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Kevin McDonald
Chief, Certificate of Need
4160 Patterson Avenue
Baltimore, Maryland 21215

October 29, 2015

**RE: Green Spring Station Surgery Center Matter No. 15-03-2369
Completeness Questions**

Dear Mr. McDonald:

Enclosed are responses to the revised completeness questions posed in your correspondence dated October 20, 2015. We look forward to the next steps in this review. Please contact me if you have any further questions or need additional information.

Sincerely,


Anne Langley

cc: Gill Wylie, President, Johns Hopkins Medical Management
Gregory Wm. Branch, M.D., MBA, CPE, Baltimore County Health Officer

1. Please provide a summary or Executive Summary of the findings from the 2013 comprehensive physician survey that identifies the problems encountered by patients and providers needing access for each surgical specialty (i.e., general surgery urology, plastic surgery, etc.), and the suggested outcomes or resolutions to resolve these problems.

Applicant Response:**Johns Hopkins Medicine 2013 Green Spring Station Physician Survey**

In April of 2013, Johns Hopkins Medical Management (the entity that manages Hopkins' presence at Green Spring Station) emailed an on-line physician survey to 227 physicians practicing at Green Spring Station. The survey was aimed at evaluating how well Johns Hopkins Medicine's presence at Green Spring Station was meeting the needs of its patient population. Further, the survey aimed to better understand what additional services or resources would be required to strengthen the ability of Green Spring Station's primary care physicians and specialists to serve its patient population across their continuum of care.

Respondents were asked to categorize what percentage of their referrals went to Johns Hopkins providers for over 40 specialties. Respondents categorized what percentage of their referrals went to Johns Hopkins providers by answering 0-19%, 20-39%, 40-59%, 60-79%, or 80-100%. Respondents were also asked the following in an open-ended format:

- What are the primary reasons keeping you from referring more of your patients to Johns Hopkins providers?
- Please list any medical, ancillary, or non-medical services currently not available at the Green Spring Station campus.
- Please describe any teaching or educational activities you do at the Green Spring Station campus.
- Please list any research you perform at the Green Spring Station campus.

Eighty-one of the 227 physicians completed the survey for a 35.7% response rate. The results of the physician-provided responses can be viewed in (Exhibit 13).

When physicians were asked to provide the primary reasons that kept them from referring patients to Johns Hopkins providers (Exhibit 14), the vast majority of responses cited:

- Access/Availability/Wait for Appointment
- Patient Preference/Distance

The survey confirmed that access issues for Green Spring patients are greatest for the Johns Hopkins surgical specialties and that some surgical specialties (including

general surgery, urology, and orthopaedics) are “referred out” at much higher rates than others. Being able to retain these referrals within the Hopkins family provides value to the patient through continuity of care. By expanding specialty surgical services at Green Spring Station, the issues preventing Green Spring Station providers from referring to Johns Hopkins specialists could be directly addressed by:

- Providing an additional route to access JHM providers
- Centralizing the care continuum to one site
- Reducing appointment wait times
- Providing a convenient location to access care
- Reducing the travel distance needed to access JHM providers relative to Green Spring Station

2. Please provide a brief description of what will be located on each floor of the new 110,000 sq. ft. medical office building.

Applicant Response:

The new, 110,000 sq. ft., 3-story medical office building will include the following:

1st Floor:

- Diagnostic Imaging
- Orthopaedic Physician Offices
- Rehabilitation and Physical Medicine (Physical Therapy, Occupational Therapy, Speech Therapy, and Physician Offices)

2nd Floor:

- Otolaryngology Physician Offices
- Medical Oncology Physician Offices and Infusion Therapy
- Lab/Phlebotomy
- Shared Office Space, Examination Rooms and Patient Conference Rooms to include: Breast, General Surgery, Neurosurgery and Plastic Surgery
- Building Support Space: Mechanical/Electrical/Medical Gas/Storage

3rd Floor:

- Ambulatory Surgery Center
- Urology Physician Offices

3. Please augment your response to COMAR 10.24.11.06C, *Assessing Impact*, by providing the current locations at which the surgeons listed in response to Standard .05B(2) currently perform their outpatient surgical procedures. Do all of these surgeons currently have privileges with Johns Hopkins Medicine, and/or will you recruit new physicians who will relocate to this new ambulatory surgery center?

Applicant Response:

COMAR 10.24.11.06C, *Assessing Impact* reads:

C. Assessing Impact.

An application to establish a new ambulatory surgical facility shall present the following data as part of its impact assessment, in addition to addressing COMAR 10.24.01.08G(3)(f):

- (1) The number of surgical cases projected for the facility and for each physician and practitioner;*
- (2) A minimum of two years of historic case volume data for each physician or practitioner, identifying each facility at which cases were performed and the average operating room time per case. Calendar year or fiscal year data may be provided as long as the time period is identified and is consistent for all physicians; and*
- (3) The proportion of case volume expected to shift from each existing facility to the proposed facility.*
- (4) Impact on an affected hospital.*
 - (a) If the needs assessment includes surgical cases performed by one or more physicians who currently perform cases at a hospital within the defined service area of the proposed ambulatory surgical facility that, in the aggregate, account for 18 percent of the operating room capacity at a hospital, then the applicant shall include, as part of the impact assessment, a projection of the levels of use at the affected hospital for at least three years following the anticipated opening of the proposed ambulatory surgical facility; and*
 - (b) The operating room capacity assumptions in .06A of this Chapter and the operating room inventory rules in .06D of this Chapter shall be used in the impact assessment.*

Please see Exhibit 20 for the number of OR cases projected for the facility for each physician and practitioner, separated by specialty, for FY2018, FY2019, and FY2020.

Please see Exhibit 20 for historic case volume data for FY2012 to FY2014 and FY2015 March annualized for each physician and practitioner projected to perform OR cases at the GSSSC. Exhibit 20 also contains the proportion of each physician and practitioner's FY2015 annualized outpatient OR volume to be shifted to the GSSSC.

