IN THE MATTER OF	*	**BEFORE THE**
	*	
THE JOHNS HOPKINS	*	**MARYLAND**
	*	
HOSPITAL	*	**HEALTH CARE**
	*	
Docket No. 10-24-2320	*	**COMMISSION**
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Staff Report and Recommendation

January 12, 2012

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STAFF REPORT AND RECOMMENDATION

I. INTRODUCTION

The Applicant and the Project

The Johns Hopkins Hospital ("JHH") is a 1,006-bed acute care general hospital in Baltimore City. It is an academic medical center affiliated with the Johns Hopkins University School of Medicine and is the largest hospital of the Johns Hopkins Health System, that includes four Maryland general hospitals.

In May, 2007, JHH received a Certificate of Need ("CON") to develop the Wilmer Eye Institute ("WEI") ambulatory surgical facility, consisting of six operating rooms ("ORs"), located on the first floor of a new 6-story building (then called the "New Wilmer Building") on the hospital campus at Broadway and Orleans streets (Docket Number 07-24-2189). Subsequently renamed the Robert H. and Clarice Smith Building, it was completed in June 2009, and the new first-floor surgical suite (now named the Bendann Surgical Pavilion ('the Pavilion") began treating patients in August of that year.

The eventual need for expansion of the surgical facilities was anticipated at the time of the original application, and one additional room was designed and built within the sterile core of the facility to accommodate an expanded OR complement. The proposed project would build-out and equip this space, which has been used as support space since the facility opened, for use as OR #7. This room is identical in size to, and would be a mirror-image of, OR # 6 in the Pavilion (Appendix 1).

This project encompasses finishing and equipping 431 gross square feet of space as an OR, and would entail installation of a new ceiling, medical gas columns, surgical light boom, nurse call system, security camera and modifications to the electrical, plumbing and mechanical systems. No changes are planned for existing pre- and post-operative facilities, registration and waiting areas or staff support rooms in the Pavilion. The total estimated project budget of $1,430,037 includes $324,522 in direct construction costs, $746,298 for major and minor movable equipment and $359,217 for fees, permits, contingencies and other costs.

Summary of Staff Recommendation

Staff finds that the proposed project complies with the applicable State Health Plan standards for this project and that consideration of the project in the light of the required review criteria support approval of the project.

II. PROCEDURAL HISTORY

Review of the Record

On June 6, 2011, JHH filed a letter of intent for the project. MHCC acknowledged receipt of this letter on June 13, 2011. (DI #1)

On August 5, 2011, JHH filed a CON application for the project. (DI#2). On August 9, 2011 MHCC acknowledged receipt of the application (DI #3). On that same date, MHCC requested publication of a notice of the receipt of the application in the *Baltimore Sun.* (DI #4) and the *Maryland Register* ((DI #5).

On August 18, 2011, MHCC received certification of publication, on August 13, 2011, of the notice concerning receipt of the application from the *Baltimore Sun.* (DI #6).

On August 19, 2011, MHCC provided the application with completeness questions. (D.I.#7) On September 6, 2001, JHH responded to the completeness questions. (DI #8).

On September 23, 2011, MHCC requested publication of a notice concerning docketing of the application by the *Maryland Register*. (DI #9) On September 26, 2011, MHCC requested publication of a notice concerning docketing of the application by the *Baltimore Sun.* (DI #10)

On October 6, 2011, MHCC received certification of publication, on October 6, 2011, of the notice concerning docketing of the application from the *Baltimore Sun.* (DI #11).

On December 19, 2011, the applicant responded to a request for additional information from the MHCC staff. DI #12).

On January 5, 2012, MHCC staff requested comments on the application from the Health Service Cost Review Commission Staff. (DI #13). A memorandum commenting on the application was received from HSCRC on January 6, 2012. (D.I.#14)

Local Government Review and Comment

No comments on this project have been received from the Baltimore City Department of Health or other local government entities.

Interested Parties in Review

There are no interested parties in this review.

III. STAFF REVIEW AND ANALYSIS

A. STATE HEALTH PLAN

COMAR 10.24.01.08G(3)(a) 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 10.24.10, *State Health Plan for Facilities and Services: Acute Inpatient Services*. Assumptions concerning operating room capacity found in COMAR 10.24.11, *State Health Plan for Facilities and Services: Ambulatory Surgical Services*, have also been used in consideration of the Need review criterion at COMAR 10.24.01.08G(3)(b).

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COMAR 10.24.10 State Health Plan for Facilities and Services: Acute Inpatient Services

COMAR 10.24.10.04A — General Standards.

(1) Information Regarding Charges.

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

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;

(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and

(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

JHH provided a Hospital Service Charges Policy and Procedure delineating the process for development and distribution of a list of representative services and charges to the public, both through referral to the hospital website and through hardcopy distribution by either the admitting or financial counseling office. Training for staff in the process for distribution of this information is covered in the Policy & Procedure. The Hospital has posted a representative rate sheet on its website, as required, and it is easily accessed from the Home Page through the Patients & Guests Services link or through the on-site search engine. A copy of the FY2012 charges listed on the web site[1] and dated 9/6/11 was provided as an exhibit to the application. JHH's Policy requires that the information be updated quarterly. JHH complies with this standard.

[1] http://www.hopkinsmedicine.org/bin/e/b/jhh_charges.pdf

(2) Charity Care Policy.

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

(a) The policy shall provide:

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

(ii) Minimum Required Notice of Charity Care Policy.

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

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

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

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

JHH's Financial Assistance policy provides for determination of eligibility for charity care or medical assistance, or both, within two business days of application. JHH also provides notice of its Charity Care Policy through publication in the *Baltimore Sun* (the most recent notice published on February 5, 2011 was provided), notices posted in the admissions office, business office and emergency department, and by hardcopy distribution to each patient admitted to the hospital.

According to the most recent data available from HSCRC, JHH provided $36,059,669 in charity care in FY2010, equal to 2.27 percent of its operating expenses and placing it in the second quartile for all hospitals ranked by this charity care measure. JHH complies with this standard, and no further demonstration of the appropriateness of the hospital's level of charity care for its service area population is required under this standard.

(3) Quality of Care.

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

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

(ii) Accredited by the Joint Commission; and

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

(b) A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90% level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

JHH is licensed in good standing by the Maryland Department of Health and Mental Hygiene, and the Hospital is accredited by the Joint Commission. The Hospital has submitted documentation of its most recent accreditation from the Joint Commission for the 39 month period commencing on October 9, 2010, and its licensure by DHMH from October 8, 2010 through October 8, 2013 The Hospital reports that it was the subject of a survey earlier this year which revealed "certain deficiencies with respect to transplant conditions of participation," and asserts that its corrective action plan with respect to these deficiencies was to be filed by August 2011. The Hospital states that "nothing regarding the transplant survey affects the hospital's deemed status as a general acute care facility with respect to other conditions of participation."

The performance of JHH on Quality Measures in the most recently published Maryland Hospital Performance Evaluation Guide (CY2010) was provided as an exhibit to the application.

