Guide

On February 5, 2018, Johns Hopkins Bayview Medical Center ("JHBMC") submitted a Certificate of Need ("CON") application, Matter Number 18-24-2414, for the capital expenditures associated with a campus redevelopment project that includes construction of a new inpatient building and renovation of two existing buildings on its campus ("New Inpatient Building CON").

On July 6, 2018, JHBMC submitted a Letter of Intent indicating it would apply for a Certificate of Need to add 16 licensed Comprehensive Inpatient Rehabilitation ("CIR") beds to its existing complement of 12 licensed CIR beds. A pre-application conference was held July 18, 2018. At the conference, JHBMC and MHCC staff discussed the fact that, while the two projects are unrelated, there is extensive overlap in the content required for both applications. Further, the New Inpatient Building CON application has already been reviewed by MHCC staff, and responses to the first round of completeness questions have been submitted, amending and/or supplementing the content in the original submission.

In order to minimize duplication of effort and ensure consistency, in this CIR CON application, where appropriate, JHBMC has copied material directly from the New Inpatient Building CON and related responses to the first round of completeness questions. This material is included according to a color-coding system to allow staff to easily discern where the response is an exact copy of content that has been submitted and reviewed by MHCC staff previously.

The approach used is as follows:

- Text in Red is a direct copy from the New Inpatient Building CON
- Text in *Red Italics* is a direct copy from responses to the New Inpatient Building Completeness Questions Round 1. The copy includes both the staff's question and the applicant's response.
- Text in Black is new content.
- Red text combined with Black text is a combination of text copied directly from New Inpatient Building CON and new text in Black.

For internal staff use

MARYLAND HEALTH CARE COMMISSION

_____
MATTER/DOCKET NO.

_____
DATE DOCKETED

HOSPITAL
APPLICATION FOR CERTIFICATE OF NEED

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: Johns Hopkins Bayview Medical Center

Address:

4940 Eastern Avenue	Baltimore	21224	Baltimore City
Street	City	Zip	County

Name of Owner (if differs from applicant):
The Johns Hopkins Health System Corporation

2. OWNER

Name of owner: The Johns Hopkins Health System Corporation

3. APPLICANT. ***If the application has co-applicants, provide the detail regarding each co-applicant in sections 3, 4, and 5 as an attachment.***

Legal Name of Project Applicant
Johns Hopkins Bayview Medical Center, Inc.

Address:
Above

Street	City	Zip	State	County

Telephone: 410-550-0123

Name of Owner/Chief Executive: Richard G. Bennett, MD, President

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from applicant:
N/A

5. LEGAL STRUCTURE OF APPLICANT (and LICENSEE, if different from applicant).

Check ☑ or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☒	
	(2) For-profit	☐	
	(3) Close	☐	State & date of incorporation
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited liability partnership	☐	
	Limited liability limited partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☐	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	☒	

6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Name and Title: Anne Langley, Sr. Director, Health Planning & Community Engagement
Mailing Address:

3910 Keswick Road, Suite N-2200	Baltimore	21211	MD
Street	City	Zip	State

Telephone: 443-997-0727
E-mail Address (required): alangle2@jhmi.edu
Fax: 443-6997-0731

B. Additional or alternate contact:

Name and Title: Spencer Wildonger, Director of Health Planning
Mailing Address:

3910 Keswick Road, Suite N-2200	Baltimore	21211	MD
Street	City	Zip	State

Telephone: 443-997-0742
E-mail Address (required): swildon1@jhmi.edu
Fax: 443-997-0731

7. TYPE OF PROJECT

The following list includes all project categories that require a CON under Maryland law. Please mark all that apply.

If approved, this CON would result in:

(1) A new health care facility built, developed, or established ☐

(2) An existing health care facility moved to another site ☐

(3) A change in the bed capacity of a health care facility ☒

(4) A change in the type or scope of any health care service offered by a health care facility ☐

(5) A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf ☐

8. PROJECT DESCRIPTION

A. Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is; why you need/want to do it; and what it will cost. A one-page response will suffice. Please include:

(1) Brief description of the project – what the applicant proposes to do;
(2) Rationale for the project – the need and/or business case for the proposed project;
(3) Cost – the total cost of implementing the proposed project; and
(4) Master Facility Plans – how the proposed project fits in long term plans.

B. Comprehensive Project Description: The description must include details, as applicable, regarding:

(1) Construction, renovation, and demolition plans;
(2) Changes in square footage of departments and units;
(3) Physical plant or location changes;
(4) Changes to affected services following completion of the project; and
(5) If the project is a multi-phase project, describe the work that will be done in each phase. If the phases will be constructed under more than one construction contract, describe the phases and work that will be done under each contract.

Introduction

Johns Hopkins Bayview Medical Center ("JHBMC") proposes to convert 16 beds, currently licensed as Chronic beds, to become 16 licensed Comprehensive Inpatient Rehabilitation ("CIR") beds, bringing JHBMC's licensed bed complement into alignment with the current utilization. No capital expenditures, construction, renovations, or operational changes are required for this license conversion to occur. The only change that will result from this project is the number of licensed Chronic beds at JHBMC will decrease from 76 to 60, and the number of licensed CIR beds will increase from 12 to 28. No changes are anticipated in the number of patients served or revenues or expenses as a result of this project.

All of JHBMC's Chronic and CIR beds are located in the John R. Burton Pavilion ("Burton Pavilion") on the JHBMC campus. Floor 01 of the Burton Pavilion contains a total of 20 beds. Of these, 12 are currently licensed as CIR beds and 8 are licensed as Chronic beds. Floor 1, Wing C of the Burton Pavilion currently contains 8 licensed Chronic beds. Combined these 28 beds are accredited by the Commission on Accreditation of Rehabilitation Facilities ("CARF") and are currently used to provide CIR services. JHBMC proposes to convert the 8 Chronic beds on Floor 01 and 8 Chronic beds on Floor 1 to be licensed as CIR, for a total of 16 additional CIR beds.

The History of Physical Medicine and Rehabilitation at Johns Hopkins

Arthur Siebens, a Johns Hopkins University School of Medicine ("JHUSOM") alumnus, was recruited in 1970 as the first Director of the Division of Rehabilitation Medicine at Johns Hopkins. The major site of clinical activity at that time was Good Samaritan Hospital, where Dr. Siebens developed an acute Comprehensive Inpatient Rehabilitation program. The original 36-bed inpatient program grew to 51 beds, and included specialty programs in stroke, spinal cord injury and ventilator dependency.

Dr. Siebens worked with colleagues at the Kennedy Krieger Institute to develop rehabilitation programs for children. In 1979, he launched one of the first programs for rehabilitation of impaired swallowing (dysphagia). A major expansion occurred in 1983 with the addition of electrodiagnostic medicine and rehabilitation psychology. A joint residency program in Physical Medicine and Rehabilitation ("PM&R") was established with Sinai Hospital in 1984. The program's first National Institute of Health funding was awarded to Dr. Jeffrey Palmer in 1987.

PM&R was recognized as a full department in the JHUSOM in 1992. Dr. Barbara de Lateur became the director of the department in 1994. She was also the first woman to direct any department at the JHUSOM.

In 1999, a CIR unit was created at The Johns Hopkins Hospital. In July 2000, PM&R admitted its first trainees. Good Samaritan continued to be the site of the majority of clinical and training activity.

Dr. De Lateur stepped down in 2004, succeeded by Dr. Jeffrey Palmer. During his tenure, the department moved its administrative offices from Good Samaritan to The

Johns Hopkins Hospital, while maintaining clinical services at Good Samaritan. In December 2014, Dr. Palmer stepped down and Dr. Pablo Celnik, the vice chair for research in the department at that time, became the director after a nationwide search.

Johns Hopkins PM&R enjoyed a 40-year relationship with Good Samaritan Hospital, pre-dating the creation of both the MedStar and Johns Hopkins health systems. JHUSOM faculty served as the clinical providers of CIR services, and Good Samaritan served as the clinical training site for a significant portion of the JHUSOM PM&R training programs, with 5.5 residents (out of 18) and 8 FTE faculty (out of 24) providing clinical care and training and conducting research there. MedStar Health elected to terminate this relationship effective June 10, 2017. JHUSOM PM&R faculty and trainees no longer provide clinical services at MedStar Good Samaritan Hospital.

The JHUSOM Physical Medicine and Rehabilitation Department Today

At Johns Hopkins Medicine, the PM&R team is devoted to the diagnosis, treatment and prevention of all types of disabilities with world-class, patient-centered care. This vision is supported by the pursuit of the Johns Hopkins Medicine tripartite mission of excellent clinical care, research, and education. Currently, the department spans the Baltimore-Washington metropolitan area. There are CIR and outpatient programs at both The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, and a pediatric rehabilitation unit at the Kennedy Krieger Institute.