Exhibit 20 contains a column titled "FY2015 Volume Baseline Assigned to GSSSC", a sub-column of "Proportion of Volume Allocated to GSSSC". The column lists a total of 3,496 OR cases for FY2015. All cases listed would be moved to the GSSSC today if it were available. This column ties to Exhibit 21's "Total" column. All 3,496 OR cases for FY2015 are listed for each physician and practitioner and include the site where the cases are currently being performed.

Please see page 105-108 of the application for the estimated impact of GSSSC on JHM Facilities and page 109-113 for the estimated impact of GSSSC on non-JHM Facilities.

All of the surgeons listed currently have privileges with Johns Hopkins Medicine. New physicians will be recruited to perform cases at GSSSC, however no volume is attributed to them at this time. Please see page 53-66 of the application for specialty-specific projections and recruitment plans

4. Is there a timeframe for turning the shell space into the 6th OR?

Applicant Response:

GSSSC's ability to turn the shell space into a sixth OR will be governed by the Surgical Services Chapter of the State Health Plan, Standard .05(B)(3) (Need - Minimum Utilization for Expansion of An Existing Facility), which states:

(3) Need - Minimum Utilization for Expansion of An Existing Facility.

An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall:

(a) Demonstrate the need for each proposed additional operating room, utilizing the operating room capacity assumptions and other guidance included at Regulation .06 of this Chapter;

(b) Demonstrate that its existing operating rooms were utilized at optimal capacity in the most recent 12-month period for which data has been reported to the Health Services Cost Review Commission or to the Maryland Health Care Commission; and

(c) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the completion of the additional operating room capacity. The needs assessment shall include the following:

(i) Historic trends in the use of surgical facilities at the existing facility;

(ii) Operating room time required for surgical cases historically provided at the facility by surgical specialty or operating room category; and

(iii) Projected cases to be performed in each proposed additional operating room.

Hence, per (3)(b), GSSSC will have to demonstrate that its five ORs are operating at 489,600 minutes in the previous 12 month period ($97,920 \times 5 = 489,600$). In the CON application, GSSSC provided projections through the year 2020. These projections were impacted by the number of existing Johns Hopkins Medicine cases being relocated from Johns Hopkins Hospital and other sites, the anticipated ability to retain referrals that Johns Hopkins Medicine is currently losing to other surgery sites (for reasons explained in the application), and population changes. In the table "GSSSC Projected Annual Volume" below, GSSSC has extended the projections through 2022. However, for years 2021 and 2022, the only annual impact is population change. GSSSC did not include growth based on any other factor. One can see that in 2022,

GSSC projects that it will just exceed the 80% utilization of the five ORs, even only accounting for population changes, in 2022. Of course, GSSSC anticipates that its volumes will continue to grow, but GSSSC is being conservative in its projections.

Therefore, GSSSC anticipates that it will seek regulatory approval to convert the shell space to a sixth OR in 2022.

GSSSC Projected Annual Volume
2018-2022

	FY '18	FY '19	FY '20	FY '21	FY '22
Cases	4,346	4,731	5,078	5,129	5,181
Min/Case	95.1	95.1	95.1	95.1	95.1
Min	413,305	449,918	482,918	487,768	492,713
Capacity/OR	97,920	97,920	97,920	97,920	97,920
ORs	4.221	4.595	4.932	4.981	5.032

5. What plans are in place to accommodate the referenced patients who may need 23 hour stay? Where will this space be located within the facility?

Applicant Response:

Included in the design of the Ambulatory Surgery Center was planning for the potential future inclusion of 23 hour stay patients. The prospect of patients undergoing total joint surgery and other procedures requiring an extended recovery period was considered since this practice is already in place in many ambulatory facilities around the country. Within the Ambulatory Surgery Center, two of the Stage II bays have been designed to be larger, with private bathroom facilities to accommodate patients with an extended stay (see Exhibit 6 drawing with rooms labeled: "Stage II Extended") These larger rooms provide space for family members to comfortably stay with the patient during the extended recovery period. Patients will have a more private, quiet setting in which to recover for a longer timeframe. Nursing staff in close proximity with visualization of the patient will assure safety during the extended stay. In addition, since all of the Preop/PACU and Stage II bays have been designed with 3 solid walls, should the volume of 23 hour patients exceed the capacity of these two rooms, patients will be accommodated in any of the other bays within close proximity to a patient bathroom.

6. Under Source of Funds, please explain "Other (Landlord for Tenant Allowance)" of \$1,361,900.

Applicant Response:

As with many commercial leases between independent parties, the landlord is providing the tenant with an incentive to help defray the tenant's cost of customizing the space to the meet the tenant's needs. In this case, the landlord (Johns Hopkins Suburban Health Center LP) has agreed to provide \$50.00 per square foot of leased space to the applicant.

27,238 Square Feet of Leased Space

 X \$50 per Square Foot

\$1,361,900

7. Please revise Exhibit 10 to delineate GSSSC's primary and secondary service areas.

Applicant Response:

Please see Exhibit 24 for a map of the GSSSC primary service area and secondary service area. The list of zip codes contained in the primary service area and secondary service area can be found in Exhibit 11 of the application.

8. *Standard .05B(2) – Need* : Please respond to the following:

- a. Explain the assumption of 4.15 FTE IM Physicians that appears as a footnote for the table on p. 42.

Applicant Response:

There are currently 4.15 FTE Johns Hopkins Community Physicians Internal Medicine (IM) physicians practicing at Green Spring Station. The total number of FTEs currently practicing at Green Spring Station was needed to calculate the rate of “Referrals per IM FTE”.

8. *Standard .05B(2) – Need* : Please respond to the following:

- b. Please show the calculations used to arrive at the ratio of New Visits to Outpatient cases on p. 45, and how the ratio of 4 visits/1case was established.

