STATE OF MARYLAND

MARYLAND HEALTH CARE COMMISSION

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MEMORANDUM

TO: Commissioners

FROM: Kevin R. McDonald
Chief, Certificate of Need

DATE: May 16, 2019

SUBJECT: Peninsula Regional Medical Center
Docket No. 18-22-2417

Enclosed is the staff report and recommendation for a Certificate of Need (CON) application filed by Peninsula Regional Medical Center (PRMC), which proposes to establish a 15 bed inpatient psychiatric unit for the treatment of children and adolescents, adjacent to the existing 13 bed adult psychiatric unit.

Currently, there are no pediatric inpatient psychiatric resources available on Maryland's Eastern Shore, resulting in the transfer of children and adolescents to out-of-area hospitals for psychiatric care. The closest child and adolescent inpatient psychiatric units are at the Dover Behavioral Health Hospital in Dover, Delaware and the Psychiatric Institute of Washington in Washington, D.C.

The project would renovate 9,983 square feet (SF). The current occupants of this space, used for offices and support services, will move to a currently vacant portion of the hospital, requiring renovation of 8,038 SF. The new inpatient unit will also require the addition of new air handlers, which will go into 1,374 SF of new construction on the roof. Thus the project is comprised of renovation of 18,021 SF and new construction of 1,374 SF

The estimated capital cost of the project is $8,520,716. The applicant plans to fund the project with $2 million in philanthropy and $6,520,716 in cash.

Staff recommends approval of the project based on its conclusion that the proposed project complies with the applicable State Health Plan standards and that the need for the project, its cost effectiveness, and its viability have been demonstrated. Staff also recommends that the Commission find that the project would have negligible impact on existing health care providers and would have a positive impact on the health care delivery system.

IN THE MATTER OF	*	**BEFORE THE**
	*	
PENINSULA REGIONAL	*	**MARYLAND**
	*	
MEDICAL CENTER	*	**HEALTH CARE**
	*	
Docket No. 18-22-2417	*	**COMMISSION**
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Staff Report and Recommendation

May 16, 2019

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I. INTRODUCTION

A. The Applicant

The applicant, Peninsula Regional Medical Center, Inc. ("PRMC," or "Peninsula"), is a 288-bed general hospital located in Salisbury, in Wicomico County. PRMC is the largest hospital on Maryland's Eastern Shore, providing inpatient medical/surgical, pediatric, obstetric, perinatal, and adult acute psychiatric services. It was eighth largest general hospital in Maryland, based on acute inpatient discharge volume in the twelve months ending June 30, 2018 and the eleventh largest general hospital, based on global budget revenue for rate year 2019.

PRMC is a wholly-owned subsidiary of Peninsula Regional Health System, Inc. ("PRHSI"). PRHSI also operates physician practices and outpatient facilities in PRMC's service area. See Appendix 1 for the corporate structure of PRHSI.

B. The Project

PRMC proposes to establish a 15-bed inpatient psychiatric unit for the treatment of children and adolescents on the third floor of the "South Tower" of the general hospital, adjacent to the existing 13-bed adult psychiatric unit. Currently, there are no pediatric inpatient psychiatric hospital facilities in operation on Maryland's Eastern Shore. The closest child and adolescent inpatient psychiatric units to Salisbury are the Dover Behavioral Health Hospital in Dover, Delaware, approximately 60 miles away, and hospitals in Baltimore or Washington, D.C., which are approximately 110 to 120 miles from Salisbury. PRMC states that the proposed project will complement the existing partial hospitalization and outpatient psychiatric services provided by PRMC and community mental health providers.

The project would renovate 9,983 square feet ("SF") of existing space, including 571 SF in the adjacent adult psychiatric unit, to accommodate overlapping staff functions. The space is currently used for offices and support services, which will move to vacant space on the fourth floor of the "East Tower" of PRMC. This relocation will requiring additional renovation of 8,038 SF. The new psychiatric unit will be created in conjunction with the addition of new air handlers in the South Tower, which will involve new construction of 1,374 SF on the Tower roof. Thus, the project includes renovation of just over 18,000 SF of new space and new mechanical space construction to service the building component in which the new psychiatric unit will be housed.

The estimated capital cost of the project is $8,520,716. The applicant plans to fund all but $2 million of the project expenditure with cash reserves and the rest with philanthropic donations. [See Table I-1 below.] (DI #3).

Table I-1 Project Budget Estimate
Development of a Combined Child/Adolescent Psychiatric Unit
Peninsula Regional Medical Center

Uses of Funds	
Capital Costs	
New Construction	
Building and Fixed Equipment (Rooftop Air Handlers)	$2,000,000
Renovation	
Building	$3,759,741
Architect/Engineering Fees	$531,785
Permits (Building, Utilities, Etc.)	$112,792
Subtotal-Renovation	$4,404,318
Other Capital Costs	
Contingency Allowance	$1,036,398
Movable Equipment	1,005,000
Movable Equipment	1,005,000
Subtotal-Other Capital	$2,041,398
Total Current Capital Costs	$8,445,716
Inflation Allowance	-
Total Capital Costs	$8,445,716
Financing Cost and Other Cash Requirements	
CON Application Assistance	$ 55,000
Legal Fees	$20,000
Subtotal-Financing and Other Cash	$75,000
Total Uses of Funds	**$8,520,716**
Sources of Funds	
Cash	$6,520,716
Philanthropy	$2,000,000
Total Sources of Funds	**$8,520,716**

(DI #3, Att. 3, Table E).

C. Staff Recommendation

Staff recommends that the Maryland Health Care Commission APPROVE this Certificate of Need application. Our review shows the proposed project to be in compliance with the applicable State Health Plan standards. The applicant has demonstrated the need for the project and that it is a cost-effective alternative for meeting the demonstrated need. The project will be viable if the hospital is successful in attaining projected levels of demand. Staff believes that the impact of the project on other providers is acceptable and its impact on health care delivery will be positive because it will substantively improve access to adolescent psychiatric hospital care on the Eastern Shore.

II. PROCEDURAL HISTORY

A. Record of the Review

See Appendix 2, Record of the Review.

B. Interested Parties and Participating Entities in the Review

There are no interested parties or participating entities in this review

C. Local Government Review and Comment

The County Health Officers of Wicomico (Lori Brewster) and Dorchester (Roger Harrell) Counties wrote letters of support for the proposed project describing a "critical shortage of inpatient child and adolescent services," (DI#3, Appendix 20) as did the then-Deputy Secretary for Behavioral Health, Barbara Bazron, Ph.D.

D. Community Support

The application included numerous letters of support for the project from a variety of individuals and organizations, including legislators, local providers of primary pediatric medical care, and several pediatric mental health organizations in the region. The legislators are:

- James N. Mathias, Jr., Senate of Maryland, 38th Legislative District, Somerset, Wicomico, and Worcester Counties
- Christopher T. Adams, House of Delegates, Legislative District 37B, Caroline, Dorchester, Talbot, and Wicomico Counties
- Carl Anderton, Jr., House of Delegates, Legislative District 38B, Wicomico County
- Johnny Mautz, House of Delegates, Legislative District 37B, Caroline, Dorchester, Talbot, and Wicomico Counties

III. BACKGROUND

Child and Adolescent Psychiatric Hospital Care in Maryland

Only three general acute care hospitals in Maryland provide acute inpatient psychiatric services for children; The Johns Hopkins Hospital and UMMC, both in Baltimore City, and Adventist HealthCare Shady Grove Medical Center in Rockville (Montgomery County).[1] Two private special psychiatric hospitals also provide hospital services for this age group; Brook Lane in Hagerstown (Washington County) and Sheppard and Pratt Hospital in Towson (Baltimore County).

Nine hospitals in Maryland report the provision of adolescent psychiatric hospital services.[2] Six are general acute care hospitals; Adventist HealthCare Shady Grove Medical Center, CalvertHealth Medical Center in Prince Frederick (Calvert County), Carroll Hospital in Westminster (Carroll County), MedStar Franklin Square Hospital in the Rosedale area of eastern

[1] Historically, Adventist HealthCare provided psychiatric hospital services in a special hospital setting, Adventist HealthCare Behavioral Health and Wellness. This special hospital was authorized to consolidate its facilities with those of the adjacent Shady Grove Medical Center in May 2018.