Additional outpatient services are provided at the following locations:

- Green Spring Station
- White Marsh
- Odenton
- Howard County General Hospital
- Suburban Hospital
- The Peabody Institute
- The ACAC at Timonium

Research programs have expanded significantly, with research grants and career development awards from the National Institutes of Health, the Department of Defense, and private foundations. The Department has numerous specialized training programs including in psychology, physical therapy residency programs and fellowships.

The Department has 30 full-time faculty members, 18 residents, 10 postdoctoral fellows and three staff clinical physiatrists. At The Johns Hopkins Hospital and outpatient locations, the department is responsible for rehabilitation nursing and rehabilitation therapy services: physical therapy, occupational therapy and speech language pathology.

JHM's multidisciplinary team of physiatrists, physical and occupational therapists, speech language pathologists, psychologists, nurses, social workers, pharmacists and dieticians work with patients who have a reasonable expectation to improve function and achieve a satisfactory discharge plan. All patients must be willing and able to tolerate at least three hours of therapy daily, or up to 15 hours of therapy weekly. The

team of experts specializes in rehabilitation care for amputation, spinal cord injury and dysfunction, complex medical conditions, brain injury and illness, musculoskeletal injury, and stroke, among other disabling disorders.

Leadership: Dr. Pablo Celnik

Currently Dr. Pablo Celnik is the Director of the Johns Hopkins Department of Physical Medicine and Rehabilitation and Physiatrist-in-Chief at The Johns Hopkins Hospital. Dr. Celnik came to JHUSOM in 2000 as a resident. Since 2003, he has been part of the Johns Hopkins faculty in the PM&R, neurology and neuroscience departments. He serves as vice chair for research in the PM&R department, medical director of the outpatient neurorehabilitation program, and director of the Human Brain Physiology and Stimulation Laboratory. He is internationally-recognized for his expertise and research in neurologic rehabilitation, particularly with stroke and traumatic brain injury patients.

Rehabilitation Therapy Services

In addition to services on the CIR units, PM&R offers daily physical therapy, occupational therapy and speech-language pathology services in multiple adult and pediatric settings at The Johns Hopkins Hospital, including ICU, stepdown and inpatient hospital units. JHM's therapy staff is divided into multidisciplinary therapy teams, including cardiac, ICU, surgery, medicine, neurosciences and oncology.

Physician Consult Services

Inpatient Physical Medicine and Rehabilitation physician consultation is provided at both primary hospital sites —The Johns Hopkins Hospital and Johns Hopkins Bayview. Consultation staff also include physician assistants and rehabilitation nurse liaisons, who assist in the evaluation of patients referred to our CIIRPs. JHM's enhanced consultation service provides an extra level of assistance and support to long-stay patients, post-solid transplant patients, and those suffering from a stroke.

Outpatient Rehabilitation Clinical Programs and Specialties

PM&R physiatrists, therapists, and psychologists treat a number of rehabilitation conditions in the outpatient setting. JHM's experienced team works with individuals to address rehabilitation needs and restore function for a variety of conditions, including spasticity, musculoskeletal and spine pain, back and neck injury, brain and spinal cord injury, stroke, deconditioning and fatigue, falls and balance difficulties, injuries, lymphedema, cognitive and communication disorders, aphasia, swallowing disorders, voice disorders, and other neurological conditions.

Specialty programs include:

- Amputation and prosthetics clinics
- Brain and stroke rehabilitation program
- Cancer Rehabilitation Program
- Multiple Sclerosis Rehabilitation

- Musculoskeletal and spine program
- Neuromuscular Rehabilitation Program
- Noninvasive Brain Stimulation Program
- Performing Arts Physical Therapy Program
- The International Center for Spinal Cord Injury at Kennedy Krieger Institute
- Rehabilitation for Postural Orthostatic Tachycardia Syndrome (POTS)

Pediatric Outpatient Rehabilitation

The state-of-the-art Pediatric Rehabilitation Clinic at the Johns Hopkins Children's Center provides a therapeutic environment for children from birth to age 21 as they receive outpatient physical and occupational therapy services. The specialized pediatric programs are for orthopaedics, hand therapy, cancer, traumatic brain injury and children requiring pulmonary rehabilitation due to conditions like cystic fibrosis.

Psychiatric Rehabilitation Services

The rehabilitation psychology and neuropsychology providers play an integral role in evaluating the full spectrum of cognitive, behavioral and psychosocial functioning for CIR patients. Our psychologists provide interventions to aid patients and their families in managing chronic illness, pain and disability. Outpatient services are offered at The Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Green Spring Station.

The Kennedy Krieger Institute

JHUSOM PM&R has 10 faculty members deployed to the Kennedy Krieger Institute, where a wide array of innovative clinical and research programs focusing on pediatric rehabilitation and spinal cord injury are offered. Over 20,000 distinct patients with approximately 165,000 visits are served in the outpatient programs at the Institute each year. The Kennedy Krieger Institute Rehabilitation Continuum of Care has been accredited by CARF. It includes a 50-bed inpatient pediatric rehabilitation hospital, a rehabilitation day hospital program providing coordinated interdisciplinary therapies, a community-based rehabilitation program providing service in the home, and outpatient clinics that provide ongoing rehabilitation care. Unique resources at the Institute include a state-of-the-art aquatic therapy center; inpatient and outpatient therapy gyms equipped with a large variety of robotic, electrical stimulation and virtual reality technology; a gait analysis laboratory; and a neuroimaging center.

Kennedy Krieger is the home of several clinical and research centers. They include:

- The Center for Brain Injury Recovery
- The International Center for Spinal Cord
- The Philip A. Keelty Center for Spina Bifida and Related Conditions
- The Bennett Institute Physically Challenged Sports Program
- The Dorothy L. and Henry A. Rosenberg Jr. Center for Clinical Research
- The F.M. Kirby Research Center for Functional Brain Imaging

Training Program

The Johns Hopkins University School of Medicine Residency in Physical Medicine and Rehabilitation was founded in 1999 and currently has 17 filled spots for the residency program. Residency clinical sites include The Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, The Kennedy Krieger Institute, and The University of Maryland Rehabilitation and Orthopaedic Institute. The Hopkins PM&R education program also includes two different accredited fellowship programs, spinal cord injury medicine and pediatric rehabilitation. The program is one of only two non-military residency programs in the state. It is not only the largest in the state, but has the highest rate of board-certified physicians upon completion of the program in Maryland.

PM&R training programs like JHUSOM's play a vital role in facilitating recovery and improving the quality of life of individuals disabled by injury or disease. Academic PM&R generates essential new knowledge, shapes public policy, and provides the finest medical care. It is the optimal environment for developing and testing novel interventions, assessing best practices and evaluating the efficacy and efficiency of different care models in the context of population health. Academic rehabilitation programs are fundamental to train the future leaders in patient care and clinical research. In their absence, there is no one to test the efficacy and efficiency of new rehabilitation care models addressing population health and train a new work force in this new era.

Research

Hopkins PM&R received $2.5 million in research funding for FY18 and a total of $16 million in research funding from FY13-18. This research infrastructure allows the JHM PM&R department to test novel interventions and engage in innovative care models to improve quality outcomes for patients as well as the rehabilitation community at large. The breadth and success of the PM&R department's research initiatives is contingent on the hospitals ability to effectively serve PM&R patients. Without adequate bed capacity to service the increasing volume at JHBMC, there could be downstream effects on the department's ability to effectively conduct cutting edge clinical research within the field of PM&R.

Complete the DEPARTMENTAL GROSS SQUARE FEET WORKSHEET (Table B) in the CON TABLE PACKAGE for the departments and functional areas to be affected.

Applicant Response:

Standard does not apply. This project does not contain any construction or renovations.

9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES

Complete the Bed Capacity (Table A) worksheet in the CON Table Package if the proposed project impacts any nursing units.

Applicant Response:

See Exhibit 1 (NIB Exhibit 1A) for Bed Capacity Table A. The exhibit is a copy of Exhibit 1A from the NIB CON application, modified in red text to show how bed and room types will change as result of this project.

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: ___1.1___ acres

B. Have all necessary State and local land use approvals, including zoning, for the project as proposed been obtained? YES_____ NO __X__ (If NO, describe below the current status and timetable for receiving necessary approvals.)

Site is governed by a Planned Unit Development Ordinance (PUD). PUD permits proposed use, but is subject to Baltimore City planning review. Planning review will be concurrent with design and document development, as it is a prerequisite for the building permit.

C. Form of Site Control (Respond to the one that applies. If more than one, explain.):

(1) Owned by: _____
Please provide a copy of the deed.

(2) Options to purchase held by: _____
Please provide a copy of the purchase option as an attachment.

(3) Land Lease held by: JHBMC
Please provide a copy of the land lease as an attachment.

Land title held by FSK Land Corp., an affiliate of the Johns Hopkins Health System Inc. The buildings are new, and the New Inpatient Building will be owned by JHBMC Inc.