The Hospital had two Quality Measures that fell within the bottom quartile of all hospitals' reported performance, and also fell below a 90 percent level of compliance with the Quality Measure. Both are pneumonia measures (influenza vaccination status and pneumococcal vaccination). JHH received a 79% compliance rating for each measure.

The Hospital reports that it has instituted an improvement plan to address performance on both of the measures. An electronic order set was implemented at JHH for all adult services that facilitates patient vaccination screening and administration, when appropriate, for both pneumococcal and influenza vaccines. Additionally, real time feedback is provided to nurse educators on a daily basis whenever a failure is found, or documentation is missing, while the patient is still in the hospital. Educators then follow up with the individual nurses to improve documentation or to re-educate regarding the failure.

JHH reports that the improvement plan has shown significant success in the first three quarters of FY2011, with pneumococcal and influenza vaccination compliance improving to 89% and 83%, respectively. MHCC staff has verified improvement for the broader period of April 2010 through March 2011, with compliance rates of 86% and 83%.[2] The hospital expects continued improvement in FY2012.

Given the information above, including the actions taken by JHH to improve its performance on the Quality Measures for which it fell below 90 percent compliance and was in the bottom quartile of all hospitals' reported performance, JHH is in compliance with this standard.

[2] http://mhcc.maryland.gov/consumerinfo/hospitalguide/hospital_guide/reports/find_a_quality_measure/quality_detail.asp?quality_care_cd=PNE

COMAR 10.24.10.04B — Project Review Standards

(1) Geographic Accessibility

The geographic access standard is applicable only to a new acute care general hospital or for the replacement of an acute care general hospital on a new site, which is not proposed in this application

(2) Identification of Bed Need and Addition of Beds

The standard for identification of bed need is not applicable because JHH is not proposing any change in its licensed bed capacity

(3) Minimum Average Daily Census for Establishment of a Pediatric Unit

The standard regarding establishment of a pediatric unit is not applicable because JHH is not proposing a new pediatric service.

(4) Adverse Impact.

With regard to the standard for adverse impact, the proposed project would not reduce the availability or accessibility of a facility or service. In addition, JHH has stated that it is not seeking a contemporaneous rate increase related to the capital costs of this project. For these reasons, the adverse impact standard is not applicable.

(5) Cost-Effectiveness.

A proposed hospital capital project should represent the most cost effective approach to meeting the needs that the project seeks to address.

(a) To demonstrate cost effectiveness, an applicant shall identify each primary objective of its proposed project and shall identify at least two alternative approaches that it considered for achieving these primary objectives. For each approach, the hospital must:

(i) To the extent possible, quantify the level of effectiveness of each alternative in achieving each primary objective;

(ii) Detail the capital and operational cost estimates and projections developed by the hospital for each alternative; and

(iii) Explain the basis for choosing the proposed project and rejecting alternative approaches to achieving the project's objectives.

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

(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital to a new site that is not within a Priority Funding Area as

defined under Title 5, Subtitle 7B of the State Finance and Procurement Article of the Annotated Code of Maryland shall demonstrate:

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

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

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

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

This project involves the very limited objective of adding a single OR to a specialized, hospital-based ambulatory surgical suite. As such, under the terms of Part (b) of this standard, it is appropriate for JHH to address the cost-effectiveness of the project without undertaking the analysis outlined in Part (a) of the standard, by demonstrating that there is only one practical approach to achieving the project's objectives.

JHH provided a discussion of costs and effectiveness in the application in addressing the review criterion at COMAR 10.23.01.08G(3)(c). It noted that the existing building space that will be used to create the additional OR was designed for this purpose. As such, a substantial proportion of the cost of expanding OR capacity at the Pavilion have already been incurred, and would be stranded if alternative approaches to achieve this expansion objective at this time. Finally, the existing OR capacity is now operating at a level indicating the need for additional OR capacity.

JHH notes that more OR time could be obtained by extending operating hours for the existing ORs. It states that its experience suggests that, over time, this alternative would be more expensive, given the adjustments it would require in staffing, supply, and the provision of support services. This option places difficult strains on staff, reducing satisfaction. The second alternative discussed is the use of alternative facilities, such as the smaller Wilmer ambulatory surgical facility operated in Baltimore County (Green Spring Station).This alternative is ineffective because the two ORs at this facility are also operating at a high level of optimal capacity.

JHH has adequately addressed the costs and effectiveness of this simple expansion project, consistent with Part (b) of this standard.

(6) Burden of Proof Regarding Need.

A hospital project shall be approved only if there is demonstrable need. The burden of demonstrating need for a service not covered by Regulation .05 of this Chapter or by another chapter of the State Health Plan, including a service for which need is not

separately projected, rests with the applicant.

JHH has submitted an analysis of the need for the project in addressing COMAR 10.24.01.08G(3)(b). As discussed later in this report under that criterion, Commission staff concludes that JHH has adequately demonstrated the need for the proposed project based upon utilization of its current OR complement at the Pavilion, based on the OR capacity assumptions found at COMAR 10.24.11.05A(3).

(7) Construction Cost of Hospital Space.

The proposed cost of a hospital construction project shall be reasonable and consistent with current industry cost experience in Maryland. The projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

As noted previously, this project involves finishing space that has already been constructed. The space was constructed with the potential for use as future OR space when it was designed and built.

As shown in the following table, JHH calculates that its adjusted project cost per square foot ("SF") is less than the applicable Marshall Valuation Service ("MVS") cost per SF for construction of OR space.

Table 1: JHH Calculation of Marshall Valuation Service Benchmarks
Wilmer Eye Institute – OR Expansion

	Renovations	MVS Reference
Construction Quality/Class	Good/B	
Number of Stories	1 (above ground)	
Square Feet	431	
Perimeter (feet)	84	
Average Floor to Floor Height (feet)	15.5	
Base Cost per SF		
Basic Structure	$309.10	Section 15-24
Adjustment for Departmental Cost Differences	$275.10	Section 87, P. 8, OR factor 1.89
Adjusted Base Cost per SF	**$584.20**	
Square Foot Refinements		
Sprinkler Additions	$4.90	Section 15-36 (wet system)
Refined Base Cost per SF	**$589.10**	
Multipliers		
Perimeter Multiplier	1.13696	Section 15-37
Height Multiplier	1.081	Section 15-37
Combined Multiplier	1.228	
Final Adjusted Base Cost per SF	**$723.70**	
Update/Location Multipliers		
Update Multiplier	1.07	Section 99-3
Location Multiplier (July, 2010)	1.04	Section 99-8
Combined Multiplier	1.113	
Final Benchmark MVS Cost per SF	**$805.33**	

Source: JHH Completeness Question Responses, September 6, 2011, Attachment 2 (DI #8)

As shown in Table 1, JHH has calculated MVS base costs for the new first floor OR including multipliers for departmental space use, perimeter, height per story, update and location, and has included an add-on for the sprinkler system addition. Each of these adjustments appears to be consistent with the MVS guidelines, including the sprinkler system add-on, which although at the high-end of the permissible range, is justifiable due to the highly-intensive nature of mechanical/electrical/plumbing system construction in an OR setting.

