%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2) Medicaid	84.9%	84.9%	85.3%	85.3%	85.3%	85.3%	85.3%	85.3%	85.3%	85.3%
3) Blue Cross	8.2%	8.2%	5.7%	5.7%	5.7%	5.7%	5.7%	5.7%	5.7%	5.7%
4) Commercial Insurance	6.3%	6.3%	5.1%	5.1%	5.1%	5.1%	5.1%	5.1%	5.1%	5.1%
5) Self-pay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
6) Other	0.6%	0.6%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Assumptions for Revenue and Expense Projections - MWPH

Financial Assumptions

1. HSCRC rate increases are estimated at 2.05% per year, consistent with the approved increase for FY 2017.
2. Inflation is estimated at 2.5% per year.
3. Bad debt and charity care are estimated at a combined 1% per year.
4. Expense variability is projected at 50%.

Volume Assumptions - PGHC / PGRMC Unit

1. Inpatient volume assumptions are based on use rate: the number of admissions per projected Maryland population aged 0-4.
3. Use rate for FY 2017 - FY 2023 is based on average from FY12 - FY16. Growth is expected due to new waiver with population health model, encouraging hospitals to move patients to lower-cost settings. Increased admissions also seen resulting from closer relationship between PG hospital and UMMS, of which MWPH is a part.
4. Average length of stay is based on average of FY12 - FY16
5. Average length of stay for FY 2017 - FY 2023 grows at .25 days per year. Increase is expected due to new waiver with population health model, encouraging hospitals to move patients more quickly to lower-cost settings.
6. Outpatient volumes assumptions are based on current demand. Rehabilitation and psychology are projected grow 50% in first year of new building; then reach double the previous volumes in the subsequent year. Clinic volumes are projected to remain stable.
7. The base year for revenue and costs was projected Fiscal Year 2016.

Volume Assumptions - Rogers

1. Inpatient volume assumptions are based on use rate: the number of admissions per projected Maryland population aged 0-4.
2. Use rate for FY 2017 forward is based on average of FY14 - FY16. Unit expansion was completed in FY13.
5. Average length of stay for FY 2017 - FY 2023 grows at .25 days per year. Increase is expected due to new waiver with population health model, encouraging hospitals to move patients more quickly to lower-cost settings.
6. Outpatient volumes are projected to grow by 3% per year, consistent with current trends.
7. The base year for revenue and costs was Fiscal Year 2016.

TABLE L2. WORK FORCE INFORMATION - MWPH at PGHC/PGRMC

INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables G and J. See additional instruction in the column to the right of the table.

	CURRENT ENTIRE FACILITY			***PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)***			***OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)***			***PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) ****	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table J)*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Site Manager	1.0	$94,000	$94,000	0.0	$94,000	$0			$0	1.0	$94,000
Unit Clerk	1.0	$34,000	$34,000	0.0	$34,000	$0			$0	1.0	$34,000
Outpatient clerical	1.0	$35,000	$35,000	0.0	$35,000	$0			$0	1.0	$35,000
			$0			$0			$0	0.0	$0
Total Administration	$3	$163,000	$163,000			$0			$0	3.0	$163,000
Direct Care Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
RN	13.5	$82,000	$1,107,000	3.9	$82,000	$319,660				17.4	$1,426,660
CNAs	0.2	$31,000	$6,200	0.0	$31,000	$0				0.2	$6,200
PT	1.0	$84,000	$84,000	1.0	$84,000	$84,000				2.0	$168,000
OT	1.0	$87,000	$87,000	1.0	$87,000	$87,000				2.0	$174,000
SP	1.0	$92,000	$92,000	1.0	$92,000	$92,000				2.0	$184,000
Psych	1.0	$95,000	$95,000	1.0	$95,000	$95,000				2.0	$190,000
Medicine	5.7	$158,000	$900,600	1.0	$158,000	$157,259				6.7	$1,057,859
Outpatient RN	1.0	$84,000	$84,000	0.0	$84,000	$0				1.0	$84,000
Outpatient PCA	0.5	$34,000	$17,000	0.0	$34,000	$0				0.5	$17,000
			$0			$0			$0	0.0	$0
Total Direct Care	25	$747,000	$2,472,800			$0			$0	33.8	$3,307,719
Support Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
Social Work	1.0	$67,000	$67,000	0.2	$67,000	$12,753			$0	1.2	$79,753
Child Life	0.1	$44,000	$4,400	0.0	$44,000	$0			$0	0.1	$4,400
Dietary	0.2	$35,000	$7,000	0.0	$35,000	$0			$0	0.2	$7,000
Total Support	1.3	$ 146,000	$ 78,400			$0			$0	1.5	$91,153
REGULAR EMPLOYEES TOTAL	29.2	$ 1,056,000	$ 2,714,200			$0			$0	38.3	$3,561,872
2. Contractual Employees[1]											
Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff			$0			$0			$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL			$0			$0			$0	0.0	$0
Benefits *(State method of calculating benefits b*			664,979								872,659
TOTAL COST	***29.2***		***$3,379,179***	***0.0***		***$0***	***0.0***		***$0***		***$4,434,531***

Note 1: MWPH pays for certain contractual services, including respiratory therapy, lab, and radioly, on an as needed basis per RVU. MWPH is not able to calculate these services on an FTE basis, but has included the cost in the contractual services line in Tables G, H, J and K.

EXHIBIT 64

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EXHIBIT 65

	Cumulative Projected Impact of Performance Improvements						
Performance Improvement Category	**FY 2017 Budget**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
PGHC / PGRMC							
Revenue Cycle							
Reduction in Denials	$2.1	$3.6	$3.8	$3.9	$4.4	$4.6	$4.8
Improved Hospital Collections (Bad Debt)	5.0	8.5	8.7	6.8	4.7	4.2	4.2
Increase in DHA Physician Collections	1.4	1.5	1.5	1.5	1.8	2.0	2.2
Subtotal Revenue Cycle	**$8.6**	**$13.6**	**$13.9**	**$12.1**	**$11.0**	**$10.9**	**$11.2**
Quality - Reward / (Penalty)	**$1.9**	**$3.8**	**$7.6**	**$9.2**	**$10.8**	**$12.4**	**$12.4**
Readmissions	($3.7)	($2.2)	$0.0	$0.0	$0.0	$0.0	$0.0
MHAC	($0.5)	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
QBR	$0.1	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Composite Method	$0.0	$0.0	$1.6	$3.2	$4.8	$6.4	$6.4
Total Reward / (Penalty)	($4.1)	($2.2)	$1.6	$3.2	$4.8	$6.4	$6.4
Utilization							
ALOS Reduction Resulting in Lower FTEs and Variable Costs	$0.2	$1.7	$3.1	$3.9	$3.1	$2.9	$2.7
Subtotal Utilization	**$0.2**	**$1.7**	**$3.1**	**$3.9**	**$3.1**	**$2.9**	**$2.7**
Labor							
Reduction in Labor and Premium Pay/Overtime	$3.0	$6.2	$11.2	$13.9	$16.2	$16.6	$17.0
Subtotal Labor	**$3.0**	**$6.2**	**$11.2**	**$13.9**	**$16.2**	**$16.6**	**$17.0**
Supply Chain, Drugs and Contract Services	**$2.0**	**$4.0**	**$6.0**	**$8.0**	**$10.0**	**$10.3**	**$10.5**
Total PGHC / PGRMC	**$15.6**	**$29.4**	**$41.8**	**$47.1**	**$51.1**	**$53.0**	**$53.8**

Exhibit 65 – Full Size Version of Table 92.

EXHIBIT 66

Rushern L. Baker, III
County Executive

HEALTH DEPARTMENT
Prince George's County

PRINCE GEORGE'S COUNTY EFFORTS TOWARDS PRIMARY CARE EXPANSION/INCREASE

I. PRINCE GEORGE'S COUNTY EFFORTS TO INCREASE PRIMARY CARE IN THE COUNTY

1. In 2011, the county only had one FQHC that offered primary care, Greater Baden Medical Center (GBMC). GBMC has 3 locations that support southern county. Since that time the county has assisted 4 additional FQHCs to open within the county.
    - The Mary's Center - Adelphi, Maryland
    - CCI Health and Wellness - Greenbelt, Maryland
    - Family Medical and Counseling Services - Capital Heights, Maryland
    - La Clinica del Pueblo - Hyattsville, Maryland

2. Planned Parenthood of the Metro Washington area opened a primary care model program in Suitland, Maryland at the request of the County and State.