Please see Exhibit 2 (NIB Exhibit 4). The exhibit is an exact copy of Exhibit 4 from the NIB CON application.

(4) Option to lease held by: _____
Please provide a copy of the option to lease as an attachment.

(5) Other: _____
Explain and provide legal documents as an attachment.

11. PROJECT SCHEDULE

In completing this section, please note applicable performance requirement time frames set forth at COMAR 10.24.01.12B & C. Ensure that the information presented in the following table reflects information presented in Application Item 7 (Project Description).

Applicant Response:

Standard does not apply.

	Proposed Project Timeline	
Single Phase Project		
Obligation of 51% of capital expenditure from CON approval date		months
Initiation of Construction within 4 months of the effective date of a binding construction contract, if construction project		months
Completion of project from capital obligation or purchase order, as applicable		months
Multi-Phase Project for an existing health care facility (Add rows as needed under this section)		
One Construction Contract		months
Obligation of not less than 51% of capital expenditure up to 12 months from CON approval, as documented by a binding construction contract.		months
Initiation of Construction within 4 months of the effective date of the binding construction contract.		months
Completion of 1st Phase of Construction within 24 months of the effective date of the binding construction contract		months
Fill out the following section for each phase. (Add rows as needed)		
Completion of each subsequent phase within 24 months of completion of each previous phase		months
Multiple Construction Contracts for an existing health care facility (Add rows as needed under this section)		
Obligation of not less than 51% of capital expenditure for the 1st Phase within 12 months of the CON approval date		months
Initiation of Construction on Phase 1 within 4 months of the effective date of the binding construction contract for Phase 1		months
Completion of Phase 1 within 24 months of the effective date of the binding construction contract.		months
To Be Completed for each subsequent Phase of Construction		
Obligation of not less than 51% of each subsequent phase of construction within 12 months after completion of immediately preceding phase		months
Initiation of Construction on each phase within 4 months of the effective date of binding construction contract for that phase		months
Completion of each phase within 24 months of the effective date of binding construction contract for that phase		months

12. PROJECT DRAWINGS

A project involving new construction and/or renovations must include scalable schematic drawings of the facility at least a 1/16” scale. Drawings should be completely legible and include dates.

Project drawings must include the following before (existing) and after (proposed) components, as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, room sizes, number of beds, location of bathrooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as “shell space”.

B. For a project involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.

C. For a project involving site work schematic drawings showing entrances, roads, parking, sidewalks and other significant site structures before and after the proposed project.

D. Exterior elevation drawings and stacking diagrams that show the location and relationship of functions for each floor affected.

Applicant Response:

Standard does not apply.

13. **FEATURES OF PROJECT CONSTRUCTION**

A. If the project involves new construction or renovation, complete the Construction Characteristics (Table C) and Onsite and Offsite Costs (Table D) worksheets in the CON Table Package.

B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project, and the steps necessary to obtain utilities. Please either provide documentation that adequate utilities are available or explain the plan(s) and anticipated timeframe(s) to obtain them.

No additional utilities are needed the proposed project beyond what is currently available at Johns Hopkins Bayview Medical Center.

Applicant Response:

A.) Table C and Table D do not apply. This project does not contain any construction or renovations.

PART II - PROJECT BUDGET

Complete the Project Budget (Table E) worksheet in the CON Table Package.

Note: Applicant must include a list of all assumptions and specify what is included in all costs, as well the source of cost estimates and the manner in which all cost estimates are derived.

Applicant Response:

Table E does not apply. There is no capital expenditure for this project.

1. List names and addresses of all owners and individuals responsible for the proposed project.

   Richard G. Bennett, M.D.
   President
   Johns Hopkins Bayview Medical Center
   4940 Eastern Avenue
   Baltimore, Maryland 21224

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2. Is any applicant, owner, or responsible person listed above now involved, or has any such person ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each such facility, including facility name, address, the relationship(s), and dates of involvement.

   Past:
   Haven Nursing Home, Inc. (Owner) – 3939 Penhurst Avenue, Baltimore, MD 21215, (1995 – 2013)
   Penhurst Healthcare, Inc. (DBA Kenesaw Nursing Home), (Owner) 2601 Roslyn Ave., Baltimore, MD 21216 (1997 -2003)
   Broadmead Lifecare Community (Board Member), 13801 York Rd., Cockeysville, MD 21030 (1988 – 1996)
   Deaton Specialty Hospital and Home (Board Member), 611 S. Charles St, 21230 (1994 - 1996)
   Keswick Multi-Center (Board Member), 700 W. 40th St., Baltimore, MD 21209 (2000 – 2012)

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3. In the last 5 years, has the Maryland license or certification of the applicant facility, or the license or certification from any state or the District of Columbia of any of the facilities listed in response to Question 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) ? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant(s), owners, or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

   No

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4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) ever received inquiries from a federal or any state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with Maryland, another state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation

   including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

   No

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5. Has any applicant, owner, or responsible individual listed in response to Question 1, above, ever pled guilty to, received any type of diversionary disposition, or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

   No

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

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.

September 4, 2018
Date


Signature of Owner or Board-designated Official

President
Position/Title

Richard G. Bennett, M.D.
Printed Name

PART IV - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

INSTRUCTION: Each applicant must respond to all criteria included in COMAR 0.24.01.08G(3), listed below.

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

If a particular standard or criteria is covered in the response to a previous standard or criteria, the applicant may cite the specific location of those discussions in order to avoid duplication. When doing so, the applicant should ensure that the previous material directly pertains to the requirement and the directions included in this application form. Incomplete responses to any requirement will result in an information request from Commission Staff to ensure adequacy of the response, which will prolong the application's review period.

10.24.01.08G(3)(a). <u>The State Health Plan</u>.

To respond adequately to this criterion, the applicant must address each applicable standard from each chapter of the State Health Plan that governs the services being proposed or affected, and provide a direct, concise response explaining the project's consistency with each standard. <u>In cases where demonstrating compliance with a standard requires the provision of specific documentation, documentation must be included as a part of the application.</u>

Every acute care hospital applicant must address the standards in **COMAR 10.24.10: Acute Care Hospital Services**. A Microsoft Word version is available for the applicant's convenience on the Commission's website. Use of the *CON Project Review Checklist for Acute Care Hospitals General Standards* is encouraged. This document can be provided by staff.

Other State Health Plan chapters that may apply to a project proposed by an acute care hospital are listed in the table below. A pre-application conference will be scheduled by Commission Staff to cover this and other topics. It is highly advisable to discuss with Staff which State Health Plan chapters and standards will apply to a proposed project before application submission. Applicants are encouraged to contact Staff with any questions regarding an application.

COMAR 10.24.09 Specialized Health Care Services –
Acute Inpatient Rehabilitation Services
.04A. General Review Standards.

(1) Charity Care Policy.

(a) Each hospital and freestanding acute inpatient rehabilitation provider shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide acute inpatient rehabilitation services on a charitable basis to qualified persons consistent with this policy. The policy shall have the following provisions:

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

(ii) Notice of Charity Care Policy. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's admission, facilities should address any financial concerns of patients, and individual notice regarding the facility's charity care policy shall be provided.

(iii) Criteria for Eligibility. A hospital shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. A hospital that is not subject to HSCRC regulations regarding financial assistance policies shall at a minimum include the following eligibility criteria in its charity care policies. Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge. At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of hospitals that are not subject to HSCRC regulations regarding financial assistance policies.

(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 HSCRC Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

(c) A proposal to establish or expand an acute inpatient rehabilitation hospital or subunit, for which third party reimbursement is available, and which is not subject to HSCRC regulations regarding financial assistance policies, shall commit to provide charitable rehabilitation services to eligible patients, based on its charity care policy, which shall meet the minimum requirements in .04A(1)(a) of this Chapter. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(d) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a CON for a project that involves acute inpatient rehabilitation services, shall commit to provide charitable services to indigent patients. Charitable services may be rehabilitative or non-rehabilitative and may include a charitable program that subsidizes health plan coverage. At a minimum, the amount of charitable services provided as a percentage of total operating expenses for the health maintenance organization will be equivalent to the average amount of charity care provided statewide by acute general hospitals, measured as a percentage of total expenses, in the most recent year reported. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If the health maintenance organization's track record is not consistent with the expected level for the population in the proposed service area, the applicant shall demonstrate that the historic level of charity care was appropriate to the needs of the population in the proposed service area.

Applicant Response:

(a) Please see response to 10.24.10.04A(2) Charity Care In the Acute Care Hospital Chapter below. The response is a copy of the answer provided in the Acute Care Hospital section of the NIB CON.

(b) Please see response to 10.24.10.04A(2) Charity Care In the Acute Care Hospital Chapter below. The response is a copy of the answer provided in the Acute Care Hospital section of the NIB CON.

