ANNE ARUNDEL MEDICAL CENTER

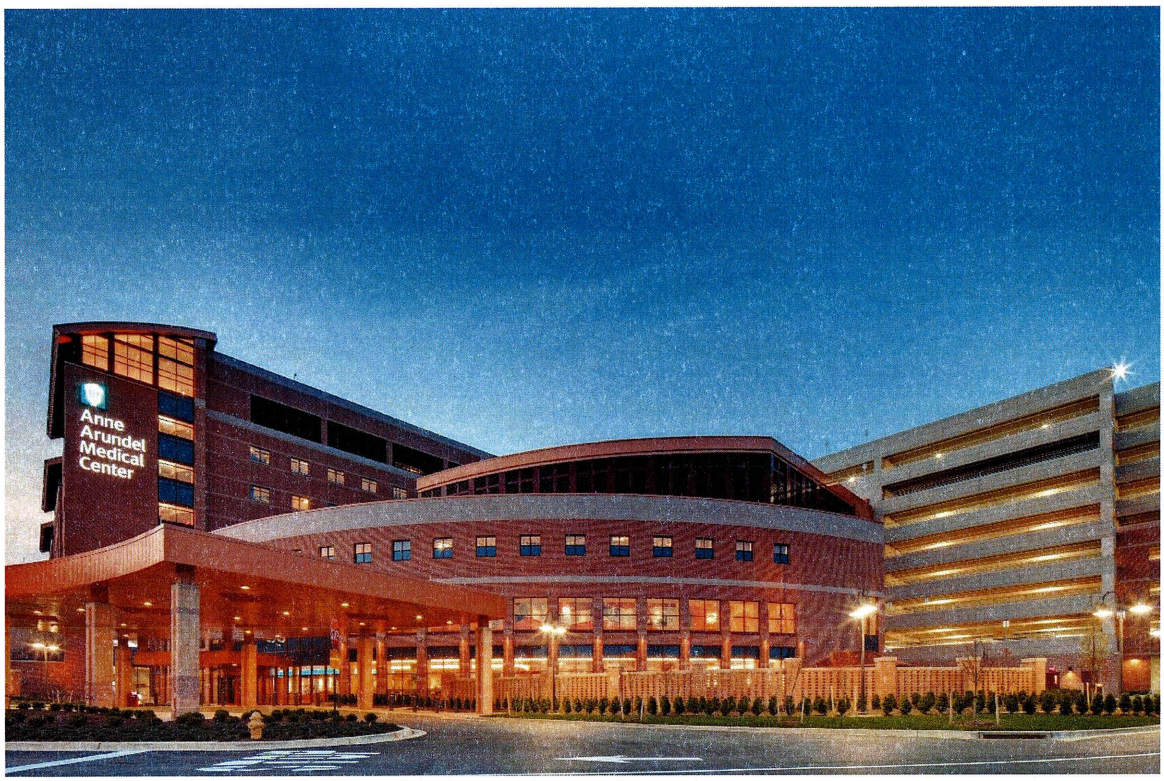
CERTIFICATE OF NEED

Johns Hopkins Cardiac Surgery at Anne Arundel Medical Center

Matter No. 15-02-2360

RESPONSE TO 2ND SET OF COMPLETENESS QUESTIONS

MAY 6, 2015



Anne Arundel Medical Center

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RESPONSE TO SECOND SET OF COMPLETENESS QUESTIONS
MAY 6, 2015

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QUESTION 1:

Question 1 in the March 10 letter inquired about the zips codes that the application referenced as being in "HSCRC's GBR-defined service area." Your response listed the zip codes as requested. However, HSCRC does not seem to be aware of *assigning* a "GBR-defined service area." Please define what you mean by "HSCRC's GBR-defined service area."

APPLICANT RESPONSE

Anne Arundel Medical Center, Inc. ("**AAMC**") and the Health Services Cost Review Commission ("**HSCRC**") have entered into a global budget revenue agreement for AAMC (the "**AAMC GBR Agreement**").[1]

The AAMC GBR Agreement states that the HSCRC will monitor AAMC's market share and overall case volume levels "derived from its Primary Service Area (PSA) or Secondary Service Area (SSA) as defined in Appendix E" of the AAMC GBR Agreement.[2]

When referencing its "HSCRC's GBR-defined service area," AAMC means this service area, the service area defined in Appendix E of the AAMC GBR Agreement.

[1] The AAMC GBR Agreement is enclosed as Exhibit 23.
[2] AAMC GBR Agreement at p. 9.

QUESTION 2:

With reference to the charity care standard, documentation of the statement "AAMC's patient population (is) relatively more affluent when compared to median incomes for Maryland" should be provided.

APPLICANT RESPONSE

The United States Census Bureau uses its American Community Survey to estimate incomes for residents of states and states' political subdivisions. According to the American Community Survey's estimates, median household income in Anne Arundel County in 2013 was $86,230, vs. $72,483 in Maryland as a whole. The American Community Survey also showed the rate of poverty is much lower in Anne Arundel County (7.1% of individuals, 4.7% of families) than in Maryland as whole (10.1% of individuals, 7.1% of families).[3]

[3] A U.S. Census Bureau chart reflecting the data referenced in this response is enclosed as Exhibit 24.

QUESTION 3:

Your response to question 7 states that: "AAMC documented the number of cardiac surgery cases that affiliated cardiologists generated in FY2014" and references Chart 8(a) as well as letters from potentially-referring cardiologists who "estimate that I refer approximately _____ patients for cardiac surgery each year."

a) Are these letters with their approximate estimates the documentation referred to in this response?

b) If feasible, it would be much stronger documentation if the referral numbers were confirmed by these physicians' practices. Staff also notes, however, that AAMC has provided other forms of need projections, and will not insist on a further response to part b) of this question; response is left to the applicant's discretion.

APPLICANT RESPONSE

(a) Documentation

The documentation referred to in AAMC's response to Question 7 of the first round of completeness question denotes the referral data AAMC collected from the six local cardiology practices listed in Chart 8(a). Each practice was asked to estimate how many patients it referred for cardiac surgery in FY 2014. These six cardiology practices represent 26 individual cardiologists, all of whom regularly admit patients to AAMC and refer their patients for cardiac surgery to outside hospitals.

In that regard, for five out of the six practices referenced in Chart 8(a), AAMC received a letter of support (see Exhibit 17a) containing that practice's estimate. For the sixth practice, Cardiology Associates, three senior members of that practice participated as members of the Clinical Development Team advising AAMC on its CON application for cardiac surgery. During these meetings, the participating members of Cardiology Associates provided a verbal estimate of percent of potential referrals for cardiac surgical cases originating from their practices and stated that - with the assumption of a high quality cardiac surgical program at AAMC, 75%-80% of their patients would be referred to AAMC for cardiac surgery. This is consistent with the estimates reflected in Chart 8(a). It is our understanding from conversations with members of Cardiology Associates' governing body that MedStar Health – the parent health system of Cardiology Associates – has asked that Cardiology Associates not submit a formal letter of support for AAMC's certificate of need application for cardiac surgery. That said, Cardiology Associates physicians have longstanding relationships with AAMC and are a key part of the Heart Institute at AAMC (including AAMC's Cardiac Cath Lab, Heart Station, and Heart and Vascular Unit). Cardiology Associates are part of the fabric of AAMC, and their patients receive the vast majority of their cardiac care at AAMC and would clearly benefit from a cardiac surgery program at AAMC. Senior members of Cardiology Associates have on several occasions

expressed their continued support for the cardiology program at AAMC and have expressed support for a high quality cardiac surgical program at AAMC.

(b) Quality of Documentation

The local practice estimates referenced in the letters of support contained in Exhibit 17(a) should be taken at face value for three reasons.

First, AAMC conducted discussions with the referring cardiologists in each of the six cardiology practices, and/or received written communications from them. Each of the responding cardiologists were asked to estimate how many total patients they referred for cardiac surgery based on his/her most recent practice year's activity level.