3. The county has increased the number of providers who serve the underserved with the implementation of the Health Enterprise Zone in Capital Heights. In addition to funding GBMC already in the zone, this grant provided incentives that brought 2 practices (Gerald Family Care and Global Vision) and a new FQHC to the zone. Dimensions will open a PCMH extended program this year in the zone that provides specialists and behavioral health services to the zone. The following outcomes have been achieved to date:
    - 30,117 Unduplicated patients seen; 42,897 patient visits at HEZ practices by Year 3
    - 7.25 FTE health practitioners (4.3 MDs, PAs, NPs)
    - 17 FTE new jobs created
    - 24.75 FTE capacity by end of Year 3

II. COUNTY EFFORTS TO ASSIST W/ SELF-MANAGEMENT OF CHRONIC DISEASES

1. Dine and Learn: Promotes a healthy lifestyle through nutrition, physical activity and health education. Through partnership, the program consists of four components, namely:

- Nutrition
- Physical Fitness
- Blood Pressure and Cholesterol Screenings
- Healthy Meal Preparation

2. On the Road Diabetes Classes: Program designed to raise the awareness about the importance of diabetes screenings, management and prevention. Sessions are conducted in partnership with the Joslin Diabetes Center of Doctor's Community Hospital.

3. Support of the County Council's Biggest Loser Program.

4. Healthy Revolution Program that encourages healthy eating and active living among residents.

III. HEALTH ENTERPRISE ZONE (HEZ)

The Prince George's County Health Enterprise Zone (PGCHEZ) was jointly issued and funded by the State of Maryland Community Health Resources Commission (CHRC) and the Department of Health & Mental Hygiene (DHMH) in January 2013 with one of the designations awarded to the Prince George's County Health Department (PGCHD). The proposal from the PGCHD focuses on Capitol Heights, zip code 20743, which includes the town of Capitol Heights, Fairmont Heights, Seat Pleasant, and Coral Hills, a Transforming Neighborhoods Initiative (TNI) Community. The population is diverse with over 95% belonging to racial and ethnic minorities. According to the Prince George's County Maryland Public Health Impact Study by University of Maryland, School of Public Health (July, 2012), this zip code was medically underserved with no Board-certified primary care physicians and only one healthcare clinic serving its 38,621 residents.

In planning for the work and targeted goals in the PGCHEZ, the PGCHD convened a wide range of community partners and stakeholders to expand the primary resources and recruit primary care providers to establish five (5) Patient Centered Medical Homes (PCMHs) to serve a minimum of 10,000 residents. Since part of its mission is to assure the availability of access to quality healthcare services for all County residents, PGCHD welcomed the opportunity to not only address health disparities for a particularly challenged community, Capitol Heights, but also to build new

and reinforce existing health infrastructure components through the proposed project. Consequently, by leveraging the CTG, TNI, and other local partner resources, and existing PGCHD programs in combination with HEZ funding, PGCHD and its partners created in Capitol Heights the blueprint for establishing and sustaining PCMHs in underserved communities throughout the County. The PGCHEZ provided primary care providers with a package of benefits and incentives from the State funds designed to attract and retain them in the Zone. All providers and partners are linked via a public health information Network (PHIN) that integrates with local and state information exchanges which enables PCMHs located within PGCHEZ to share patient information among themselves, local hospitals, partner programs and the Health Department. PGCHEZ recruited, trained, and deployed five full-time Community Health Workers (CHWs) to facilitate access to care; connect residents to health insurance registration tools and primary care medical practices; provide assistance and navigation with various social services resources; promote medication adherence and health literacy education resources; and coordination care to minimize hospital readmissions.

PGCHEZ is managed by PGCHD with input from a Coalition and a Community Advisory Board (CAB) and Steering Committee of the Health Literacy Campaign, and the Community Care Coordination Team (CCCT). Outcome evaluation will assess the degree to which PGCHEZ has met the outline goals in 20743 by the end of the project period with a completion date of December 31, 2017. The overall goals of the HEZ include increasing access to healthcare, reducing healthcare costs, and improving health outcomes, an expanded primary care workforce, and an increased community health workforce.

The PGCHEZ offers a package of benefits and incentives to recruit and retain high quality providers. This includes combination of grants, loan repayment assistance, and tax credits. The PGCHD is tasked as the Zone's care coordinator and manager of the HEZ and is working with partners to expand the number of new providers that move into the Zone.
The major accomplishments to date include the opening of the four medical practices since 2013. The practices are Global Vision Community Health Services, Greater Baden Medical Services' expansion, Gerald Family Care, P.C. and Family and Medical Counseling Service, Inc. The Dimensions Specialty Care Center will open in September, 2016.

The total PCMH provider capacity total is 7.25 FTE in the Zone as of June, 2016 and 4.30 FTE new providers added as a result of the PGCHEZ. Total

practitioner capacity is 15.45 FTE and total Zone FTE is 24.75 (all jobs). Presently, 17.0 FTE new jobs have been created in the Zone. As of April, 2016, Zone practices have provided services for 42,897 patient visits and seen 30,117 patient visits since the being of the HEZ Initiative.

The preliminary economic analysis started by UMSPH, analyzed 77 clients looking at a six-month period before they enrolled in the CHW program and six-months after enrollment (excluding those who moved, expired, or were non-compliant or lost to follow up). Of those 77, the average age was 48 and 92 were African American, and 62% women. The overall preliminary results show a 17.3% reduction overall for hospital, inpatient, ED, and observation visits and a 11.3% reduction in hospital charges. For those with the highest number of identified needs (>5), hospital charges were reduced by 31.8% from $61,872 to $42,208.24. Of the most frequently pathways used, the clients who enrolled with transportation issues had the largest reduction in hospital-related charges, from $29,657 to $16,973. NOTE: This data is considered preliminary. We anticipate acquiring additional utilization data for our partner hospitals and EMS services, and plan to analyze results with a longer timeframe and large sample size.

The PGCHEZ model was designed to be sustainable and the PGCHD's long-term sustainability as the Zone Coordinator is assured because care coordination services are reimbursable when linked to a PCMH.

IV. COMMUNITY HEALTH WORKER (CHW) PROGRAM

(CHW) Program Mission:

The Health Enterprise Zone Community Health Worker Program's mission is to provide care coordination services to high risk and at-risk Prince George's County residents with frequent hospital readmissions, ED visits, and unmet social needs that are affecting their health. The CHW Program staffs five (5) Community Health Workers who use evidence-based pathways and workflows to address social determinants of health, with the ultimate goal of guiding individuals to adopt healthy behaviors that promote, maintain, and improve their quality of life. CHW Program Referrals are initiated by ED case managers, hospital care transition nurses, ambulatory and primary care practices, health department clinics, payers and community non-profit organizations.

Rushern L. Baker, III
County Executive

HEALTH DEPARTMENT
Prince George's County

CHW Program Workflow:

CHW referrals are initiated by referral sources who obtain a signed patient consent for our services. A CHW brochure was created to assist referral sources with promoting our program to their patients. Referrals are received by our Intake Nurse Coordinator who reviews and assigns cases to CHWs. Our CHWs maintain a case load of approximately 20-25 clients. Once assigned, the CHW contacts the client and schedules a home visit. During the initial home visit, the CHW completes the Initial Adult Checklist which is a 9-page document created by the HEZ Team that gathers the client's current health status, social needs and family support. At the conclusion of the initial visit, the CHW works with the client and family to summarize the client's needs, identify gaps in care, jointly establish a care plan with patient goals and timelines. The CHWs use Pathways which are event-based, sequence of steps that guide the CHWs toward the established goal. Each pathway step has an established timeline for completion, and completion criteria. This allows program managers to measure, track and monitor individual CHW productivity and progress. We are currently implementing a Pathway Tracking System to electronically collect and aggregate data, which will provide analytics for overall supervision and management.

Current pathways used by Community Health Workers:

❑ Asthma Self-Management	❑ Housing	❑ Medical Referral
❑ Behavioral Health	❑ Food Insecurity	❑ Prime Time Sister Circle – Behavioral Modification for Women
❑ Care Team	❑ Health Insurance	❑ Smoking Cessation
❑ Companion Care	❑ Health Literacy	❑ Social Service Referral
❑ Diabetes Self-Management	❑ Medical Home/Primary Care Doctor	❑ Transportation
❑ Dietitian or Nutrition Consult	❑ Medication Assessment	❑ HEZ Transportation
❑ Domestic Violence	❑ Medication Therapy Management	

CHW Program Outcomes:
A preliminary analysis shows that in Figure 1 Overall hospital utilization decreased by 44.5%. Figure 2 demonstrates the correlation between the number of pathways initiated and hospital charges. When 1 pathway was initiated, hospital charges decreased. However, when 5 or more pathways are initiated, the impact on reduction in hospital charges is greater.