(c) Standard does not apply.

(d) Standard does not apply.

(2) Quality of Care.

A provider of acute inpatient rehabilitation services 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 Commission for Accreditation of Rehabilitation Facilities.

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

Applicant Response:

(a)(i) Please see response to 10.24.10.04A(3) Quality of Care in the Acute Care Hospital chapter below. The response is a copy of the answer provided in the Acute Care Hospital section of the NIB CON.

(a)(ii) Please see Exhibit 3 for JHBMC's CARF Survey Report and Exhibit 4 for JHBMC's CARF accreditation letter attached.

a)(iii) Please see response to 10.24.10.04A(3) Quality of Care in the Acute Care Hospital chapter below. The response is a copy of the answer provided in the Acute Care Hospital section of the NIB CON.

(b) An applicant that currently provides acute inpatient rehabilitation services that is seeking to establish a new location or expand services shall report on all quality measures required by federal regulations or State agencies, including information on how the applicant compares to other Maryland acute inpatient rehabilitation providers. An applicant shall be required to meet quality of care standards or demonstrate progress towards reaching these standards that is acceptable to the Commission, before receiving a CON.

Applicant Response:

Data for the following measures are referenced below and included in Exhibits 5-8:

- Functional Independence Measure
- Average Length of Stay
- Disposition
- CLABSI
- CAUTI
- Hand Hygiene
- Falls
- Pressure Ulcers

Comparisons to State and National data are included when available.

<u>FIM, ALOS, and Disposition</u>

Functional Independence Measure ("FIM"), Average Length of Stay ("ALOS"), and Disposition data for JHBMC Comprehensive Inpatient Rehabilitation services is housed in the Uniform Data System (UDS) database. FIM and Disposition data are benchmarked at the state level. ALOS data is benchmarked at the state and national level.

Please see Exhibit 5 for data for FY16-FY18.

<u>Summary of FY18 results:</u>

ALOS at JHBMC was within the confidence interval for both the National and the State ALOS.

FIM improvement from admission to discharge was slightly higher for JHBMC than for Maryland overall.

FIM efficiency (# of FIM score points gained per patient day) was slightly higher for JHBMC than for Maryland overall.

For Disposition, nearly an equivalent percentage of patients were discharged to an Acute Service from the Rehabilitation Unit at JHBMC as for Maryland overall, and a slightly greater percentage of patients were discharged to Home or Assisted Living from JHBMC than for Maryland overall.

CLABSI, CAUTI, and Hand Hygiene

Please see the table below for CLABSI, CAUTI, and Hand Hygiene compliance rates for Comprehensive Inpatient Rehabilitation services at JHBMC for FY16-FY18. These metrics are reported at the state level.

REHAB	FY2016	FY2017	FY2018
CLABSI Infection Rate (Per 1000 Central Line Days)	0.00	0.00	0.00
CAUTI Infection Rate (Per 1000 Foley Catheter Days)	3.15	0.00	7.59
Hand Hygiene Compliance Rate	87%	91%	91%

Falls & Pressure Ulcers

Patient falls and pressure injuries data is reported nationally to the NDNQI database.

Please see Exhibit 6 for patient falls data from the NDNQI database. The data reporting period is two years, or eight quarters. In order to meet target (green) the rate of falls must be below the mean for 5 out of the 8 most recent quarters.

As result of a spike in the incidence of patient falls in CY17, the rehabilitation unit implemented a project to reduce falls in October of 2017. Please see Exhibit 7. The rate of falls has since declined.

Please see Exhibit 8 for patient pressure injuries data from the NDNQI database. With the exception of one quarter in the last two years, the unit has successfully prevented pressure ulcers.

(c) An applicant that does not currently provide inpatient rehabilitation services that is seeking to establish an inpatient rehabilitation unit within an acute care hospital or an inpatient rehabilitation specialty hospital shall demonstrate through reporting on quality measures that it provides high quality health care compared to other Maryland providers that provide similar services or, if applicable, nationally.

Applicant Response:

Standard does not apply.

COMAR 10.24.09 Specialized Health Care Services –
Acute Inpatient Rehab Services
.04B. PROJECT REVIEW STANDARDS

In addition to these standards, an acute general hospital applicant shall address all applicable standards in COMAR 10.24.10 that are not duplicated in this Chapter. These standards apply to applicants seeking to provide comprehensive acute rehabilitation services or both comprehensive acute rehabilitation services and specialized acute rehabilitation services to adult or pediatric patients.

(1) Access.

A new or relocated acute rehabilitation hospital or subunit shall be located to optimize accessibility for its likely service area population. An applicant that seeks to justify the need for a project on the basis of barriers to access shall present evidence to demonstrate that barriers to access exist for the population in the service area of the proposed project, based on studies or other validated sources of information. In addition, an applicant must demonstrate that it has developed a credible plan to address those barriers. The credibility of the applicant's plan will be evaluated based on whether research studies or empirical evidence from comparable projects support the proposed plan as a mechanism for addressing the barrier(s) identified, whether the plan is financially feasible and whether members of the communities affected by the project support the plan.

Applicant Response:

Standard does not apply. The applicant is not seeking to justify the need for the project on the basis of barriers to access.

(2) Need.

A project shall be approved only if a net need for adult acute rehabilitation beds is identified by the need methodology in Section .05 in the applicable health planning region (HPR) or if the applicant meets the applicable standards below. The burden of demonstrating need rests with the applicant.

(a) An application proposing to establish or expand adult acute inpatient rehabilitation services in a jurisdiction that is directly contiguous to another health planning region may be evaluated based on the need in contiguous regions or states based on patterns of cross-regional or cross-state migration.

(b) For all proposed projects, an applicant shall explicitly address how its assumptions regarding future in-migration and out-migration patterns among Maryland health planning regions and bordering states affect its need projection.

(c) If the maximum projected bed need range for an HPR includes an adjustment to account for out-migration of patients that exceeds 50 percent of acute rehabilitation discharges for residents of the HPR, an applicant proposing to meet the need for additional bed capacity above the minimum projected need, shall identify reasons why the existing out-migration pattern is attributable to access barriers and demonstrate a credible plan for addressing the access barriers identified.

(d) An applicant proposing to establish or expand adult acute rehabilitation beds that is not consistent with the projected net need in .05 in the applicable health planning region shall demonstrate the following:

(i) The project credibly addresses identified barriers to access; and

(ii) The applicant's projection of need for adult acute rehabilitation beds explicitly accounts for patients who are likely to seek specialized acute rehabilitation services at other facilities due to their age or their special rehabilitative and medical needs. At a minimum, an applicant shall specifically account for patients with a spine or brain injury and pediatric patients; and

(iii) The applicant's projection of need for adult acute rehabilitation beds accounts for in-migration and out-migration patterns among Maryland health planning regions and bordering states.

(e) An applicant that proposes a specialized program for pediatric patients, patients with brain injuries, or patients with spinal cord injuries shall submit explanations of all assumptions used to justify its projection of need.

(f) An applicant that proposes to add additional acute rehabilitation beds or establish a new health care facility that provides acute inpatient rehabilitation services cannot propose that the beds will be dually licensed for another service, such as chronic care.

Applicant Response:

The applicant proposes to convert 16 beds, currently licensed as Chronic beds, to 16 licensed CIR beds, to bring JHBMC's CIR bed licenses into alignment with its current CIR patient utilization rate. All of JHBMC's Chronic and CIR beds are located in the John R. Burton Pavilion on the JHBMC campus.

Floor 01 of the Burton Pavilion contains a total of 20 beds. Of the 20 beds, 12 are licensed CIR bed and 8 are licensed Chronic beds. Floor 1, Wing C of the Burton Pavilion contains 8 licensed chronic beds. These 3 units, totaling 28 beds, are all CARF accredited and are being used to provide comprehensive inpatient rehabilitation services. The applicant proposes to convert the 8 Chronic beds on Floor 01 and 8 Chronic beds on Floor 1 to be licensed for Comprehensive Inpatient Rehabilitation services, for a total of 16 additional CIR beds.

In FY18, the utilization statistics for the 28 beds used for CIR services at JHBMC were as follows:

JHBMC FY2018 – 28 Beds

Discharges: 732
Patient Days: 9,365
ADC: 25.66
Occupancy Rate: 91.63%

The Occupancy Rate at JHBMC for all months in FY18 never dipped below 84.68% and had a one-month high of 96.89%.

	FY16	FY17	FY18
Inpatient Discharges	441	530	732
Total Patient Days	5,740	8,234	9,365
Beds	20	28*	28
Occupancy (calculated)	78.6%	90.3%	91.6%

*20 beds July 1, 2016 - November 14, 2016, 28 beds November 15, 2016 - June 30, 2017

The table above shows significant volume growth in CIR services at JHBMC since FY16. JHBMC's inpatient discharges increased from 441 to 732, and patient days increased from 5,740 to 9,365. The occupancy rate increased from 78.6% to 91.6%, even

over a period of time when the total number of beds increased from 20 to 28. This growth trend reflects an increased demand for rehabilitation services at JHBMC in recent years that has prompted JHBMC to commit additional resources to this service.

