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November 7, 2016

VIA EMAIL & HAND DELIVERED

Craig Tanio, M.D.
Chair/Reviewer
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Modification to Certificate of Need Application
Anne Arundel Medical Center - Docket No. 15-02-2360

Dear Chairman Tanio:

Enclosed please find Anne Arundel Medical Center, Inc.'s Modification to its Certificate of Need Application to establish cardiac surgery services ("Modification"). This Modification results from the project status conference of October 27, 2016, and provides the information requested in your October 28 letter in regard thereto.

Thank you for your attention to this matter.

Sincerely,

Jonathan Montgomery

cc: Suellen Wideman, DHMH (via email)
Thomas Dame, Esquire (via email)
Ella Aiken (via email)
Natalie McSherry, Esquire (via email)
Louis P. Malick (via email)
Christopher C. Jeffries (via email)
Joel Suldan, Esquire (via email)

John Brennan, Esquire (via email)
Stephanie D. Willis (via email)
Jinlene Chan, M.D. (via email)
Steven Schuh, Anne Arundel County Executive (via email)
Gregory W. Branch, Baltimore County Health Dept. (via email)
Leana S. Wen, M.D., Baltimore City Health Dept. (via email)
Ed Singer, Carroll County Health Dept. (via email)
Stephanie A. Garrity, Cecil County Health Dept. (via email)
Susan Kelly, Harford County Health Dept. (via email)
Maura J. Rossman, M.D., Howard County Health Dept. (via email)
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Michael Pantelides, Mayor of Annapolis (via email)
Thomas C. Andrews, Annapolis City Manager (via email)
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Kevin R. McDonald, DHMH (via email)
Ruby Potter, DHMH (via email)
Ben Steffen, DHMH (via email)
Siobhan Madison, DHMH (via email)
Donna Kinzer, DHMH (via email)
AAMC for Internal Distribution (via email)

IN THE MATTER OF	*	
ANNE ARUNDEL MEDICAL CENTER	*	
Docket No. 15-02-2360	*	
* * * * * *	*	BEFORE THE
IN THE MATTER OF UNIVERSITY	*	MARYLAND HEALTH CARE
OF MARYLAND BALTIMORE	*	COMMISSION
WASHINGTON MEDICAL CENTER	*	
Docket No. 15-02-2361	*	
* * * * * *	*	* * * * *

ANNE ARUNDEL MEDICAL CENTER
MODIFICATION TO CERTIFICATE OF NEED APPLICATION

Anne Arundel Medical Center, Inc. ("**AAMC**"), by its undersigned counsel, hereby submits this modification (this "**Modification**") of the above-captioned certificate of need application of AAMC to establish cardiac surgery services.[1]

This modification results from the project status conference of October 27, 2016, and provides the information requested in Commissioner Tanio's October 28 letter in regard thereto.

Respectfully submitted,

Jonathan E. Montgomery
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Baltimore, Maryland 21202
Tel: (410) 576-4088
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Attorneys for Anne Arundel Medical Center

[1] This Modification is submitted pursuant to COMAR 10.24.01.09A(2)(d).

INTRODUCTION

AAMC hereby submits revised versions of all financial schedules regarding revenues, expenses, and income for: (1) for its proposed cardiac surgery service (the "**Revised Cardiac Tables**"; and (2) its general hospital operation (the "**Revised Facility Tables**" and together with the Revised Facility Tables, the "**Revised Tables**"). The Revised Tables are enclosed as Exhibit 38.

This submission will first describe how the Revised Tables differ from those submitted in the original application, then will relate the Revised Tables – and the updated charts derived from those tables – to the project review criteria identified by Commissioner Tanio pursuant to his October 28, 2016 project status conference letter. The Revised Tables differ from the original application tables as follows:

Revised Cardiac Tables

The Revised Cardiac Tables now present the financial information for AAMC's proposed cardiac surgery service in two ways.

First, Table J-1 details the direct revenues and expenses to be generated by AAMC's proposed cardiac surgery service, as a service line, from billable charges.[2] That is, Table J-1 lists the projected income derived from charges to patients and payers for cardiac surgery at AAMC, comparing it to the direct costs of the proposed program.