Figure 1.

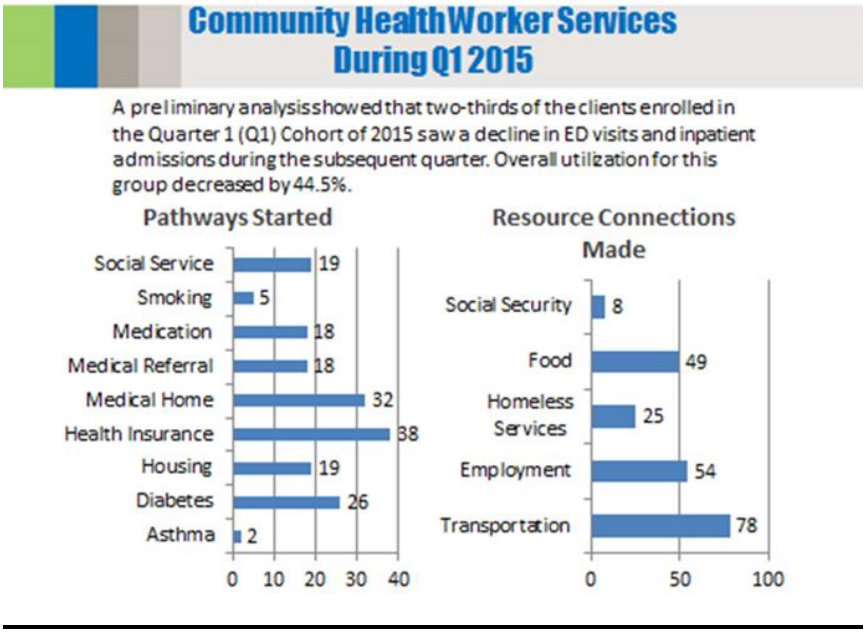
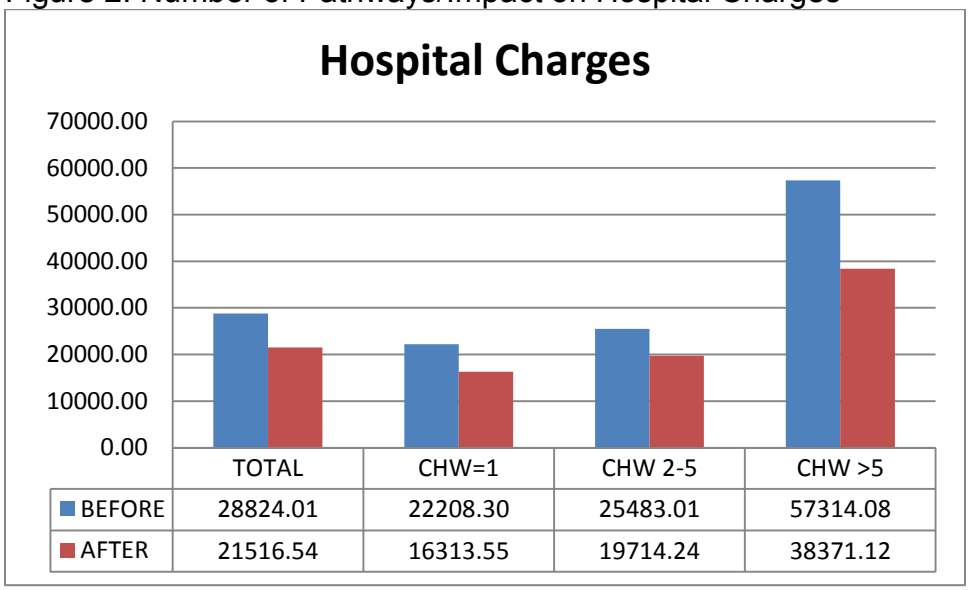


Figure 2. Number of Pathways/Impact on Hospital Charges



V. HEZ COMMUNITY CARE COORDINATION TEAM OVERVIEW

Care Coordination Team Mission:

The Community Care Coordination Team (CCCT) was formed by Dr. Ernest Carter, Deputy Health Officer and Barbara Banks-Wiggins, HEZ Partner Services Coordinator in February, 2015. Dr. Carter's vision was to establish an integrated health system which consists of public-private partnerships with shared responsibility and accountability for care coordination and case management of high risk and at-risk populations in the community. The CCCT is a multidisciplinary group of healthcare professionals working together to provide care coordination to high risk patients with frequent hospital readmissions and ED visits. The CCCT's mission is to:

1. To assist providers with implementing an evidence-based framework for improving the health outcomes of high risk and at-risk populations in the community.

2. To develop care transition and care coordination protocols, workflows and pathways to guide the Community Health Workers in addressing the social determinants of health of high risk and at-risk Prince George's County residents.

3. To monitor and measure the health outcomes of this population, and to educate and motivate improvements in the healthcare system.

4. To promote provider adoption of innovative health information technology, innovative delivery models, and chronic disease initiatives to reduce hospital re-admissions and non-urgent ED visits

The CCCT is represented by the following partners:

- *Prince George's County Health Department*
- *Health Enterprise Zone Project Team*
- *Prince George's Hospital Center*
- *Doctors Community Hospital*
- *Dimensions Healthcare System*
- *University of Maryland School of Public Health*
- *University of Maryland School of Pharmacy Innovations*
- *University of Maryland Center for Health Literacy*
- *Beacon Health*
- *Amerigroup*
- *Sodexo Healthcare*
- *VHQC*
- *Prime Time Sister Circles*
- *Gerald Family Care*
- *Global Visions*
- *Fire/EMS*
- *Department of Social Services*
- *Visiting Nurses Association*
- *Electronic Health Network*

The CCCT meets monthly to review difficult cases, organize patient care activities and share information to improve care coordination and address the social determinants that affect the health of this high-risk population. Since its inception, the CCCT has assisted with development and implementation of over 20 CHW Pathways (listed below) and provided intensive care plans for 40 high-risk patients.

VI. BRIDGE TO CARE OVERVIEW

In March, 2015 the Prince George's County Health Department in partnership with the George Washington University School of Medicine opened a free, primary care clinic at the Cheverly Health Center located at 3003 Hospital Drive, Cheverly, Maryland. For many years, GW medical students have operated a volunteer clinic called the GW Healing Clinic at Bread for the City, a non-profit organization in the Howard Shaw neighborhood in D.C. The clinic has been providing primary care services to underserved patients in the neighborhood since 2004, regardless of insurance status or ability to pay.

In 2014, the GW Healing Clinic directors desired to expand their services to Prince George's County. Health Officer, Ms. Pamela Creekmur, supported the directors' vision but insisted that county residents be linked to primary care providers and health centers for ongoing management of chronic conditions. With Ms. Creekmur' s vision in mind, the GW Healing Clinic was renamed the GW Bridge to Care clinic whose mission is to expand access to primary care, offer high quality care to uninsured patients while enriching the educational experience of medical, physician assistant, and public health students.

The Bridge to Care clinic is open on Thursday nights from 5:00 pm to 8:00 pm by appointment only. The clinic averages 10 volunteer students per night, including 2-3 faculty preceptors and patient navigators. The volunteer attending physicians staff the exam rooms, oversee physical examinations, develop treatment plans with students and patients, provide lab services, order prescriptions, document in the Health Department's electronic medical record, and provide health. As needed, patients are referred to other required medical specialists with patient navigators on site to assist with linking patients to

specialists and primary care physicians in the community. Dr. Ernest Carter, Deputy Health Officer, is the medical director of the clinic and he audits, reviews and signs off on all patient charts within 24 hours of the visit.