The Johns Hopkins Hospital's CIR unit is operating at an even higher occupancy rate than JHBMC. In FY18, the utilization statistics for the 18 beds at JHH were as follows:

JHH FY2018 – 18 Beds

Discharges: 558

Patient Days: 6,213

ADC: 17.02

Occupancy Rate: 94.57%

The occupancy rate at JHH for all months in FY18 never dipped below 91.40% and had a one-month high of 97.41%.

By converting 16 Chronic bed licenses at JHBMC to 16 CIR licenses, JHBMC will bring its CIR bed licenses into alignment with its current CIR patient utilization rate. The conversion of bed licenses will have no impact on the operations of the 28 beds at JHBMC currently treating CIR patients. No construction, renovations, or capital expenditures are necessary for this conversion to occur.

(3) Impact.

A project shall not have an unwarranted adverse impact on the cost of hospital services or the financial viability of an existing provider of acute inpatient rehabilitation services. A project also shall not have an unwarranted adverse impact on the availability of services, access to services, or the quality of services. Each applicant must provide documentation and analysis that supports:

(a) Its estimate of the impact of the proposed project on patient volume, average length of stay, and case mix, at other acute inpatient rehabilitation providers;

(b) Its estimate of any reduction in the availability or accessibility of a facility or service that will likely result from the project, including access for patients who are indigent or uninsured or who are eligible for charity care, based on the affected acute rehabilitation provider's charity care policies that meet the minimum requirements in .04A(1)(a) of this Chapter;

(c) Its estimate of any reduction in the quality of care at other providers that will likely be affected by the project; and

(d) Its estimate of any reduction in the ability of affected providers to maintain the specialized staff necessary to provide acute inpatient rehabilitation services.

Applicant Response:

(a) The proposed project will not impact patient volume, average length of stay, or case mix at other acute inpatient rehabilitation providers.

(b) The proposed project will not result in a reduction in the availability or accessibility of rehabilitation services.

(c) The proposed project will not result in a reduction in quality of care by other providers.

(d) The proposed project will not impact the ability of any providers to maintain the specialized staff necessary to provide acute inpatient rehabilitation services.

(4) Construction Costs.

(a) The proposed construction costs for the project shall be reasonable and consistent with current industry and cost experience in Maryland.

(b) For a hospital that is rate-regulated by the Health Services Cost Review Commission, 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.

Applicant Response:

(a) Standard does not apply. There is no construction for the proposed project.

(b) Standard does not apply.

(5) Safety.

The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety.

Applicant Response:

Standard does not apply. This project contains no construction or renovation.

(6) 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 CON 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 the 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 expense (including debt service expenses and plant and equipment depreciation), if the applicant's utilization forecast is achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital proposing an acute inpatient rehabilitation unit that does not generate excess revenues over total expenses, even if utilization forecasts are achieved for the services affected by the project, may demonstrate that the hospital's overall financial performance will be positive.

Applicant Response:

Standard does not apply. There are no capital expenditures associated with this project.

(7) Minimum Size Requirements.

(a) A proposed acute inpatient rehabilitation unit in a hospital shall contain a minimum of 10 beds and shall be projected to maintain an average daily census consistent with the minimal occupancy standard in this Chapter within three years.

(b) A proposed acute inpatient rehabilitation specialty hospital shall contain a minimum of 30 beds and shall be projected to maintain within three years an average daily census consistent with the minimum occupancy standard in this Chapter.

Applicant Response:

(a) The proposed acute inpatient rehabilitation unit will contain 28 beds.

The current Average Daily Census for these 28 beds in FY18 was 25.66 with an Occupancy Rate of 91.63%.

The Chapter's Minimum Occupancy Rate, for an Average Daily Census of 0-49, is 75%.

The proposed unit's Average Daily Census is consistent with the standard.

(b) Standard does not apply.

(8) Transfer and Referral Agreements.

Each applicant shall provide documentation prior to licensure that the facility will have written transfer and referral agreements with facilities, agencies, and organizations that:

(a) Are capable of managing cases that exceed its own capabilities; and

(b) Provide alternative treatment programs appropriate to the needs of the persons it serves.

Applicant Response:

The applicant's program is already licensed by CARF.

Please see Exhibit 9 (Exhibit CQ42.1**)** for Johns Hopkins Bayview Medical Center's policy for inter-hospital transfers of patients. Exhibit 9 is an exact copy of Exhibit CQ42.1 from the NIB CON Completeness Questions 1.

(9) Preference in Comparative Reviews.

In the case of a comparative review of applications in which all standards have been met by all applicants, the Commission will give preference to the applicant that offers the best balance between program effectiveness and costs to the health care system as a whole.

Applicant Response:

Standard does not apply.

COMAR 10.24.10 ACUTE CARE CHAPTER
.04A. GENERAL STANDARDS

The following general standards encompass Commission expectations for the delivery of acute care services by all hospitals in Maryland. Each hospital that seeks a Certificate of Need for a project covered by this Chapter of the State Health Plan must address and document its compliance with each of the following general standards as part of its Certificate of Need application. Each hospital that seeks a Certificate of Need exemption for a project covered by this Chapter of the State Health Plan must address and demonstrate consistency with each of the following general standards as part of its exemption request.

Standard .04A (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.

Applicant Response:

The response below is copied from the NIB CON:

A copy of JHBMC's policy regarding the provision of information about charges is attached as Exhibit 10 (NIB Exhibit 6). Exhibit 10 is an exact copy of NIB Exhibit 6 from the NIB CON Application. JHBMC provides information about estimated charges on our website: http://www.hopkinsmedicine.org/johns_hopkins_bayview/planning_your_visit/billing_insurance/estimated_charges.html

These estimates of charges for frequently occurring services and procedures are updated quarterly, and copies are available upon request from financial counseling staff. Patients with inquiries related to hospital charges prior to or on the day of service can contact Financial Counseling for a copy of the list of representative charges, or request current charges for specific service/procedure(s). A copy of the estimated charges is also mailed upon request.

Staff is trained regularly to respond appropriately to the requests for information regarding charges and is aware of the location of the information. Financial staff is

educated about the criteria to build the charge report and how to update the list of representative charges quarterly on our website.

The response below is copied from Completeness Questions Round 1:

Information Re: Charges

15. Excerpt the language from JHBMC's policy that relates to subparts (b) and (c) of this standard, and cite their location in the policy.

Applicant Response:

(b) The procedures for promptly responding to individual requests for current charges for specific services/procedures can be found on page 2, Section IV PROCEDURE, subsection B Management of Inquires Related to Hospital Charges.

"1. Inpatient Prior To/Day of Service
a. Patient can contact Admitting and Registration for a copy of the list of charges. Patients can also request current charges for specific services/procedures from the JHH or the Johns Hopkins Bayview Medical Center (JHBMC) Admitting and Registration offices.

Contact Number	*Contact Department*
410-955-6056	*JHH Admitting & Registration*
410-955-9464	*JHH Outpatient Services*
410-550-0830	*JHBMC Admitting Office*
410-550-7900	*JHBMC Outpatient Services*

b. Inquiries regarding hospital charges will be directed to the public website.

2. Post-Day of Service/Discharge
a. Patient can contact Johns Hopkins Patient Financial Services Customer Service (All Johns Hopkins Medicine facilities):

JHH/JHBMC – 443-997-3370	*Toll Free # JHH/JHBMC – 855-662-3017*

b. Inquiries regarding hospital charges will be directed to the public website.
c. A copy will be mailed upon request."

(c) The requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled can be found on page 2, Section VI COMMUNICATION AND EDUCATION:

"Each Johns Hopkins entity is responsible for proper training of staff to ensure that they respond appropriately to the request for information regarding charges for specific

services and procedures and are aware of the location of this information. This policy will be communicated to the appropriate JHHS personnel via the following channels:

1. Departmental Leadership: Admitting will distribute information concerning the website address and the appropriate information to respond to patient requests.

2. Patient Financial Services: Customer Service staff will be educated concerning the website address and the appropriate information to respond to patient requests.

3. Director of Casemix Information Management: Will assure staff is knowledgeable about the criteria to build the charge report, how to post the report to the appropriate JHHS websites quarterly and will ensure that the charge listing is distributed to the appropriate partiers at each of the Hospitals."

Standard .04A(2) – <u>Charity Care Policy</u>.

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; and**
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.

Applicant Response:

The response below is copied from the NIB CON:

JHBMC provides quality care to patients regardless of their ability to pay. The charity care policy is attached as Exhibit 11 (NIB Exhibit 7). Exhibit 11 is an exact copy of Exhibit 7 from the NIB CON.