Second, AAMC used cardiologists' estimates of their existing caseloads conservatively, minimizing the risk of any overestimation by the cardiologists:

- In cases where the cardiologist indicated that s/he would refer "all" cases to AAMC's new program, AAMC assumed (conservatively) that 90% of those cases would be treated at AAMC.

- In cases where the cardiologist indicated that s/he would refer "the majority" of cases to AAMC's new program, AAMC assumed that 75% of those cases would be treated at AAMC.

- In cases where the cardiologist indicated that s/he would refer "a significant amount" of cases to AAMC's new program, AAMC assumed that 50% of those cases would be treated at AAMC.

Unlike Baltimore-Washington Medical Center – which circulated a survey to cardiologists instructing them to "enter…the number of patients you will refer to UM BWMC" – AAMC is reluctant to insist that its affiliated cardiologists commit to a precise number of cardiac surgery referrals to AAMC. Such projections are always estimates since patients have freedom of choice as to where to receive care and services such as cardiac surgery.[4] Moreover, the federal appellate court with jurisdiction over Maryland has recently said that the Social Security Act's self-referral prohibition – commonly known as "Stark" – may be implicated when a hospital's financial relationship with physicians depends upon or "takes into account additional revenue the hospital anticipates will result from the physician's referrals."[5] AAMC wishes to respect patient choice. AAMC cannot order affiliated cardiologists to use AAMC's cardiac surgery program. No hospital or hospital system could do so, and that includes BWMC. All that can be provided are estimates, and AAMC has estimated conservatively.

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[4] *See, e.g.,* 42 U.S.C. §1395a(a) (defining the right of Medicare beneficiaries to choose from whom to obtain health services).

[5] *U.S. ex rel Drakeford v. Toumey Healthcare System,* 675 F. 3d 394, 409 (4th Cir. 2012).

Third, the estimates reflected in AAMC's letters of support fit other data. As this Question 3 notes, AAMC has offered multiple forms of substantiation for AAMC's volume projections, including data regarding cases generated by AAMC affiliated cardiologists and Johns Hopkins Medicine ("**JHM**") surgeons, data regarding cases generated at AAMC (*e.g.* through AAMC's PCI laboratory), and data regarding population-level use rates and need for Anne Arundel County and AAMC's projected service area as a whole. As AAMC has shown, the total projection of AAMC service area cases for FY2018-2019 is remarkably consistent across these various projection methodologies.

EXHIBIT 22

CITY OF BALTIMORE
STEPHANIE RAWLINGS-BLAKE, Mayor

HEALTH DEPARTMENT
Leana S. Wen, M.D., M.Sc.
Commissioner of Health
1001 E. Fayette Street
Baltimore, Maryland 21202

April 24, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

RE: Anne Arundel Medical Center's Certificate of Need Application for Cardiac Surgery Services

Dear Mr. McDonald:

The Baltimore City Health Department is pleased to support the Anne Arundel Medical Center's (AAMC) Certificate of Need application to establish a cardiac surgery program. We are aware of AAMC's longstanding commitment to establishing a cardiac surgery program to complement its quality heart and vascular services in order to meet the needs of the community and assure timely access.

Anne Arundel County is the largest county in Maryland without cardiac surgery. In 2013, approximately 500 residents left Anne Arundel County for heart surgery. In addition, an estimated 200 patients were transferred from AAMC to other hospitals for heart surgery. This is stressful for the patient and for family members who must travel back and forth to a hospital outside the area to be with their loved one.

AAMC has a strong track record of advancing high quality clinical programs. In addition to its heart care, AAMC is recognized for joint replacement and cancer care. A leader in women's services, AAMC ranks second in Maryland for the number of births annually and has a Level III neonatal intensive care unit. Patients, families and organizations consistently give AAMC high marks for quality, patient satisfaction and innovation. AAMC's patient-and family-centered care model, which aims at engaging patients and families as partners in healthcare delivery, serves as a national model of excellence.

The hospital already has a highly regarded cardiac program and it seems only logical to allow AAMC to include a remaining piece of this program—cardiac surgery. Given the outstanding reputation of AAMC and its isolation from existing cardiac surgery programs, we unreservedly recommend that the Maryland Health Care Commission approve AAMC's application to provide this critical service.

Thank you for your consideration in this very important matter.

Sincerely,

Olivia Farrow, Esq., R.S.
Deputy Commissioner

Printed on recycled paper with environmentally friendly soy based ink.

EXHIBIT 23

AGREEMENT

BETWEEN

THE HEALTH SERVICES COST REVIEW COMMISSION

AND

ANNE ARUNDEL MEDICAL CENTER, INC.

REGARDING

GLOBAL BUDGET REVENUE AND NON-GLOBAL BUDGET REVENUE

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AGREEMENT
BETWEEN
THE HEALTH SERVICES COST REVIEW COMMISSION
AND
Anne Arundel Medical Center, Inc.
REGARDING GLOBAL BUDGET REVENUE AND NON-GLOBAL BUDGET REVENUE

This Agreement, made this 6th day of March, 2014, between Anne Arundel Medical Center, Inc. (the "Hospital") and the MARYLAND HEALTH SERVICES COST REVIEW COMMISSION (the "Commission" or "HSCRC"), is subject to the following provisions:

I. Overview

The Global Budget Revenue ("GBR") model is a revenue constraint and quality improvement system designed by the Maryland Health Services Cost Review Commission ("HSCRC") to provide hospitals with strong financial incentives to manage their resources efficiently and effectively in order to slow the rate of increase in health care costs and improve health care delivery processes and outcomes. The GBR model is consistent with the Hospital's mission to provide the highest value of care possible to its patients and the communities it serves.

This Agreement is intended to promote the achievement of the goals of the Maryland All-Payer Model Agreement between the State of Maryland and the Center for Medicare & Medicaid Innovation (CMMI). The Hospital and HSCRC agree to modify this Agreement, if necessary, to ensure that it is consistent with the main provisions, objectives and requirements of the application that was filed with CMMI in October 2013, and meets the requirements of the final contract between CMMI and the State of Maryland.

The GBR model assures hospitals that adopt it that they will receive an agreed-on amount of revenue each year—i.e., the Hospital's "Approved Regulated Revenue" (Approved Regulated Revenue) under the GBR system-- regardless of the number of Maryland residents they treat and the amount of services they deliver provided that they meet their obligations to serve the health care needs of their communities in an efficient, high quality manner on an ongoing basis. The GBR model removes the financial incentives that have encouraged hospitals to increase their volume of services and discouraged them from reducing their levels of "Potentially Avoidable Utilization" (PAU) and marginal services. It provides hospitals with much-needed flexibility to use their agreed-on global budgets to effectively address the "Three Part Aim" objectives of better care for individuals, higher levels of overall population health, and improved health care affordability.

In accepting this Agreement, the Hospital agrees to operate within the GBR's financial constraints and to comply with the various patient-centered and population-focused performance standards that have been or will be established by the HSCRC, including all of the existing components of the Maryland

Hospital Acquired Conditions (MHAC) program, the Quality Based Reimbursement (QBR) program, the readmissions reduction program, and a number of other existing and future quality improvement programs. The Hospital agrees to cooperate with HSCRC in the collection and reporting of data needed to assess and monitor the performance of the GBR model and in the refinement of the GBR model and the related performance standards in the future. The HSCRC will delineate the performance standards and program refinements in policies that it will issue on a timely basis and the Hospital agrees that it will comply with these policies.

The HSCRC will carefully monitor the Hospital's activities under this Agreement, including any service discontinuations, shifts of services from the Hospital to other related or non-related hospitals or non-hospital providers, changes in the Hospital's market share and other relevant factors that are pertinent to the effective operation of the GBR model in accordance with the Three Part Aim and the final contract that is established by CMMI and the State of Maryland. The HSCRC will reasonably adjust the Hospital's Approved Regulated Revenue as it deems necessary to ensure that the Hospital receives the revenue it needs to meet its obligations under this Agreement.

The Hospital agrees to comply with the policies of the HSCRC with respect to any services it provides that are regulated by the HSCRC that are not covered under the GBR model. The services that are not covered by the GBR model are specified in Appendix B.