Second, Table J-2 matches Table J-1, except that Table J-2ascribes to AAMC's proposed cardiac surgery service only the revenue AAMC expects to retain, as a facility, as a result of the service line revenue generated by AAMC's proposed cardiac surgery service. That is, Table J-2

[2] AAMC references the uninflated tables throughout this Modification, for consistency.

discounts the service line revenue generated by AAMC's proposed cardiac surgery service by 50%.[3]

The Revised Cardiac Tables do not reflect any change to estimated expenses or revenues of AAMC's proposed cardiac surgery service, other than as described above.[4]

Revised Facility Tables

The Revised Facility Tables show less revenue for AAMC as a whole for FY 2018 (the first full year of projected operation of the program), namely $502,597,216 in net operating revenue for FY 2018.[5] This change reflects guidance in the Health Services Cost Review Commission's August 24, 2016 memorandum (the "**HSCRC Memo**") that AAMC global budget revenue would increase, as a result of the project, by an amount equal to 50% of the revenue generated by AAMC's proposed cardiac surgery service. The Revised Facility Tables do not reflect any change to estimated expenses.[6]

The Revised Facility Tables do not change whether one views cardiac revenue under Table J-1 or Table J-2, because in either event, facility revenue is the same.

Context

Context helps in understanding the Revised Tables. AAMC, like other Maryland hospitals, operates under a global budget revenue system whereby the HSCRC sets the amount

[3] As explained below, however, the HSCRC Memo has indicated that the HSCRC would permit AAMC to allocate additional revenue to the proposed cardiac surgery service, through the other resources provided in the GBR system for new projects.

[4] Commissioner Tanio's October 28 letter that this Modification should not include an update of AAMC's volume projections for its proposed cardiac surgery service. As a result, the financial projections enclosed in the Revised Tables are based on revenue and expenses generated at the level of volume AAMC anticipated as of February 20, 2015.

[5] *See* Table H (inflated).

[6] For consistency, the Revised Tables retained the assumptions underlying its original overall hospital financial projections, with the exception of a revision accounting for the effect of the market shift policy and the 50% variable cost factor identified in the HSCRC Memo.

of revenue the hospital is allowed to earn annually (a "**GBR Budget**"). At the same time, each hospital's individual service lines still generate billable revenue (at HSCRC approved rates) standing alone. The GBR Budget, then, is an aggregation of the revenue independently generated by each of the hospital's service lines. For example, as reflected in Exhibit 39, AAMC's estimates that its cardiac surgery service will have a charge per case of $37,501 generating charges of $11,147,964 (after accounting for transfer revenue). However, AAMC will need to decrease its charges across all hospital services to offset the excess revenue generated by the proposed cardiac surgery service.[7]

BWMC has recognized this distinction as well. For example, in its August 10, 2015 modification to its certificate of need application in this Review, BWMC noted that its "cardiac surgery charges to payers will increase by $11.8 million but the allowable GBR adjustment for UM BWMC will only be $4.6 million after consideration of the 50% revenue variability factor. As such, it is expected that hospital-wide rates at UM BWMC would need to decrease by the difference between these two numbers, or $7.2 million."[8]

The Commission should evaluate financial feasibility in this Review with this distinction in mind – the distinction between service line revenue and expenses for the proposed cardiac surgery programs, and overall GBR Budget of the hospital. The State Health Plan itself mandates both that a "cardiac surgery program…be financially feasible" ***and*** that it "not jeopardize the financial viability of the hospital."[9] To be financially feasible means, among other things, to

[7] The process of rate realignment across the facility will also have a *de minimus* feedback effect on AAMC's proposed cardiac surgery program as well, as decreases in unit rates at the hospital level will decrease AAMC's charge per case for cardiac surgery, since those unit rates compose, in part, such charge per case figure.

[8] (internal citations omitted).

[9] COMAR 10.24.17.05(A)(7).

"generate revenues over total expenses for cardiac surgery, if utilization forecasts are achieved for cardiac surgery services."[10]

Here, AAMC will generate revenues over expenses for cardiac surgery, per Table J-1 While AAMC will need to decrease revenue overall at the hospital level to accommodate income from the cardiac surgery service, it will not jeopardize the financial viability of the hospital.