Applicant Response:

In the table “Johns Hopkins at Green Spring Station, Ratio of New Visits to Outpatient Cases” below, JHM estimated the number of new patient visits that are expected to result in a surgical case using FY14 actual new patient visit data extracted from EPIC for the physicians that will be performing cases at the GSS ASC. The number of new visits (“Total New Visits”) were then divided by the FY14 actual outpatient cases performed by each physician (“Total Cases”) to obtain the ratio of cases to new patient visits (“Ratio of Visits/Case”). These ratios were then vetted by department leadership for each of the departments listed. For three departments, alternative methods were utilized.

For Gynecology and Podiatry, new visit and case data were not available. For Gynecology, JHM consulted Dr. Andrew J. Satin, M.D., Director of Gynecology and Obstetrics at Johns Hopkins Hospital. Dr. Satin recommended using a ratio of 20.0 new visits per case. For Podiatry, JHM consulted Dr. Zachary L. Chattler, DPM. Dr. Chattler recommended using a ratio of 10.0 new visits per case.

For Urology, actual new patient visit data indicated a ratio of 1.1 visits per case. In consultation with Dr. Alan W. Partin, M.D., Ph.D., Chairman of the Johns Hopkins Department of Urology, JHM felt this ratio was not representative of the patterns that will occur when Urology establishes a practice at Green Spring. Currently, patients have had Urology visits with non-JHM Urologists (typically a urologist with more of a generalist practice) before they are referred to JHM Urologists (currently highly-specialized). In the future, with the expanded presence of Urology at Green Spring, JHM anticipates it will have a general urologist available and that these earlier visits will then occur at Green Spring. Dr. Partin recommended using a ratio of 4 new visits per case.

Johns Hopkins at Green Spring Station
Ratio of New Visits to Outpatient Cases

Department	Total New Visits	Total Cases	Ratio of Visits/Case	Ratio Used in Projections
Gynecology ¹	-	-	20.0	20.0
Podiatry ¹	-	-	10.0	10.0
Neurosurgery	511	101	5.1	5.1
General Surgery	924	252	3.7	3.7
Vascular Surgery	708	225	3.1	3.1
Orthopedic Surgery	2,429	823	3.0	3.0
Plastic Surgery	900	319	2.8	2.8
Otolaryngology	4,013	1,567	2.6	2.6
Breast Surgery	1,336	878	1.5	1.5
Urology ²	1,956	1,837	1.1	4.0

¹ Ratio provided by physician leadership

² Ratio modified by physician leadership

8. *Standard .05B(2) – Need* : Please respond to the following:

c. Please discuss what the applicant means by “limited presence” on p. 46.

Applicant Response:

JHM defines a “limited presence” as any specialty with a presence at Green Spring Station that is less than full-time. The specialties with a limited presence at Green Spring Station now include Breast Surgery, General Surgery, Plastic Surgery, and Urology. The presence of each specialty is defined by the number of sessions they have on-site per week. A session is equal to one 4-hour time block where a physician is on-site.

The number of sessions per week for each of the specialties with a limited presence are as follows:

Breast Surgery = 1.0
General Surgery = 0.0
Plastic Surgery = 2.5
Urology = 2.0

8. *Standard .05B(2) – Need* : Please respond to the following:

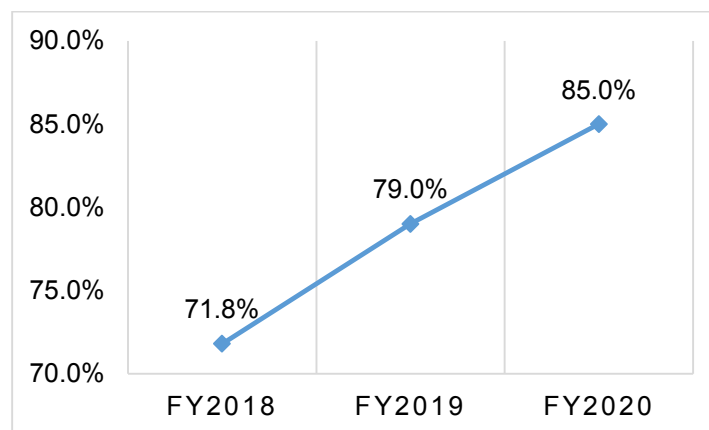
- d. On p. 48, please show how you calculated the 79.0% Referral Retention Rate for FY 2019.

Applicant Response:

JHM set the FY2018 projected Referral Retention Rate at 71.8%. This was the referral retention rate of specialties with a full-time presence at GSS in FY2014. It is projected that in FY2018, those specialties that do not currently have a presence at GSS will see their referral retention rates rise, such that the overall referral retention rate for specialties at GSS in FY2018 will be 71.8%.

JHM set the FY2020 projected Referral Retention Rate at 85.0%. This value reflects the level of referral retention specialties have historically shown to be achievable. In the “Combined JHCP and Patient First Referral Analysis” on page 44 of the application, Dermatology (81%), Neurosurgery (81%), Obstetrics/Gynecology (84%), and Podiatry (87%) display referral retention rates that greatly exceed the rates of specialties with a limited presence at GSS. The added presence of specialties at GSS, as well as the expansion of services for specialties currently present full-time at GSS, should allow JHM to reach the 85.0% referral retention rate.

JHM set the FY2019 projected Referral Retention Rate at 79.0%. This value is intended to reflect the midpoint of the FY2018 and FY2020 rates. The exact midpoint of the FY2018 and FY2020 rates is 78.4%. To simplify the projections, rather than rounding down to 78.0% and setting the FY2019 rate marginally below the exact midpoint, JHM rounded this value up to 79.0%.



8. *Standard .05B(2) – Need* : Please respond to the following:
- e. Please show how you calculated the FY 2018, 2019, and 2020 population adjustment rates for total and female population shown on p. 52.

Applicant Response:

JHM utilized Truven Health Care Analytics (“Truven”) to analyze the demographics of the zip codes contained in the Green Spring Station Surgery Center service area (Exhibit 11). Truven reported the total population of the selected zip codes for 2014, as well as a projection for 2019. Truven also reported the total population of females age 15 and older for the selected zip codes in 2014, as well as a projection for 2019.