Services provided at the Bridge to Care Clinic include:

- Primary and Preventive Care such as regular physical exams and screenings for conditions such as high blood pressure and diabetes
- Non-Emergency Urgent Care for acute illnesses or injuries that do not require emergency room attention
- Health Education and Awareness on a variety of topics that can be tailored to an individual patient's needs
- Prescribed Medications for a variety of conditions including infections, blood pressure and diabetes
- Laboratory Testing for cholesterol, glucose and more
- Gynecologic Screening for routine check-ups or specific concerns
- Specialty Care and Imaging Referrals for individuals who require additional care
- Patient Advocacy and Navigation Services
- Linkages to HEZ Community Health Workers

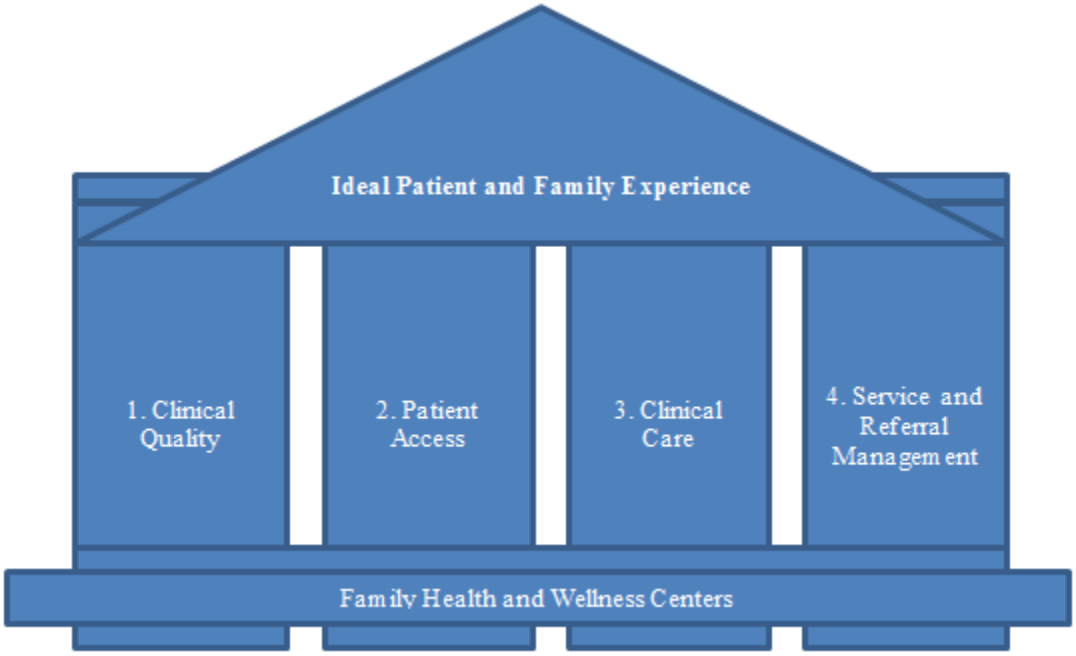
As of July 14, 2016 the clinic has offered more than 400 primary care appointments and provided 325 patient visits. Fourth year medical students are currently conducting chart audits to measure the prevalence of symptoms/diseases presenting to the clinic, to assess quality of care provided based on outcomes, and to measure the clinic's impact on the health of the community served. The final report will be available in September, 2016.

VII. Other Primary Healthcare Initiatives

The Health Department has recently completed the Joint Community Health Needs Assessment, which was conducted in coordination with all five hospitals in the county. This comprehensive Community Health Needs Assessment was completed in June 2016. This was an additional initiative that was completed as part of the overall primary care strategy for Prince George's County.

EXHIBIT 67

Four Pillars of Ambulatory Care Management



1. Clinical Quality: To assess, monitor, and improve the clinical outcomes for patients of The Family Health and Wellness Centers and create standard processes that leverage technology, simplify workflow, and result in best practices for quality and service. The Clinical Quality pillar activities will prepare The Family Health and Wellness Centers for Medicaid and CHIP Reauthorization Act ("MACRA") value-based pay-for-performance strategies. Dimensions Ambulatory Care sites are participating in the Centers for Medicaid Services Transforming Clinical Practice Initiative ("TCPI"). TCPI is a learning and diffusion model being tested by CMS in which coordinated national technical assistance will enable large scale transformation in order to deliver better care that will result in better health outcomes at lower costs. Dimensions anticipates beginning the program mid-August to early September of 2016.

2. Patient Access: To establish intentionally designed clinic-wide access standards to ensure the ideal patient and family experience. Key initiatives include: (1) consolidation / optimization of call centers, (2) improved provider flow through intentional master scheduling and (3) enhanced access to appointments and an updated patient portal. Dimensions has identified an opportunity to improve patient experience related to patient access in terms of appointment scheduling. Dimensions has partnered with a third party to pilot single site appointment scheduling for two of the busiest practices: Cheverly Family Health and Wellness Center and Suitland Health and Wellness Center. In addition to streamlined appointment scheduling, Dimensions is offering extended office hours during evenings and weekends to allow patients improved access to care. Dimensions is working to modify its patient portal to provide patients better access to their health care data and to allow the opportunity to request appointments.

3. Clinical Care: To intentionally design standard processes in the clinic environment. These processes will set the standard across clinic specialties and locations to provide the patients, staff, and providers with a consistent, patient and family centered experience. This standardization also supports regulatory compliance and gains efficiency. Dimensions is working to streamline, clarify, and simplify the models it uses to provide care in the ambulatory setting. The goal is to be consistent and effective. Key team members are engaged in intensive learning and work groups in order to study current processes and identify best practices from around the nation to design and implement the best patient centered model for the Dimensions ambulatory practices.

4. Service Management: To ensure a coordinated and consistent patient satisfaction and process improvement effort to achieve continuous improvements in creating the ideal patient and family experience.

5. Referral Management: To develop a coordinated system aimed to strengthen referring provider relationships and ensure appropriate clinical information is communicated timely to the referring provider. The current healthcare environment forces a shift in thinking from discharge to transitional care. In order to stay in tune with expectations from our patients and payers, Dimensions is investing in implementing a patient satisfaction tool in addition to providing and measuring the effectiveness of services across the care continuum. Dimensions will partner with its current provider, HealthStream, to implement the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (“CGCAHPS”) survey. CGCAHPS is a standardized tool to measure patients' perception of care provided by physicians in an office setting.

EXHIBIT 68

Dimensions Tele-Health Pilot Study

Partnerships and innovation are critical components of population health management. Dimensions has completed a successful telehealth pilot with nursing homes. The overall purpose and goal of the project was to reduce hospital admission and 30 day readmissions for patients at comprehensive care facilities (CCF) by (1) improving improve care transitions for Medicare, Medicaid and dually eligible patients who were admitted to hospital and transferred to the CCFs or who are at risk for readmission to the hospital from the CCFs and 2) reducing unnecessary emergency department visits for Medicare, Medicaid and dually eligible residents of the CCFs. The DHS project involved two telehealth interventions. The first intervention was a post-discharge e-visit between the CCF and a DHS hospital to track a patient's status during the first 30 days of discharge. The second intervention was a pre-transfer e-visit between the CCF and a DHS hospital emergency department to determine if emergency transfer is necessary or provide support to the CCF to avoid emergency transfer. Expected outcomes were: (1) reduction in the hospitalization rate for Medicare, Medicaid and dually eligible patients who are CCF residents; (2) reduction in the 30 day readmission rate for CCFs and (3) reduction in the emergency department transfer rate for Medicare, Medicaid and dually eligible patients who are CCF residents; (4) improvements in patient experience.

As the data in Table 1 below indicate the pilot was successful in reducing the hospital admission and 30 day readmission rate for the sample of CCF residents who participated in the study.

Table 1: DHS Long Term Care Hospital Telehealth Project Evaluation Findings

Measures	Patuxent CCF			Sanctuary CCF		
	Baseline Rate	Goal	Endpoint Rate	Baseline Rate	Goal	Endpoint Rate
	Jan-Mar 2015		Apr- Oct 2015	Jan-Jun 2014		Jan-Sept 2015
Hospital Admissions Numerator = Number of patients that were admitted to an ACH from the CCFP Denominator = Total number of resident days for the month at the CCF	.44%	.36%	.41%	1%	0.70%	.38%
30 day Readmissions Numerator= Number of patients that were admitted from the CCF to an ACH and were re-admitted to an ACH within 30 days of hospital discharge date Denominator Number of patients that were admitted to the CCF from an ACH 30 day Readmissions Numerator= Number of patients that were admitted from the CCF to an ACH and were re-admitted to an ACH within 30 days of hospital discharge date Denominator = Number of patients that were admitted to the CCF from an ACH%	66.6%	50%	18%	15.3%	12.5%	11.38%

Measures	Patuxent CCF			Sanctuary CCF		
	Baseline Rate	Goal	Endpoint Rate	Baseline Rate	Goal	Endpoint Rate
	Jan-Mar 2015		Apr- Oct 2015	Jan-Jun 2014		Jan-Sept 2015
ED visit rate Numerator = Number of residents that where transferred via ambulance to any ACH from the CCF Denominator = Total number of resident days for the month at the CCF	.52%	.42%	.29%	.24%	.19%	.42

Despite some initial concerns among providers, residents and residents' families, respectively, ultimately the intervention was well received. Residents who were recently discharged from acute care facilities and transferred to a CCF expressed satisfaction with the telehealth intervention. They were reassured to learn that the intervention allowed a hospital physician to speak directly to the resident, CCF staff and CCF providers to make sure that the resident experienced a smooth transition and to actually participate in the virtual encounters. These exchanges eased patients' fears relative to the transfer to post-acute care. In addition, CCF providers appreciated being able to access important and comprehensive patient information directly and in a timely manner.