Even if, however, the State Health Plan is interpreted to require a positive GBR impact of AAMC's proposed cardiac surgery service, the HSCRC Memo has indicated that the HSCRC would permit AAMC to allocate to the proposed cardiac surgery service revenue through the other resources provided in the system for new projects. The HSCRC Memo specifically states that AAMC's proposed cardiac surgery service (1) will be financially feasible, and (2) can receive allocations from budget updates associated with "the population adjustment, capacity from reduced avoidable utilization"[11] and "the annual update process for individual hospital budgets."[12]

Therefore, as described in more detail in the remainder of this Modification, the Revised Tables demonstrate that AAMC's proposed cardiac surgery service is financially feasible – whether feasibility is measured on a service line basis or a GBR Budget basis – and that the program will realize savings for cardiac surgery patients and $11,394,078 in savings for the health care delivery system as a whole.

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[10] COMAR 10.24.17.05(A)(7)(b)(iv).

[11] HSCRC Memo at p. 1.

[12] AAMC July 27, 2015 Comment on BWMC Application at p.15, n. 42.

COMAR 10.24.17.05A(4) – Cost Effectiveness

An applicant proposing establishment or relocation of cardiac surgery services shall demonstrate that the benefits of its proposed cardiac surgery program to the health care system as a whole exceed the cost to the health care system.

(a) An applicant that proposes new construction of one or more operating rooms, cardiac catheterization laboratories, or intensive care units, or any combination thereof, as necessary infrastructure for its proposed new cardiac surgery program shall document why existing resources at the applicant hospital cannot be used to accommodate the proposed cardiac surgery services.

(b) An applicant shall provide an analysis of how the cost of cardiac surgery services for cardiac surgery patients in its proposed service area and for the health care system will change as a result of the proposed cardiac surgery program, quantifying these changes to the extent possible.

(c) An applicant shall provide an analysis of how the establishment of its proposed cardiac surgery program will alter the effectiveness of cardiac surgery services for cardiac surgery patients in its proposed service area, quantifying the change in effectiveness to the extent possible. The analysis of service effectiveness shall include, but need not be limited to, the quality of care, care outcomes, and access to and availability of cardiac surgery services.

APPLICANT RESPONSE

(b)

Under this Modification, AAMC's proposed cardiac surgery service will decrease the cost of cardiac surgery for patients in AAMC's proposed service area. As identified in AAMC's original application, AAMC's proposed cardiac surgery service will have one of the lowest charges per case of any cardiac surgery program in Maryland, at an estimated $37,501 charge per case. AAMC's anticipated charge per case has not changed pursuant to this Modification.

10.24.17.05A(7) – Financial Feasibility

A proposed new or relocated cardiac surgery program shall be financially feasible and shall not jeopardize the financial viability of the hospital.

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

(b) An applicant shall document that:

- **(i) Its utilization projections for cardiac surgery are consistent with observed historic trends in the use of cardiac surgery by the population in the applicant's proposed service area;**
- **(ii) Its revenue estimates for cardiac surgery are consistent with utilization projections and account for current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, for cardiac surgery, as experienced by similar hospitals;**
- **(iii) Its staffing and overall expense projections for cardiac surgery are based on current expenditure levels and are consistent with utilization projections and with reasonably anticipated future staffing levels as experienced by the applicant hospital, or, if applicable, the recent experience of similar hospitals; and**
- **(iv) Within three years or less of initiating a new or relocated cardiac surgery program, it will generate excess revenues over total expenses for cardiac surgery, if utilization forecasts are achieved for cardiac surgery services.**

APPLICANT RESPONSE

(a)

The Revised Tables are enclosed as Exhibit 38. AAMC retains all assumptions set forth in its original application, except for the following assumptions:

1. The increase in AAMC's GBR Budget resulting from AAMC's proposed cardiac surgery service will equal 50% of the charges generated by the proposed program, pursuant to the HSCRC market shift adjustment policy's 50% variable cost factor, rather than 85%.

2. Pursuant to the August 24, 2016 memorandum, the HSCRC will permit allocation of certain future adjustments to AAMC's global revenue, namely:

    A. The "population adjustment"[13]

    B. "Capacity from reduced avoidable utilization"[14]

    C. AAMC's existing and anticipated operating margin, i.e. "reallocation of overhead already funded in the system as evidenced by [AAMC's] profits"[15]

AAMC cannot provide, at this time, a breakdown of the relative expected contribution to AAMC's proposed cardiac surgery service of each of the above three revenue sources, for the simple reason that the HSCRC has not yet granted AAMC all the potential adjustments, nor has the HSCRC indicated its expectations of AAMC as to the relative allocation expected between these three sources. However, the GBR Budget impact of AAMC's proposed cardiac surgery service (negative $3,289,059) would be equivalent to only about 0.65% of AAMC's FY 2018 revenue ($502,597,216).[16] Therefore, any substantial general adjustment to GBR Budget revenue would offset the GBR Budget impact of AAMC's proposed cardiac surgery service.