JHH has also compared its estimated budget for the proposed renovation project to the MVS benchmark cost per square foot calculated above, as shown in Table 2 below.

Table 2: Comparison of JHH's Estimated Renovation Costs to Marshall Valuation Service Benchmarks

Project Budget Item	Estimated Cost by Applicant
Building Renovations	$324,522
Fixed Equipment	-
Site Preparation	-
Architectural Fees	34,000
Permits	4,650
Capitalized Construction Interest	-
Subtotal	**$363,172**
Extraordinary Cost Adjustments	
Off Hours Labor Shift Adjustment	$59,496
Infection Control Premium	24,000
Total Adjustments to Cost	**$83,496**
Adjusted Total for MVS Comparison	**$279,676**
Square Feet	431
Adjusted Project Cost Per SF	**$648.90**
Cost Comparisons	
MVS Benchmark Cost Per SF	$805.33
Adjusted Project Cost Per SF	$648.90
Total Over (Under) MVS Benchmark per SF	($156.43)
MVS Total Cost Estimate per SF	$347,10
Project Adjusted Total Cost per SF	$279,68
Variance per SF	($67.42)

Source: JHH Completeness Question Responses, September 6, 2011, Attachment 2 (DI #8)

To arrive at comparable cost per square foot, JHH has made adjustments to its estimated costs for two expenditures that are not contemplated in the MVS benchmark.

The first of these adjustments is an "Off Hours Labor Shift Adjustment" credit, reflecting the fact that all renovation activity will take place during evenings and weekends, permitting the six existing ORs to continue operation uninterrupted throughout project implementation. The applicant projects this premium to be 150% ("time and one-half") of the expected base labor cost of $120,000, or a total of $60,000. This cost appears to be reasonable, as there is no apparent alternative to maintaining the active surgical schedule while the renovation is being undertaken, and no acceptably safe and sanitary method by which the work could be completed during normal hours of surgery.

The second related adjustment contemplates a premium for "Infection Control" during the renovation process, and reflects the need for the sterility of the surgical suite to be maintained during the renovation process. This additional burden upon the contractor to provide needed infection control is expected to generate an added cost of approximately $3,000 per week, or $24,000 over the course of the 8-week renovation process, and also appears to be reasonable, as allowances for such costs are not provided within the MVS guidelines.

MHCC staff revised the JHH cost analysis of the MVS bench mark using the latest MVS data (base costs were revised by MVS in November 2011 for the first time since November 2009). The result is that the project costs are $30.11 under the MVS benchmark (compared to the $156 variance found by the applicant).

Table 3: MHCC Staff Calculation of MVS Benchmarks

Construction Cost Analysis	
Square Footage	431
Perimeter	84
Wall Height	15.5
Stories	1
Average Area Per Floor	431
As Outlined in Section 1, Page 11	
Net Base Cost (15.24 or 26) (11/2011) per SF	$336.71
Sprinkler Add-on (15.37)	5.45
Revised Base	$342.16
Departmental Differential Cost factor	1.89
Adjusted Base Cost	$646.68
Perimeter Multiplier (15.38)	0.93359008
Height Multiplier (15.38)	1.081
Multi-story Multiplier (15.24)	1
Multipliers	1.009210876
Refined Square Foot Cost	$652.64
Current Cost Modifier (99.3) (11/2011)	1.02
Local Multiplier (99.8)(10/2011)	1.02
CC & Local Multipliers	1.0404
Updated MVS (Benchmark) Building Cost Per SF	**$679.01**
Adjusted Project Cost Per SF (from Table 2)	**$648.90**
Variance	**($30.11)**

Source: JHH Completeness Question Responses, September 6, 2011, Attachment 2 (DI #8)

No exclusion of depreciation and interest costs associated with the renovation construction costs estimated for this project would be required if a rate adjustment related to the capital cost of this project was requested by JHH. JHH states that it does not anticipate a rate adjustment related to this project.

(8) Construction Cost of Non-Hospital Space

This standard is not applicable.

(9) Inpatient Nursing Unit Space

This standard is not applicable. No development of bed space is involved.

(10) Rate Reduction Agreement

JHH is not a high-charge hospital under the terms of this standard.

(11) Efficiency.

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

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

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

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

JHH notes that the approval of the CON application to relocate the Wilmer Eye Institute to its current location in 2007 was largely based upon the increased efficiencies that would be achieved by having all pre-op, surgical, and post-op functions performed within the same surgical unit. Following implementation of the project in 2009, the applicant notes that a significant reduction in minutes per case has been achieved, falling from 82.5 minutes in the previous facilities to 74.6 minutes in the new surgical center, and attributes this 9.6% drop to the efficiencies achieved in the new building. Also, largely as a result of the increased efficiency of the new location, as well as implementation of electronic medical record-keeping and centralized surgical scheduling, JHH notes that WEI experienced a significant 7.7% increase in the number of cases treated in FY2011, its first full year of operation in the new facility.

As the proposed 7th OR would be located within the same surgical suite as the other six rooms, JHH asserts that it would benefit from the same efficiencies achieved during the first two years of operation of the Pavilion, but does not anticipate additional efficiencies as a result of the project.

When comparing the projected staffing and utilization data provided by the applicant, the addition of the 7th OR appeared to have a negative impact on staff productivity following implementation of the project. Table 3 below summarizes the comparison, showing that the proposed increase of 6.8 FTE direct and support staff attributable to the project would result in an immediate rise in the number of staff hours per 1,000 OR minutes that would not return to current levels, despite projected increases in cases, through the first projected five years of operation:

Table 4: Current and Projected Staffing Efficiency
Wilmer Eye Institute – FY2011 – FY2017

	Actual FY2011	FY2013	FY2014	FY2015	FY2016	FY2017
Operating Rooms	6	7	7	7	7	7
Cases	6,375	7,149	7,206	7,266	7,329	7,396
OR Minutes	634,842	711,919	717,615	723,571	729,866	736,508
FTEs (Direct Care and Support)	38.5	45.3	45.3	45.3	45.3	45.3
FTEs per 100 Cases	0.60	0.63	0.63	0.62	0.62	0.61
Staff Hours per 1,000 OR Minutes	126.1	132.4	161.3	160.2	129.1	127.9

Sources: Application; Table 5 (p. 43); Application, Tables A and B (p. 31 DI #2)

JHH responded to the apparent declince in staff productivity by pointing out that the addition of 6.8 FTE employees (6.5 clinical staff) is only a representation of how it would prefer to staff the additional OR, and not an approved expenditure at this point. The applicant also notes that in the current operation, the number of clinical staff per OR equals 6.08, whereas the addition of 6.5 new clinical staff members would bring that total to 6.14 per OR, which from the perspective of operating the entire suite, is a small difference. JHH notes that further examination of the staffing request will take place prior to implementation of the project.