JHM then calculated the Compound Annual Growth Rate (CAGR) for the 5 year period from 2014 to 2019 and used the CAGR as the basis for calculating the change in the population value for each calendar year. It was then assumed that the CAGR could be used to forecast one additional year into the future for 2020.

This calculation is provided in Exhibit 25.

9. *Standard .05B(7) – Construction Costs:* While the benchmark Marshall Valuation Service (“MVS”) cost per square foot is for construction of a complete building, it appears that the project cost used for comparison is limited to the fit out of the ambulatory surgery center space. Please revise the MVS benchmark so that it is a more comparable to the project costs.

Applicant Response:

GSSSC will be located in leased space in a building that is otherwise a medical office building (MOB). The owner of the building (Johns Hopkins Suburban Health Center LP) will construct the MOB, shelling in most of the third floor for GSSSC to fit-out for its use. Hence, GSSSC will be renovating shell space in an existing MOB. GSSSC has devised two approaches to evaluate whether the renovation costs of shell space are reasonable, given that the Marshall Valuation Service (MVS) cost/sq. foot benchmark for Outpatient (Surgical) Centers is for new construction of a complete building. While the two alternative approaches share most characteristics, they do differ in a few respects. Each approach will be explained below.

Approach 1

In addition to a cost per sq. foot benchmark for “Outpatient (Surgical) Centers,” MVS also has a benchmark for “Medical Office Buildings.” In Table 1, GSSSC compares the calculation of the MVS benchmark for a generic Outpatient (Surgical) Center. Table 1 also calculates a benchmark for a generic MOB, using parallel assumptions. In this analysis, GSSSC assumed the following:

- Perimeter Multiplier – GSSSC assumed that the Perimeter Multiplier for both the Outpatient Surgical Center and the MOB is 1.
- Height Multiplier (plus/minus from 12') - GSSSC assumed that the floor to ceiling height of both the Outpatient Surgical Center and the MOB is 12 feet, and, therefore, the MVS multiplier of 1.
- Multi-story Multiplier (0.5%/story above 3) – GSSSC assumed that both the Outpatient Surgical Center and MOB are no higher than 3 stories and that, therefore, the multiplier is 1.
- Sprinklers – While the cost of sprinklers is not in the GSSSC calculation of its own benchmark, it would be a cost of building the shell. Therefore, GSSSC has added a sprinkler cost to the benchmark for the MOB. GSSSC has used the average of the highest sprinkler cost/sf (\$5.82) and the lowest cost (\$2.15) at the Good Quality level.
- Update and Local Multipliers – GSSSC applied the same multipliers that were reflected in the CON application.

Table 1
MVS Benchmarks
A Generic Outpatient Surgical Center and a Generic Medical Office Building

	Outpatient (Surgical) Centers	Medical Office Building
A. Base Costs	A-B/Good	A/Good
Basic Structure	358.66	222.78
Elimination of HVAC cost for adjustment	0	0
HVAC Add-on for Mild Climate	0	0
HVAC Add-on for Extreme Climate	0	0
Total Base Cost	\$358.66	\$222.78
B. Additions		
Elevator (If not in base)	\$0.00	\$0.00
Other	\$0.00	\$0.00
Subtotal	\$0.00	\$0.00
Total	\$358.66	\$222.78
C. Multipliers		
Perimeter Multiplier	1	1
Product	358.66	222.78
Height Multiplier (plus/minus from 12')	1	1
Product	\$358.66	\$222.78
Multi-story Multiplier (0.5%/story above 3)	1	1
Product	\$358.66	\$222.78
D. Sprinklers		
Sprinkler Amount	-	3.99
Subtotal	\$358.66	\$226.77
E. Update/Location Multipliers		
Update Multiplier	1.05	1.05
Product	\$376.59	\$238.10
Location Multiplier	1.01	1.01
Product	\$380.36	\$240.48

Final Square Foot Cost Benchmark

\$380.36

\$240.48

In Section 87, page 8, MVS shows the “Budget Differential Costs by Department” (to which we refer to as Departmental Cost Differential Factors) for Hospitals (the only type of structure for which MVS supplies these factors). The area of the MOB in which GSSSC will be located would be otherwise considered shell space (or, as MVS terms it on page 8, “Unassigned Space”). MVS estimates that the Departmental Cost Differential Factor for this kind of space is 0.5. GSSSC assumed that the Departmental Cost Differentiation factor of 0.5 should be applied to the MVS benchmark for an MOB of \$240.48 (calculated above) to reflect the cost of constructing the shell of the MOB. If all of the building was shell space (and not fitted out in any way), applying the MVS Departmental Cost Differential Factor to the entire building would suggest that the benchmark for the entire MOB would be half of the full benchmark. Hence, this reflects that the cost of building the shell of the MOB is half the cost of the MVS benchmark for an MOB.

$$\$240.48 \times 0.50 = \$120.24.$$

Therefore, the cost of building the MOB shell is estimated to be \$120.24.

In order to calculate a benchmark for only the fitting out of shell space in an MOB into a surgery center, GSSSC subtracted the \$120.24 from the benchmark for Outpatient (Surgical) Centers (\$380.36, as calculated in Table 1) to obtain the benchmark for the fitting out of the MOB as a surgery center.

$$\$380.36 - \$120.24 = \$260.12$$

GSSSC then calculated the percentage that the \$260.12 represents of the benchmark for a generic Outpatient Surgery Center, in order to apply it to the benchmark calculated by GSSSC in its CON application.

$$\$260.12 / \$380.36 = 0.684$$

This means that the cost of renovating generic shell space in an MOB to establish an Outpatient Surgery Center should be 68.4% of the cost of constructing a generic Outpatient Surgery Center building.