II. Term of Agreement

This Agreement will become effective on July 1, 2013 and will continue through June 30, 2014. On July 1, 2014, and each year thereafter, the Agreement will renew for a one year period unless it is canceled by the HSCRC or by the Hospital in accordance with Section XII.

III. Revenue Governed by Agreement

This Agreement will apply to all of the inpatient and outpatient revenues of the Hospital that are regulated by the HSCRC including those associated with services that are covered by the GBR model (i.e., the "GBR Revenue") and those that are not covered by the GBR model (i.e., the "Non-GBR Revenue). The services and revenues that are not covered by the GBR model are delineated in Appendix B. Any services and revenue which are excluded from the GBR model, as specified in Appendix B, will be subject to the policies of the applicable rate setting policies HSCRC regarding unit rates, quality, efficiency, readmissions, variable cost factors (VCFs), volume/case mix governors and other policies that the HSCRC establishes for hospitals (or categories of revenue) that are not covered by the GBR model.

This Agreement will establish the Approved Regulated Revenue of the Hospital, which shall mean the revenue for services covered by the GBR model, and the terms and provisions governing it and the revenue associated with services that are not covered by the GBR model, for each Rate Year. The Approved Regulated Revenue and the associated Unit Rates for the Hospital will be set forth in the

Hospital's Order Nisi for the particular Rate Year. Any revenues excluded from the GBR limits, pursuant to Section B, are specified in Appendix B and will be identified in the Order Nisi.

IV. Specification of the Approved Regulated Revenue of the Hospital

A. Overview

The Approved Regulated Revenue of the Hospital for the July 1, 2013 through June 30, 2014 period is specified in Appendix A. As shown in Appendix A, the Approved Regulated Revenue includes several components: the Permanent Base Revenue, which may include permanent positive or negative adjustments; and a series of other Annual or Periodic adjustments, assessments and settlements. Appendix A also identifies the approved revenue for services that are not covered by the GBR model and the Order Nisi for the Hospital for the particular Rate Year. Appendix A and Appendix B will be updated as needed by the HSCRC on a periodic basis.

The Approved Regulated Revenue of the Hospital may include permanent or temporary rate adjustments designed to provide the Hospital with funds it needs to establish programs and capabilities that are essential to the effective implementation of the GBR model. These adjustments will be provided only to the extent that the Hospital demonstrates that it cannot reasonably afford to establish such activities without the additional resources. The amount, duration and purpose of any such adjustments will be clearly specified in Appendix B (and/or in accompanying documents) for the time period extending from the Effective Date of this Agreement through June 30, 2014. In addition, for any Rate Years beginning on or after July 1, 2014, the Hospital will provide the HSCRC with a prospective written description of the particular performance improvements it will seek to achieve through its use of the additional funds (if any) that are provided by these rate adjustments. The Hospital will also provide the HSCRC with credible, retrospective documentation of the performance improvements that it actually achieves by its use of the additional funds.

B. Detailed Description of the of the Basic Components of the Hospital's Approved Regulated Revenue

The HSCRC will develop the Approved Regulated Revenue of the Hospital for any particular Rate Year in the following way:

1. Initially, the HSCRC staff will determine the Base Approved Regulated Revenue of the Hospital by adjusting the Hospital's approved revenue for a specified historical base period to reflect settlements and adjustments. These adjustments may include additional funding to support programs and capabilities to be established by the Hospital that are necessary to permit it to operate efficiently and effectively in the public interest within the revenue constraints required by the GBR model.

2. The HSCRC staff will adjust the Base Approved Regulated Revenue of the Hospital that is subject to the GBR model to establish the Approved Regulated Revenue for the Rate Year(s) by applying a series of rate adjustments including the following:

a. The revenue will be adjusted to the Rate Year by multiplying it by 1 plus the annual Update Factor percentage(s) approved by the HSCRC for the Rate Year for hospitals operating under the GBR model. A portion of the revenues may not be updated, based on the policies then applicable, for revenues associated with Potentially Avoidable Utilization;

b. The revenue will be adjusted to reflect any performance-based purchasing rewards, penalties, scaling adjustments and hospital improvement targets contained in Appendix C that are applicable at the time to GBR hospitals. The HSCRC expects to develop additional value-based policies that will apply to GBR hospitals in the future. These policies will be incorporated into the annual update factor adjustment process;

c. The revenue will also be adjusted to reflect changes in the mix of the Hospital's payers or changes in approved differential amounts and uncompensated care levels;

d. The revenue will be adjusted to reflect the reversal of any previous one-time adjustments that were in effect during the year;

e. The revenue will be adjusted to reflect any adjustments pursuant to programs such as the readmissions reduction program's prescribed savings adjustment;[1]

f. The revenue will be adjusted to reflect any targeted revenue adjustments, if any, designed to ensure compliance with the limits of the new All-Payer model or the savings requirements established for the Medicare program in the final contract between CMMI and the State of Maryland;

g. The revenue may include adjustments to reflect changes in the expected service volumes of the Hospital that are driven by changes in the demographics as described in Appendix D. The policies governing demographic adjustments may be modified from time to time by HSCRC. The demographic allowance may not be applied to revenues for Potentially Avoidable Utilization based on policies then applicable;

h. The revenue may include adjustments to reflect the relative efficiency of the Hospital. The HSCRC staff and the relevant Work Group(s) will engage in efforts to develop appropriate methods to measure and compare efficiency under the GBR model including measurements that will be applied on a per capita basis to ensure that hospitals that reduce their unnecessary volumes are not penalized on the basis of comparisons that focus exclusively on per case or per unit definitions of efficiency;

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[1] For SFY 2014 through 2018, the Hospital will be subject to a **Readmission Policy Adjustment.**

i. The revenue will be adjusted to reflect amounts or percentages that are imposed on the rates of all hospitals by the HSCRC to cover the costs of certain assessments.[2] These assessments will apply to the Hospital in the same manner in which they are applied to other hospitals;

j. The revenue will be adjusted to reflect revenue overages or underages pursuant to variances between the Hospital's actual revenue and its approved revenue for the previous Rate Year (as described in Section III. C.); and

k. The revenue may also be adjusted in other ways as needed to ensure that the revenue limits and performance improvements imposed by the final contract between CMMI and the State of Maryland are met.[3]

The result of these adjustments will be the amount of revenue which is herein referred to as the Approved Regulated Revenue of the Hospital for the Rate Year. The Approved Regulated Revenue may be further adjusted as described below for any Rate Year.

3. Other Adjustments

a. The HSCRC and the Hospital recognize that some services may be offered more effectively in an unregulated setting. When services covered by the GBR model are moved to an unregulated setting, the HSCRC staff will calculate and apply a reduction to the Hospital's Approved Regulated Revenue. At a minimum, the reduction will ensure that the shift provides a savings to the public and Medicare after taking into consideration the payment amounts likely to be made for the same services in an unregulated setting.

b. The HSCRC may initiate a review, or Hospital may request, an adjustment to the Hospital's Approved Regulated Revenue to reflect changes in the market share of the Hospital. The HSCRC staff and the relevant Work Group(s) will be engaged during CY 2014 (and thereafter) in efforts to develop and refine rate setting policies to appropriately adjust for the impact of market share changes. These policies will be designed to separate the impact of reductions in avoidable volumes and volume increases, to the extent possible, from market share changes.

c. The HSCRC staff will work with the Hospital and with other hospitals that adopt the GBR model to calculate and evaluate any volume increases experienced by the Hospital and other hospitals that are induced by the expansion of health care coverage under the Affordable Care Act ("ACA") in 2014 and 2015, for insured populations under the age of 65, net of reductions in volumes for uninsured populations. Based on the

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[2] Health Care Coverage Fund, MHIP, Deficit Assessment, HSCRC and MHCC user fees, NSP, and CRISP are examples of such assessments currently in place and are subject to change by the Commission.
[3] For SFY 2014 through 2018, the Hospital will be subject to a **Readmission Policy Adjustment.**

findings of this evaluation, the HSCRC staff may provide a one-time adjustment to the Hospital's Approved Regulated Revenue.[4]

d. The HSCRC staff will consider one-time adjustments to the Hospital's regulated revenue for unanticipated events beyond the control of the Hospital that generate substantial increases in the Hospital's utilization levels but only to the extent that the impact of such events on the Hospital materially and demonstrably exceeds the impact of similar events on other hospitals covered by the GBR model.