Even though the proposed project may not result in greater staff productivity, JHH has demonstrated that the Pavilion operation has, as expected in 2007, improved efficiency. The addition of a seventh OR would not be expected to significantly improved productivity or efficiency. On this basis, Staff recommends that the project be found compliant with this standard.

(12) Patient Safety.

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

JHH notes that patient safety was an important factor in its decision to develop the Pavilion as a replacement for the outpatient eye surgical facilities that WEI had been using prior to 2009. Patient safety was enhanced through: (1) the construction of larger, more state-of-the-art ORs with more room for staff and equipment; (2) co-locating all pre-operative, surgical, and post operative facilities on one floor, obviating the need for patients to travel between floors to access these facilities; (3) placing the family waiting area close to the recovery area; (4) introducing the latest-technology stretcher-chairs, eliminating the need for patients to move from pre-operative chairs to stretchers and back to post-operative chairs and thus reducing the likelihood of falls; and (5) having the surface parking area closer to the surgical facilities, also reducing the potential for falls that may exacerbate medical conditions.

The applicant reasonably asserts that the proposed seventh OR will benefit from the patient safety improvements realized through the move to the new surgical facility, and that current high levels of patient and family safety will be undiminished by the expansion of the

surgical capacity. Staff finds the project to be consistent with the standard.

(13) Financial Feasibility

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

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

(b) Each applicant must document that:

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

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

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or, if a new hospital, the recent experience of other similar hospitals; and

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

Regarding section (a), JHH has provided revenue and expense projections for the entire hospital, as well as for the project specifically, through FY2016 Similarly, a detailed list of assumptions has been provided.

With respect to subsection (i), the utilization of the outpatient OR suite is projected to increase by 6.5% this fiscal year, and by 5.3% in FY2013 (the first full year of operation of the 7th OR), with increases of slightly less than 1% per year in the following 4 years. Historic data indicate a fluctuating trend in use over the last three years, with a decrease in the number of cases from FY2009 to FY2010 of 1.95% (the year of the move into the new facility), followed by a sharp increase of 7.7% in case volume in FY2011. JHH's projections have been developed based upon the Outpatient Market Estimator model of The Advisory Board, assume no change in market share or procedure mix from current experience, and hold case time constant at the current level of 74.6 minutes per case.

With respect to subsection (ii), the revenue projections for the expanded service show

growth consistent with the utilization projections and assumptions discussed in subsection (i) above, and take into account current charge rates and assumptions regarding HSCRC-approved rate increases and requested update factors .

With respect to subsection (iii), JHH projects expenses to increase in a manner consistent with the increases in revenue. Staffing is expected to increase in relative proportion to case volume for direct care staff and support staff (see discussion under *[11]Efficiency*, above).

With respect to subsection (iv), JHH is projecting that the new OR will result in a contribution in excess of $125,000 to income for the Hospital in the first year of operation, with progressively larger profits in subsequent years.

JHH has complied with this standard. The project complies with this standard and the project is financially feasible.

(14) Emergency Department Treatment Capacity and Space

(15) Emergency Department Expansion

(16) Shell Space

These standards are not applicable. This project does not involve expansion of emergency medical service capacity or development of shell space.

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.

JHH has provided a map of the primary and secondary service areas for the Wilmer Eye Institute (Exhibit 7), based upon zip code area patient origin data collected through the third quarter of FY2011. The primary service area, accounting for 62% of surgical cases, shows a concentration in the Central Maryland jurisdictions of Baltimore City and County and Anne Arundel County, but also extending to Washington D.C. and its Maryland and Virginia suburbs, and zip code areas on the Eastern Shore and in Western Maryland. The secondary service area, which expands to include an additional 18% of cases, extends the boundaries of the primary area in each direction. The applicant states that while the primary and secondary service areas offer a glimpse of the geographic origin of patients from the region, it does not reflect the international scope of WEI's reputation and services, noting that patients travel from across the country and around the world to receive specialized ophthalmologic services at the Institute. The current patient origin patterns have not changed appreciably from those experienced at the time of the relocation proposal in 2007, and are not expected to be altered by the addition of the proposed OR.

Utilization rates at WEI, measured in cases per year, have increased robustly in the past two years with the move to the new building, attributed in large part to the significant reduction in minutes per case that has been discussed in *(11) Efficiency*, above. This vigorous growth is expected to continue through FY2013 with the introduction of the new OR, but would then revert to a more modest annual increase of slightly less than 1% per year through FY2017, according to the trend analysis conducted by JHH using the Advisory Board Market Estimator. This tool applies national utilization patterns to local populations, and considers changes in population, epidemiology, technology and physician supply. The applicant reasonably characterizes this projected growth pattern as conservative.

JHH's utilization forecast for WEI holds the current case time constant at 74.6 minutes per case. While this case time is a significant improvement compared to the average of 82.5 minutes prior to the move into the new facility, the applicant believes that further reductions are unlikely to be achieved. While case times at WEI continue to be significantly longer than at other outpatient eye surgery centers in Maryland, the constraints of case mix complexity, the large percentage of multiple-procedure cases and the Institute's training mission continue to contribute to longer case times, as acknowledged in the Staff analysis of the relocation project several years ago.

The SHP standards for Acute Care Hospital Services do not have specific standards for assessing the need for operating room capacity in hospitals. However, the Ambulatory Surgical Services chapter of the SHP (COMAR 10.24.11) includes optimal capacity standards for operating rooms. Full capacity is defined as 2,040 hours per OR per year and optimal capacity is defined as 80% of full capacity, or 1,632 hours per OR per year.

As shown in Table 4, recent utilization of the six Pavilion ORs has exceeded been significantly higher than would be expected using the optimal capacity assumption for special-purpose operating rooms in the State Health Plan. It is noted that clean-up and preparation time reported by JHH for the three-year period averaged 25 minutes, which is less than the SHP assumption of 30 minutes.

Table 5: Historic Cases, Minutes, and Utilization of Room Capacity
WEI Special-Purpose Operating Rooms:, Fiscal Years 2009-2011

Fiscal Year	Total Cases	Surgery Minutes	Clean/Prep Minutes (@25/case)	Total Minutes	Optimal Capacity Minutes	Percent of Optimal Capacity Use
2009	6,037	453,860	150,925	604,785	587,520	103%
2010	5,919	436,376	147,975	584,351	587,520	99%
2011	6,375	475,467	159,375	634,842	587,520	108%

Source: Application, p.31 and MHCC Staff calculation of optimal capacity use based on SHP assumptions

JHH projects surgery utilization (cases and minutes) and OR need, based upon the growth assumptions described above, as shown in Table 5.