Due to the success of this pilot Dimensions is working to strengthen partnerships with CCFs to provide the most appropriate care to patients in our community. The success of this pilot has also positioned Dimensions as a go to partner for other telehealth projects. We are partnering with Gerald Family Care (GFC), a patient-centered medical home network providing family practice services to Prince George's County, to implement an 18-month pilot telehealth program funded by MHCC to increase patient access to specialty care in Prince George's County through the use of telehealth.

The project is targeted at cutting in half patient wait time to see specialists and at increasing the proportion of patients screening positive for depression who can access behavioral health services promptly. It will also reduce the number of hospitalizations and ED visits associated with gastroenterological, cardiologic, dermatologic, neurologic and/or behavioral health diagnoses.

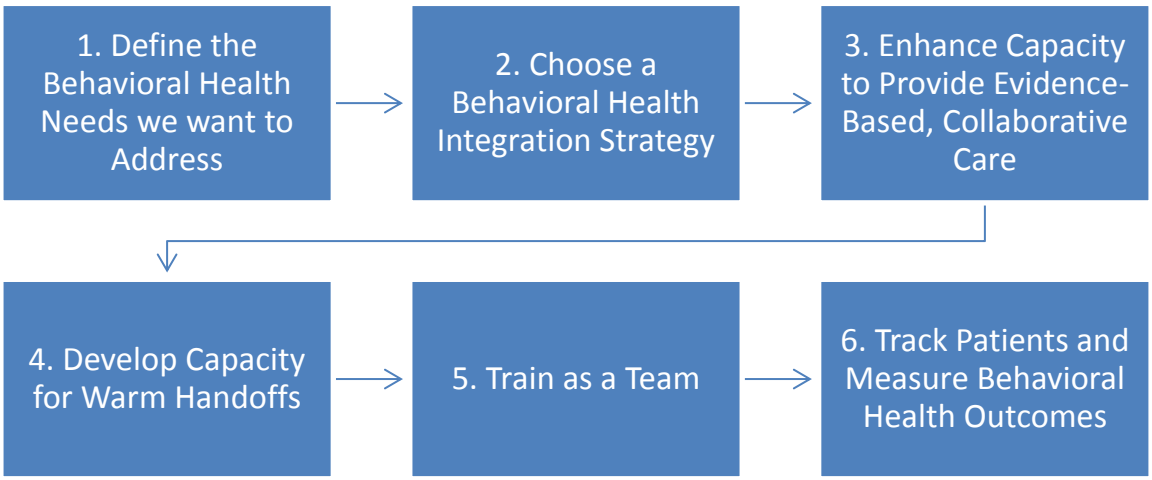
The intervention increases the accessibility of specialist and subspecialty services to traditionally underserved communities in Prince George's County. For providers, it offers a sustainable model of care reimbursable by Medicare, Medicaid and most commercial health plans.

Through telehealth hardware and software, specialists from Dimensions will be enabled to visit with patients of GFC. The project anticipates serving approximately 180 unique GFC patients. This project will engage CRISP, the State-designated health information exchange (HIE), to facilitate information exchange between DHS acute care facilities and the practice sites. The project also seeks to help destigmatize behavioral health treatment.

EXHIBIT 69

Exhibit 69

Implementation Strategy for Integrating Behavioral Health Into Primary Care Sites



Adapted from the Primary Care Team Guide

1. **Define the behavioral health needs we want to address.**

Behavioral health encompasses a wide array of services. Each practice organization needs to define the scope of behavioral health needs it wants to address in an integrated fashion. Does the practice feel confident that it can efficiently deal with acutely distressed patients? Is substance abuse expertise critical for your population? Does the scope include behavior change, like smoking cessation, improving medication adherence, goal setting for healthy eating and improving physical activity, or meeting common social needs? Nonetheless, essentially all primary care practices must have integrated strategies in place to effectively and efficiently deal with acutely distressed patients, and manage patients with chronic psychiatric disorders such as major depression.

2. **Choose a behavioral integration strategy.**

How a practice tries to integrate behavioral health expertise will be influenced by practice size, payment options, patient population needs, and behavioral health resources in the community. Practices need to select behavioral health specialists and organizations with whom to collaborate, as well as the level of integration. Many practices find having a behavioral health specialist on-site attractive and reassuring because it facilitates warm handoffs. In addition to having a behavioral health specialist who can provide patient counseling (such as a masters-level therapist or psychologist) and potentially an addictions counselor, most practices will also need a psychiatric consultant for consultation on psychotropic medication management (a Psychiatrist or Psychiatric Nurse Practitioner). Consultation may not involve direct contact with the patient, as long as behavioral health specialists are willing to work in non-traditional ways with non-traditional payment arrangements.

Regardless of the approach, integrated care must also include a shared commitment to measurement-driven, treat-to-target care for chronic problems (see Step 3), as well as interactive communication and sharing of care among behavioral health and primary care providers. Choose a model that fits your organizational and community resources, but remember the importance of proximity and availability.

3. Enhance the capacity to provide evidence-based, collaborative care.

To provide evidence-based collaborative care, the primary care team should have:

- Explicit guidelines for the treatment of chronic mental health/substance abuse disorders, and standing orders that enable appropriate members of the care team to deliver evidence-based treatment and act independently.
- The capability to provide care management services to patients.
- Collaborative care is delivered by a team that includes the patient, the primary care provider, a care manager, and a Psychiatric consultant. The Care Manager supports the primary care provider by coordinating treatment, regularly monitoring treatment response, and alerting the provider when the patient is not improving. The professional background of the Care Manager varies depending on the staffing of the primary care clinic and the treatment regimen. RN and behavioral health specialist care managers can also evaluate and influence treatment, and facilitate communication with the psychiatric consultant regarding treatment changes. Behavioral Health specialist care managers can further add psychotherapy to the treatment regimen.

4. Develop the capacity for warm hand-offs.

Other sites have found value in being able to obtain timely assessments and short-term therapy from co-located or affiliated behavioral health specialists. Some ways to foster warm handoffs include:

- Developing schedules for behavioral health providers that allow for regular breaks between appointments—for example, 30 minutes with a scheduled patient, then 30 minutes open.
- Having a behavioral health provider sit with the primary care team.
- Introducing the behavioral health provider to patients by phone.

5. Train as a team.

High-quality integrated care requires effective teamwork with: clear roles and work processes, shared expectations and protocols, and effective communication approaches. It is important to bring all members of the team together for training and discussion about working together. This is especially important for the primary care provider, behavioral health specialist, care manager, and psychiatric consultant to train as a team around collaborative care processes. The goals of their training include: agreement on treatment, treatment targets, assessment methods, and follow-up; criteria for hand-offs; and guidelines and strategies for communication.

6. Track patients and measure behavioral health outcomes.

Tracking treatment and outcomes over time in patients with common disorders such as depression gives practices the information needed to treat-to-target. By measuring patient outcomes, providers can adjust therapy to reach clinical goals. The first steps are to:

- Create a registry of patients needing behavioral health services.
- Develop quality improvement measures and a process for monitoring behavioral health patients.
- Meet regularly as a team to review outcomes for behavioral health patients.