(b) (iv)

Under this Modification, AAMC's proposed cardiac surgery service will generate excess revenues over total expenses for cardiac surgery by the third year of its existence, whether considered on a service line basis or considered on the basis of AAMC's GBR Budget.

As demonstrated in Table J-1, AAMC's proposed cardiac surgery service will generate an operating margin, standing alone, of $1,432,104 by FY 2018. That is, charges generated by

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[13] HSCRC Memo at p. 2.

[14] HSCRC Memo at p. 2.

[15] HSCRC Memo at p. 2.

[16] Table G – Net Operating Revenue

the proposed program will exceed the direct costs of the proposed program. The Commission should adopt this basis for analyzing financial feasibility for the following reasons.

First, doing so follows the language of the relevant section of the State Health Plan, COMAR 10.24.17.05(A)(7):

- COMAR 10.24.17.05A(7) distinguishes between the mandate that a "cardiac surgery program shall be financial feasible" and that the program "not jeopardize the financial viability of the hospital." That is, the State Health Plan distinguishes between the viability of the project itself, and the impact of the project on the hospital as a whole.
- COMAR 10.24.17.05A(7)(b)(iv) asks whether revenues will exceed expenses "***for cardiac surgery***" in particular. (emphasis added).
- COMAR 10.24.17.05A(7)(b)(iv) appears to refer to "a new or relocated cardiac surgery program" as the entity that must "generate excess revenues" ("***it*** will generate excess revenues…"). (emphasis added).

Second, doing so follows the State Health Plan philosophy of considering each proposed project on its own merits.

Third, this approach makes the most sense in the context of the new GBR system. The HSCRC has indicated that it will apply the market shift adjustment policy to volume generated by a new cardiac surgery program – meaning that a hospital establishing a new program receives a GBR Budget increase equivalent to only about half the revenue the program generates. Under a 50% variable cost factor for new revenue, any new service would operate at a loss unless expenses are implausibly low (and the HSCRC recognized this in its Memo by stating that one can allocate other revenue from other sources to open a financially feasible new service, as discussed in the "Financial Feasibility" section of this Modification).

BWMC has similarly acknowledged this problem in its own August 10, 2015 modification to its CON application. "Under the Global Budget Revenue agreements between the HSCRC and most Maryland hospitals, it is not possible to achieve financial feasibility of a new stand-alone cardiac surgery program because revenue can only be achieved through market share adjustments and certain other adjustments to revenue."[17] The premise behind BWMC's modification is that BWMC's proposed cardiac surgery service could only achieve financial feasibility, on a GBR Budget basis, when considering revenue generated by "the combination of the proposed program with the existing cardiac surgery program at UMMC"[18] – i.e. when combining BWMC's proposed program with the revenue generated outside BMWC, by UMMS' existing cardiac surgery programs.

Alternatively, if the feasibility of AAMC's proposed cardiac surgery service is judged on a GBR Budget basis, the HSCRC Memo states that AAMC's proposed cardiac surgery service will be financially feasible. Specifically the HSCRC has indicated that application of a 50% variable cost factor to AAMC's GBR Budget would not "impact the feasibility of the program" because "AAMC has other sources of revenue" in the GBR system "to apply to the project..."[19] These sources of funds include the following anticipated future adjustments to AAMC's GBR Budget by the HSCRC:

- The "population adjustment"[20]
- "Capacity from reduced avoidable utilization"[21]

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[17] BWMC Modification at p. 7, n.2

[18] BWMC Modification at p. 7.

[19] HSCRC Memo at p. 2.

[20] HSCRC Memo at p. 2.

[21] HSCRC Memo at p. 2.