In summary, the GBR model is a new approach to hospital rate regulation in Maryland. The HSCRC and the Hospital agree to work together to address any significant unforeseen consequences of this Agreement to ensure that it meets the revenue constraints, savings targets and performance improvement requirements required by the final contract between CMMI and the State of Maryland.

V. Compliance

A. General Compliance Under the GBR Model

The Hospital will be subject to any rate adjustments that are necessary to bring it into compliance with the GBR's Approved Regulated Revenue. If the gross revenue charged by the Hospital exceeds the Approved Regulated Revenue, the difference between the gross revenue charged and the Approved Regulated Revenue will be subtracted from the Approved Regulated Revenue that would otherwise have been approved for the Hospital for the subsequent Rate Year. Conversely, if the gross revenue charged by the Hospital is less than the Approved Regulated Revenue, the difference will be added to the Approved Regulated Revenue of the Hospital for the subsequent Rate Year, except that undercharges below the corridor specified in Section B below will not be added to the Approved Regulated Revenue for the subsequent Rate Year.

B. Unit Rate Flexibility

The Hospital will be expected to monitor and adjust its unit charges on an ongoing basis to ensure that it operates within the Annual Regulated Revenue that is approved by the HSCRC under the GBR model and the revenue constraints that are applicable to its services that are regulated by the HSCRC and not covered by the GBR model. In order to facilitate the Hospital's compliance with these revenue constraints, the HSCRC will relax the rate unit rate compliance corridors that it generally applies to hospitals (and particular revenues) that are not governed by the GBR model. Specifically, the Hospital

[4] National estimates are projecting modest or little growth in hospital volumes resulting from expansion of access under ACA. However, HSCRC recognizes that the impact is unknown and that it is the intent of the HSCRC to provide a timely revenue adjustment for the impact of volume increases arising from the expansion of access to insurance. HSCRC staff will develop a methodology to identify such volume increase and Hospital will have the opportunity to submit supporting information and request an adjustment to its GBR Revenue Base.

will be permitted to charge at a level up to five percent (5%) above the approved individual unit rates without penalty. This limit may be extended to ten percent (10%) at the discretion of the HSCRC staff if the Hospital presents satisfactory evidence that it would not otherwise be able to achieve its approved total revenue for the Rate Year. Similarly, the Hospital will be permitted to charge at a level up to five percent (5%) below the approved individual unit rates without penalty if it needs to lower its charges to meet its revenue constraints. This limit may be extended to ten percent (10%) at the discretion of the HSCRC staff if the Hospital presents satisfactory evidence that it needs this additional flexibility to meet its revenue constraints for the Rate Year. The Hospital will generally need to spread rate adjustments across all centers, avoiding adjustments concentrated in a few rate centers, unless it has received approval from HSCRC staff for an alternative approach. Charges beyond the corridors shall be subject to penalties as specified in HSCRC regulations (COMAR 10.37.03.05).

C. Overall Compliance Corridors

The overall compliance corridors (overcharge and undercharge) for the total Approved Regulated Revenue and the revenue excluded from the Approved Regulated Revenue will be .5%, with such amount subject to change from time to time in accordance with HSCRC policies. The Hospital agrees that it will not overcharge the limits of the total Approved Regulated Revenue and that it will take prompt action to gain compliance, within the boundaries of unit rate compliance that are specified above. Charges beyond the corridors shall be subject to penalties as specified in HSCRC regulations (COMAR 10.37.03.05).

VI. Monitoring of GBR Operation and Performance

The successful implementation of the GBR model will require strict adherence to the various revenue constraints, savings requirements and performance targets that are contained in the final contract between CMMI and the State of Maryland. Therefore, the HSCRC will engage in a variety of monitoring and evaluation efforts to determine whether all of these requirements are being met and to ensure that it introduces any corrective actions that may be needed on a timely basis.

1. Market Share

The HSCRC and the Hospital will monitor the Hospital's market share on an ongoing basis by analyzing and identifying changes in the levels of the Hospital's patient volumes that are derived from its Primary Service Area (PSA) or Secondary Service Area (SSA) as defined in Appendix E. The HSCRC staff and the Hospital will also monitor the total level of services and revenues which are provided by the Hospital to Maryland residents who live outside of the Primary and Secondary service areas of the Hospital, or to patients who live outside of Maryland in other states or foreign countries, and will track (to the extent possible) any changes in in-migration and out-migration patterns and their effects on the Hospital.

The HSCRC will make appropriate adjustments in the Hospital's Approved Regulated Revenue based on significant changes in the Hospital's market share or service levels; provided, however, that the HSCRC does not intend to provide increases in the Approved Regulated Revenue of individual hospitals based on market share analysis for volume increases that are not offset by reductions in the Approved Regulated Revenue(s) of other hospitals. The HSCRC also does not intend to make revenue adjustments based on market share changes that would discourage the Hospital from reducing its level of Potentially Avoidable Utilization.

2. Case Mix/Severity Levels

The HSCRC will pay close attention to the overall case mix index and the severity levels within DRGs at the Hospital. If requested, the Hospital will demonstrate to the HSCRC that any reductions in its case mix index or its severity levels are not the result of deliberate efforts by the Hospital to deny, for inappropriate financial reasons, any services to particular patients, or treatments for particular conditions, that fall within the scope of the medical capabilities of the Hospital and its attending medical staff. The HSCRC plans to review data from multiple sources, including CRISP, in its evaluation of case mix and severity changes at the Hospital and, more generally, in the hospital industry.

3. Changes in Ownership and Control and Related Service Relocations

Significant changes in the health care delivery system in the Hospital's Primary and Secondary Service Areas could influence the appropriateness of the Approved Regulated Revenue established for the Hospital under this Agreement. Therefore, the Hospital agrees to declare and describe, in Appendix G, any financial interest (or control) it holds in other hospitals or entities that provide services, including non-hospital services, in the Hospital's Primary and Secondary Service Areas, as of the Effective Date of this Agreement.

In addition, the Hospital agrees to inform the HSCRC at least thirty (30) days in advance, in writing, or at the earliest practicable time thereafter, of any acquisitions or divestitures which it undertakes regarding such interests.[5] The HSCRC may request data from the Hospital, on a periodic or ongoing basis, regarding the utilization of the services provided by such related entities, to ensure that the Hospital complies with the GBR constraint through better management of its existing regulated services and not by moving services from the HSCRC-regulated sector to unregulated sectors of the hospital or non-hospital environment in ways that do not comport with the objectives of the GBR model, the Three Part Aim and the final contract between CMMI and the State of Maryland.

The Hospital will provide an annual disclosure and certification report, which is presented in Appendix F and Appendix G, regarding changes in the services it provides. The initial report will be due upon signing of this Agreement and additional reports will due on an annual basis within 30 days after the end of each subsequent Rate Year.

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[5] This would include the purchase or divestiture of physician practices, joint-venture arrangements with other providers to establish unregulated services that duplicate or could substitute for regulated services currently provided by the Hospital (such as, but not limited to, unregulated clinic, urgent care, or ambulatory surgery services), or other non-hospital services.