[2] Maryland Health Care Commission, *Annual Report on Selected Maryland Acute Care and Special Hospital Services, FY 2018.*

Baltimore County, MedStar Montgomery Medical Center in Olney (Montgomery County), and Suburban Hospital in Bethesda (Montgomery County). Three are special psychiatric hospitals; Brook Lane, Sheppard and Pratt Hospital, and Sheppard Pratt of Ellicott City.

Hospital use for both children and adolescents diagnosed with mental diseases or disorders increased between 2008 and 2017; quite modestly for children and more significantly for adolescents. For children, use levels are very slight. On a per capita basis, adolescents were hospitalized at almost seven times the rate experienced by children and adults were hospitalized over four times more frequently than persons aged 12 or younger. Over the period of time shown in the table below, use of psychiatric hospitalization by children peaked in 2012 and declined, at a rate of about 3.2% per year between 2012 and 2017, to a level that was only about 2.2% higher than the use rate observed in 2008. For adolescents, use peaked in 2014 and has moderated more recently, declining about 4.2% by 2016 and holding steady in 2017. However, the adolescent use rate in 2017 was still about 26.3% higher than that recorded in 2008. (See Table III-1).

Table III-1: Hospital Discharge Rate of Maryland Residents with a Discharge Recorded within the Major Diagnostic Category of Mental Disease or Disorder
III. Residents in Three Age Groupings

Age Group	Discharges Per 100,000 Maryland Residents										Average Annual Change
	008	009	010	011	012	013	014	015	016	017	
Child (0-12)	179	189	204	209	217	201	192	170	175	183	+ 0.4%
Adolescent (13-17)	1,008	1,199	1,190	1,291	1,294	1,328	1,329	1,318	1,273	1,273	+ 2.8%
Adult (>18)	853	896	896	905	887	869	850	804	802	772	- 1.1%
All Ages	**52**	**99**	**01**	**16**	**04**	**90**	**75**	**34**	**31**	**09**	**- 0.6%**

Source: MHCC staff analysis of HSCRC discharge abstract, District of Columbia discharge abstract, and private psychiatric hospital data, CY 2008 to CY 2017; Population data from the U.S. Census Bureau for 2008 and 2009; Maryland Department of Planning Projections, March 2018.

Note: For the HSCRC and D.C. data, psychiatric discharges are defined as records with major diagnostic category (MDC) coded for mental diseases and disorders. All records from private psychiatric hospitals are included regardless of the MDC category. The discharge rates do not incorporate discharges from State psychiatric hospitals.

Child and Adolescent Population and Child/Adolescent Psychiatric Hospital Care in the PRMC Service Area

PRMC defines the primary service area ("PSA") for the child and adolescent psychiatric hospital program it proposes as four Maryland jurisdictions, Dorchester, Somerset, Wicomico, and Worcester, and two border state jurisdictions contiguous with the Maryland PSA counties, Accomack County, on Virginia's Eastern Shore, and Sussex County, Delaware. It defines the secondary service area ("SSA") for these new hospital services as the Mid-Shore Maryland jurisdictions of Caroline, Kent, Queen Anne's and Talbot Counties and the other Virginia Eastern Shore jurisdiction of Northampton County.

Table I-3 below shows the projected growth for the child and adolescent population aged 5-17 between 2015 and 2030. The defined primary and secondary service areas are projected to grow about 5.3% over this 15-year period. There are no other child or adolescent psychiatric

hospital units in the PSA or SSA. There was a 15-bed child and adolescent special psychiatric hospital, operated by Adventist HealthCare, in conjunction with a residential treatment center program, in Cambridge (Dorchester County) until 2016. Since 2016, Adventist HealthCare has only served these age groups in its Rockville facilities.

Table I-3: Projected Change in the Child and Adolescent (5-17) Population, 2015-2030
Wicomico County and the PRMC-Defined Service Area

Geographic Area	2015	2030	Change	% Change
Wicomico County	18,023	18,597	574	3.2%
PSA	66,381	70,835	4,454	6.7%
SSA	23,233	23,495	262	1.1%
Total Service Area	89,614	94,330	4,716	5.3%

Sources: Maryland Department of Planning, Delaware Population Consortium, U.S. Bureau of the Census

The applicant provided information of child and adolescent psychiatric hospital discharges originating in its defined primary service area between 2010 and 2016. The annual average over this period was 256 and the average daily census yield of these hospitalized patients was 6.5. For the combined PSA and SSA, the annual average discharge count for the seven-year period was 373 with an average daily census of 9.5. (See Table I-4 below.)

Table 1-4: Child and Adolescent Psychiatric Hospital Discharges, Average Length of Stay ("ALOS"), and Average Daily Census ("ADC")
PRMC-Defined Service Area
2010-2016

	2010	2011	2012	2013	2014	2015	2016	Annual Average
PSA	273	282	313	244	262	225	196	256
SSA	134	119	126	97	85	122	136	117
Total Service Area	407	401	439	341	347	347	332	373
ALOS (Total Service Area)	10.9	7.6	8.4	9.2	9.5	9.4	10.1	9.3
ADC (Total Service Area)	12.2	8.3	10.0	8.6	9.1	8.9	9.1	9.5

Source: HSCRC Discharge Database, Inpatient and Psychiatric Files (DI#2, p. 31)

IV. REVIEW AND ANALYSIS

The Commission is required to make its decisions in accordance with the general CON review criteria at COMAR 10.24.01.08G(3)(a) through (f). The first of these six general criteria requires the Commission to consider and evaluate this application according to all relevant State Health Plan standards and policies.

A. The State Health Plan

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.

The relevant State Health Plan chapter is COMAR 10.24.07: Psychiatric Services.

Since the Psychiatric Services Chapter was written there have been changes in the role and scope of State-operated psychiatric hospital facilities. There have also been substantial changes in the use of acute psychiatric beds. Because of these changes, some of the standards in the Chapter are out of date. In particular, Standard AP 1a – AP 1d (which reference an obsolete bed need methodology) is no longer applicable.

Two other standards do not apply in this review:

- AP 9, which references conditions under which an acute child psychiatric patient can be admitted to a general pediatric unit; and
- AP 11, which refers only to private psychiatric hospitals.

Standard AP 2a

All acute general hospitals with psychiatric units must have written procedures for providing psychiatric emergency inpatient treatment 24 hours a day, 7 days a week with no special limitation for weekends or late night shifts.

PRMC states that it provides psychiatric emergency treatment 24 hours a day, 7 days a week, with no exceptions. (DI# 3, Exh.17). PRMC complies with this standard.

Standard AP 2b

Any acute general hospital containing an identifiable psychiatric unit must be an emergency facility, designated by the Department of Health and Mental Hygiene to perform evaluations of persons believed to have a mental disorder and brought in on emergency petition.

PRMC states that its child and adolescent inpatient psychiatric unit will be an emergency facility designated by the Maryland Department of Health ("MDH," formerly the Department of Health and Mental Hygiene) to perform evaluations as specified in the standard, and that the unit will be locked for the treatment of involuntary patients. (DI#3, p.52). Its adult unit has been designated a psychiatric emergency facility by MDH. (DI #3, Att. 17, pg. 1).

Staff concludes that PRMC satisfies this standard.

Standard AP 2c

Acute general hospitals with psychiatric units must have emergency holding bed capabilities and a seclusion room.

PRMC has a child psychiatric holding area in its Emergency Department. The design for the proposed project includes two seclusion rooms. (DI #3, p.53 and Att. 18).

Staff concludes that PRMC satisfies this standard.

Standard AP 3a

Inpatient acute psychiatric programs must provide an array of services. At a minimum, these specialized services must include: drug-therapy, individual psychotherapy, group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies.

PRMC states that its child and adolescent acute inpatient services will include appropriate staff to provide the services required by this standard. PRMC's staffing projections show that the project will include 26 new full-time equivalent direct care staff in social work, nursing or nurse aides, and an art therapist. (DI #3, Att. 3, Table L).

Staff concludes that PRMC satisfies the standard.