One could then assume that 68.4% of the actual benchmark for GSSC that it included on pages 77 and 78 of the CON application (and also in Table 2, below), (\$386.32) would reflect the component of that benchmark that reflects the fit-out only.

$$\$386.32 \times 0.684 = \$264.20$$

As shown on pages 78-79 of the CON application, the cost per square foot of renovation of the shell space by GSSSC is \$265.46:

II. The Project

A. Base Calculations	Actual	Per Sq. Foot
Building	\$7,009,541	\$257.34
Fixed Equipment	In Building	
Site Preparation	\$0	\$0.00
Architectural Fees	\$211,000	\$7.75
Capitalized Construction Interest	\$0	\$0.00
Permits	\$10,000	\$0.37
Subtotal	\$7,230,541	\$265.46

III. Comparison

A. Project Cost/Sq. Ft.	\$265.46
B. Estimated Marshall Valuation Service Benchmark	\$264.20

As GSSSC's costs are \$265.46, GSSSC is reasonably consistent with this approach. It is only \$1.26 (0.48%) higher than the benchmark, using this approach. Any amount that GSSSC's capital costs exceed the estimated MVS benchmark will not be passed on to patients because of the way payors reimburse. Payors do not include a capital component in their reimbursement.

Approach 2

One could think it more appropriate to directly compare GSSSC's actual benchmark to the benchmark for a generic MOB. That is, rather than use the benchmark for a generic Outpatient (Surgery) Center, one should use the GSSSC's benchmark because that reflects any real differences in the factors for Wall Height, Perimeter Multiplier, etc. This is shown in Table 2. Table 2 reflects the MVS analysis that GSSSC submitted on pages 77-78 of its CON application. It also includes the analysis of a generic MOB that was included in Table 1.

Table 2
MVS Benchmarks
GSSSC and a Generic Medical Office Building

Type	Outpatient (Surgical) Centers	Medical Office Building
Construction Quality/Class	A-B/Good	A/Good
Stories		
Perimeter	1,027	
Height of Ceiling	15.33	

Square Feet	27,238	
f.1 Average floor Area	27,238	
A. Base Costs		
Basic Structure	358.66	222.78
Elimination of HVAC cost for adjustment	0	0
HVAC Add-on for Mild Climate	0	0
HVAC Add-on for Extreme Climate	0	0
Total Base Cost	\$358.66	\$222.78
B. Additions		
Elevator (If not in base)	\$0.00	\$0.00
Other	\$0.00	\$0.00
Subtotal	\$0.00	\$0.00
Total	\$358.66	\$222.78
C. Multipliers		
Perimeter Multiplier	0.943407684	1
Product	338.3625999	222.78
Height Multiplier (plus/minus from 12')	1.077	1.000
Product	\$364.28	\$222.78
Multi-story Multiplier (0.5%/story above 3)	1	1
Product	\$364.28	\$222.78
D. Sprinklers		
Sprinkler Amount	-	3.99
Subtotal	\$364.28	\$226.77
E. Update/Location Multipliers		
Update Multiplier	1.05	1.05
Product	\$382.49	\$238.10
Location Multiplier	1.01	1.01
Product	\$386.32	\$240.48
Final Square Foot Cost Benchmark	\$386.32	\$240.48

Then, GSSSC used the Departmental Cost Differential factor of 0.5 to calculate the cost of building the shell of an MOB, as we did before.

$$\$240.48 \times 0.50 = \$120.24.$$

GSSSC then subtracted the cost of building the MOB shell (\$120.24) from the benchmark for GSSSC's Outpatient Surgery Center (\$386.32) to reflect the benchmark for an Outpatient Surgery Center.

$$\$386.32 - \$120.24 = \$266.07$$

Comparison

A. Project Cost/Sq. Ft.	\$265.46
B. Estimated Marshall Valuation Service Benchmark	\$266.07

Therefore, the benchmark would be \$266.07. As GSSSC's costs are \$265.46, GSSSC is consistent with this approach, also.

Using either approach, GSSSC's costs are consistent with the estimated MVS benchmarks for renovation only.

GSSSC believes that Approach 1 is the most appropriate approach because it uses parallel assumptions about both a generic MOB and an ASF to calculate a percentage that the MOB shell comprises that can be applied to the actual benchmark for GSSSC. It does not directly compare the benchmark for a generic MOB to GSSSC's actual benchmark. However, the difference between the two approaches turns out to be minimal.

	Final MVS Benchmark
Approach 1	\$264.20
Approach 2	\$266.07
Difference	\$1.87
% Difference	0.7%

10. Regarding Table 2, please reconcile the total number of surgical minutes reported on Table 2 on p. 89 with the information provided in the response given regarding COMAR 10.24.11,05B(2), Need, on p. 67 of the CON application.

Applicant Response:

A computational error was made in Table 2 on page 89. The line "Total Surgical Minutes in the ORs" should equal the "Total Cases in ORs" multiplied by the average minutes per case value of 70.7 minutes.

Exhibit 26 includes a revised Table 2 where the "Total Surgical Minutes in the ORs" line now equals the "Case Minutes" line of the table on page 67.

For calculations that include turnover time, please see the table on page 67.

11. Please provide a response to COMAR 10.24.11.06C, *Assessing Impact*.

Applicant Response:

Please see the response to question #3 above.

12. Please provide audited financial statements or documentation regarding the financial condition of Johns Hopkins Surgery Centers Series.

Applicant Response:

Audited financial statements are not available for the Johns Hopkins Surgery Center Series. However, Exhibit 27 includes unaudited financial statements for the White Marsh Surgery Center Series for FY2015.

Please note that currently, the White Marsh Surgery Center is the lone entity contained within the Johns Hopkins Surgery Center Series. The proposed Green Spring Station Surgery Center will be the second entity contained within the Johns Hopkins Surgery Center Series.

13. Please augment the table at the bottom of p. 105 to show the total number of outpatient surgical cases at Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center for FY 2015 (annualized).

Applicant Response:

See augmented table below from page 105 of the application titled “FY2015 Annualized Minutes Impact (Inpatient and Outpatient),” which includes the total outpatient operating room cases at Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center for FY 2015 (annualized) in the last row of the table.