4. Monthly Monitoring of Hospital

Within thirty (30) days after the end of every month during the Rate Years covered by this Agreement, the Hospital will provide the HSCRC with a brief written report designed to help the HSCRC to monitor the Hospital's compliance with this Agreement, to facilitate communication between the Hospital and the HSCRC staff, and to promote the success of the GBR model. This report should include the following information, which will be modified from time to time by HSCRC and the Hospital:

a. Year-to-date experience, for the current and prior year, for readmissions and comparisons of actual readmissions levels to targets, including inter-hospital readmissions experience from CRISP, for all payers combined and on a separate basis for Medicare;

b. Year-to-date experience for the current and prior year for MHACs/PPCs and associated comparisons to MHAC/PPC targets;

c. Changes in payer mix year-to-date versus prior year;

d. Changes in market share;

e. Compliance with the Hospital's GBR constraint and the Hospital's plan to eliminate any revenue overages through charge reductions in the remainder of the Rate Year;

f. Trends in Medicare charges for the Hospital and an assessment of whether the Hospital has been successful to date in achieving the needed Medicare payment reductions;

g. Trends in total regulated revenue for the Hospital broken out between revenues covered by the GBR model and revenues not covered by it with the revenues covered by the GBR model further segregated into Medicare and non-Medicare components divided between Maryland and out-of-state components;

h. Trends in revenue per Equivalent Inpatient Admission ("EIPA")/Equivalent Case Mix Adjustment Discharge ("ECMAD");

i. Trends in costs, including cost per EIPA/ECMAD, including a discussion of changes in costs relative to reductions in volumes; and

j. Other information that the Hospital wishes to report regarding the successes, failures and ongoing challenges of implementing the GBR model and its related population health strategy. This supplemental information may include brief descriptions of the efforts (such as the use of emergency room care coordinators, transition care coordinators, case management, integration with community based programs, nursing home interventions, and coordination with physician delivery system changes) that the Hospital has undertaken which have been effective (or

ineffective) in improving the efficiency, quality and/or processes of care. The objective of gathering such additional information is to develop a body of evidence that can be usefully shared with all Maryland hospitals that are operating under the GBR model.

The HSCRC recognizes that the collection and reporting of the information described above on a monthly basis may impose an unclear or excessive burden on the Hospital; therefore, the HSCRC staff intends to work with hospital representatives to refine the monthly information reporting requirements to ensure that the Hospital can provide the kinds of information needed by the HSCRC on a monthly basis without undue hardship.

VII. Evaluation of the Effectiveness of the GBR

As described above, the primary goal of the GBR model is to provide the Hospital with strong financial incentives to deliver medical care to its patients and its community in the most efficient and clinically effective ways that are consistent with the Three Part Aim.

The HSCRC staff shall evaluate the success of the GBR program established by this Agreement by measuring changes in the costs, quality and outcomes of medical care delivered by the Hospital. In these reviews, the HSCRC staff will pay particular attention to analyses of utilization trends pre-and post-implementation of the GBR model. The reviews will include evaluations of per capita hospital costs and, to the extent possible given data limitations, the total cost of health care in the Hospital's PSA and SSA. In addition, the HSCRC staff will examine the performance of the Hospital on the HSCRC's existing and future quality of care and outcomes metrics using existing standards and additional metrics that will be developed through the relevant Work Group(s).

The Hospital shall provide an annual report of its investment in infrastructure to promote the improvement of care delivery and reductions of Potentially Avoidable Utilization. This report will be due 90 days following the end of each fiscal year, and will include program descriptions, expenditures, and results.

VIII. Possible Future Modifications in the GBR Model to Achieve Improved Alignment of Incentives in the Health Care Delivery System

Under healthcare reform, a number of strategies are being considered to contain healthcare costs. For example, primary care medical homes, Accountable Care Organizations, and the bundling of services under single payment amounts are strategies that have been identified as possible ways to improve care while aligning providers for the efficient delivery of healthcare services. Health care reform efforts are progressing rapidly, and may produce environmental changes that warrant some modifications to this Agreement. Therefore, the Hospital and the HSCRC staff agree to monitor such changes and to make changes in this Agreement, on a mutually acceptable basis, as needed in the future to accommodate or comply with future developments that are mandated or permitted by law and/or regulation.

IX. Other Potential Modifications

A. Approved Regulated Revenue Modifications

The Hospital may request a reevaluation of its Approved Regulated Revenue for any Rate Year by submitting its request in writing to the HSCRC staff and including the supporting rationale and documentation for its request to the HSCRC staff. The HSCRC staff will make a determination to approve, modify, or deny the request of the Hospital under this agreement. When it deems necessary, the staff will prepare a recommendation regarding the request, and the HSCRC will review the staff recommendation and render a decision. Similarly, the HSCRC may open discussions with the Hospital regarding modifications to the GBR constraint based on its ongoing review and monitoring of the Hospital's operations, performance, market share changes and other factors. The HSCRC staff reserves the right to modify the GBR constraint in accordance with the terms of this agreement.

B. Approved Regulated Revenue Modifications Related to CON Projects

The Hospital may apply for and receive a "Certificate of Need" (CON) approval to provide a new service or to undertake a major capital project. In such instances, the Hospital may elect to petition the HSCRC staff for an associated adjustment to the Hospital's Approved Regulated Revenue. The Hospital will be expected to demonstrate to the satisfaction of the HSCRC staff that it is unable to provide the new service or to fund the major capital project within its existing revenue constraints. Requests of this kind will be evaluated by the HSCRC staff on a case-by-case basis. However, the Hospital must recognize that the new All-Payer Model that will be established in the final contract between CMMI and the State of Maryland limits the total amount of hospital revenue that can be approved within the State for any given period of time, and that this constraint will require any approvals of additional revenue for individual hospitals to pass highly stringent tests of financial and clinical necessity and to be funded by reductions in the revenue approved for other hospitals.

The HSCRC staff will work with the relevant Work Group(s) and MHCC to develop and refine policies that will appropriately address the financial issues raised by CON projects and other capital and service expansions. The HSCRC staff will make recommendations to the HSCRC regarding any requests from the Hospital for additional revenues for these reasons, when necessary.

X. Out-of-Area and Out-of-State Volumes and Revenues

Significant changes in out-of-state volumes and volumes from outside the Hospital's PSA and SSA have the potential to positively or negatively affect the success of the GBR model. In FY 2013, approximately _2.4__ percent (2.4%) of the Hospital's total revenue came from non-Maryland residents. If this percentage changes materially during the term of this Agreement, the HSCRC staff and the

Hospital will evaluate the causes of the change to ensure that the goals and objectives of this Agreement, the GBR model and the final contract between CMMI and the State of Maryland are not being undermined by such changes.

XI. Readmissions, Quality and Reductions of Potentially Avoidable Utilization

The new All-Payer Model that will be established in the final contract between CMMI and the State of Maryland will include specific requirements for readmission reductions and quality improvements. In addition, the success of the new model depends on the effectiveness of the Maryland hospitals in achieving reductions in PAU in general and, in particular, for Medicare. By July 1, 2014, the HSCRC staff will establish targets for reductions in PAU. The achievement of these targets will be tied to payment in a way that is consistent with the Three Part Aim of improving care and reducing cost. Appendix C will contain the annual PAU reduction targets for the Hospital and the associated HSCRC payment adjustment policies.

As part of this process, the Hospital will prepare a periodic plan for Population Health Improvement and reductions on Potentially Avoidable Utilization. To the extent possible, the plans should rely on evidence based approaches to accomplish the goals. HSCRC will work with hospitals to promote evidence based, standardized, regionalized approaches in an effort to ensure effective means of providing needed infrastructure. HSCRC will also work with hospitals to develop processes to review these plans, provide evaluation and feedback on the results of the approaches, and to modify the approaches to improve the results.

XII. Termination and/or Renegotiation and Other Rights

A. Termination by the HSCRC

The HSCRC reserves the right to terminate this Agreement, with cause, at any time. For the purposes of this Agreement, "with cause" includes, but is not limited to, failure by the Hospital to provide high quality needed services as contemplated by this Agreement; the inappropriate shifting of hospital services to unregulated settings; failure to achieve total all payer or Medicare per capita revenue trends and/or performance targets that are consistent with the constraints and requirements imposed by the GBR model and the final contract between CMMI and the State of Maryland; or failure of the Hospital to comply with HSCRC regulations or policies.

The HSCRC will provide the Hospital with a reasonable opportunity to cure its failure to perform under this Agreement by adopting a corrective plan designed to eliminate the defects in its performance in a timely way. The corrective plan may include an immediate reduction in the Hospital's Approved Regulated Revenue; mandatory participation by the Hospital in a regional planning process focused on

achieving the requirements of the All-Payer model; or other identified actions.