Standard AP 3b

In addition to the services mandated in Standard 3a, inpatient child and adolescent acute psychiatric services must be provided by a multidisciplinary treatment team which provides services that address daily living skills, psychoeducational and/or vocational development, opportunity to develop interpersonal skills within a group setting, restoration of family functioning and any other specialized areas that the individualized diagnostic and treatment process reveals is indicated for the patient and family. Applicants for a Certificate of Need for child and/or adolescent acute psychiatric beds must document that they will provide a separate physical environment consistent with the treatment needs of each age group.

PRMC states that it will provide a multidisciplinary treatment team approach for the new age groups it proposes to serve as inpatients. It states that, because it currently provides child and adolescent psychiatric services on an outpatient basis, some of the required personnel are already in place. It pledges to hire additional staff specialties needed to support the project.

The child patients and the adolescent patients will each have their own separate clinical space to provide services specific to the needs of their age group. (DI#3, p.53).

Staff concludes that PRMC satisfies the standard.

Standard AP 3c

All acute general hospitals must provide psychiatric consultation services either directly or through contractual arrangements.

PRMC states that it will provide psychiatric consultation services as a component of its proposed 15-bed child and adolescent inpatient psychiatric unit. (DI#3, p.53).

Staff concludes that PRMC satisfies the standard.

Standard AP 4a

A Certificate of Need for child, adolescent or adult acute psychiatric beds shall be issued separately for each age category. Conversion of psychiatric beds from one of these services to another shall require a separate Certificate of Need.

Standard AP 4b

Certificate of Need applicants proposing to provide two or more age-specific acute psychiatric services must provide that physical separations and clinical/programmatic distinctions are made between the patient groups.

In this CON application PRMC seeks to establish an inpatient psychiatric unit for both children and adolescents, two age groups it has not served in the past, with respect to psychiatric inpatient care. Thus, this application complies with Standard AP 4a.

The proposed project would entail creating two distinct sections of the new unit for children and adolescents, with six patient rooms containing ten beds for adolescents and three rooms containing five beds for children. The sections would be physically separated by a common nursing station. PRMC states that clinical programming will be "consistent with the standard" for both patient groups. (DI #3, p.54).

Staff concludes that PRMC satisfies these standards.

Standard AP 5

Once a patient has requested admission to an acute psychiatric inpatient facility, the following services must be made available:

(i) intake screening and admission;

(ii) arrangements for transfer to a more appropriate facility for care if medically indicated; or

(iii) necessary evaluation to define the patient's psychiatric problem; and/or

(iv) emergency treatment.

PRMC states that will make all of the services required by this standard available. It submitted copies of the policies it has developed for admission and discharge, transfers, evaluation and emergency treatment. (DI #8, Att. C, J, K, and N).

Staff concludes that PRMC satisfies the standard.

Standard AP 6

All hospitals providing care in designated psychiatric units must have separate written quality assurance programs, program evaluations and treatment protocols for special populations, including children, adolescents, patients with secondary diagnosis of substance abuse, and geriatric patients, either through direct treatment or referral.

PRMC submitted drafts of the following documents that it has prepared in anticipation of offering this program: Scope of Professional Services for PRMC Behavioral Health Services; Patient Safety Plan; Performance Improvement Plan; Standing Orders and Standards of Care; and Quality Management Plan. (DI #8, Att. C, D, E, F, and G).

Staff concludes that PRMC satisfies the standard.

Standard AP 7

An acute general or private psychiatric hospital applying for a Certificate of Need for new or expanded acute psychiatric services may not deny admission to a designated psychiatric unit solely on the basis of the patient's legal status rather than clinical criteria.

PRMC stated that it will admit patients without regard to their legal status. (DI #3, p. 55).

The applicant submitted a draft admissions policy. (DI #8, Att. J), which refers to the emergency policy. The applicant submitted a draft copy of its emergency admissions policy and criteria, which includes the procedures on hearings for involuntarily admissions, as an attachment to its CON application. (DI #3, Att. 17, standards 7 and 8).

Staff concludes that PRMC satisfies this standard.

Standard AP 8

All acute general and private freestanding psychiatric hospitals must provide a percentage of uncompensated care for acute psychiatric patients which is equal to the average level of uncompensated care provided by all acute general hospitals located in the health service area where the hospital is located, based on data available from the Health Services Cost Review Commission for the most recent 12-month period.

PRMC states that it expects that the level of uncompensated care for children and adolescent psychiatric inpatients will be substantially equivalent to that experienced at the hospital for its existing inpatient pediatric services. (DI #3, p. 55). PRMC correctly notes that HSCRC data do not break down uncompensated care by service line, (DI #8, p. 18) making a literal review of compliance with this standard a difficult undertaking.

Staff consulted HSCRC data and it reports that PRMC's overall uncompensated care level for FY2017 was 1.92% compared to a statewide average of 1.82%.[3] Staff would also note that PRMC projects that slightly over 80% of its child and adolescent patients will be Medicaid-eligible.

Staff concludes that PRMC satisfies the standard.

Standard AP 12a

Acute inpatient psychiatric services must be under the clinical supervision of a qualified psychiatrist.

PRMC documented that Dr. William Cerrato, a Board-Certified physician, fellowship-trained in child and adolescent psychiatry, will serve as Medical Director. (DI #3, p. 57 and Att. 19).

Staff concludes that PRMC satisfies the standard.

Standard AP 12b

Staffing of acute inpatient psychiatric programs should include therapists for patients without a private therapist and aftercare coordinators to facilitate referrals and further treatment. Staffing should cover a seven-day per week treatment program.

[3] See the information at: https://hscrc.maryland.gov/Documents/HSCRC_Initiatives/CommunityBenefits/CBR-FY17/FiscalYear17HCBFinancialReport20180501.xlsx Column K and Column E

PRMC states that individual and group therapy will be provided seven days per week on the unit. (DI #3, pg. 56). After-care coordinators will ensure that patients who are discharged without a private therapist will be given referrals for follow-up treatment. PRMC estimates that there are 150 therapists in the service area for follow-up care. (DI #8, pg. 19 and Att. I).

Staff concludes that PRMC satisfies the standard.

Standard AP 12c

Child and/or adolescent acute psychiatric units must include staff who have experience and training in child and/or adolescent acute psychiatric care, respectively.

PRMC states that all clinical staff will be licensed professionals trained and experienced in working with the needs of the child and/or adolescent patient population. (DI #3, p. 57). Staff concludes that PRMC satisfies the standard.

Standard AP 13

Facilities providing acute psychiatric care shall have written policies governing discharge planning and referrals between the program and a full range of other services including inpatient, outpatient, long-term care, aftercare treatment programs, and alternative treatment programs. These policies shall be available for review by appropriate licensing and certifying bodies.

PRMC has written policies governing discharge planning that include the involvement of the patient and family in aftercare plans in conjunction with the referral sources and community resources. (DI #8, Att. J for policy and N for referral list).

The referral list provides for a full range of services. It includes eight multi-service clinics, four addiction service centers, twelve psychiatrists or therapists, four centers offering partial hospitalization programs or case management, and an independent music therapy provider.

PRMC satisfies this requirement.

Standard AP 14

Certificate of Need applications for either new or expanded programs must include letters of acknowledgement from all of the following:

(i) the local community mental health center(s);
(ii) the Department of Health and Mental Hygiene; and
(iii) the city/county mental health department(s).

Letters from other consumer organizations are encouraged.

PRMC submitted a copy of a letter from the Deputy Secretary for Behavioral Health of the Maryland Department of Health, acknowledging notification of the proposed project. (DI #3, Att. 20). The applicant included many letters of support, including letters from the requisite agencies and organizations cited in this standard, as represented by Lori Brewster, Health Officer, Wicomico County Health Department, Roger L. Harrell, Health Officer, Dorchester County Department of Health,

and Tammy L. Griffin, Director, Wicomico Behavioral Health Authority, Wicomico County Health Department.

PRMC meets this standard.