(a)(i) Applicants are given an indication of probable eligibility at least within two business days of their inquiry, but usually the same day: "All hospital applications will be processed within two business days and a determination will be made as to probable eligibility." Page 3 of 19 of the Financial Assistance Policy, number 3a.

(a)(ii)(1-3) Minimum notice regarding the hospital's charity care policy and procedures is required by the JHBMC Financial Assistance Policy:

> "JHHS hospitals will publish the availability of Financial Assistance on a yearly basis in their local newspapers, and will post notices of availability at patient registration sites, Admissions/Business Office and Billing Office, and at the emergency department within each facility. Notice of availability will be posted on each hospital website, will be mentioned during oral communications, and will be sent to patients on patient bills. A Patient Billing and Financial Assistance Information Sheet will be provided to inpatients before discharge and will be available to all patients upon request. Page 1 of 19 of the Financial Assistance Policy, "Purpose", paragraph 3.

JHBMC complies with the policy as follows:

- JHBMC's financial assistance policy is posted on the hospital website: http://www.hopkinsmedicine.org/patient_care/pay_bill/assistance_policies.html
- Notice of the Hospital's policy on charity care and financial assistance is published in the Baltimore Sun on an annual basis and was last published Saturday, May 6, 2017. A copy of the publication is included as Exhibit 8.
- JHBMC provides each patient registered for emergency care, same day care, or inpatient care a copy of our Financial Assistance Information Sheet (Exhibit 9 (Exhibit CQ42.1)). Exhibit 9 is an exact copy of Exhibit CQ42.1 from the NIB CON Completeness Questions 1.
- Signs are also posted in English and Spanish explaining the availability of financial assistance and providing contact information.
- The financial assistance application, a copy of which is included as Exhibit 10 (NIB Exhibit 6), is given to every self-pay patient with instructions on how to apply, and contact information is available on the web link noted above. The same information is provided to all other patients upon request. This information is also available in Spanish. Exhibit 10 is an exact copy of Exhibit 6 from the NIB CON.
- Financial Counselors and Social Workers are trained to answer patient questions regarding financial assistance and linkage to other community assistance resources prior to discharge.
- Registration staff is trained to answer questions regarding financial assistance and who to contact with billing questions or other financial questions.
- Patient Financial Services staff is also trained to answer questions and provide information to patients regarding financial assistance and billing.

(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.

Applicant Response:

According to the FY16 Health Services Cost Review Commission (HSCRC) Community Benefit Financial Report, JHBMC's charity care as a percent of total operating expenses was 2.13%. JHBMC ranks 20th out of 52 Maryland non-profit hospitals, placing JHBMC in the second quartile.

The response below is copied from Completeness Questions Round 1:

Charity Care Policy

16. Please provide copies of the notices posted in English and Spanish explaining the availability of financial assistance and providing contact information (p.49 of application).

Applicant Response:

Please see Exhibit 12 (Exhibit CQ16). Exhibit 12 is an exact copy of Exhibit CQ16 from the NIB CON Completeness Questions 1.

Standard .04A (3) – <u>Quality of Care.</u>

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.

Applicant Response:

JHBMC complies with all mandated federal, state, and local health and safety regulations and applicable state certification requirements. JHBMC is fully accredited by Joint Commission and in compliance with Medicare and Medicaid programs.

A copy of the most recent Joint Commission accreditation and DHMH license is attached as Exhibit 13 (NIB Exhibit 11). Exhibit 13 is an exact copy of Exhibit 11 from the NIB CON.

(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.

Applicant Response:

Johns Hopkins Bayview Medical Center (JHBMC) has identified, collects, monitors and acts upon key quality performance indicators on a monthly basis. These measures include outcome measures; such as mortality, readmission, complication rate, length of stay and cost; serious safety events identified through our participation in the CMS Partnership for Patients Program; through review of our Maryland Hospital Acquired Conditions, the AHRQ Patient Safety Indicators as well as through use of our own internal incident reporting systems; core measures data; HCAHPS results; and Employee Safety Reports.

In looking at the Hospital Quality Measures that are available to us, we noted that our performance was better than average for 19 of the measures, average for 23 of the measures, and below average for 22 of the measures. For those measures which are below average, some significant improvements have already been made.

Please Exhibit 14 (NIB Exhibit 12) for additional information. Exhibit 14 is an exact copy of Exhibit 12 from the NIB CON.

COMAR 10.24.10 ACUTE CARE CHAPTER
.04B. PROJECT REVIEW STANDARDS

Standard .04B(1) – Geographic Accessibility.

A new acute care general hospital or an acute care general hospital being replaced on a new site shall be located to optimize accessibility in terms of travel time for its likely service area population. Optimal travel time for general medical/surgical, intensive/critical care and pediatric services shall be within 30 minutes under normal driving conditions for 90 percent of the population in its likely service area.

Applicant Response:

Standard does not apply.

Standard .04B(2) – <u>Identification of Bed Need and Addition of Beds.</u>

Only medical/surgical/gynecological/addictions ("MSGA") beds and pediatric beds identified as needed and/or currently licensed shall be developed at acute care general hospitals.

(a) Minimum and maximum need for MSGA and pediatric beds are determined using the need projection methodologies in Regulation .05 of this Chapter.

(b) Projected need for trauma unit, intensive care unit, critical care unit, progressive care unit, and care for AIDS patients is included in the MSGA need projection.

(c) Additional MSGA or pediatric beds may be developed or put into operation only if:

(i) The proposed additional beds will not cause the total bed capacity of the hospital to exceed the most recent annual calculation of licensed bed capacity for the hospital made pursuant to Health-General §19-307.2; or

(ii) The proposed additional beds do not exceed the minimum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter.

(iii) The proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant hospital for bed capacity that exceeds the minimum jurisdictional bed need projection; or

(iv) The number of proposed additional MSGA or pediatric beds may be derived through application of the projection methodology, assumptions, and targets contained in Regulation .05 of this Chapter, as applied to the service area of the hospital.

Applicant Response:

Standard does not apply.

Standard .04B(3) – <u>Minimum Average Daily Census for Establishment of a Pediatric Unit.</u>

An acute care general hospital may establish a new pediatric service only if the projected average daily census of pediatric patients to be served by the hospital is at least five patients, unless:

(a) The hospital is located more than 30 minutes travel time under normal driving conditions from a hospital with a pediatric unit; or

(b) The hospital is the sole provider of acute care general hospital services in its jurisdiction.

Applicant Response:

Standard does not apply.

Standard .04B(4) – <u>Adverse Impact.</u>

A capital project undertaken by a hospital shall not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. The Commission will grant a Certificate of Need only if the hospital documents the following:

(a) If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted average Charge Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group. In addition, if the project involves replacement of physical plant assets, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise demonstrate why the physical plant assets require replacement in order to achieve the primary objectives of the project; and

(b) If the project reduces the potential availability or accessibility of a facility or service by eliminating, downsizing, or otherwise modifying a facility or service, the applicant shall document that each proposed change will not inappropriately diminish, for the population in the primary service area, the availability or accessibility to care, including access for the indigent and/or uninsured.

Applicant Response:

(a) Standard does not apply. This project has no capital expenditures.

(b) Standard does not apply. This project has no capital expenditures.

Standard .04B(5) – <u>Cost-Effectiveness.</u>

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.

Applicant Response:

(a) Please see response to 10.24.01.08G(3)(c).Availability of More Cost-Effective Alternatives below.

(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.

Applicant Response:

(b) Please see response to 10.24.01.08G(3)(c).Availability of More Cost-Effective Alternatives below.

(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 site 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 site or sites located within a Priority Funding Area.

Applicant Response:

Standard does not apply.

Standard .04B (6) – <u>Burden of Proof Regarding Need.</u>

> **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.**

Applicant Response:

Please see response to 10.24.09.04B(2) *Need* in the Acute Inpatient Rehabilitation Services chapter above.

Standard .04B(7) – <u>Construction Cost of Hospital Space.</u>

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.

Applicant Response:

Standard does not apply. The proposed project does not include construction of hospital space.

Standard .04B(8) – <u>Construction Cost of Non-Hospital Space.</u>

The proposed construction costs of non-hospital space shall be reasonable and in line with current industry cost experience. The projected cost per square foot of non-hospital space shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide for the appropriate structure. 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 non-hospital space 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. In general, rate increases authorized for hospitals should not recognize the costs associated with construction of non-hospital space.

Applicant Response:

Standard does not apply. The proposed project does not include construction of non-hospital space.

Standard .04B(9) – <u>Inpatient Nursing Unit Space.</u>

Space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type of unit being developed shall not be recognized in a rate adjustment. If the Inpatient Unit Program Space per bed of a new or modified inpatient nursing unit exceeds 500 square feet per bed, 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 for the space that exceeds the per bed square footage limitation in this standard, or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

Applicant Response:

Standard does not apply. The proposed project does not include construction or renovation.