EXHIBIT 70

Prince George's Hospital Center

Estimated Average Charges for Common Procedures in FY16 *(updated July 25, 2016)*

The tables below provide estimated average charges for common inpatient and outpatient procedures at Prince George's Hospital Center. These tables are updated quarterly and are based on the patient charges actually incurred for these services during the previous 12 months. They may be used by patients to estimate the charge for services that they may incur. Please note that these are only estimates and are subject to change without notice. The actual cost of your procedure may be higher or lower based on factors specific to your case, such as your length of stay in the hospital and the complexity of your medical condition. If you have questions regarding an estimated charge, please call a financial counselor at 301-618-3100.

These estimates reflect hospital charges only. They do not include physician or other provider fees that are billed separately from the hospital fees. You may receive bills from multiple physicians for their services, including but not limited to your anesthesiologist, hospitalist, pathologist, radiologist, cardiologist, emergency room physician, and other specialist who participate in your care. If you have questions regarding the bill for their services, please contact the individual provider.

Most Frequent Inpatient Medical/ Surgical Cases	Estimated Average Charge
SEPTICEMIA & DISSEMINATED INFECTIONS	$22,098
HEART FAILURE	$11,775
CHRONIC OBSTRUCTIVE PULMONARY DISEASE	$10,973
DIABETES	$10,151
KNEE & LOWER LEG PROCEDURES EXCEPT FOOT	$31,447
SEIZURE	$10,634
RENAL FAILURE	$12,563
PEPTIC ULCER & GASTRITIS	$11,951
CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS	$8,433
CVA & PRECEREBRAL OCCLUSION W INFARCT	$18,309

Most Frequent Inpatient Obstetric and Newborn Cases	Estimated Average Charge
NEONATE BIRTHWT >2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM	$2,267
VAGINAL DELIVERY	$7,547
CESAREAN DELIVERY	$10,056
OTHER ANTEPARTUM DIAGNOSES	$6,573
NEONATE BWT 2000-2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM	$2,558
POSTPARTUM & POST ABORTION DIAGNOSES W/O PROCEDURE	$8,003
VAGINAL DELIVERY W STERILIZATION &/OR D&C	$11,140
NEONATE, BIRTHWT >2499G W RESP DIST SYND/OTH MAJ RESP COND	$16,306
NEONATE BIRTHWT >2449G W CONGENITAL/PERINATAL INFECTION	$11,915
NEONATE, TRANSFERRED < 5 DAYS OLD, BORN HERE	$3,252

Prince George's Hospital Center

Most Frequent Inpatient Psychiatric Cases	Estimated Average Charge
SCHIZOPHRENIA	$10,282
MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	$6,976
BIPOLAR DISORDERS	$7,773
ALCOHOL ABUSE & DEPENDENCE	$8,230
ORGANIC MENTAL HEALTH DISTURBANCES	$14,472
DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER	$5,282
OTHER DRUG ABUSE & DEPENDENCE	$6,521
CHILDHOOD BEHAVIORAL DISORDERS	$5,877
ACUTE ANXIETY & DELIRIUM STATES	$7,555
DRUG & ALCOHOL ABUSE OR DEPENDENCE, LEFT AGAINST MEDICAL ADVICE	$3,958

Most Frequent Outpatient Surgical Cases	Estimated Average Charge
ESOPHAGOGASTRODUODENOSCOPY (EGD) WITH CLOSED BIOPSY	$1,230
ENDOSCOPIC POLYPECTOMY OF LARGE INTESTINE	$1,363
COLONOSCOPY	$1,145
OTHER LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF	$1,549
RESECTION OF GALLBLADDER, PERCUTANEOUS ENDOSCOPIC APPROACH	$3,540
RESECTION OF UTERUS, PERCUTANEOUS ENDOSCOPIC APPROACH	$4,594
CLOSED BIOPSY OF LARGE INTESTINE	$1,154
TONSILLECTOMY WITHOUT ADENOIDECTOMY	$1,815
TONSILLECTOMY WITH ADENOIDECTOMY	$2,262
OTHER EXCISION OR DESTRUCTION OF LESION OF UTERUS	$1,639

Prince George's Hospital Center

Most Frequent Laboratory Services	Estimated Average Charge
PT	$17.05
CBC W/ AUTO DIFF	$21.34
URINALYSIS WITH MICROSCOPIC IF	$8.54
BASIC METABOLIC PANEL	$23.50
COMPREHENSIVE METABOLIC PANEL	$32.00
URINALYSIS MICROSCOPIC	$10.70
GLUCOMETER	$17.03
TROPONIN-T	$53.27
TOTAL CK	$12.80
U BETA HCG QL	$21.36

Most Frequent Outpatient Diagnostic Imaging Services	Estimated Average Charge
CT CORONAL SAGITTAL	$165.64
XR CHEST 2 VIEWS	$79.85
XR CHEST 1 VIEW FRONTAL	$53.20
CT HEAD OR BRAIN W/O CONTRAST	$70.71
CT SPINE CERVICAL W/O CONTRAST	$94.27
CT ABDOMEN & PELVIS WITH CONTRAST	$160.46
XR PELVIS 1 OR 2 VIEWS	$79.79
OB ULTRASOUND EXTENSIVE	$282.64
CT SPINE LUMBAR W/O CONTRAST	$94.14
CT THORAX W/ CONTRAST	$117.55

EXHIBIT 71

Marshall Valuation Service Analysis

PGRMC will be comprised of the hospital building with a rooftop mechanical penthouse. As shown below, the cost per square foot of the new construction is lower than the MVS benchmark.

I. Marshall Valuation Service
Valuation Benchmark– New Construction

Type		Hospital
Construction Quality/Class		Good/A
Stories		11
Perimeter		1,163
Average Floor to Floor Height		15.8
Square Feet		594,436
f.1	Average floor Area	54,040
A. Base Costs		
	Basic Structure	$365.78
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$365.78
Adjustment for Departmental Differential Cost Factors		1.02
Adjusted Total Base Cost		$372.48
B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$372.48
C. Multipliers		
Perimeter Multiplier		0.916298271
	Product	$341.30

Height Multiplier		1.09
	Product	$371.09
Multi-story Multiplier		1.040
	Product	$385.93
D. Sprinklers		
	Sprinkler Amount	$2.22
Subtotal		$388.15
E. Update/Location Multipliers		
Update Multiplier		1.02
	Product	$395.92
Location Multipier		1.07
	Product	$423.63
Calculated Square Foot Cost Standard		**$423.63**

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	DGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
ACUTE PATIENT CARE				
ACUTE CARE INPT. UNITS	82,492	Inpatient Unit	1.06	87,442
INTENSIVE CARE	22,980	Inpatient Unit	1.06	24,359
POST-PARTUM	18,526	Inpatient Unit	1.06	19,638
NEONATAL INTENSIVE CARE UNIT	11,479	Inpatient Unit	1.06	12,168
PEDIATRICS	400	Inpatient Unit	1.06	424
MT. WASHINGTON PEDIATRICS	10,392	Inpatient Unit	1.06	11,016
DIAGNOSTICS & TREATMENT				
SURGERY	34,626	Operating Suite, Total	1.59	55,055
CARDIAC CATH LAB	5,533	Operating Suite, Total	1.59	8,797
GI - ENDOSCOPY	2,735	Operating Suite, Total	1.59	4,349

ADULT ED	27,361	Emergency Suite	1.18	32,286
PEDS ED	1,840	Emergency Suite	1.18	2,171
TRAUMA	6,093	Emergency Suite	1.18	7,190
UNIVERSAL CARE / PRE-POST	19,273	Inpatient Unit	1.06	20,429
CLINCIAL DECISION UNIT	9,955	Inpatient Unit	1.06	10,552
IMAGING	18,217	Radiology	1.22	22,225
NEUROLOGY/CARDIOLOGY	4,758	Offices	0.96	4,568
LABOR & DELIVERY	13,682	Obstetrical Suite Only	1.44	19,702
C-SECTION	3,950	Operating Suite, Total	1.59	6,281
WOMENS CENTER	-	Radiology	1.22	0
DOMESTIC VIOLENCE CENTER	2,012	Emergency Suite	1.18	2,374
DIALYSIS	2,377	Laboratories	1.15	2,734
PT/OT	4,610	Physical Medicine	1.09	5,025
RESP THERAPY	1,062	Physical Medicine	1.09	1,158
CLINICAL SUPPORT				
LABORATORY / PATHOLOGY	14,956	Laboratories	1.15	17,199
PHARMACY	9,642	Pharmacy	1.33	12,824
NON CLINICAL SUPPORT				
DIETARY / DINING	15,782	Dietary	1.52	23,989
MATERIALS / BIO MED / EVS	20,032	Storage and Refrigeration	1.6	32,051
CENTRAL STERILE	9,771	Central Sterile Supply	1.54	15,047
FACILITIES & SUPPORT SERVICES	5,720	Offices	0.96	5,491
IT / TELECOM	5,322	Offices	0.96	5,109
REGISTRATION	1,464	Public Space	0.8	1,171
HEALTH INFORMATION MANAGEMENT	2,075	Offices	0.96	1,992
OFFICES & EDUCATION				
OFFICE / ADMINISTRATION	6,534	Offices	0.96	6,273
ON CALL	4,773	Offices	0.96	4,582
CONFERENCE CENTER	4,632	Public Space	0.8	3,706
RESIDENT / FACULTY	17,938	Offices	0.96	17,220
PUBLIC SPACES	11,728	Public Space	0.8	9,382
CIRCULATION	87,142	Internal Circulation, Corridors	0.6	52,285
MECHANICAL/ELECTRICAL	14,609	Mechanical Equipment and Shops	0.7	10,226