B. Need

COMAR 10.24.01.08G(3)(b) Need.
The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

Number of child/adolescent behavioral health discharges

As displayed in Table I-4 earlier in this report, PRMC provided data from the HSCRC Discharge Data Base indicating that, over the period of 2010 to 2016, an average of 373 patients (256 from the PSA and 117 from the SSA) aged five to 17 years were hospitalized with a primary psychiatric diagnosis, and had an ALOS of 9.3 days. That data also showed that such hospitalizations declined by about 18% over the period, from 407 in 2010 to 332 in 2017. Note that the HSCRC data only includes Maryland hospitals. Service area residents using hospitals in other states are not accounted for in Table I-4. There may be a substantive undercount for the geographic region defined by PRMC as the likely catchment area for its proposed new psychiatric services program, given that it includes a Delaware and two Virginia jurisdictions. (DI #3, Att.13).

Child/adolescent behavioral health in the Emergency Department

As another indicator of need, PRMC presented data on use of its emergency department ("ED") by children and adolescents with mental disorders. In FY 2015 PRMC reports that it saw 420 child and adolescent behavioral health patients in its ED with an ED ALOS of 7.9 hours. By FY2018, the number of such visits had grown by 69%, to 711. The ED ALOS for these patients also increased dramatically, to 651 minutes, nearly 11 hours.[4]

Table III-1 below tracks the monthly trend in ED ALOS over a two year period beginning in June 2016.

[4] PRMC cited one case of a pediatric patient who was boarded for 267 hours, i.e., 11 days, before appropriate space was found and a transfer to receive inpatient treatment was made.

Table III-1: Average Length of Stay in PRMC Emergency Department Patients Aged 5-17

	July '16	Aug '16	Sept '16	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr '17	May '17	June '17	July '17	Aug '17	Sept '17	Oct '17	Nov '17	Dec '17	Jan '18	Feb '18	Mar '18	Apr '18	May '18	Jun '18
Avg. LOS (min)	384	484	436	370	320	407	483	431	514	993	729	443	408	717	857	763	501	514	386	479	813	673	805	901

Source: PRMC ER Wait Times Transfer Roster (DI#8, p.5).

Citing a recent Maryland Hospital Association report (MHA Behavioral Health Task Force, PRMC pointed out that it is not the only hospital facing these challenges. The report contains MHCC staff extracted the passage below.

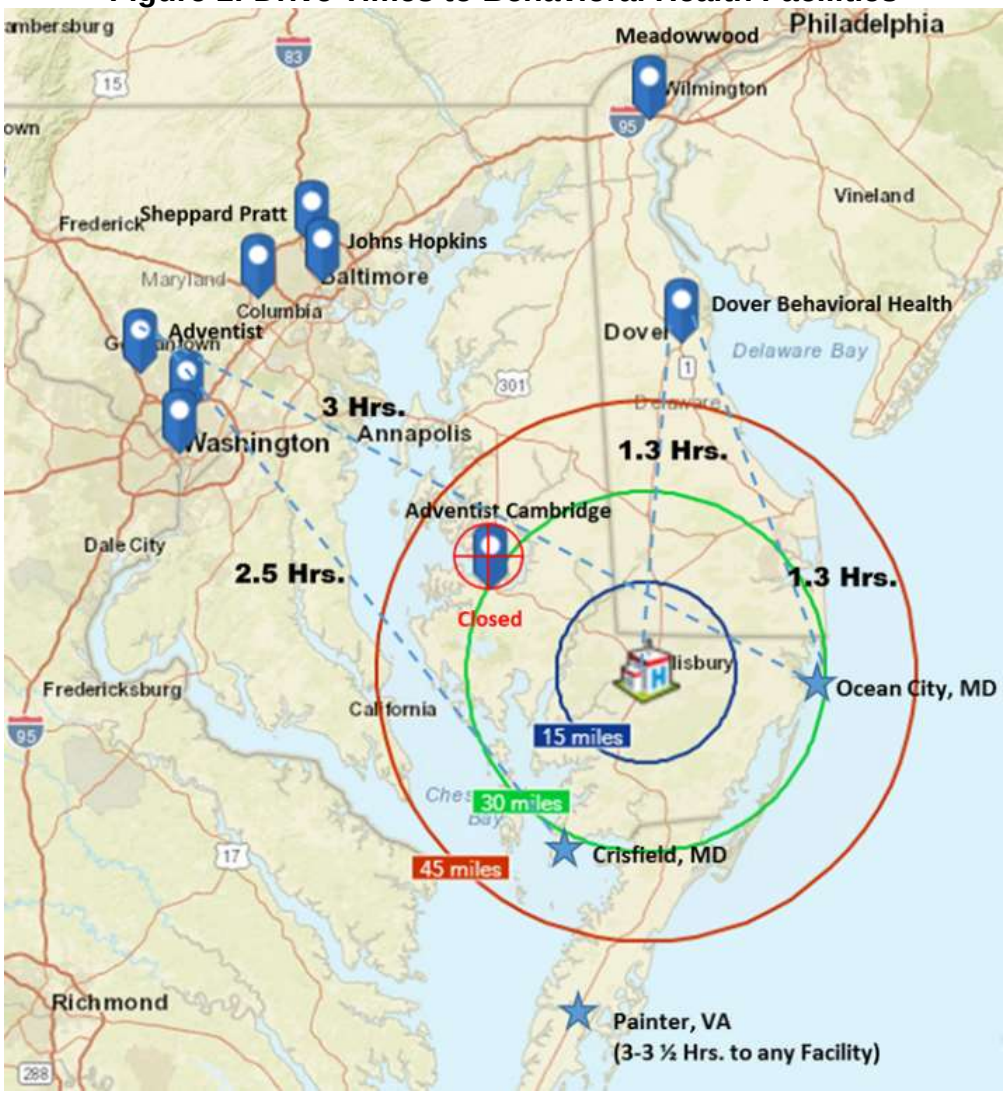
> The emergency departments of Maryland's hospitals are often the first to be affected when policies fail to facilitate access to necessary services…a lack of adequate behavioral health services in the community leaves patients with just two options for treatment: emergency departments and jails…one hospital CEO reported that on a single day, 75 percent of their facility's ED bed capacity was…behavioral health patients. Another hospital experienced a record 41-hour average length of stay for behavioral health patients. The ED chair at yet another hospital reported an average length of stay of 36 hours for psychiatric patients requiring transfer, nine times the average length of stay for non-psychiatric patients.[5]

Lack of access to child/adolescent behavioral health inpatient resources

PRMC points out that there are limited behavioral health treatment options on the Delmarva Peninsula. Consequently many patients are being sent either 1½ hours north to Dover Behavioral Health, or transported across the Chesapeake Bay Bridge, a three-hour trip. This situation was exacerbated by the 2016 closure of Adventist Behavioral Health in Cambridge. The following exhibit from the PRMC application identifies the most accessible child and adolescent hospital facility options for the Eastern Shore.

[5] https://www.mhaonline.org/docs/default-source/Resources/roadmap-to-an-essential-comprehensive-system-of-behavioral-health-care-for-maryland.pdf?sfvrsn=2 p. 5

Figure 1: Drive Times to Behavioral Health Facilities



PRMC presented internal data from its ED that showed that, in FY2018, 41% of its child and adolescent behavioral health transfers went to Delaware (Dover Behavioral Health and Rockford Medical Center); 25% went to Washington, D.C. (Children's National Medical Center and the Psychiatric Institute of Washington); and 34% went to Maryland facilities. And these numbers were reflected in community sentiment. The community ranked substance abuse and mental health concerns first and second among health concerns, and excessive travel time as a top non-medical concern, in the last two Community Health Needs Assessment Surveys.

PRMC need projections for its proposed child/adolescent inpatient psychiatric unit

PRMC arrived at the utilization and bed need model shown in the following table, keying off the average number of PSA and SSA discharges for the 2010 to 2016 period shown in the preceding Table I-4.