If the Hospital is unwilling to adopt the corrective plan described above, the HSCRC will have the right to terminate the Agreement with due consideration to the need of the Hospital to transition out of this Agreement and the need to maintain overall compliance with the requirements imposed on the State of Maryland by the final contract with CMMI.

B. Termination by Hospital

The Hospital will have the right to transition to an alternative rate setting approach after giving six months of written notice to HSCRC staff of its intent to change as of a specific date. The notice will provide a description of the Hospital's chief reasons for the proposed termination. The HSCRC staff will work with the Hospital to resolve any issues, including the possible recapture of volume support provided under this agreement, where volumes were decreased during the course of the agreement, or to remove infrastructure funding or other incentives provided in the revenue base. If the Hospital is transitioning to another model with a fixed revenue base, then these adjustments may not need to be evaluated. Any new agreement will need to be within the revenue limits and other performance tests and requirements imposed by the final contract between CMMI and the State of Maryland.

C. Other Rights

Nothing in this agreement should be construed to prevent the HSCRC or Hospital from undertaking any action that it is lawfully entitled to take, including exercising the rights to initiate a full rate review by either the HSCRC or the Hospital.

D. Other Provisions Relative to the Hospital

This section is provided to include terms and conditions applicable to a specific hospital:

1. Anne Arundel Medical Center (AAMC) will work with HSCRC staff to review the reporting requirements in the Global Budget agreement and provide assistance to HSCRC staff in developing standard formats and approaches that could be used industry wide. The HSCRC staff agrees to work with AAMC to ensure that required reporting for this contract does not result in an undue burden on hospital staff.

2. On July 1, 2014, AAMC's Global Budget Revenue will be increased by 0.325% related to funding for Population Infrastructure.

XIII. Definitions of Terms

Annual Update Factor: The update factor as approved by the Commission to apply to GBR hospitals in the State during the fiscal year, or a portion of the fiscal year.

Approved Regulated Revenue: For each Rate Year, the Hospital's approved revenue computed in accordance with this Agreement and specified in the Hospital's Order Nisi for the GBR for the particular Rate Year.

Approved Regulated Revenue Compliance and Related Adjustments: For each Rate Year, the Hospital's Approved Regulated Revenue will be compared to the Hospital's actual regulated revenue for the particular Rate Year. If the Approved Regulated Revenue exceeds the Hospital's actual regulated revenue, the amount of the excess will be added to the Hospital's Approved Regulated Revenue for the subsequent Rate Year as a One Time Adjustment.

If the Approved Regulated Revenue is less than the Hospital's actual regulated revenue, the amount of the shortfall will be subtracted from the Hospital's Approved Regulated Revenue for the subsequent Rate Year as a One Time Adjustment, except that undercharges below the corridor specified in subparagraph III. A will not be so included.

Base Approved Regulated Revenue: The total approved revenue of the Hospital for the initial year of the agreement as specified in Appendix A.

Demographic Adjustment: The Demographic Adjustment is the calculation described in Appendix D and the adjustment factors shown therein that provide an adjustment to the Approved Regulated Revenue for population and age related volume changes. This factor will be updated on an annual basis.

Maryland Hospital Acquired Conditions Initiative: The HSCRC's Maryland Hospital Acquired Condition ("MHAC") measurement methodology that compares a hospital's risk-adjusted actual rate of MHAC to an expected or predicted rate of MHAC based on state-wide experience.

One Time Adjustments: The HSCRC makes one-time adjustments to the Hospital's rates in deriving the Hospital's Approved Regulated Revenue for the particular Rate Year The HSCRC removes the One Time Adjustments from the Approved Regulated Revenue in calculating Approved Regulated Revenue for a the subsequent Rate Year.

Potentially Avoidable Utilization ("PAU") includes utilization and revenue related to preventable admissions, readmissions (Inter and Intra hospital), Observation patients that would be reflected as a readmission if admitted, and Potentially Preventable Complications. Other categories of PAUs may be added by the HSCRC.

Quality-Based Reimbursement: The HSCRC's pay-for-performance initiative that links hospital performance (both relative and year-to-year) on a list of processes of care measures.

Rate Years: The Hospital's Rate Year corresponds to the State fiscal year that begins on July 1 each year and ends on June 30.

Readmission Policy Adjustment: In each Rate Year the derivation of the Hospital's Approved Regulated Revenue will include a Readmission Policy Adjustment calculated in accordance with HSCRC policies

Service Area: Primary and Secondary Service Areas represent the zip codes from which 75% of admissions are derived in the base period. This definition may be adjusted based on agreement between the Hospital and HSCRC.

Appendix E lists the Maryland zip codes and counties that make up the Hospital's Primary Service Area and its Secondary Service Area.

Unit Rates: The Approved Regulated Revenue per unit computed for each regulated revenue center in accordance with this Agreement as specified in the Hospital's Order Nisi for the particular Rate Year.

Unit Rate Compliance: The Hospital's compliance with its approved Unit Rate in each regulated revenue calculated pursuant to the HSCRC's Unit Rate compliance regulations; however, with relaxed corridors as described in this agreement.

In Witness whereof, the Parties have executed this Agreement and have this date caused their respective signatures to be affixed hereto:

Attest: _____ by _____ Date 4-17-2014

President & Chief Executive Officer
Anne Arundel Medical Center, Inc.

Attest: _____ by _____ Date 4-22-2014

Executive Director
Health Services Cost Review Commission

Appendix A: Hospital's Base Revenue Components and Order Nisi

A.	**Base Approved Regulated Revenue**		**$ 553,115,271**
	1.	Approved Regulated Revenue	$ 553,115,271
	2.	Increment (If Any) for GBR Investments included in above amount* *Additional Increment due 7/1/14	$ 1,793,873
B.	**One Time Rate Adjustments and Annual Reversals (included in Approved Regulated Revenue above)**		
	1.	Assessments that Reverse Annually	$ 26,325,827
	2.	MHAC and QBR	$ (639,633)
	3.	Other one-time adjustments	$
	4.	Total one-time adjustments	$ 25,686,194
C.	**Revenue Excluded from Approved Regulated Revenue Under GBR but Subject to Rate Regulation** **Description** _____		$
D.	**Total Approved Revenue Per Order Nisi (Equals A + C)**		$ 553,115,271

Appendix B: Revenues and Services Excluded from GBR Model and General Description of Rate Setting Requirements for Excluded Revenues

None

Appendix C: Potentially Avoidable Utilization Targets

To be provided by HSCRC staff at the end of February

1. **Targets**

   a. Readmission and Re-Hospitalization Reduction Targets

   _____
   _____
   _____
   _____
   _____
   _____

   b. MHAC Targets

   _____
   _____
   _____
   _____
   _____
   _____

2. **Policy References**

   _____
   _____
   _____
   _____
   _____
   _____

3. **Description of Methodologies Linking Achievement of Targets and Payment Levels**

   _____
   _____
   _____
   _____
   _____
   _____

Appendix D: Demographic Adjustment

The hospital will be eligible for future demographic adjustments based on policies that will be adopted by HSCRC.

Appendix E: Definition of Hospital's Service Area

The HSCRC will use zip codes and/or counties for market analysis.

1. The Primary Service Area (PSA) of the Hospital consists of the following zip codes (or counties):

21401	21619	21146	20776	21140
21402	21666	20711	20778	
21403	21012	20733	20779	
21404	21032	20751	21035	
21405	21054	20764	21037	
21409	21114	20765	21106	

2. The Secondary Service Area of the Hospital consists of the following zip codes (or counties):

21601	21636	21658	21056	21113	20716	20774	20754	20735
21607	21638	21660	21060	21122	20720	20610	20758	
21617	21639	21668	21061	21123	20721	20639	20601	
21620	21640	21670	21062	21144	20769	20678	20602	
21623	21644	21679	21076	21240	20770	20689	20603	
21625	21649	20701	21077	20706	20771	20714	20613	
21628	21654	20724	21090	20708	20772	20732	20623	
21629	21657	20755	21108	20715	20773	20736	20695	

Appendix F: Annual Disclosure and Certification Regarding Changes in Services Provided (Due 30 days after the end of the Rate Year)

A. The following services were shifted in whole or in part to unregulated settings not regulated by the HSCRC:

For FY13 and YTD FY14 through the date of this agreement, AAMC has not shifted in whole or part, any services to unregulated settings.