Table 6: Projected Cases, Minutes, and Room Utilization
WEI Special-Purpose Operating Rooms:, Fiscal Years 2012-2017

Fiscal Year	Total Cases	Surgery Minutes	Cleanup Minutes	Total Minutes	Optimal Capacity Minutes	Percent of Optimal Capacity Use
2012	6,789	506,344	169,725	676,069	587,520	115%
2013	7,149	533,194	178,725	711,919	685,440	104%
2014	7,206	537,460	180,155	717,615	685,440	105%
2015	7,266	541,921	181,650	723,571	685,440	106%
2016	7,329	546,635	183,230	729,866	685,440	106%
2017	7,396	551,610	184,898	736,508	685,440	107%

Source: Application, p.31 and MHCC Staff calculation of optimal capacity use based on SHP assumptions

JHH has demonstrated that the need for the proposed OR addition at the Pavilion is consistent with the State Health Plan's OR capacity assumptions. Staff believes that the option of off-loading growth in eye surgery case volume to other facilities is not a reasonable option and that the need demonstrated for expansion of capacity at the Pavilion in order to maintain a reasonable surgical schedule at this center should be found to be consistent with this Need criterion.

C. AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

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.

As previously discussed under the *Cost-Effectiveness* standard of COMAR 10.24.10, JHH notes that the eventual need for expansion of the surgical pavilion at WEI was anticipated at the time of the original design of the facility, with a large storage space identical in size to the other ORs having been built to accommodate that need at some future time. The applicant notes that, since the bulk of the costs of construction were incurred when the new building was constructed, the costs associated with bringing this additional OR into service are minimal, consisting primarily of fit-out and equipment. In fact, of the $1.43 million capital costs of the project, only $324,522, or 22.7% of the total cost is in direct construction costs.

JHH reports that it considered two alternatives to the proposal. First, the possibility of operating the surgical pavilion on an extended-hour schedule was reviewed. This alternative presented a number of obstacles: it would require adjusting nursing staffing, which in addition to being a unpleasant, makes staff scheduling, recruitment and retention difficult; surgeon availability during later hours is questionable, and residents' hours are limited by law; and such a change would require the renegotiation of understandings with hospital support services such as pharmacy, nutrition, housekeeping and pathology. Based upon previous experience, JHH determined that this alternative would be more costly than opening the seventh OR, and the option was rejected.

The second alternative considered was the possibility of off-loading some of the volume experienced in the Bendann Pavilion to the 2-OR Wilmer Ambulatory Surgery Center at Green Spring. However, it quickly became apparent that Green Spring was also experiencing very heavy volumes of cases. In FY2011, these ORs billed 184,280 minutes of surgical time, or 188% of optimal capacity use as defined in the SHP for special-purpose operating rooms. Absent available capacity at Green Spring, this option was similarly discarded.

Based upon the low capital costs associated with fitting-out the proposed OR, and the apparent lack of a less expensive internal option or available local alternative, Commission staff finds that the proposed project is the most cost-effective approach to meeting the demonstrated need for increased surgical capacity at WEI.

D. VIABILITY OF THE PROPOSAL

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.

Availability of Financial Resources

The Johns Hopkins Hospital has presented the following project budget estimate for the proposed expansion of OR at the Wilmer Eye Institute:

Table 7: Project Budget Estimate

A. Uses of Funds	
Renovations	$ 324,522
Architect/Engineering Fees	34,000
Permits	4,650
Subtotal	**$363,172**
Major Movable Equipment	518,962
Minor Movable Equipment	227,336
Contingencies	238,340
Other Capital Costs (Materials Tests/Landscape	82,227
Subtotal	**$1,066,865**
Total Uses of Funds	**$ 1,430,037**
B Sources of Funds	
Cash	$ 1,430,037
Total Sources of Funds	**$ 1,430,037**

Source: JHH (DI#15)

JHH's audited financial statements, for the fiscal years ending June 30, 2010 and June 30, 2009, indicate that the hospital generated excess revenue of $50,683,000 and $6,934,000 for those years, respectively. The 2010 statement indicated a balance of cash and cash equivalents in the amount of $252,389,000 at the end of that fiscal year. These financial statements indicate the availability of funds for this project. The hospital has stated that it is not seeking a rate increase

related to the capital costs of this project. It states that it reserves the right to include those capital costs related to hospital services in future rate proceedings with HSCRC.

Recent Financial Performance

Recent operational results for JHH and its HSCRC Peer Group are summarized below:

Table 8: Financial Performance, FY2008-FY2010
Johns Hopkins Hospital

	Fiscal Year Ending		
	Jun-30-2008	Jun-30-2009	Jun-30-2010
REGULATED OPERATIONS ONLY			
Net Operating Revenue	$ 1,336,639,058	$ 1,425,445,076	$ 1,493,443,862
Net Operating Income	$ 38,339,960	$65,770,670	$ 67,456,691
Net Operating Margin	2.87%	4.61%	4.52%
REGULATED AND UNREGULATED OPERATIONS			
Net Operating Revenue	$ 1,435,238,937	$ 1,532,747,407	$ 1,610,743,523
Net Operating Income	$ 42,295,610	$ 62,135,326	$ 59,666,923
Net Operating Margin	2.95%	4.05%	3.70%
Average-Operating Margin – Peer Group 2 Regulated and Unregulated			
Average-Operating Margin	0.96%	2.62%	1.89%
Median-Operating Margin – Peer Group 2 Regulated and Unregulated			
Median-Operating Margin	1.77%	2.57%	2.06%
Average-Operating Margin – State Wide Regulated and Unregulated			
Average-Operating Margin	2.30%	2.60%	2.60%

Source: Health Services Cost Review Commission, Disclosure of Hospital Financial and Statistical Data, September 2011 (regulated and non-regulated activity as reported on the R/E Schedule of the Annual Report)

As indicated in the above table, the financial performance of JHH regulated operations improved over the three year period outlined. JHH regulated and unregulated net operating margins are above its peer group average.

Table 9: Selected Financial and Operating Indicators (Regulated and Unregulated)

Maryland Hospitals-Statewide Average		
Year	Operating Margin	Excess Margin
2010	2.60%	3.8%
2009	2.60%	0.01%
2008	2.30%	1.40%
Johns Hopkins Hospital		
Year	Operating Margin	Excess Margin
2010	3.70%	4.92%
2009	4.05%	0.45%
2008	2.95%	4.76%
HSCRC Target Values		
	2.75%	**4.0%**

Source: Report on Financial Conditions, Fiscal Year 2010 issued by the HSCRC.

The table above profiles the financial performance of hospitalw as reported in audited financial statements. In 2010, JHH reported a healthy operating margin of 3.7%, exceeding the HSCRC target value of 2.75%. In the same year excess margin also exceed HSCRC's target.

Projected Financial Performance

The applicant has provided projected financial results for FY 2011 through 2016 as follows:

Table 10: Projected Financial Performance ($000s)
Johns Hopkins Hospital

	Actual 2011	2012	2013	2014	2015	2016
Inpatient Revenue	1,190,531					
Outpatient Revenue	603,125	631,724	706,105	743,011	779,806	818,604
Gross Patient	1,793,656	1,939,798				
Net Operating	1,692,034					
Operating Expenses						
Income from						
Operating Margin	**5.95%**	**4.21%**	**3.58%**	**4.36%**	**4.32%**	**4.42%**
Admissions						
Patient Days	278,736	290,894	301,610	309,644	312,855	315,252
Outpatient Visits	500,974	510,056	518,934	540,216	551,537	563,105

Source: JHH CON application, Table 3 and Table 1 (DI #2);

Given the size of JHH, a one operating room addition will have only a negligible impact on its overall operations. Operating margins are projected to remain relatively flat. There is a small but consistent increase in admissions projected over this period. According to JHH the additional OR capacity is needed to accommodate existing volume and projected growth in demand for outpatient ophthalmologic surgery services at the Pavilion and the data presented by the applicant supports this position.