Table III-2: Projection of Demand for Child and Adolescent Psychiatric Hospital Services at PRMC and the Corresponding Bed Need

Patient Source	Discharges	% of Market Capture	PRMC Discharges	ALOS	Total Patient Days	Average Daily Census	Bed Need	
							@ Target Occupancy Rate of 71.4% [6]	Beds Needed for "Availability" on 99% of days
PSA	256	75%	192	9.27	1,778	4.87		
SSA	117	35%	41	9.25	379	1.04		
Combined SA	373	N/A	233	9.26	2,157	5.91		
ED Transfers	49	100%	49	9.27	454	1.24		
In-migration **	--	--	50	9.26	463	1.27		
Total			332	9.26	3,075	8.42	11.8	15

Sources: HSCRC Discharge Databases, 2010-2016, PRMC ED Transfer Data, 2014-2016.
*Based on a Poisson frequency distribution
**In-migration from outside the defined service area assumed to comprise 15% of total ADC

PRMC projected, for purposes of developing financial projections, that actual discharges at PRMC of child and adolescent patients would increase from 100 to 373 per year over the period of 2020 to 2023.

PRMC made the following assumptions to develop the model projections of demand for child and adolescent psychiatric beds at PRMC:

- PRMC will achieve a 75% market share of the patient population originating in the PSA that remains in Maryland for treatment and a 35% market share of the population originating in the SSA. The remainder of patients will continue to be admitted to other hospitals outside the defined service area;
- 100% of the estimated number of patients transferred from the PRMC emergency room to D.C. or Delaware hospitals, will be admitted to the unit (Transfers to Maryland hospitals would be accounted for in the first step.);
- The ALOS of the unit is assumed to be that observed by Maryland hospitals for behavioral health patient's aged 17 and under residing in the PSA and SSA during the 2010 to 2016 period. This is 9.27 days for the patients originating in the PSA and 9.25 days for SSA patients;
- 15% of the total admissions will be residents from outside the PSA and SSA[7];

[6] This occupancy rate assumption is based on the formula established in Maryland law for licensing acute care beds in general hospitals. A licensed bed total is annually calculated as 1.4 multiplied by an observed twelve-month ADC. This equates to an average annual bed occupancy target of 71.4%.

[7] PRMC states: "The beaches…in Worcester County and Ocean City…and Sussex County in Delaware continue to be destination centers of beach and ocean lovers….the influx of vacationers in the summer months and the continued growth of the shoulder months [of spring and fall]…supports a small but growing percentage of out of service area patients. The population of Ocean City is small, approximately 7,000 [but]…..during summer weekends the city hosts between 320,000 to 350,000 vacationers and up to 8 million annually. The co-occurring behavioral health patterns of

- A target bed occupancy rate of 71.4% for the child and adolescent beds; and
- A "bump-up" factor equivalent to an additional 2.2 beds derived by assuming that fluctuation in bed demand will resemble a Poisson frequency distribution. This step is intended to provide a number of beds that would be needed to assure that at least one bed would be empty and available for admission of a patient on 99% of days, i.e., 361-362 days in an average year. Staff notes that this step implies that the unit will operate at an average annual occupancy rate of 56.1%.

MHCC staff's review of this projection and bed need calculation model is that it is generous and optimistic. We would observe the following:

- It begins with a seven-year average number of discharges observed as originating from a very large service area that appears to display a definite trend of declining demand. In the last four years charted by PRMC, the combined service area generated an average of 342 discharges compared to the starting point of 373 used by PRMC, which is also the number of cases that PRMC projects by 2023; and

- A facility can turn to a frequency distribution to determine the number of beds needed for a given ADC level, such as a Poisson distribution or a cumulative binomial frequency distribution, which approximates a Poisson distribution at the small ADC levels applicable in this case. One would use this method based on a desired level of confidence concerning bed availability. Or, as an alternative, one can determine the number of beds needed for a given level of ADC, using an occupancy rate target, assumed to provide an average surplus of beds as ADC fluctuates that will assure reasonable availability. But the methods are alternatives. So, in staff's view, PRMC has produced a 12-15 bed range of required beds for its predicted ADC of 8.4 patients. And the high end of this range assumes a need to very rarely be without a bed available, which is optimal, from the perspective that longer wait times in the ED or transfers should very rarely occur, but less than optimal, given the higher level of slack bed use implied (56% average annual bed occupancy).

With those observations, staff also believes that it does not seem likely that the cost of this project would be significantly reduced by requiring PRMC to create a unit of 10 to 12 beds, more consistent with what staff believes to be needed, rather than the 15-bed unit proposed and it is assumed that PRMC will staff the unit as needed and that very small diseconomies of scale result from having the small number of potential excess beds that may result. We conclude that the need to have an alternative site for psychiatric hospital care of the younger population on the Eastern Shore has been demonstrated, because of the relatively poor geographic access that currently exists. We recommend that the Commission find that the proposed project is needed.

increased drug/alcohol use coupled with existing underlying behavioral health issues can trigger behavioral health crises during these visits." (DI# 8, pg. 12).

C. Costs and Effectiveness

COMAR 10.24.01.08G(3)(c) Availability of More Cost-Effective Alternatives.
The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

PRMC's stated primary goals in proposing this project are to:

- Enhance access to care for children and adolescents residing on the Lower Eastern Shore;
- Strengthen the established network of outpatient service providers currently serving the community; and
- Eliminate delays and barriers to timely inpatient psychiatric care that now result from patient transfers to other facilities from the PRMC Emergency Department, all sent outside of Wicomico County and most outside of Maryland. (DI #3, p. 44, DI #8, p 21).

Regarding the "compar[ison of] the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities" required by the criterion, PRMC stated that there are no other inpatient psychiatric units or programs located on Maryland's Eastern Shore, so that children and adolescents who need these services have been referred outside the service area of PRMC, either to other Maryland hospitals, or to hospitals located in Delaware or Washington, D.C.

PRMC examined, as alternatives, the construction of a freestanding psychiatric hospital and also considered renovation of another location within the hospital. It chose to renovate close to 10,000 SF currently occupied by administrative and nurse training functions to accommodate a 15-bed inpatient unit. The administrative and nurse training functions will move to unoccupied space on the fourth floor of the hospital's East Tower. The total capital cost of this option is approximately $8.5 million, which PRMC determined to be the lowest cost option to provide the proposed services.

Staff concludes that PRMC has reasonably demonstrated that the project is a cost effective approach for introducing inpatient child and adolescent psychiatric services.

D. Viability

COMAR 10.24.01.08G(3)(d) Viability of the Proposal.
The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

This criterion requires consideration of three questions: availability of resources to implement the proposed project; the availability of resources to sustain the proposed project; and community support for the proposed project.

Availability of Resources to Implement the Proposed Project

PRMC estimates that the project's total cost will be $8,520,716, to be funded with $6,520,716 from cash reserves and $2 million in philanthropic dollars already in-hand for the project. (DI #3, p. 48 and Table E). The audited consolidated financial statements for Peninsula Regional Health System, Inc. and Subsidiaries for 2017 and 2018 showed that the system had $36.9 million in cash and cash equivalents as of the end of fiscal year (FY) 2018 and that total assets exceeded total liabilities ($732 million to $207 million).

Availability of Resources to Sustain the Proposed Project

(a) Finances

The applicant's utilization forecast was reviewed earlier in this report under the Need criterion. Its projected financial performance for the unit is summarized in Table III-3. in the need section above.

Table III-3: Proposed PRMC Child and Adolescent Psychiatric Service Use, Revenue, and Expense Projections

	Operating Year			
UTILIZATION	**Year 1**	**Year 2**	**Year 3**	**Year 4**
Discharges	100	225	335	373
Patient days	926	2,084	3,102	3,458
ALOS	9.3	9.3	9.3	9.3
Average annual occupancy rate	16.9%	38.1%	56.7%	63.2%
FINANCIAL				
Net patient services revenues	$1,289,737	$2,975,139	$4,539,211	$5,186,384
Expenses	$1,340,275	$2,710,798	$3,338,194	$3,405,813
Net income	$(50,538)	$264,341	$1,201,017	$1,780,571

Source: DI#3, Table I and K.

(b) Community Support

The applicant addressed community support for the project by submitting letters of support for the project from members of its Board of Trustees, members of its medical staff leadership, community physicians, several State and federal legislators, and Lori Brewster, Wicomico County Health Officer, all wrote a letter of support for the project. (DI #2, DI #3, Att. 20). In addition, the applicant has been able to raise $2 million in philanthropic support for the project.