FY2015 Annualized Minutes Impact (Combined Inpatient and Outpatient)

	JHH	Bayview
OP OR Cases Shifted to GSSSC	2,447	123
Average OR Minutes/Case	95.7	95.7
OP OR Minutes Shifted to GSSSC	234,178	11,771
Total OR Minutes (IP+OP)	5,872,436	1,279,528
% of Minutes Shifted to GSSSC	4.0%	0.9%
OP OR Cases	16,093	5,457

14. Please augment the discussion of “JHH Backfill Strategy” with statistics showing the current utilization vis a vis capacity of JHH ORs.

Applicant Response:

See Exhibit 28 for historical, current, and projected JHH OR capacity and utilization. Descriptions for each of the sections in Exhibit CQ14 are included here.¹

JHH OR Utilization for FY2011 to FY2019

Physical Rooms & Staffed Rooms

- Sections list the total number of outpatient and mixed-use operating rooms at Johns Hopkins Hospital by fiscal year
- FY11 – FY15 reflect actual physical and staffed ORs
- FY16 – FY19 reflect projected physical and staffed ORs

Available Minutes – Physical & Available Minutes – Staffed

- Sections list the total number of available minutes in the outpatient and mixed-use operating rooms at JHH by fiscal year
- The capacity standards used for this analysis reflect those in COMAR 10.24.11.06(A)(1) and are listed in the table below:

Mixed-Use OR Physical Capacity (min/yr)	= (# of physical ORs) x 2,375 hr/yr x 60 min/hr
Mixed-Use OR Staffed Capacity (min/yr)	= (# of staffed ORs) x 2,375 hr/yr x 60 min/hr
Outpatient OR Physical Capacity (min/yr)	= (# of physical ORs) x 2,040 hr/yr x 60 min/hr
Outpatient OR Staffed Capacity (min/yr)	= (# of staffed ORs) x 2,040 hr/yr x 60 min/hr

¹ The minutes values listed in Exhibit 28 differ slightly from those provided on page 106 of the application in the graphic “JHH OR Minute Projections” and paragraph below. This is because JHH’s definition of its total OR minutes varied slightly from the state health plan standard COMAR 10.24.11.06(A)(1). For this response, the total OR minutes values were adjusted to conform to the standard. The difference between what was included in the application on page 106 and what is included here is less than 1%.

Actual & Projected Minutes

- This section lists the total number of OR minutes in outpatient and mixed-use ORs at JHH by fiscal year
- FY11 – FY15 reflect actual OR minutes
- FY16 – FY19 reflect projected OR minutes

Utilization Rate & Growth Rate

- Sections list the utilization growth rates of outpatient and mixed-use OR minutes at JHH by fiscal year
- FY11 – FY15 reflect actual OR minutes
- FY16 – FY19 reflect projected OR minutes

Minutes Removed for Cases Transferred to GSSSC

- This section ties to Exhibit 21, “FY2015 Baseline Volumes”, column “JHH”.
- 2,447 cases will be moved out of JHH to GSSSC
- Average case length of 95.7 minutes

Total OR Minutes, Growth Rate & Utilization Rate Accounting for GSSSC Cases

- FY18 – FY19 projections adjusted to reflect movement of 2,447 cases from JHH to GSSSC

For Affirmations, please see Exhibit 29.





Service Area Population

Total Population

2014	10,259,895
2019	10,764,216
CAGR	0.96%

Notes:

Source: Truven Health Analytics

Source: Truven Health Analytics

$CAGR = [(2019 \text{ Pop}/2014 \text{ Pop})^{1/5 \text{ years}}] - 1$

Calendar Year	Population	n
2014	10,259,895	0
2015	10,358,833	1
2016	10,458,724	2
2017	10,559,579	3
2018	10,661,407	4
2019	10,764,216	5
2020	10,868,017	6

Source: Truven Health Analytics

$2015 \text{ Pop} = (2014 \text{ Pop}) * (1 + CAGR)^1$

$2016 \text{ Pop} = (2014 \text{ Pop}) * (1 + CAGR)^2$

$2017 \text{ Pop} = (2014 \text{ Pop}) * (1 + CAGR)^3$

$2018 \text{ Pop} = (2014 \text{ Pop}) * (1 + CAGR)^4$

$2019 \text{ Pop} = (2014 \text{ Pop}) * (1 + CAGR)^5$

$2020 \text{ Pop} = (2014 \text{ Pop}) * (1 + CAGR)^6$

2018 Pop. Adj.	2.921%
2019 Pop. Adj.	3.913%
2020 Pop. Adj.	4.915%

$2018 \text{ Pop. Adj.} = [(2018 \text{ Pop} / 2015 \text{ Pop}) - 1] * 100$

$2019 \text{ Pop. Adj.} = [(2019 \text{ Pop} / 2015 \text{ Pop}) - 1] * 100$

$2020 \text{ Pop. Adj.} = [(2020 \text{ Pop} / 2015 \text{ Pop}) - 1] * 100$

Females 15 and Older Population

2014	4,327,653
2019	4,568,140
CAGR	1.09%

Source: Truven Health Analytics

Source: Truven Health Analytics

$CAGR = [(2019 \text{ Pop}/2014 \text{ Pop})^{1/5 \text{ years}}] - 1$

Calendar Year	Population	n
2014	4,327,653	0
2015	4,374,716	1
2016	4,422,290	2
2017	4,470,382	3
2018	4,518,997	4
2019	4,568,140	5
2020	4,617,818	6

Source: Truven Health Analytics

$2015 \text{ Pop} = (2014 \text{ Pop}) * (1 + CAGR)^1$

$2016 \text{ Pop} = (2014 \text{ Pop}) * (1 + CAGR)^2$

$2017 \text{ Pop} = (2014 \text{ Pop}) * (1 + CAGR)^3$

$2018 \text{ Pop} = (2014 \text{ Pop}) * (1 + CAGR)^4$

$2019 \text{ Pop} = (2014 \text{ Pop}) * (1 + CAGR)^5$

$2020 \text{ Pop} = (2014 \text{ Pop}) * (1 + CAGR)^6$

2018 Pop. Adj.	3.298%
2019 Pop. Adj.	4.421%
2020 Pop. Adj.	5.557%

$2018 \text{ Pop. Adj.} = [(2018 \text{ Pop} / 2015 \text{ Pop}) - 1] * 100$

$2019 \text{ Pop. Adj.} = [(2019 \text{ Pop} / 2015 \text{ Pop}) - 1] * 100$

$2020 \text{ Pop. Adj.} = [(2020 \text{ Pop} / 2015 \text{ Pop}) - 1] * 100$

TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT
(INSTRUCTION: All applicants should complete this table.)