B. The following services were shifted in whole or in part to the regulated activities of other hospitals:

For FY13 and YTD FY14 through the date of this agreement, AAMC has not shifted in whole or part, any services to other hospitals.

C. Or: The Hospital is not aware of any services that were shifted in whole or in part to unregulated settings.

Yes, correct.

Signature of Officer of Hospital

4/14/14
Date

Robert Reilly
Name (Please Print)

CFO
Title

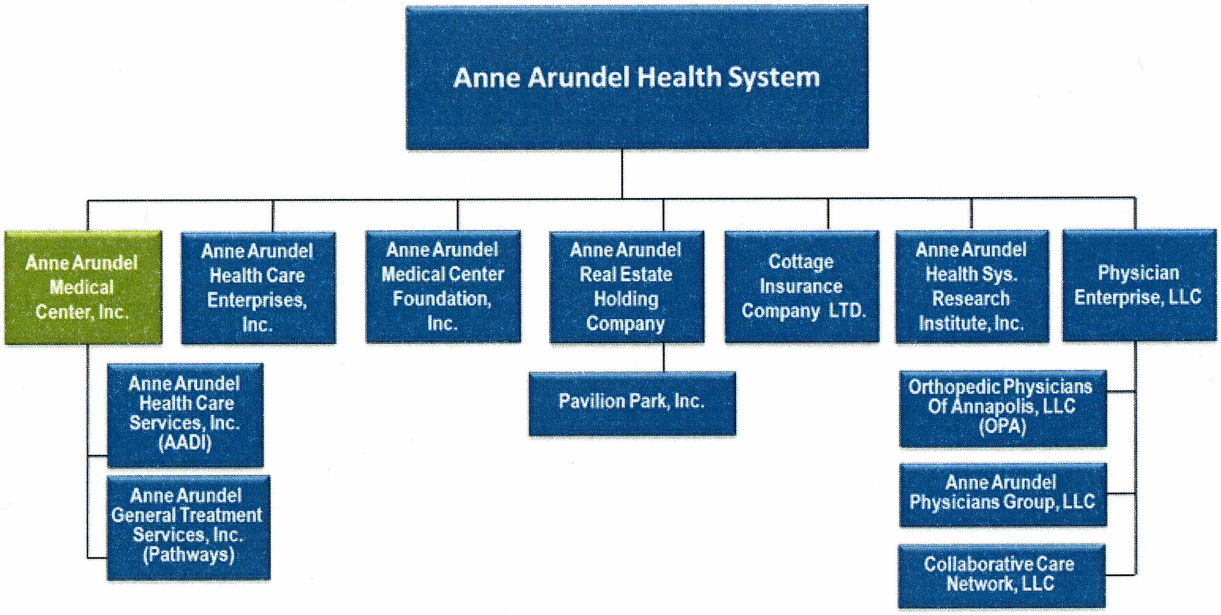
443-481-1308
Telephone Number

breilly@aahs.org
E Mail Address

Appendix G: Hospital Financial Interest, Ownership, or Control of other Hospital or Non-Hospital Services Provided Within the Service Area

The Hospital owns, has a substantial financial interest in, controls, or is financially or organizationally related to the following provider organizations or systems.

The corporate structure is illustrated in the following organizational chart:



Anne Arundel Medical Center, Inc.

The Medical Center is a private, not-for-profit corporation that operates a 385-licensed bed acute care hospital located adjacent to U.S. Route 50, approximately three miles from the center of Annapolis, Maryland, the state capital. Established in 1902, the Medical Center operates the only hospital within a 15 mile radius. The Medical Center provides a full-range of inpatient acute care services including medicine, surgery, intensive care, coronary care, intermediate cardiac services including primary angioplasty, obstetrics, gynecology, pediatrics, and Level IIIB neonatal intensive care services. In addition, the Medical Center provides a comprehensive range of outpatient services including emergency medicine, outpatient surgery, oncology treatment services, and advanced diagnostic services, including CT scanning and interventional radiology. Healthcare services provided at the Medical Center are regulated by the HSCRC.

The Medical Center is the sole corporate member of its two subsidiaries, Health Care Services and Anne Arundel General Treatment Services, Inc. ("Treatment Services"), each a non-profit corporation. Healthcare services provided by the subsidiaries are not regulated by the HSCRC.

Anne Arundel Health Care Services, Inc.
Anne Arundel Health Care Services operates outpatient diagnostic imaging centers in key locations throughout our primary and secondary service area. The diagnostic centers, operated under the trade name "Anne Arundel Diagnostics Imaging" by Health Care Services, provide radiology services at locations including Odenton, Bowie, Kent Island, and Annapolis.

Anne Arundel General Treatment Services, Inc.
Treatment Services owns and operates Pathways Treatment Center ("Pathways"), a 40-bed drug and alcohol treatment facility that provides sub-acute care on both an inpatient and outpatient basis. Pathways is licensed as an intermediate care nursing facility. Pathways is situated on an 8.2 acre site located approximately two miles from the Medical Center campus.

Other Health System Subsidiaries
The following companies are also subsidiaries of the Health System but are not owned by the Hospital. None of these Health System subsidiaries are regulated by the HSCRC.

Anne Arundel Health System Research Institute, Inc.
Anne Arundel Health System Research Institute, Inc. (the "Research Institute") was incorporated in July 2008 and is exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code. The Research Institute supports and facilitates clinical research activities within the Medical Center.

Physician Enterprise, LLC.
Physician Enterprise, LLC. ("Physician Enterprise") was incorporated in July 2009 and is exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code. Physician Enterprise employs physicians and other clinicians to support the Medical Center. Clinicians are embedded into two entities within Physician Enterprise: Anne Arundel Physicians Group, LLC (AAPG) and Orthopedic Physicians of Annapolis, LLC (OPA). Physical therapists and orthopedists are hired into OPA. The Collaborative Care Network was incorporated in July 2012 and serves as the corporate platform for the Health System's Accountable Care Organization.

Anne Arundel Health Care Enterprises, Inc.
Anne Arundel Health Care Enterprises, Inc. ("Health Care Enterprises"), a for-profit subsidiary of the Health System, was developed as the entity providing services linking elements of the integrated delivery system. Services of this subsidiary include:

- a management services organization, providing practice management, consulting, and billing to certain medical staff and health entities; and
- investment holdings in a joint venture with Fresenius Anne Arundel Dialysis Services, LLC, a provider of dialysis services, and Riva Road Surgical Center, an ambulatory surgery center.

The following Health System Subsidiaries depicted on the organizational chart do not provide healthcare services:

- Anne Arundel Real Estate Holding Company, Inc.
- Anne Arundel Medical Center Foundation, Inc.
- Cottage Insurance Company, Ltd.

Appendix H: Calculation of Market Share

This section is informational only and does not contain contract requirements.

While the following calculation is not binding, it is suggested as a calculation that can be used to examine possible changes in market share given the complexities arising from evaluating shifts in market share under the incentives of population-based payment models. The HSCRC staff will instruct the appropriate Work Group(s) to examine this issue and to recommend policies to the HSCRC.

1. Volume of Services: In considering whether adjustments to the Hospital's Approved Regulated Revenue are warranted for shifts in market share, the changes in the service levels of the Hospital and of other hospitals in the Hospital's Service Area (i.e., its PSA and its SSA) will need to be calculated for selected services. These service levels will be calculated for the Base Year and for each Rate Year.