Staff Summary of Compliance with Viability Criterion

The applicant's financial statements demonstrate that the hospital is financially strong and has the financial resources to implement the project. (DI #8, Att. B, Consolidated Financial Statements and Supplementary Information).

As previously noted, PRMC's volume projections appear to staff to be optimistic, given the possibility that use rates may be declining in the PRMC-determined service area. However, statewide, adolescent psychiatric hospital use rates have trended up over a longer time period, as shown in the Background section of this report.

MHCC requested the Health Services Cost Review Commission ("HSCRC") to review the financial projections provided in the CON application and subsequent filings, and advise MHCC whether the project is financially feasible**.** HSCRC staff reviewed the PRMC audited financial statements for the year ended June 30, 2018. HSCRC staff indicated that PRMC has sufficient funds for this project. In addition, HSCRC staff expressed its expectation that the parties would be able to agree on rates that are reasonable and supportive of the cost of the child and adolescent psychiatric unit. (Appendix 4).

Staff recommends that the Commission find this proposed project to be viable.

E. Compliance with Previous Certificates of Need

COMAR 10.24.01.08G(3)(e), Compliance with Conditions of Previous Certificates of Need.
An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

PRMC has been issued four CONs since 2003 and has complied with all terms and conditions of those CONs. (See Appendix 4).

PRMC has demonstrated that it has an acceptable track record in implementing approved projects.

F. Impact

COMAR 10.24.01.08G(3)(f) Impact
An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

PRMC addressed the impact that its proposed psychiatric hospital would have on the volumes of other providers, access for the service area population, and costs to the health care system.

Impact on volumes of other providers

PRMC notes that most of the child and adolescent behavioral health patients it projects serving are currently being referred out-of-area by PRMC's ED or other regional providers because child and adolescent psychiatric hospital facilities are not available in the region.

In FY2018, two-thirds of PRMC's referrals went to facilities in Dover, Delaware or to Washington, D.C., while 34% were referred to Maryland facilities, primarily in the Baltimore area (see Table III-4 below). PRMC identified Dover Behavioral Health in Delaware, the Psychiatric Institute of Washington in Washington, D. C., and Sheppard Pratt Hospitals in

Baltimore and Howard County as facilities that would experience an impact as a result of the proposed project. (DI #10, pg. 21).

Table III-3, Hospital Affected by PRMC Introduction of Child and Adolescent Hospital Services

Referrals from PRMC ED By Receiving Hospital FY 2018	Discharges
Dover Behavioral Health, DE	44
Psych Institute Of Washington, DC	33
Sheppard Pratt, MD	22
Other Maryland	22
Other Delaware	10
Rockford Medical Center, DE	9
University of Maryland, MD	8
Children's National, DC	5
TOTAL	**153**

Source: DI 3, Att. 12, DI 10, Att. D

PRMC: Impact on access for the service area population and costs to the health care system

Addressing the impact on access for the service area population, PRMC states that the proposed inpatient unit will "significantly diminish if not eliminate" the out-of-area referrals and transfers for inpatient child and adolescent behavioral health patients. (DI #3, p. 49). PRMC presented mileage and drive time comparisons for residents of Wicomico County and the surrounding area to existing providers, as shown in Table III-5 below.

Table III-5 Drive Times from the service area to current psychiatric facilities

Various Sites Within PRMC Service Area	Sheppard Pratt at Ellicott City	Johns Hopkins	Adventist at Shady Grove	Dover Behavioral Health DE
Painter, VA	3 hr. 28 min	3 hr. 34 min	3 hr. 45 min	2 hr. 28 min
Chincoteague Island, VA	3 hr. 9 min	3 hr. 15 min	3 hr. 27 min	2 hr. 11 min
Crisfield, MD	2 hr. 51 min	2 hr. 55 min	3 hr. 6 min	1 hr. 56 min
Ocean City, MD	3 hr. 20 min	2 hr. 46 min	2 hr. 56 min	1 hr. 25 min
Cambridge, MD	1 hr. 43 min	1 hr. 47 min	1 hr. 55 min	1 hr. 24 min
Easton, MD	1 hr. 33 min	1 hr. 31 min	1 hr. 37 min	1 hr. 8 min
Denton, MD	1 hr. 27 min	1 hr. 27 min	1 hr. 33 min	45 min
Seaford, DE	1 hr. 54 min	1 hr. 56 min	2 hr. 5 min	54 min

PRMC states that its proposed project will reduce driving time for acute psychiatric care for patients and families living in the Wicomico County area, and will encourage more active engagement of family members in the treatment process by providing a service site closer to home. It also notes that the proposed facility will improve continuity of care and provide improved coordination with existing outpatient services, including a partial hospitalization program it

intends to develop along with the inpatient unit. This hopefully should serve to reduce readmissions and thus the costs to the health care system. (DI #10, pg.3).

Staff concludes that this project will have an impact on existing health care providers in the Baltimore and Washington, D.C. areas that provide psychiatric hospital services to children and adolescents and on hospitals in Delaware. All are relatively distant from the lower Eastern Shore of Maryland. It will increase revenues at PRMC as a result of the shift in patient care from other hospitals to PRMC. It should have a positive impact on health care delivery by shortening wait times for Eastern Shore patients needing hospitalization. On balance, staff concludes that the impact of this project is positive and recommends that the Commission make the same finding.

V. SUMMARY AND STAFF RECOMMENDATION

PRMC proposes to establish a 15-bed child and adolescent inpatient behavioral health unit to fill a need that results in child and adolescent patients having to travel long distances for needed care by renovating about 10,000 SF in the hospital to establish a child and adolescent inpatient psychiatric unit. The estimated cost is projected to be $8.5 million and will be funded with approximately $6.5 million in cash and philanthropy of $2.0 million.

Commission staff concluded that the applicant demonstrated that the program is needed and its implementation will advance the development of a comprehensive, community-based behavioral health program with the potential to enhance collaboration and synergy among local providers. The applicant is strong financially and has the resources to implement the project, for which it projects a self-sustaining operating margin. The project has garnered community support.

Based on its review and analysis of the Certificate of Need application, the Commission staff recommends that the Commission find that the proposed capital project complies with the applicable State Health Plan standards, is needed, is a cost-effective approach to meeting the project's goals and objectives, is viable, and will have a positive impact on the health care delivery system without adversely affecting other providers of health care services. Accordingly, Staff recommends that the Commission **APPROVE** PRMC's application for a Certificate of Need to offer inpatient child and adolescent psychiatric care.

IN THE MATTER OF	*	**BEFORE THE**
	*	
PENINSULA REGIONAL	*	**MARYLAND**
	*	
MEDICAL CENTER	*	**HEALTH CARE**
	*	
Docket No. 18-22-2417	*	**COMMISSION**
	*	