BEHAVIORAL HEALTH				
CLINICAL PROGRAMS	2,430	Outpatient Department	0.99	2,406
ACUTE BEHAVIORAL HEALTH	20,646	Inpatient Unit	1.06	21,885
ASSESSMENT STABILIZATION	3,605	Inpatient Unit	1.06	3,821
AMBULATORY/CANCER CLINICAL PROGRAMS				
CANCER CENTER	-	Radiology	1.22	0
	12,000			
SHAFTS / EXTERIOR WALL THICKNESS		Shafts and Exterior wall	0.6	0
	20,541			
TOTAL	595,695		1.01830771	606,601

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

Type	Mechanical Penthouse
Construction Quality/Class	ExcellentA
Stories	7
Perimeter	145
Average Floor to Floor Height	12.00
Square Feet	1,259
Average floor Area	1,259

A. Base Costs

Basic Structure	$80.77
Elimination of HVAC cost for adjustment	0
HVAC Add-on for Mild Climate	0
HVAC Add-on for Extreme Climate	0
Total Base Cost	$80.77

B. Additions

Elevator (If not in base)	$7.78
Other	$0.00
Subtotal	$7.78
Total	$88.55

C. Multipliers

Perimeter Multiplier	0.943788975
Product	$83.58
Height Multiplier	1.413
Product	$118.09
Multi-story Multiplier	1.035
Product	$122.23
D. Sprinklers	
Sprinkler Amount	$0.00
Subtotal	$122.23
E. Update/Location Multipliers	
Update Multiplier	1.02
Product	$124.67
Location Multipier	1.07
Product	$133.40
Calculated Square Foot Cost Standard	**$133.40**

III. Consolidated MVS Benchmark

		MVS Benchmark	Sq. Ft.		Total Cost Based on MVS
Standard					
"Tower" Component		$423.63	594,436	$	251,820,444.22
Mechanical Penthouse		$133.40	1,259	$	167,948.08
Consolidated	**$**	**423.02**	595,695	$	251,988,392.31

IV. Cost of New Construction

A. Base Calculations	Actual	Per Sq. Foot
Building	$225,000,000	$377.71
Fixed Equipment	$35,967,350	$60.38
Site Preparation	$23,833,950	$40.01
Architectual Fees	$15,177,571	$25.48
Permits	$10,088,060	$16.93

Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	$310,066,931	$520.51

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

B. Extraordinary Cost Adjustments

	Project Costs	
Canopy	$3,620,400	Building
Foundation Drainage/Dewatering	$250,000	Building
LEED Silver Premium	$11,392,052	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	$1,729,453	Building
Underground 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	$19,232,575	Building
Premium for Paying Prevailing Wage	$3,596,735	Fixed Equipment
Premium for Paying Prevailing Wage	$724,871	Site
Premium for Minority Business Enterprise Requirement	$9,115,520	Building
Premium for Minority Business Enterprise Requirement	$1,798,368	Fixed Equipment
Premium for Minority Business Enterprise Requirement	$384,866	Site
Total Cost Adjustments	$74,963,799	

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 Foundation[1] – 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

[1] 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.

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.

- 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.[2] Dimensions assumes the premium will be 10%. Because prevailing wage will have to be paid for Building, Fixed Equipment, and site preparation, Dimensions has applied it to all three items.

- Premium for Minority Business Enterprise Requirement – This construction will be subject to the Minority Business Enterprise Requirement ("MBE"). Dimensions estimates that the premium will be 5%, based on input from contractors. Because prevailing wage will have to be paid for Building, Fixed Equipment, and site preparation, Dimensions has applied it to all three items.

- Capitalized Construction Interest on Extraordinary Costs – The $22,900,000 in capitalized interest and $2,500,000 financing costs ($25,400,000 in total) shown on the project budget sheet are for the entire costs of the project. . However, because Dimensions projects that there will be $9,190,283 interest earned on the borrowing, Dimensions used the net capitalized interest ($13,709,717). ($22,900,000 - $9,190,283 = $13,709,717) Hence the total amount used was $13,709,717 in capitalized interest plus $2,500,000 in financing fees, for a total of $16,209,717. 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

2 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

the Building costs to include the associated capitalized construction interest. The amount used was calculated as follow:

Hospital	New	Renovation	Total		
Building Cost	$173,194,880	$0			
Subtotal Cost (w/o Cap Interest)	$231,135,740	$0	$231,135,740		
Subtotal/Total	100.0%	0.0%		Cap Interest	Financing
Total Project Cap Interest &Financing [(Subtotal Cost/Total Cost) X Total Cap Interest]	$16,209,717	$0	$16,209,717	$13,709,717	$2,500,000
Building/Subtotal	74.9%			$9,190,283	
Building Cap Interest & Financing	$12,146,283	$0		$22,900,000	

- 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, Fixed Equipment, and Site Prep costs, multiplying that percentage times the sum of the adjusted Building, Fixed Equipment and Site Prep costs.

Eliminating all of the extraordinary costs reduces the project costs that should be compared to the MVS estimate to $408.40. As noted below, the project's cost per square foot is below the MVS benchmark.

C. Adjusted Project Cost		**Per Square Foot**
Building	$173,194,880	$290.74
Fixed Equipment	$30,572,248	$51.32
Site Preparation	$6,587,574	$11.06
Architectual Fees	$11,210,179	$18.82
Permits	$9,570,860	$16.07
Subtotal	$231,135,740	$388.01
Capitalized Construction Interest	$12,146,283	$20.39
Total	$243,282,022	$408.40

V. Comparison to the MVS Benchmark

MVS Benchmark	$423.02
The Project	$408.40

EXHIBIT 72

MEMORANDUM OF UNDERSTANDING AMONG
PRINCE GEORGE'S COUNTY,
UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION,
AND DIMENSIONS HEALTH CORPORATION

This Memorandum of Understanding (hereinafter "MOU") is entered into this 30th day of August, 2016, by and among Prince George's County, Maryland, a body corporate and politic, organized pursuant to Article XI-A of the Constitution of Maryland, (hereinafter the "County"), the University of Maryland Medical System Corporation, (hereinafter "UMMS"), and Dimensions Health Corporation (hereinafter "Dimensions") and collectively referred to as the "Parties."

PREAMBLE

WHEREAS, the Parties have collaborated on transforming the health care facilities, assets, and operations of Dimensions since the execution of the 2011 Memorandum of Understanding (MOU) in July 2011, including the selection of a site for the Regional Medical Center near the Largo Metro Station, submission of the certificate of need (CON) application to the Maryland Health Care Commission for the Regional Medical Center and the related partial rate application to the Health Services Cost Review Commission, improvements in emergency room operations, and transformation of the cardiac surgical program at the Prince George's Hospital Center; and

WHEREAS, the Maryland General Assembly enacted *SB 324 – Prince George's County Regional Medical Center Act of 2016* (Chapter 13 of the 2016 Laws of Maryland) that codifies the State of Maryland and Prince George's County operating and capital funding commitments through FY 2021 and makes the Act contingent upon UMMS becoming the sole corporate member of Dimensions and responsible for the governance of Dimension; and

WHEREAS, the health care facilities and assets are currently leased to Dimensions by the County (hereinafter the "Prince George's County health care system," or the "System,") pursuant to a long-term Fourth Amended and Restated Lease Agreement (hereinafter the "Master Lease Agreement"); and

WHEREAS, the Parties are prepared to transfer ownership of the health care facilities and assets of Dimensions to UMMS, and the governance of Dimensions to UMMS.