	Projected Years			
	(Ending with first full year at full utilization)			
CY or FY (Circle)	2018	2019	2020	20__
1. Admissions				
a. ICF-MR				
b. RTC-Residents				
Day Students				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
2. Patient Days				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
3. Average Length of Stay				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
4. Occupancy Percentage*				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				

Table 2 Cont.	Projected Years			
	(Ending with first full year at full utilization)			
CY or FY (Circle)	2018	2019	2020	20__
5. Number of Licensed Beds				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
6. Home Health Agencies				
a. SN Visits				
b. Home Health Aide				
c.				
d.				
e. Total patients served				
7. Hospice Programs				
a. SN Visits				
b. Social work visits				
c. Other staff visits				
d. Total patients served				
8. Ambulatory Surgical Facilities				
a. Number of operating rooms (ORs)	5	5	5	
• Total Procedures in ORs	10,865	11,828	12,695	
• Total Cases in ORs	4,346	4,731	5,078	
• Total Surgical Minutes in ORs**	307,262	334,482	359,015	
b. Number of Procedure Rooms (PRs)	4	4	4	
• Total Procedures in PRs	4,312	4,784	5,315	
• Total Cases in PRs	3,450	3,827	4,252	
• Total Minutes in PRs**	138,000	153,080	170,080	

**Do not include turnover time

Johns Hopkins Surgery Centers Series - White Marsh

Balance Sheet

As of the Dates Indicated

(Unaudited - For Internal Use Only)

	June 30, 2015	June 30, 2014
ASSETS		
Current Assets		
Cash	\$ 40,186	\$ 103,238
Patient Receivables	610,211	446,270
Less Contractual Adjustments & Bad Debts	(379,179)	(283,930)
	<u>231,032</u>	<u>162,340</u>
Due From Third Party Payer	121,049	-
Employee Receivable	1,762	-
Prepaid Maintenance Contracts	-	1,332
Prepaid Insurance	-	344
Medical Supplies & Instruments	70,175	70,175
	<u>192,986</u>	<u>71,851</u>
Property and Equipment		
Furniture & Fixtures	6,036	6,036
Medical Equipment	1,131,435	1,130,670
Leasehold Improvements	1,634,976	1,634,976
	<u>2,772,446</u>	<u>2,771,681</u>
Accumulated Depreciation	(1,595,405)	(1,592,263)
	<u>1,177,041</u>	<u>1,179,418</u>
Other Assets		
Development Costs	271,156	271,156
Accum Amort of Development Costs	(149,271)	(132,459)
	<u>121,885</u>	<u>138,697</u>
	<u>\$ 1,763,130</u>	<u>\$ 1,655,544</u>
LIABILITIES AND CAPITAL		
Current Liabilities		
Accrued Expenses	\$ 124,263	\$ 17,501
Accrued Salaries	49,450	33,419
Payroll Taxes Payable	957	1,616
Current Portion - Lease Payable - Buildout	180,733	173,061
Loan Payable - JHHS	-	104,000
Patient Prepayments	22,174	-
Due To Affiliate	3,803	800
	<u>381,379</u>	<u>330,397</u>
Long-Term Liabilities		
Lease Payable - Buildout	1,513,113	1,693,845
Deferred Rent	305,439	310,167
	<u>1,818,552</u>	<u>2,004,012</u>
Capital		
Deficit (beginning of period))	(678,864)	(846,178)
Net Income	242,063	167,314
	<u>(436,801)</u>	<u>(678,864)</u>
	<u>\$ 1,763,130</u>	<u>\$ 1,655,544</u>

Johns Hopkins Surgery Centers Series - White Marst
Statement of Income
For the Years Ended June 30,
(Unaudited - For Internal Use Only)

	2015	2014
Revenue		
Facility Fees	\$ 5,496,624	\$ 4,889,614
Contractual Adjustments	(2,819,090)	(2,439,381)
Charity Care	(13,987)	(37,756)
	<u>2,663,547</u>	<u>2,412,477</u>
Expenses		
Salaries - Nurses	501,239	401,714
Salaries - Techs	207,678	204,196
Salaries - Office	121,386	127,132
Salaries - Bonuses	25,000	25,000
Payroll Taxes	69,800	64,521
Fringe Benefits	104,204	92,739
Profit Sharing Contribution	20,000	10,000
Temporary Help	1,189	4,999
Rent	243,138	243,138
Insurance - Other	3,941	5,065
Drugs	44,568	46,316
Medical Supplies	406,293	396,315
Equipment Maintenance	85,922	76,699
Minor Equipment	31,666	37,541
Office Expense	69,899	62,518
Telephone	8,750	8,246
Utilities	6,398	-
Meals & Entertainment	911	315
Training	3,854	3,555
Information Systems	14,117	16,640
Laundry	19,588	12,899
Miscellaneous	2,539	677
Depreciation & Amortization	191,947	197,409
Interest Expense	85,058	100,649
Licensure & Accreditation	3,504	4,090
Medical Director	30,000	30,000
Management Fees	120,000	120,000
	<u>2,422,589</u>	<u>2,292,371</u>
Operating Income	240,958	120,106
Other Income (Expense)		
Grant-Women's Board of JHH	-	47,165
Miscellaneous Income	1,105	43
	<u>1,105</u>	<u>47,208</u>
Net Income	<u>\$ 242,063</u>	<u>\$ 167,314</u>