- AAMC's existing and anticipated operating margin, i.e. "reallocation of overhead already funded in the system as evidenced by [AAMC's] profits"[22]

AAMC operating margin alone could suffice to fund the proposed cardiac surgery service, because this margin itself is larger than the projected difference between the expenses of AAMC's proposed cardiac surgery service and AAMC's anticipated GBR Budget increase associated with the service. That is, Table J-2 shows a margin of negative $3,289,059 for FY 2018. However, AAMC anticipates net income of $54,284,672 for FY 2018, as shown in Table G. Therefore, at the volumes AAMC projects, there is no scenario whereby AAMC's proposed cardiac surgery service would be not financially feasible under either the GBR Budget methodology or when considering the proposed program standing alone.

[22] HSCRC Memo at p. 2.

10.24.17.05(A)(8) – Preference in Comparative Reviews

In the case of a comparative review of applications in which all policies and standards have been met by all applicants, the Commission will give preference based on the following criteria.

(a) The applicant whose proposal is the most cost effective for the health care system.

(b) An applicant with an established record of cardiovascular disease prevention and early diagnosis programming that includes provisions for educating patients about treatment options.

(c) An applicant with an established record of cardiovascular disease prevention and early diagnosis programming, with particular outreach to minority and indigent patients in the hospital's regional service area.

(d) An applicant whose cardiac surgery program includes a research, training, and education component that is designed to meet a local or national need and for which the applicant's circumstances offer special advantages.

APPLICANT RESPONSE

(a)

This Modification reinforces AAMC's status as the most cost effective proposal for the health care system in this comparative review, for the following reasons.

First, since the Modification does not increase AAMC's projected charges for cardiac surgery, AAMC will still generate superior savings for cardiac surgery patients than BWMC. In its August 10, 2015 modification, BWMC, using a (flawed) rate center methodology calculation, estimated that AAMC will charge cardiac surgery patients $1,203 less per case than BWMC.[23] AAMC's more accurate case-mix adjusted calculations showed even greater superiority on

[23] *Compare* BWMC Exhibit 49 at Line 1 (BWMC rate center charge per case of $51,952) with BWMC Exhibit 50 at Line 1 (AAMC rate center charge per case of $50,749).

estimated charges: $37,501 per case for AAMC vs. $40,490 per case for BWMC, a $2989 difference (see enclosed Exhibit 40).[24]

Second, the Modification shows a wider gap between the amount AAMC expects to save the health care system, and the amount it expects BWMC to save. AAMC now projects total system savings of $11,394,078, as compared to $3,677,584 for BWMC, as shown on the enclosed Exhibit 40. The improved savings reflects the Modification's recognition of the 50% variable cost factor of the HSCRC market shift adjustment policy, resulting in a smaller AAMC projected GBR Budget revenue increase associated with the project, as reflected in Table H (net income).

[24] BWMC acknowledged its $40,490 charge per case in Table 30 of its modified application (at p. 11).

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.

APPLICANT RESPONSE

For the reasons articulated in the "Cost Effectiveness" and "Preference in Comparative Reviews" sections of this Modification, AAMC's proposed cardiac surgery service would be more cost effective than either the status quo or BWMC's proposed cardiac surgery service.

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.

APPLICANT RESPONSE

For the reasons articulated in the "Financial Feasibility" section of this Modification, AAMC would have the financial resources necessary to sustain AAMC's proposed cardiac surgery service

10.24.01.08G(3)(f) – Impact on Existing Providers & 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.

APPLICANT RESPONSE

The Revised Tables – and the updated charts derived from those tables – demonstrate that AAMC's proposed cardiac surgery service would generate even greater savings to the health care delivery system than originally projected.

The enclosed Exhibit 39 projects total health care expenditure savings of $11,394,078 resulting from AAMC's proposed cardiac surgery service, versus the $7.74 million originally projected. This improvement reflects the Revised Tables' reduction in overall AAMC revenue caused by the move from an 85% variable cost factor to a 50% variable cost factor.

These savings improve AAMC's case that AAMC's proposed cardiac surgery service would help Maryland's performance with regard to the Medicare Waiver.

As explained in its March 30, 2016 completeness response, Maryland's All-Payer Model Agreement with the Centers for Medicare and Medicaid Services requires Maryland to limit both (1) growth in Maryland hospital expenditures (the "**All-Payer Test**"); and (2) the growth in Medicare expenditures for Maryland Medicare beneficiaries (the "**Medicare Expenditure Test**"). The Medicare Expenditure Test is the harder test for Maryland.[25]

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[25] The HSCRC cannot easily predict, and cannot control, Medicare expenditures at District of Columbia hospitals, let alone nationwide Medicare expenditures. Therefore, actual savings achieved in Medicare spending per beneficiary are more valuable to the HSCRC in preserving the Medicare Waiver. In contrast, Maryland currently has

Under the Modification, AAMC's proposed cardiac surgery service would provide Maryland with even greater improvements to the Medicare Expenditure Test while having almost no negative impact on the All-Payer Test.