2. The measure of the volume of service will be calculated for the Hospital and for each other applicable Hospital separately for inpatient and outpatient services

3. The outpatient services will be converted to an inpatient equivalent volume of services.

4. For each hospital, including the GBR Hospital, which provides services in the particular category of service, the Hospital's Volume of Service will be calculated as follows:

   a. The Inpatient Volume of Services will equal the number of case mix adjusted discharges (CMADs) of the Hospital's inpatients whose services are included in the particular category; and

   b. The Outpatient Volume of Services will be computed as follows:

      i. The Hospital's Unit Charge will be calculated as the average charge per CMAD over all of the Hospital's inpatients, excluding outliers.

      ii. The outpatient equivalent CMADs (ECMADs) will be calculated as the Hospital's total charges, exclusive of the charges of inpatients included in the count of CMADs, divided by the Unit Charge.

5. The Hospital's volume of service for the particular category of services will equal the sum of the number of CMADs calculated in Step 4(a) and the number of ECMADs calculated in Step 4(b).

6. The calculations described above will be performed separately for PAUs, in recognition that a primary objective of the Agreement is to reduce PAUs. The HSCRC will ensure that the Hospital is not penalized for its PAU reductions in the market share calculation.

7. The total volume of service of a particular category of services which are provided by several hospitals will equal the sum of the volume of services for each hospital as calculated above.

The HSCRC will continue to work with the Hospital and the relevant Work Group(s) on the methods for calculating service level and market share changes. The parties recognize that this effort is a "work in progress" and they will work cooperatively to improve the methods of evaluating changes in market share and changes in efficiency levels.

Appendix I: Readmission Policy Adjustment

The Hospital's readmission savings requirement for the Rate Year FY 2014 applied in the model was -.19% of total revenue.

EXHIBIT 24

AMERICAN FactFinder

DP03 | SELECTED ECONOMIC CHARACTERISTICS

2013 American Community Survey 1-Year Estimates

Note: This is a modified view of the original table.

Supporting documentation on code lists, subject definitions, data accuracy, and statistical testing can be found on the American Community Survey website in the Data and Documentation section.

Sample size and data quality measures (including coverage rates, allocation rates, and response rates) can be found on the American Community Survey website in the Methodology section.

Although the American Community Survey (ACS) produces population, demographic and housing unit estimates, it is the Census Bureau's Population Estimates Program that produces and disseminates the official estimates of the population for the nation, states, counties, cities and towns and estimates of housing units for states and counties.

Subject	Maryland		Anne Arundel County, Maryland	
	Estimate	Percent	Estimate	Percent
INCOME AND BENEFITS (IN 2013 INFLATION-ADJUSTED DOLLARS)				
Total households	2,161,680	2,161,680	201,695	201,695
Less than $10,000	120,858	5.6%	7,243	3.6%
$10,000 to $14,999	71,689	3.3%	4,420	2.2%
$15,000 to $24,999	151,806	7.0%	11,477	5.7%
$25,000 to $34,999	157,896	7.3%	12,031	6.0%
$35,000 to $49,999	231,020	10.7%	19,385	9.6%
$50,000 to $74,999	376,788	17.4%	33,109	16.4%
$75,000 to $99,999	293,822	13.6%	30,496	15.1%
$100,000 to $149,999	386,731	17.9%	41,453	20.6%
$150,000 to $199,999	179,258	8.3%	20,833	10.3%
$200,000 or more	191,812	8.9%	21,248	10.5%
Median household income (dollars)	72,483	(X)	86,230	(X)
Mean household income (dollars)	96,032	(X)	106,490	(X)
PERCENTAGE OF FAMILIES AND PEOPLE WHOSE INCOME IN THE PAST 12 MONTHS IS BELOW THE POVERTY LEVEL				
All families	(X)	7.1%	(X)	4.7%
All people	(X)	10.1%	(X)	7.1%

Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90 percent margin of error. The margin of error can be interpreted roughly as providing a 90 percent probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to nonsampling error (for a discussion of nonsampling variability, see Accuracy of the Data). The effect of nonsampling error is not represented in these tables.

In data year 2013, there were a series of changes to data collection operations that could have affected some estimates. These changes include the addition of Internet as a mode of data collection, the end of the content portion of Failed Edit Follow-Up interviewing, and the loss of one monthly panel due to the Federal Government shut down in October 2013. For more information, see: User Notes

Employment and unemployment estimates may vary from the official labor force data released by the Bureau of Labor Statistics because of differences in survey design and data collection. For guidance on differences in employment and unemployment estimates from different sources go to Labor Force Guidance.

The Census Bureau introduced an improved sequence of labor force questions in the 2008 ACS questionnaire. Accordingly, we recommend using caution when making labor force data comparisons from 2008 or later with data from prior years. For more information on these questions and their evaluation in the 2006 ACS Content Test, see the "Evaluation Report Covering Employment Status" at http://www.census.gov/acs/www/Downloads/methodology/content_test/P6a_Employment_Status.pdf, and the "Evaluation Report Covering Weeks Worked" at http://www.census.gov/acs/www/Downloads/methodology/content_test/P6b_Weeks_Worked_Final_Report.pdf. Additional information can also be found at http://www.census.gov/people/laborforce/.

Workers include members of the Armed Forces and civilians who were at work last week.

Industry codes are 4-digit codes and are based on the North American Industry Classification System 2012. The Industry categories adhere to the guidelines issued in Clarification Memorandum No. 2, "NAICS Alternate Aggregation Structure for Use By U.S. Statistical Agencies," issued by the Office of Management and Budget.

Occupation codes are 4-digit codes and are based on Standard Occupational Classification 2010.

The health insurance coverage category names were modified in 2010. See ACS Health Insurance Definitions for a list of the insurance type definitions.

While the 2013 American Community Survey (ACS) data generally reflect the February 2013 Office of Management and Budget (OMB) definitions of metropolitan and micropolitan statistical areas; in certain instances the names, codes, and boundaries of the principal cities shown in ACS tables may differ from the OMB definitions due to differences in the effective dates of the geographic entities.

Estimates of urban and rural population, housing units, and characteristics reflect boundaries of urban areas defined based on Census 2010 data. As a result, data for urban and rural areas from the ACS do not necessarily reflect the results of ongoing urbanization.

Source: U.S. Census Bureau, 2013 American Community Survey

Explanation of Symbols:

1. An '**' entry in the margin of error column indicates that either no sample observations or too few sample observations were available to compute a standard error and thus the margin of error. A statistical test is not appropriate.
2. An '-' entry in the estimate column indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest interval or upper interval of an open-ended distribution.
3. An '-' following a median estimate means the median falls in the lowest interval of an open-ended distribution.
4. An '+' following a median estimate means the median falls in the upper interval of an open-ended distribution.
5. An '***' entry in the margin of error column indicates that the median falls in the lowest interval or upper interval of an open-ended distribution. A statistical test is not appropriate.
6. An '*****' entry in the margin of error column indicates that the estimate is controlled. A statistical test for sampling variability is not appropriate.
7. An 'N' entry in the estimate and margin of error columns indicates that data for this geographic area cannot be displayed because the number of sample cases is too small.
8. An '(X)' means that the estimate is not applicable or not available.

EXHIBIT 25

ANNE ARUNDEL MEDICAL CENTER

CARDIAC SURGERY PROGRAM CERTIFICATE OF NEED APPLICATION

RESPONSE TO COMPLETENESS QUESTIONS

Attestation by Victoria W. Bayless

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

_____ **5/05/15**
Victoria W. Bayless **Date**

President &CEO
Title

4158280.1 46208/124959 05/04/2015

EXHIBIT 26

ANNE ARUNDEL MEDICAL CENTER

CARDIAC SURGERY PROGRAM CERTIFICATE OF NEED APPLICATION

RESPONSE TO COMPLETENESS QUESTIONS

Attestation by Robert Reilly

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

Robert E. Reilly

5/5/15
Date

Chief Financial Officer
Title

4159980.1 46208/124959 05/05/2015

EXHIBIT 27

ANNE ARUNDEL MEDICAL CENTER

CARDIAC SURGERY PROGRAM CERTIFICATE OF NEED APPLICATION

RESPONSE TO COMPLETENESS QUESTIONS

Attestation by Jerome Segal, M.D.

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

Jerome Segal, M.D.

5/6/15
Date

Director, the Heart Institute at Anne Arundel Medical Center
Title

4158283.1 46208/124959 05/04/2015