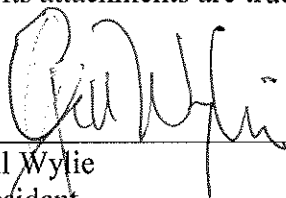
JHH OR Utilization for FY2011 to FY2019

	Actual					Projected			
	FY11	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19
Physical Rooms									
Outpatient	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0
Mixed Use	37.0	37.0	46.0	46.0	46.0	46.0	46.0	46.0	46.0
Total ORs	45.0	45.0	54.0	54.0	54.0	54.0	54.0	54.0	54.0
Staffed Rooms									
Outpatient	8.0	8.0	7.0	7.0	7.0	7.5	8.0	8.0	8.0
Mixed Use	37.0	37.0	44.5	44.5	44.8	45.0	46.0	46.0	46.0
Total ORs	45.0	45.0	51.5	51.5	51.8	52.5	54.0	54.0	54.0
Available Minutes - Physical									
Outpatient	979,200	979,200	979,200	979,200	979,200	979,200	979,200	979,200	979,200
Mixed Use	5,272,500	5,272,500	6,555,000	6,555,000	6,555,000	6,555,000	6,555,000	6,555,000	6,555,000
Total ORs	6,251,700	6,251,700	7,534,200	7,534,200	7,534,200	7,534,200	7,534,200	7,534,200	7,534,200
Available Minutes - Staffed									
Outpatient	979,200	979,200	856,800	856,800	856,800	918,000	979,200	979,200	979,200
Mixed Use	5,272,500	5,272,500	6,341,250	6,341,250	6,384,000	6,412,500	6,555,000	6,555,000	6,555,000
Total ORs	6,251,700	6,251,700	7,198,050	7,198,050	7,240,800	7,330,500	7,534,200	7,534,200	7,534,200
Actual & Projected Minutes									
Outpatient	655,609	664,404	508,034	493,328	526,658	583,240	594,905	606,803	618,939
Mixed Use	4,511,706	4,646,890	4,939,478	5,162,046	5,329,938	5,443,197	5,552,061	5,663,102	5,776,365
Total ORs	5,167,315	5,311,294	5,447,512	5,655,374	5,856,596	6,026,437	6,146,966	6,269,905	6,395,304
Utilization Rate									
Outpatient ORs - Physical	67%	68%	52%	50%	54%	60%	61%	62%	63%
Outpatient ORs - Staffed	67%	68%	59%	58%	61%	64%	61%	62%	63%
Mixed Use ORs - Physical	86%	88%	75%	79%	81%	83%	85%	86%	88%
Mixed Use ORs - Staffed	86%	88%	78%	81%	83%	85%	85%	86%	88%
Total ORs - Physical	83%	85%	72%	75%	78%	80%	82%	83%	85%
Total ORs - Staffed	83%	85%	76%	79%	81%	82%	82%	83%	85%
Total OR Min	5,167,315	5,311,294	5,447,512	5,655,374	5,856,596	6,026,437	6,146,966	6,269,905	6,395,303
Growth Rate	-	2.8%	2.6%	3.8%	3.6%	2.9%	2.0%	2.0%	2.0%
						Minutes Removed for Cases Transferred to GSSSC			
						Cases		2,447	2,447
						GSSSC Length of Case		95.7	95.7
						Minutes		234,178	234,178
Total OR Min with GSSSC	5,167,315	5,311,294	5,447,512	5,655,374	5,856,596	6,026,437	6,146,966	6,035,727	6,161,126
Growth Rate with GSSSC	-	2.8%	2.6%	3.8%	3.6%	2.9%	2.0%	-1.8%	2.1%
Utilization Rate with GSSSC									
Total ORs - Physical	83%	85%	72%	75%	78%	80%	82%	80%	82%
Total ORs - Staffed	83%	85%	76%	79%	81%	82%	82%	80%	82%

AFFIRMATIONS

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.



Gill Wylie
President
Johns Hopkins Medical Management Corporation

October 28, 2015
Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.



Beth Plavner

Director of Development & Planning

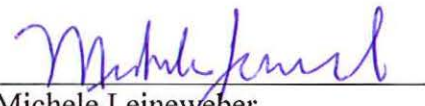
Johns Hopkins Medical Management Corporation



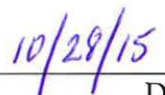
Date

AFFIRMATION

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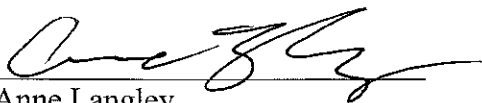
Michele Leineweber
Director of Finance & Management
Johns Hopkins Medical Management Corporation



Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.



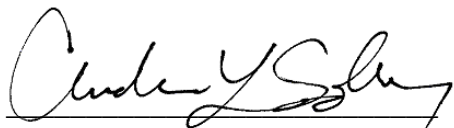
Anne Langley
Senior Director
Health Planning and Community Engagement
Johns Hopkins Health System

10/28/2015

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

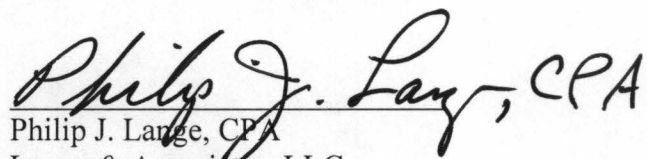
A handwritten signature in black ink, appearing to read "Andrew Solberg", written over a horizontal line.

Andrew Solberg
A.L.S. Healthcare Consultant Services

10/28/15
Date

AFFIRMATION

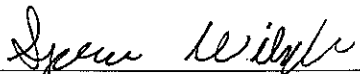
I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.


Philip J. Lange, CPA
Lange & Associates, LLC

10-28-2015
Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.



Spencer Wildonger
Senior Project Analyst
Health Care Transformation & Strategic Planning
Johns Hopkins Health System

10/28/2015
Date