* *

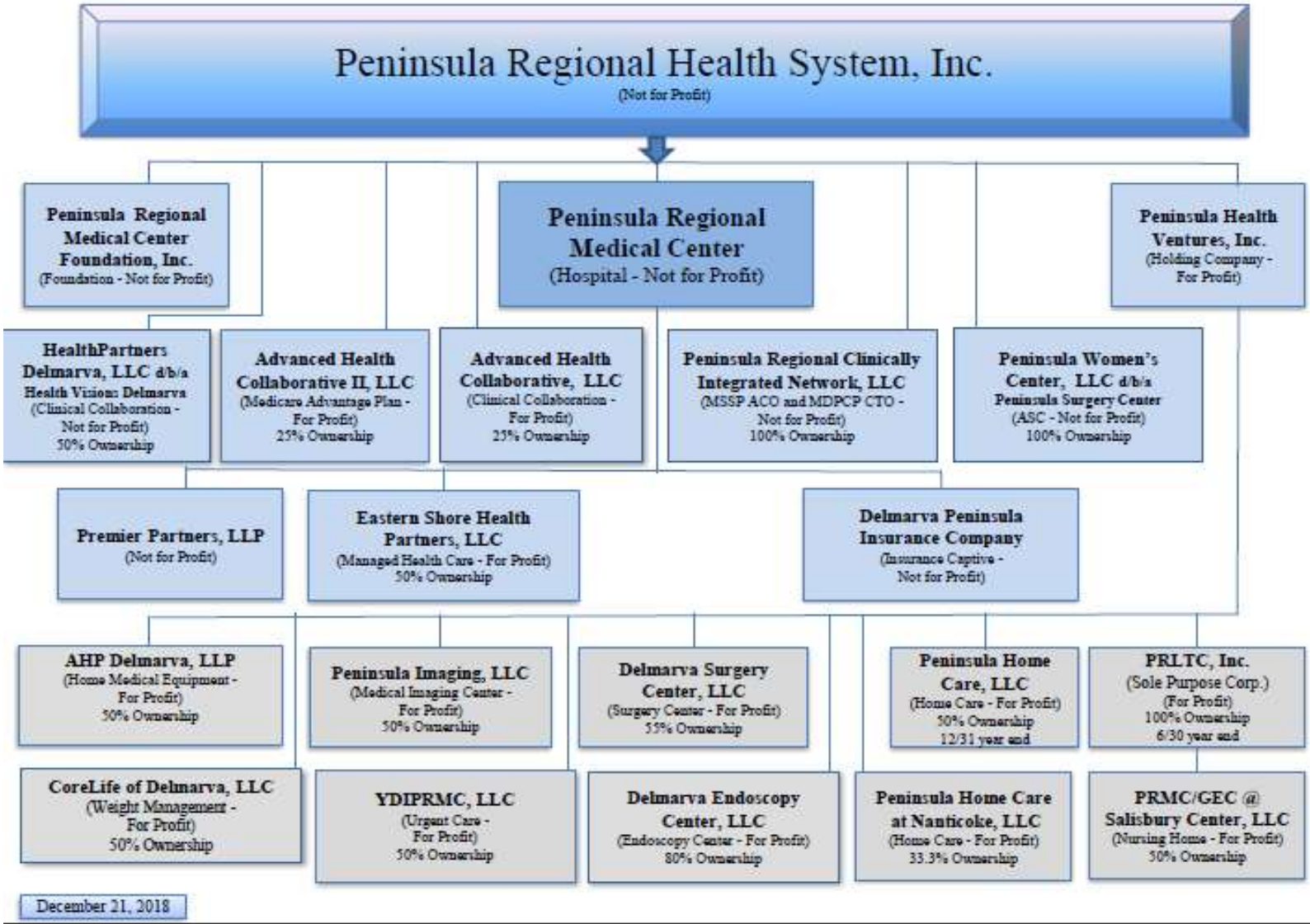
FINAL ORDER

Based on Commission staff's analysis and recommendations, it is, this 16th day of May 2019, by the Maryland Health Care Commission, **ORDERED**:

That the application of University of Peninsula Regional Medical Center, Inc. for a Certificate of Need to establish a 15-bed child and adolescent inpatient behavioral health unit on the third floor of the South Tower of the hospital at a total cost of $8,520,716 be, and hereby is, **APPROVED**.

MARYLAND HEALTH CARE COMMISSION

APPENDIX 1: PENINSULA REGIONAL HEALTH SYSTEM CORPORATE STRUCTURE


Peninsula Regional Health System, Inc.
(Not for Profit)
Peninsula Regional Medical Center Foundation, Inc.
(Foundation - Not for Profit)
Peninsula Regional Medical Center
(Hospital - Not for Profit)
Peninsula Health Ventures, Inc.
(Holding Company - For Profit)
HealthPartners Delmarva, LLC d/b/a Health Vision Delmarva
(Clinical Collaboration - Not for Profit)
50% Ownership
Advanced Health Collaborative II, LLC
(Medicare Advantage Plan - For Profit)
25% Ownership
Advanced Health Collaborative, LLC
(Clinical Collaboration - For Profit)
25% Ownership
Peninsula Regional Clinically Integrated Network, LLC
(MSSP ACO and MDPCP CTO - Not for Profit)
100% Ownership
Peninsula Women's Center, LLC d/b/a Peninsula Surgery Center
(ASC - Not for Profit)
100% Ownership
Premier Partners, LLP
(Not for Profit)
Eastern Shore Health Partners, LLC
(Managed Health Care - For Profit)
50% Ownership
Delmarva Peninsula Insurance Company
(Insurance Captive - Not for Profit)
AHP Delmarva, LLP
(Home Medical Equipment - For Profit)
50% Ownership
Peninsula Imaging, LLC
(Medical Imaging Center - For Profit)
50% Ownership
Delmarva Surgery Center, LLC
(Surgery Center - For Profit)
55% Ownership
Peninsula Home Care, LLC
(Home Care - For Profit)
50% Ownership
12/31 year end
PRLTC, Inc.
(Sole Purpose Corp.)
(For Profit)
100% Ownership
6/30 year end
CoreLife of Delmarva, LLC
(Weight Management - For Profit)
50% Ownership
YDIPRMC, LLC
(Urgent Care - For Profit)
50% Ownership
Delmarva Endoscopy Center, LLC
(Endoscopy Center - For Profit)
80% Ownership
Peninsula Home Care at Nanticoke, LLC
(Home Care - For Profit)
33.3% Ownership
PRMC/GEC @ Salisbury Center, LLC
(Nursing Home - For Profit)
50% Ownership
December 21, 2018

APPENDIX 2: RECORD OF THE REVIEW

RECORD OF THE REVIEW

IN THE MATTER OF

Peninsula Regional Medical Center (Psych)
Docket No. 18-22-2417

Docket Item #	Description	Date
1	MHCC staff acknowledges receipt of Letter of Intent	1/10/18
2	Letters of Support	Various Dates
3	Certificate of Need Application filed	3/9/18
4	MHCC staff acknowledges receipt of application for completeness review	3/12/18
5	MHCC staff requests Daily Times to publish notice of receipt of application	3/12/18
6	MHCC staff requests Maryland Register to publish notice of receipt of application	3/12/18
7	MHCC staff requests completeness information	10/19/18
8	Peninsula submits completeness information	11/2/18
9	MHCC staff requests additional completeness information	12/21/18
10	Peninsula submits a response to request for completeness information	1/8/19
11	Commission staff notifies applicant of formal start of review of the application of review of application will begin 2/1/19	1/16/19
12	MHCC staff requests that Daily Times publish notice of the formal start of the review	1/16/19
13	MHCC staff requests that Maryland Register publish notice of the formal start of the review	1/16/19
14	MHCC staff requests local Health Department comments	1/16/19
15	Notice of formal start of the review published in the Daily Times	1/28/19

APPENDIX 3: HSCRC Memo

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

Memorandum

Date: April 15, 2019

To: Eric Baker, Program Manager, CON, MHCC

From: Gerard J. Schmith
Director, Revenue and Compliance, HSCRC

Subject: Peninsula Regional Medical Center -- Certificate of Need -- Capital Expenditure for a 15-Bed Child and Adolescent Psychiatric Unit for $8,520,716

At your request, this memo provides our comments regarding the feasibility of a 15-bed child and adolescent psychiatric unit at Peninsula Regional Medical Center (PRMC) to be built on the third floor of the Hospital. The budgeted cost for the project is $8,520,716 and will include renovating 18,012 square feet and constructing 9,983 new square feet.

PRMC is projecting that admissions to the proposed 15-bed unit will increase from 100 in FY 2020, the first year of operations, to 373 admission in FY 2023, the last year of the projection period. The projected occupancy of the 15-bed unit will increase from 16.9% during FY 2020 to 70.6% in FY 2023.

General Comments on Financial Feasibility

Data Reviewed

Staff reviewed audited financial statements for the years ended June 30, 2017 and 2018 for PRMC and projected financial statements for the 15-bed unit and the entire hospital for the years ended June 30, 2019 through June 30, 2023 provided as part of the CON. According to the audited financial statements for the year ended June 30, 2018, PRMC had an excess of revenues over expenses of $44,113,000 for the year ended June 30, 2018.