Conclusion

HSCRC provided an opinion on financial feasibility of this project. (Appendix B) According to HSCRC, the estimated project expenditure would have a minimal impact on the financial position of JHH and could not have an impact warranting analysis or comment.

The proposed project is considered to be financially feasible and JHH will be financially viable on an ongoing basis.

E. COMPLIANCE WITH CONDITIONS OF 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.

Since 1990, five Certificates of Need have been issued to The Johns Hopkins Hospital by the Maryland Health Care Commission. Four were completed in good standing and in compliance with all terms and conditions. One remains in progress and is in good standing.

Docket No. 96-24-1983, approved on April 8, 1997, was for the relocation of eighteen (18) acute comprehensive inpatient rehabilitation beds from the Good Samaritan Hospital to The Johns Hopkins Health System Corporation; fourteen (14) to be relocated to The Johns Hopkins Hospital, and four (4) to be located at the Johns Hopkins Bayview Medical Center. No conditions were applied to the approval of the project. The relocation of the four beds to the Johns Hopkins Bayview Medical Center was completed on June 17, 1997. On February 16, 1998, the relocation of the fourteen beds was completed at The Johns Hopkins Hospital.

Docket No. 02-24-2110, approved April 22,2003, was for capital expenditures of $27,057,596 by The Johns Hopkins Hospital to purchase and implement two comprehensive patient care information systems to support clinical care delivery. No conditions were applied to the approval of this project. First use approval was granted October 23,2007.

Docket No. 03-24-2119, approved March 19,2004, was for capital expenditures of $25,324,978 for the exterior restoration of four historic buildings on the campus and rehabilitation and upgrades to key infrastructure elements located in the hospital's existing power plant. No conditions were applied to the approval of this project. First use approval was granted April 25, 2008.

Docket No. 03-24-2123, originally approved February 16, 2005, is for the construction of new clinical buildings and a multi-phased reconfiguration of The Johns Hopkins Hospital campus. To date all quarterly progress reports have been submitted and all performance requirements have been met.

Docket No. 07-24-2189, approved May 17, 2007, was for the construction of the New Wilmer Building, later named the Robert H. and Clarice Smith Building, on the hospital campus on the corner of Broadway and Orleans streets. This building houses the Bendann Surgical Pavilion, subject of this application. The project was completed and first use was granted August 17, 2009. Its implementation was found to be consistent with the terms of the May 17. 2007 Certification of Need.

F. IMPACT ON EXISTING PROVIDERS AND THE HEALTH CARE DELIVERY SYSTEM

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

JHH proposes to increase the number of outpatient special purpose operating rooms by one, for a total of seven, located in the Bendann Outpatient Surgical Center in the Smith Building on the JHH campus. JHH foresees no negative impact on existing providers as a result of this proposed project. The existing suite of six ORs is operating above the optimal capacity for such ORs. The additional OR capacity is needed to accommodate current surgical volume more efficiently and comfortably. Costs and charges for procedures at the Bendann Outpatient Surgical Center will not change as a result of the project and should not be affected at any other provider site. Geographic and demographic access to services should not be affected. Access to outpatient eye surgery will marginally improve for JHH patients

JHH reports that it generally attracts new, non-professional staff either internally through promotions or within the community through a variety of recruiting sources. Based upon turnover and vacancy rates provided, it appears that little difficulty would be experienced in attracting the 6.5 FTE direct care and 0.3 FTE support staff projected as need through these methods. Based on current turnover and vacancy rates, it does not appear that candidates for the planned staff additions will be in short supply.

Table 11: Staff Turnover and Vacancy Rates, WEI, FY2011

Affected positions	Average turnover FY11	Average vacancy rate FY11
Direct care staff – OR and PACU nurses	4.7% (1/21.5)	4.7% (1/21.5)
Direct care staff – pre- and Post-op nurses	6.7% (1/15)	6.7% (1/15)
Support staff	0%(0/2)	0%(0/2)

Source: JHH con application (DI #2)

It is unlikely that the proposed project will have an impact on existing providers in the Hospital's service area. Since the additional OR is proposed to meet current and near-term projected increases in case volume, the proposed project is unlikely to have any significant impact on surgical volumes of other providers of surgical services in the service area. As a result, the project is also unlikely to have any impact on the costs and charges of other providers. Staff concludes that this project will not have an unacceptable negative impact on existing health care providers in the service area, access to services, or costs and charges of other providers.

IV. SUMMARY AND STAFF RECOMMENDATION

Staff has analyzed the proposed project's compliance with the applicable State Health Plan criteria and standards in COMAR 10.24.01.08.05A and B, and with the other Certificate of Need review criteria, COMAR 10.24.01.08G(3)(b)-(f).

Based on these findings, Staff recommends that the project be **APPROVED.**

IN THE MATTER OF	*	**BEFORE THE**
	*	
THE JOHNS HOPKINS	*	**MARYLAND**
	*	
HOSPITAL	*	**HEALTH CARE**
	*	
Docket No. 10-24-2320	*	**COMMISSION**
	*	