NOW, THEREFORE, in consideration of the mutual promises of the Parties herein and other good and valuable consideration, the Parties hereto stipulate and agree as follows:

ARTICLE I.

Health Care Facilities and Assets

Subtitle 12, Division 3 of the Prince George's County Code requires the County to enter into a lease agreement with a non-profit corporation for Prince George's Hospital Center, Laurel Regional Hospital, and the Bowie Health Center, including all related facilities and equipment.

Section A. Termination of County Lease Agreement

1. The County agrees to modify the lease requirement and other related provisions of Subtitle 12, Division 3 of the County Code so that the lease covers only the Prince George's Hospital Center facilities. Dimensions will continue to lease the Prince George's Hospital Center facilities until the new regional medical center is completed and operations are transferred to the Largo site.

2. The County also agrees to terminate the lease requirement and other related provisions of Subtitle 12, Division 3 of the County Code for the Bowie Health Center and Laurel Regional Hospital, provided the following occurs:

a. Unless otherwise agreed to in writing by the County, both during and after the transfer of the System from Dimensions to UMMS, Dimensions and/or UMMS agree(s) to provide indigent care consistent with Maryland's financial assistance regulations for Maryland hospitals, emergency treatment of County and municipal public safety personnel (including County volunteer fire personnel) injured in the line of duty, and services rendered to prisoners held at the County's detention facilities;

b. The termination of the lease requirement for the Bowie Health Center and Laurel Regional Hospital, and the modification of the lease requirement for the Prince George's Hospital Center and other related provisions of Subtitle 12, Division 3 of the County Code are subject to the provisions of Section B 1 of this Article.

Section B. Transfer of Health Care Facilities and Assets

1. The County agrees to transfer the health care facilities and assets associated with the Bowie Health Center and Laurel Regional Hospital to Dimension and/or UMMS under the following conditions:

a. The Maryland Health Care Commission approves the Certificate of Need (CON) application for the Regional Medical Center by Dimensions (Docket Number 13-16-2351);

b. The Maryland Health Services Cost Review Commission approves the partial rate application by Dimensions;

c. UMMS becomes the sole corporate owner of Dimensions; and

d. If any health care facility and/or asset that is transferred by the County to Dimensions and/or UMMS ceases to be used for a health care purpose within ten (10) years from the transfer date, the asset shall revert to the County

ARTICLE II.

Governance of the System

The Parties agree that the governance of the system should be modified to ensure effective oversight and proper direction in order to respond to the ever-changing and diverse health care environment. The parties also agree that in order to effectuate efficiencies throughout the system there is need for an interim governance structure that will transition to a new permanent governance structure.

Section A. Interim Board of Directors

1. Voting Members. A seven (7) voting member interim Board of Directors will serve as the Dimensions Board of Directors effective on the date UMMS becomes the sole corporate member of Dimensions ("Interim Board"). The Interim Board will remain in place through December 31, 2018 and will be comprised of the following members:

a. Four (4) members appointed by UMMS
   i. UMMS President and Chief Executive Officer
   ii. Executive Vice President and Chief Financial Officer
   iii. John Ashworth
   iv. Stephen Bartlett, MD ;
b. Bradford Seamon;
c. The County's Health Officer; and
d. The Liaison to the Prince George's County Board of Health.

Elected officials at any level of government may not serve as voting members on the Interim Board.

2. Non-voting members. The County Executive and the County Council may each appoint an individual to serve as a non-voting member of the Interim Board. These individuals must be residents of the County. The non-voting members will be excused in the event the Interim Board convenes an executive session.

3. The Chairman of the Interim Board shall be Bradford Seamon. In the event of a vacancy in the Chairman position, the remaining voting members of the

Interim Board shall fill the vacancy by selecting a new Chairman with the consent of the County Executive and the Chair of the County Council.

4. The Interim Board shall provide oversight and direction of the system, including:

a. drafting and approving new bylaws for the System;
b. nominating individuals to serve on the permanent Board of Directors; and
c. other duties and responsibilities as necessary to operate the System.

5. A two-thirds affirmative vote of the Interim Board shall be required for the following:

a. modify the bylaws and/or articles of the System;
b. reduce or expand services provided by the System; and
c. expand or close facilities operated by the System.

6. Actions and decisions of the Interim Board are subject to UMMS' reserve and initiation rights as contained in the bylaws and articles of the System (to be approved by the current Dimensions Board of Directors prior to UMMS becoming Dimensions' sole corporate member).

Section B. Permanent Board of Directors

1. Commencing January 1, 2019, there shall be a twenty-one (21) member Board of Directors ("Permanent Board") of the System to be comprised of the following members:

a. The Liaison to the Prince George's County Board of Health;
b. The County's Health Officer;
c. Four (4) members appointed by UMMS;
d. The remaining members shall be residents of Prince George's County and Southern Maryland (Calvert, Charles, and St. Mary's counties), one of whom shall be a member from the Prince George's County Medical Association who resides in Prince George's County

2. Between January 1, 2019 and the earlier of (i) June 30, 2022 or (ii) June 30th of the fiscal year in which the County ceases to provide operating funds to the System, the Permanent Board will include one (1) individual who has been recommended by the County Executive, subject to UMMS' approval.

3. Two-thirds of the Permanent Board members shall be residents of Prince George's County, and no member shall be an elected official at any level of government.

4. The Chairman of the Permanent Board shall be selected by the members of the Board.

5. A two-thirds affirmative vote of the Permanent Board shall be required for the following:

a. modify the bylaws and/or articles of the System;
b. reduce or expand services provided by the System; and
c. expand or close facilities operated by the System.

6. Actions and decisions of the Permanent Board are subject to UMMS reserve and initiation rights as contained in the bylaws and articles of the System.

Section C. Advisory Boards

1. There shall be an Advisory Board for each of the facilities owned and operated by the System.

2. The Interim Board (or the Permanent Board commencing January 1, 2019) shall select the members of the Advisory Boards.

3. Each of the Advisory Boards shall be comprised of seven (7) members who reside in the area served by the each facility.

4. The Advisory Boards shall:

a. Obtain community input on existing health services provided by the facility;

b. Make recommendations about existing health services provided by the facility;

c. Obtain community input on potential health services to be provided by the facility;

d. Make recommendations on potential health services to be provided by the facility; and

e. Provide input on proposed modifications of health services at the facility

ARTICLE III.

President and Chief Executive Officer of the System

Section A. Appointment or Removal

1. The UMMS President and Chief Executive Officer will consult with the County Executive and the Chairperson of the County Council before taking action to remove or appoint the Dimensions President and Chief Executive Officer. These individuals may provide comment and input but cannot veto or override the final decision of the UMMS President and Chief Executive Officer.

3. Section A of this Article shall be applicable through the earlier of June 30, 2022 or June 30th of the fiscal year in which the County ceases to provide operating funds to the System.

ARTICLE IV.

Miscellaneous Provisions

Section A. State and County Laws

The provisions of this MOU shall in no way diminish or infringe any rights, responsibilities, power or duties conferred on the parties by the Constitution of the State of Maryland, the Annotated Code of Maryland, the Prince George's County Charter, and the Prince George's County Code, and all such laws are hereby incorporated in this Agreement as if fully set forth herein. In the event of a conflict between this MOU and any of these laws, the applicable law shall prevail.

Section B. Effective Date and Modification of Agreement

The MOU shall become effective on the date herein above written. It may be modified only by written agreement of all Parties, with any such modifications to become effective on the date determined by the Parties.

Section C. Final Agreements

The terms and provisions of Article II and Article III hereof are binding on the Parties and will be memorialized in the final agreements (e.g., amended Master Lease Agreement, land transfer agreement, Dimensions corporate bylaws). The Parties will use their best efforts to cause the final agreements to be prepared in final form, submitted for all necessary actions and approvals and to be executed not later than, December 31, 2016.

[Signature page follows]

IN WITNESS THEREOF, the Parties hereto have caused this Agreement to be executed on the date herein above written.

PRINCE GEORGE'S COUNTY, MARYLAND

Rushern L. Baker, III
County Executive

Derrick Leon Davis
Chairman, Prince George's County Council

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION

Robert A. Chrencik
President and Chief Executive Officer

DIMENSIONS HEALTH CORPORATION

C. Philip Nichols, Jr.
Chairman

DIMENSIONS HEALTH CORPORATION

Neil J. Moore
President and Chief Executive Officer