Standard .04B(10) – Rate Reduction Agreement.

A high-charge hospital will not be granted a Certificate of Need to establish a new acute care service, or to construct, renovate, upgrade, expand, or modernize acute care facilities, including support and ancillary facilities, unless it has first agreed to enter into a rate reduction agreement with the Health Services Cost Review Commission, or the Health Services Cost Review Commission has determined that a rate reduction agreement is not necessary.

Applicant Response:

The response below is copied from the NIB CON:

JHBMC is not subject to a rate reduction agreement with the HSCRC.

On July 14, 2014, JHBMC entered an Agreement with the Maryland Health Services Cost Review Commission regarding Global Budget Revenue (GBR) covering the period from July 1, 2013 through June 30, 2014. The agreement renews every year unless cancelled by the HSCRC or JHBMC. A copy of the 2014 HSCRC Agreement can be accessed on the HSCRC website as follows:

Original Agreement:
http://www.hscrc.state.md.us/Documents/global-budgets/Global-Budget-Revenue-Agreement-Hopkins-07-17-14.pdf

Addendum 1:
http://www.hscrc.state.md.us/Documents/global-budgets/HOPKINS-Addendum-to-Section-5-of-Global-Budget-Agreements-6-9-2016.pdf

Addendum 2:
http://www.hscrc.state.md.us/Documents/global-budgets/Hopkins-Second-Addendum-to-GBRAgreeement-102516.pdf

Under the GBR, current proposals to achieve revenue growth in relation to volume growth is considered a market share adjustment and is recognized at 50% variability in the year after the growth in volume. In the financial projections included in this CON application, JHBMC assumes that any changes in patient volumes as a result of market shift will be adjusted for in the GBR at 50% variability in the year the volume changes occur.

The expected growth in revenue at 50% revenue variability while volumes grow at 100% variability will result in a reduction in JHBMC's average charges over the projection period, thereby improving its price competitiveness and savings to Medicare.

Standard .04B(11) – <u>Efficiency.</u>

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.

Applicant Response:

(a) The applicant proposes to convert 16 licensed Chronic beds to be 16 licensed CIR beds. These beds are already in use treating CIR patients, therefore the conversion of bed licenses will not have an effect on operations.

(b) The applicant is not projecting an increase in volume of CIR patients over the number currently being served. In fact, given the very high occupancy rate, an increase is not feasible within the existing 28 beds.

(c) The applicant proposes to convert 16 licensed Chronic beds to 16 licensed CIR beds. These beds are already in use treating CIR patients, therefore the conversion of bed licenses will not have an effect on operations.

Standard 04B(12) – <u>Patient Safety.</u>

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.

Applicant Response:

Standard does not apply. The proposed project does not include construction or renovation.

Standard .04B(13) – <u>Financial Feasibility.</u>

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.

Applicant Response:

See response to 10.24.09.04B(6) Financial Feasibility in the Acute Inpatient Rehabilitation Services chapter above.

Standard .04B(14) – <u>Emergency Department Treatment Capacity and Space.</u>

(a) An applicant proposing a new or expanded emergency department shall classify service as low range or high range based on the parameters in the most recent edition of *Department Design: A Practical Guide to Planning for the Future* from the American College of Emergency Physicians. The number of emergency department treatment spaces and the departmental space proposed by the applicant shall be consistent with the range set forth in the most recent edition of the American College of Emergency Physicians *Emergency Department Design: A Practical Guide to Planning for the Future*, given the classification of the emergency department as low or high range and the projected emergency department visit volume.

(b) In developing projections of emergency department visit volume, the applicant shall consider, at a minimum:

- **(i) The existing and projected primary service areas of the hospital, historic trends in emergency department utilization at the hospital, and the number of hospital emergency department service providers in the applicant hospital's primary service areas;**
- **(ii) The number of uninsured, underinsured, indigent, and otherwise underserved patients in the applicant's primary service area and the impact of these patient groups on emergency department use;**
- **(iii) Any demographic or health service utilization data and/or analyses that support the need for the proposed project;**
- **(iv) The impact of efforts the applicant has made or will make to divert non-emergency cases from its emergency department to more appropriate primary care or urgent care settings; and**
- **(v) Any other relevant information on the unmet need for emergency department or urgent care services in the service area.**

Applicant Response:

Standard does not apply.

Standard .04B(15) – Emergency Department Expansion.

A hospital proposing expansion of emergency department treatment capacity shall demonstrate that it has made appropriate efforts, consistent with federal and state law, to maximize effective use of existing capacity for emergent medical needs and has appropriately integrated emergency department planning with planning for bed capacity, and diagnostic and treatment service capacity. At a minimum:

- **(a) The applicant hospital must demonstrate that, in cooperation with its medical staff, it has attempted to reduce use of its emergency department for non-emergency medical care. This demonstration shall, at a minimum, address the feasibility of reducing or redirecting patients with non-emergent illnesses, injuries, and conditions, to lower cost alternative facilities or programs;**
- **(b) The applicant hospital must demonstrate that it has effectively managed its existing emergency department treatment capacity to maximize use; and**
- **(c) The applicant hospital must demonstrate that it has considered the need for bed and other facility and system capacity that will be affected by greater volumes of emergency department patients.**

Applicant Response:

Standard does not apply.

Standard .04B(16) – <u>Shell Space.</u>

(a) Unfinished hospital shell space for which there is no immediate need or use shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective.

(b) If the proposed shell space is not supporting finished building space being constructed above the shell space, the applicant shall provide an analysis demonstrating that constructing the space in the proposed time frame has a positive net present value that:

- **(i) Considers the most likely use identified by the hospital for the unfinished space;**
- **(ii) Considers the time frame projected for finishing the space; and**
- **(iii) Demonstrates that the hospital is likely to need the space for the most likely identified use in the projected time frame.**

(c) Shell space being constructed on lower floors of a building addition that supports finished building space on upper floors does not require a net present value analysis. Applicants shall provide information on the cost, the most likely uses, and the likely time frame for using such shell space.

(d) The cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the construction cost of the shell space will be excluded from consideration in any rate adjustment by the Health Services Cost Review Commission.

Applicant Response:

Standard does not apply.

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.

INSTRUCTIONS: Please identify the need that will be addressed by the proposed project, quantifying the need, to the extent possible, for each facility and service capacity proposed for development, relocation, or renovation in the project. The analysis of need for the project should be population-based, applying utilization rates based on historic trends and expected future changes to those trends. This need analysis should be aimed at demonstrating needs of the population served or to be served by the hospital. The existing and/or intended service area population of the applicant should be clearly defined.

Fully address the way in which the proposed project is consistent with each applicable need standard or need projection methodology in the State Health Plan.

If the project involves modernization of an existing facility through renovation and/or expansion, provide a detailed explanation of why such modernization is needed by the service area population of the hospital. Identify and discuss relevant building or life safety code issues, age of physical plant issues, or standard of care issues that support the need for the proposed modernization.

Please assure that all sources of information used in the need analysis are identified. Fully explain all assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), the relevant population considered in the analysis, and the service capacity of buildings and equipment included in the project, with information that supports the validity of these assumptions.

Explain how the applicant considered the unmet needs of the population to be served in arriving at a determination that the proposed project is needed. Detail the applicant's consideration of the provision of services in non-hospital settings and/or through population-based health activities in determining the need for the project.

Complete the Statistical Projections (Tables F and I, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package.

Applicant Response:

Need To Be Addressed By The Proposed Project

Please see response to COMAR 10.24.09.04(2)Need above.

Table F & Table I

Please See Exhibit 15 (Exhibit CQ21) for Table F. It is an exact copy of Exhibit CQ21 from the NIB CON Completeness Questions.

Table I does not apply.

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.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the proposed project. The applicant should identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including:

a) the alternative of the services being provided through existing facilities;

b) or through population-health initiatives that would avoid or lessen hospital admissions.

Describe the hospital's population health initiatives and explain how the projections and proposed capacities take these initiatives into account.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development costs to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective method to reach stated goal(s) and objective(s) or the most effective solution to the identified problem(s) for the level of costs required to implement the project, when compared to the effectiveness and costs of alternatives, including the alternative of providing the service through existing facilities, including outpatient facilities or population-based planning activities or resources that may lessen hospital admissions, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Applicant Response:

Primary Objective

The primary objective of this project is to bring JHBMC's CIR bed licenses into alignment with its current CIR bed utilization rate. To do this, JHBMC proposes a project that causes no operational disruption and requires no capital expenditure, construction or renovation. The project is simply to convert 16 beds, currently licensed as Chronic beds, to 16 licensed CIR beds. The conversion of 16 Chronic bed licenses to CIR bed licenses will result in a total of 28 CIR bed licenses at JHBMC, all of which are already CARF-accredited.