*** ***

FINAL ORDER

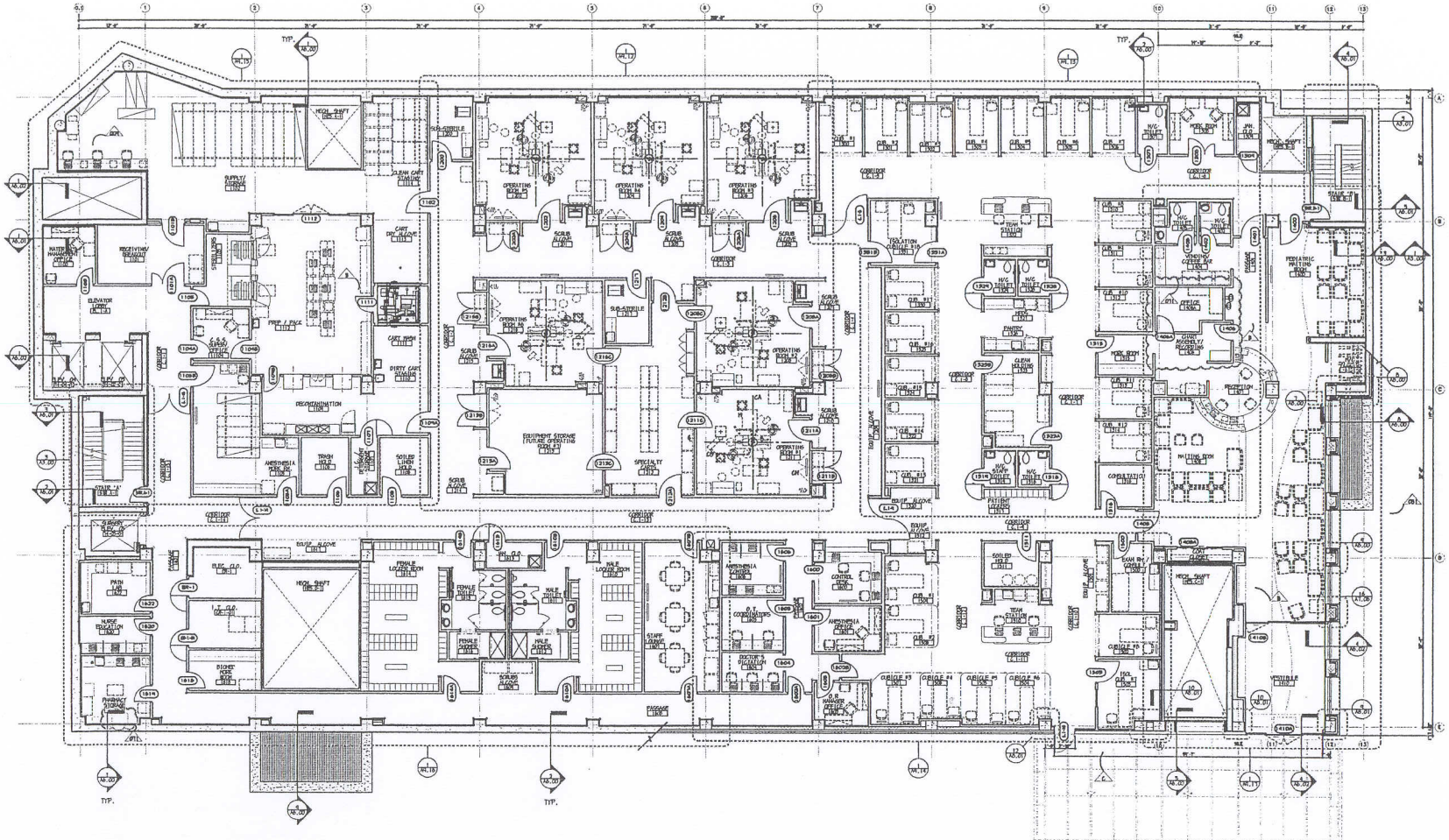
Based on Commission Staff's analysis and findings, it is this 19th day of January 2012, **ORDERED** that the application for a Certificate of Need, submitted by The Johns Hopkins Hospital to retrofit and finish existing space in the Bendann Surgical Pavilion of the Robert H. and Clarice Smith Building to add a seventh dedicated ophthalmic outpatient operating room, at an estimated cost of $1,430,037, Docket No. 10-24-2320, be **APPROVED.**

MARYLAND HEALTH CARE COMMISSION
January 19, 2012

MARYLAND HEALTH CARE COMMISSION

APPENDIX A

Floor Plans



FIRST FLOOR PLAN

SCALE: 1/8" = 1'-0"

GENERAL NOTES - DRAWING A1.01

1. SEE 'A9' DRAWING SERIES FOR ENLARGED FLOOR PLANS, EQUIPMENT, PARTITION TYPES, DIMENSIONS, CASEWORK & INTERIOR ELEVATIONS, AND ACCESSORIES & SPECIALTIES.

2. SEE 'A3' DRAWING SERIES FOR REFLECTED CEILING PLANS AND CEILING HEIGHTS. CEILING HEIGHTS ARE TO BE MEASURED FROM THE TOP OF THE STRUCTURAL SLAB TO THE BOTTOM OF THE CEILING SYSTEM. SEE STRUCTURAL PLANS FOR SLAB ELEVATIONS. SEE SPECIFICATIONS FOR FLATNESS AND SMOOTHNESS REQUIREMENTS.

3. SEE 'L5' AND 'A4' SERIES FOR LOCATION OF FIRE RATED PARTITIONS, PARTITION TYPES, AND DETAILS. SEE DETAILS FOR METAL STUD BACKS AT EQUIPMENT SUPPORTS. SEE ROOM FINISH SCHEDULE NOTES FOR LOCATION OF HIGH IMPACT WALLBOARD. PARTITIONS SHALL BE TYPE 2A UNLESS OTHERWISE NOTED.

4. SEE 'A10' DRAWING SERIES FOR FLOOR PATTERNS.

CONSTRUCTION DOCUMENTS

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Revisions	Date	No.
ADDENDUM-B	06-01-2007	/A\
ADDENDUM-C	06-08-2007	/B\
AS1-009	10-24-2007	/C\
AS1-051	04-28-2008	/D\
AS1-011	10-05-2006	/E\

FIRST FLOOR PLAN

I certify that these documents were prepared or approved by me, and that I am a duly licensed architect under the laws of the State of Maryland, license number ____, expiration date ____

KEY PLAN

PLAN NORTH

TRUE NORTH

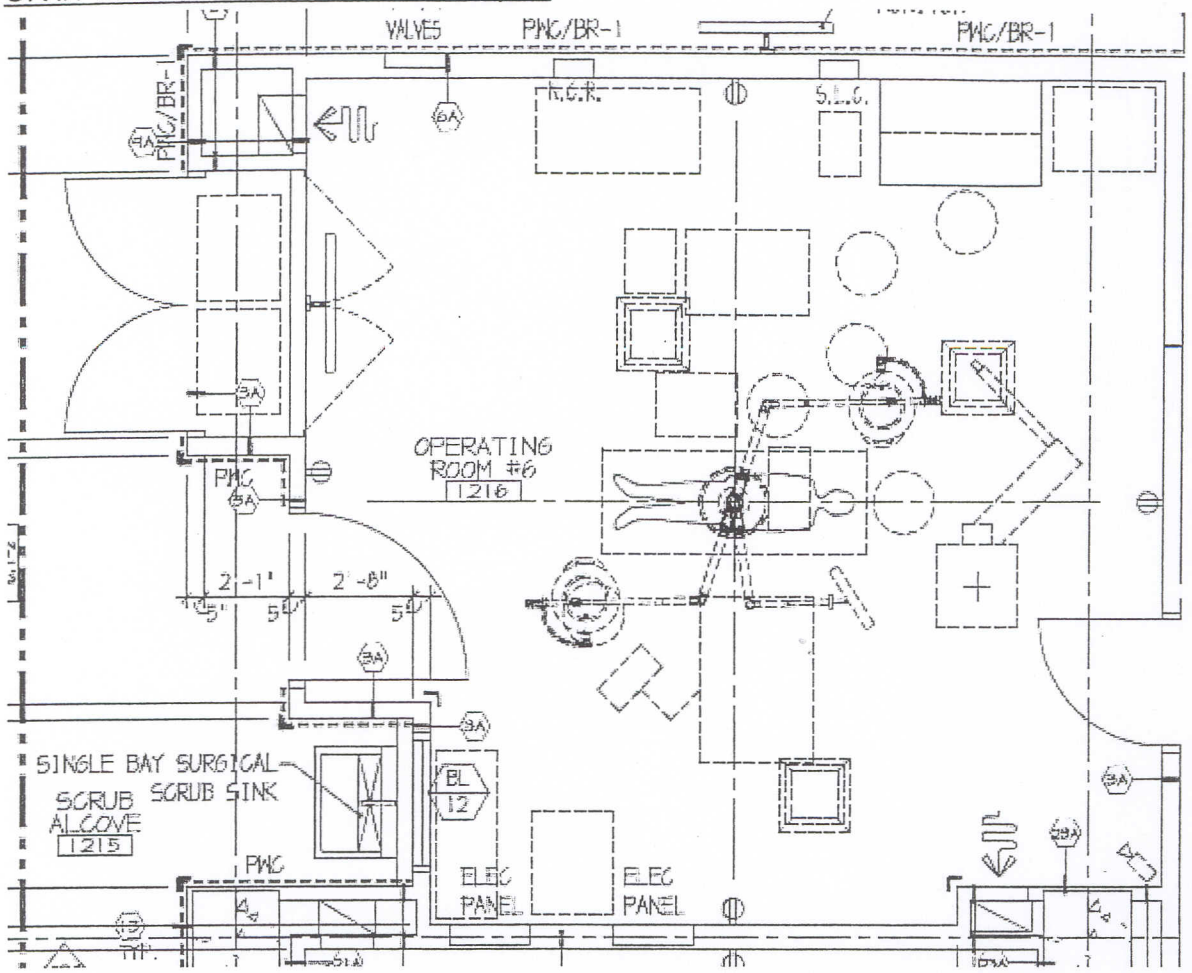
THE WILMER EYE INSTITUTE
OUTPATIENT SURGERY & LABORATORY BUILDING
EAST ORLEANS & BROADWAY STREETS
BALTIMORE, MARYLAND 21287