Sources of Funds

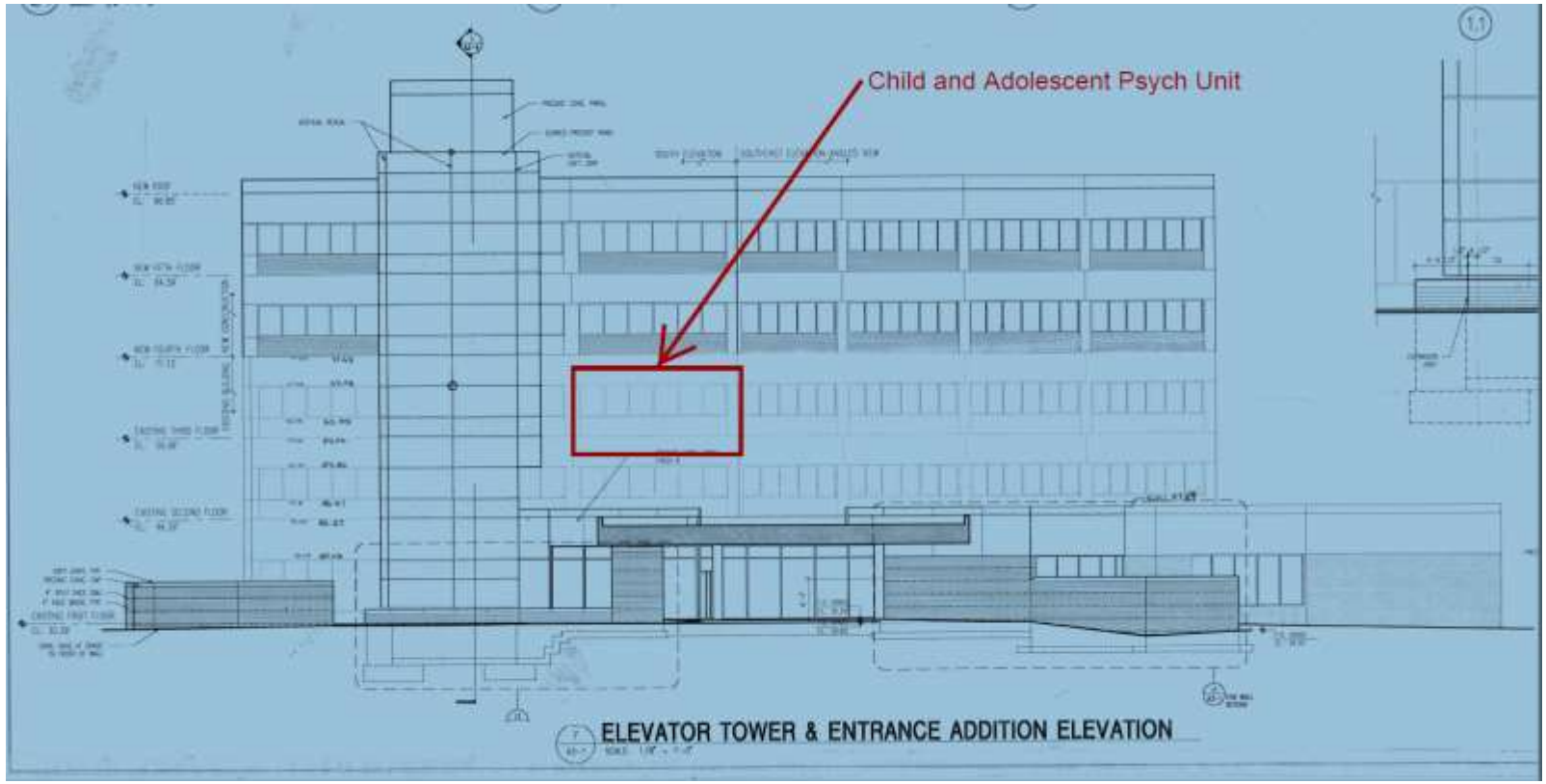
The financing for the 15-bed unit includes $2,000,000 from donations and $6,520,716 from cash

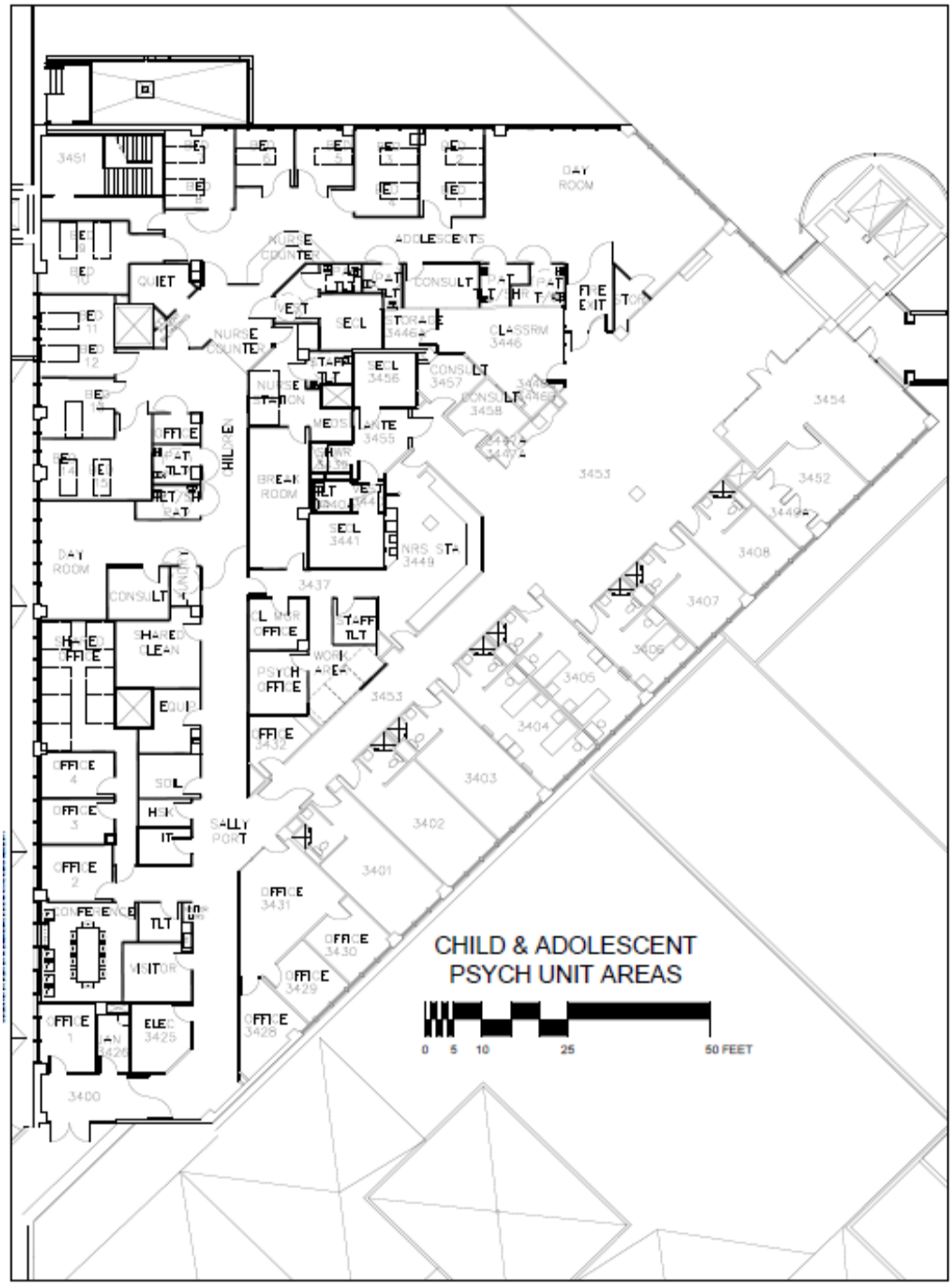
reserves. According to PRMC's audited financial statements for the year ended June 30, 2018, the Hospital had $46,035,000 in cash and short-term investments and $311,657,000 in other investments as of June 30, 2018.

Staff believes that PRMC has sufficient funds for this project and that the staff and the Hospital will be able to reach agreement on providing rates that are reasonable and will support the cost of the new program.

If you have any further questions, please do not hesitate to contact me.

APPENDIX 4: Project Drawings


Child and Adolescent Psych Unit
ELEVATOR TOWER & ENTRANCE ADDITION ELEVATION



PRMC
Peds + Adol Psych Unit
Option 3_05
January 17, 2018