In FY18, the utilization statistics for these 28 beds at JHBMC were as follows:

JHBMC – 28 Beds

Admissions: 728
Discharges: 732
Patient Days: 9,365
ALOS: 12.79
ADC: 25.66
Occupancy Rate: 91.63%

The Occupancy Rate at JHBMC for all months in FY18 never dipped below 84.68% and had a one-month high of 96.89%. Such high monthly occupancy rates present significant challenges for JHBMC to meet the demand for its services. Given that JHBMC's rehabilitation services have been and continue to be in such high demand at JHBMC, a license conversion is the optimal approach to aligning JHBMC's patient utilization and bed licensure with zero capital expenditures and no operational changes.

There are two alternatives to this project as proposed. One alternative would be for JHBMC to stop providing CIR services to patients in beds that are licensed as Chronic beds, and not to develop any replacement CIR capacity. This would result in the following:

- In FY18, JHBMC had 732 CIR patients discharged, operating 28 beds at an occupancy of 91.63% with ALOS of 12.79 days. Were JHBMC to only operate 12 beds, with the same occupancy rate and ALOS, it would have only discharged 314 CIR patients. This means that approximately 418 patients served by JHBMC in FY18 would have had to be turned away and required to obtain care from another provider.
- The CIR unit at JHH currently operated at 94.6% occupancy in FY18, so it is not an option for these patients.
- JHBMC would experience a decrease in revenue from CIR services
- The JHUSOM PM&R training program would lose crucial clinical training capacity, causing trainees to seek placements elsewhere in order to complete training requirements and jeopardizing the viability of the program
- JHBMC would maintain its current Chronic capacity of 76 licensed beds

A second alternative would be for JHBMC to stop providing CIR services in 16 chronic beds as it currently does, and to develop alternative equivalent CIR capacity either at JHBMC or at JHH, resulting in the following:

- JHM would have sufficient CIR capacity to serve existing demand, although there would likely be a significant gap of time where capacity would be reduced while the new capacity is developed
- JHM would retain CIR revenues at current level, albeit after a period of time of reduced revenue while the capacity is developed
- Training opportunities would be retained, again with a significant time delay making it difficult to attract new trainees

- Development of new bed capacity at either campus would require significant capital expenditure
- JHBMC would maintain its current Chronic capacity of 76 licensed beds

The proposed project is clearly superior to either of these two alternatives. Approval and implementation of the proposed project would result in the following:

- Existing demand will continue to be met, and patients will be served
- Revenues at JHBMC will be unchanged
- No capital expenditures will be required
- The Chronic bed capacity at JHBMC will be reduced from 76 to 60 licensed beds with no significant consequences as patients are not currently receiving Chronic services in these beds
- The CIR bed capacity at JHBMC will be increased from 12 to 28 licensed beds, with no significant consequences because these beds are already occupied by patients receiving CIR services at a high capacity

Population Health Initiatives

JHBMC's inpatient rehabilitation service effectively serves as a population health tool, in that it creates opportunities to shift appropriate patients from a higher-cost acute inpatient environment to a lower-cost rehabilitation environment, reducing overall health care costs and providing care in the most appropriate setting.

Additionally, JHBMC has an extensive array of programs and initiatives designed to meet the needs of community residents and address acute and chronic health conditions in the population. The intention of these programs is to improve the health of the community through programming and partnerships that augment resources, address social determinants, improve health literacy, and increase access to needed health care and other services. Many of these programs are unique in Maryland, and some are unique in the country. An overview of some of the key programs is included below. A more comprehensive and detailed inventory of JHBMC's Community Health Improvement Efforts is provided at Exhibit 16 (NIB Exhibit 3). Exhibit 16 is an exact copy of Exhibit 3 from the NIB CON.

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.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

- Complete applicable Revenues & Expenses (Tables G, H, J and K as applicable), and the Work Force information (Table L) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable.

- Describe and document relevant community support for the proposed project.

- Identify the performance requirements applicable to the proposed project and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, contracting and obtaining and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame.

- Audited financial statements for the past two years should be provided by all applicant entities and parent companies.

Applicant Response:

Tables

Please see Exhibit 17 (Exhibit CQ39.1) for Table G and Table H. These are an exact copy of Exhibit CQ39.1 from the NIB CON Completeness Questions 1.

Please see Exhibit 18 (Exhibit CQ 39.2) for list of Assumptions for Table G and Table H. This is an exact copy of Exhibit CQ39.2 from the NIB CON Completeness Questions 1.

Please see Exhibit 19 (NIB Exhibit 1L) for Table L. This is an exact copy of Exhibit 1L from the NIB CON application.

Project Viability

The proposed project is viable. There are no capital expenditures, construction or renovation associated with the proposed project.

Community Support

Please see Exhibit 20 for letter of support from JHBMC's Patient and Family Advisory Council.

Performance Requirements

There are no applicable performance requirements. The proposed project has no capital expenditures, construction or renovation associated with it. If the CON is awarded, the project will be fully implemented as soon as the licensing status of the beds is changed by the Maryland Department of Health's Office of Health Care Quality.

Audited Financial Statements

Please see Exhibit 21 (Exhibit CQ56). This is an exact copy of Exhibit CQ56 from the NIB CON Completeness Questions 1.

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.

INSTRUCTIONS: List all of the Certificates of Need that have been issued to the applicant or related entities, affiliates, or subsidiaries since 2000, including their terms and conditions, and any changes to approved CONs that were approved. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

Applicant Response:

The response below is copied from the NIB CON (amended last paragraph):

The Johns Hopkins Bayview Medical Center ("JHBMC") submitted six CON applications since 1983.

JHBMC was a co-applicant with The Johns Hopkins Hospital for a Certificate of Need issued by the Maryland Health Resources Planning Commission. Docket No. 96-24-1983, approved on April 8, 1997, was for the relocation of eighteen acute comprehensive inpatient rehabilitation beds from the Good Samaritan Hospital to The Johns Hopkins Health System Corporation; fourteen to be relocated at The Johns Hopkins Hospital, and four (4) to be located at the JHBMC. No conditions were applied to the approval of the project. The relocation of the beds to JHBMC was completed on June 17, 1997. On February 16, 1998, the relocation of the fourteen (14) beds was completed at The Johns Hopkins Hospital.

On November 22, 2005, JHBMC was awarded a CON, Docket Number 05-24-2165, to expand its mixed-use general-purpose operating room capacity from 10 to 14 rooms, increase the capacity of its pre- and post-anesthesia care unit, and to construct new air handling infrastructure to support the expanded surgical facilities. A request for modification was approved May 10, 2007. Due to increased capital costs and changes to the project, the original CON was replaced by a new one, submitted to the MHCC December 15, 2008 and approved February 19, 2009. Final first use approval was granted November 20, 2009.

On February 16, 2012, JHBMC was awarded a CON, Docket Number 11-24-2321, to construct an annex building next to the Emergency Department. The first floor of this three-story building would house an expanded adult ED and a new Psychiatric Evaluation Services Unit. The second floor would house a 13-space all private room adult observation and holding unit. The third floor would house a new combined pediatric inpatient, emergency, and observation/holding unit. There were no conditions placed on the award of this CON. The project was deemed complete and first use approval was granted May 18, 2015.

Also on February 16, 2012, JHBMC was awarded a CON, Docket Number 11-24-2322, for capital expenditures associated with the creation of a comprehensive program including the construction of two linear accelerator vaults and equipping one. No conditions were placed on the award of this CON. First use occurred February 23, 2015.

On March 12, 2012, “Genesis Bayview Joint Venture, LLC” was awarded a CON, Docket Number 11-24-2323, to establish a new 132-bed comprehensive care facility on the JHBMC campus. The project was a joint venture of JHBMC and Genesis Bayview JV Holdings, a subsidiary of Genesis HealthCare. On January 2, 2014, Genesis Bayview Joint Venture, LLC notified staff at the MHCC that it would not proceed with this project and would relinquish the CON. The project was in good standing with respect to the CON at the time it was halted.

On February 5, 2018, JHBMC submitted a CON application, Matter Number 18-24-2414, for the capital expenditures associated with a campus redevelopment project that includes construction of a New Inpatient Building (NIB) and renovation of two existing buildings on its campus.

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.

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project:

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project[2];

b) On access to health care services for the service area population that will be served by the project. (state and support the assumptions used in this analysis of the impact on access);

c) On costs to the health care delivery system.

If the applicant is an existing hospital, provide a summary description of the impact of the proposed project on costs and charges of the applicant hospital, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

Applicant Response:

a) The proposed project will not impact the volume of service provided by any other existing health care provider.

b) The proposed project will not impact access to health care services for the service area population.

c) The proposed project will not impact costs to the health care delivery system.

[2] **Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, the relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions.**

Please see Exhibit 22 for affirmations.