JOHNS HOPKINS MEDICINE
THE JOHNS HOPKINS HOSPITAL
THE JOHNS HOPKINS SCHOOL OF MEDICINE

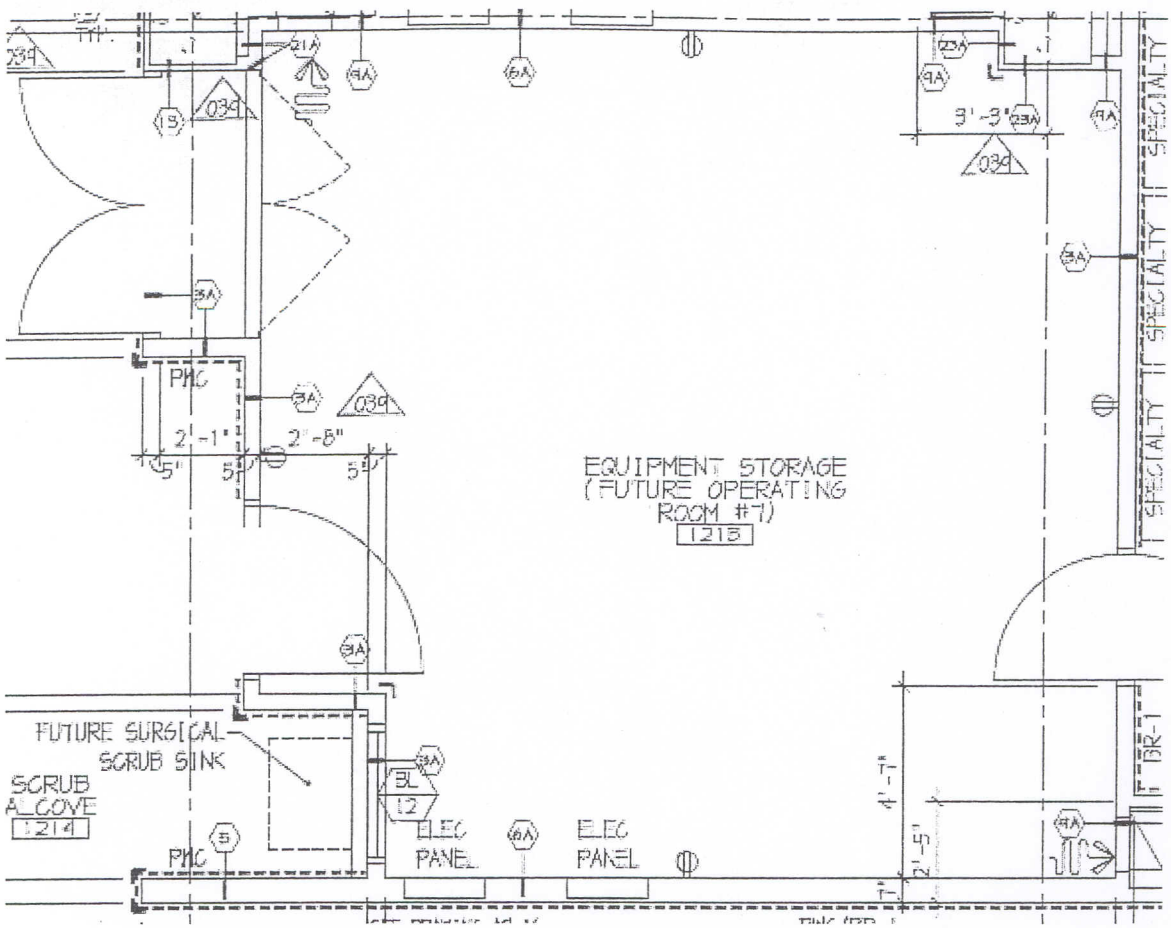
JHH-Project Number:	2006-001698
WRS-Project Number:	J.480.06.4068
WS-Project Number:	9604.13
Scale:	1/8" = 1'-0"
Date:	MAY 04, 2007

Drawing No.: A1.01

OR #7 will mirror the current OR # 6 layout



Future OR #7 Existing Space



MARYLAND HEALTH CARE COMMISSION

APPENDIX B

HSCRC Comments

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
www.hscrc.state.md.us

Memo

To: Paul Parker, MHCC

From: Gerard J. Schmith
Date: January 6, 2012
Subject: Johns Hopkins Hospital, Wilmer Eye Institute ("Hospital" or "JHH")
Certificate Of Need (CON) #11-24-2320

On January 6, 2012, you requested that HSCRC staff comment on the above-referenced capital project proposed by John Hopkins Hospital ("JHH"). This project is located in the outpatient surgical facilities of the Wilmer Eye Institute ("WEI") building, approved in May, 2007, which replaced former WEI facilities on the JHH campus in June, 2009. At that time, space for one additional operating room was constructed in anticipation of future needs. The proposed capital expenditure would build out and equip that space.

The total estimated cost of the project is $1,430,037, to be funded with JHH cash. This expenditure would have a minimal impact on the financial position of JHH. Therefore, HSCRC staff has no comment on the project.