Medicare will now save **$4,126,834** on FY 2018 hospital expenditures for Maryland residents, only spending an additional $2,835,819 (as opposed to the $4,820,900 originally projected) at AAMC, but saving (i) $1,849,373 at other Maryland hospitals (after market share adjustments), and (ii) $5,113,280 at District of Columbia hospitals.

REVISED Chart 37
Impact on the Medicare Waiver Test
Twelve Month Period Ended FY 2018*

Medicare Payment Increases: the Medicare Component of the Cardiac Surgery Program Adjustments to AAMC's GBR Target Budget	$2,835,819
Medicare Payment Decreases (1) the Medicare Component of the Market Shift Adjustments of the Maryland Cardiac Surgery Hospitals (Chart 53, Exhibit 41) (2) the Reduction in Payments to D.C. Hospital Total	 ($1,849,373) ($5,113,280) ($4,126,834)
Medicare Hospital Payments on behalf of Maryland Residents	$6,000,000,000
Favorable Impact on the Medicare Waiver Test	(0.00069)= (0.069%)[26]

AAMC's impact on the All-Payer test will also decline to a nominal $1,926,509, which is $3,901,788 less than the $5,828,297 originally estimated (see Exhibit 39).

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a wide cushion under the All-Payer Test. Moreover, the HSCRC has many levers to address the All-Payer Test, because that test measures only the revenues of Maryland hospitals.

[26] The actual Medicare Test is calculated on a calendar year basis. FY 2018 volumes were used here for illustrative purposes. However, the same favorable results would be found over a calendar basis using similar volumes

The assumptions and calculations underlying AAMC's above conclusions regarding the Medicare Waiver are set forth in Exhibit 41, enclosed.

CONCLUSION

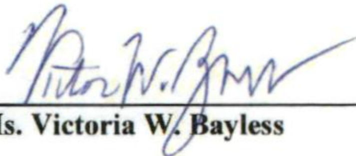
Under the Modification, AAMC's proposed cardiac surgery service will (1) be financially feasible on a service line basis and a GBR Budget basis, (2) generate $11,394,078 in savings for the health care delivery system as a whole, and (3) be more cost-effective than an alternative program at BWMC, or the status quo. The Commission should therefore grant AAMC a certificate of need to establish a cardiac surgery service.

ANNE ARUNDEL MEDICAL CENTER

MODIFICATION TO CERTIFICATE OF NEED APPLICATION

Attestation by Victoria W. Bayless

Affirmation: I hereby declare and affirm under the penalties of perjury that the facts stated in the November 7, 2016 Modification to Certificate of Need Application, and its attachments, of Anne Arundel Medical Center are true and correct to the best of my knowledge, information, and belief.



Ms. Victoria W. Bayless

November 7, 2016
Date

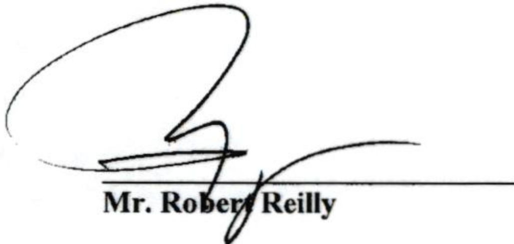
President/CEO Anne Arundel Medical Center
Title

ANNE ARUNDEL MEDICAL CENTER

MODIFICATION TO CERTIFICATE OF NEED APPLICATION

Attestation by Robert Reilly

Affirmation: I hereby declare and affirm under the penalties of perjury that the facts stated in the November 7, 2016 Modification to Certificate of Need Application, and its attachments, of Anne Arundel Medical Center are true and correct to the best of my knowledge, information, and belief.



Mr. Robert Reilly

November 7, 2016
Date

CFO, Anne Arundel Medical Center
Title

List of Exhibits

Exhibit 38 Revised Tables

Exhibit 39 Supporting Calculations for System Savings

Exhibit 40 Comparative Cost-Effectiveness of BWMC and AAMC

Exhibit 41 Supporting Calculations for Medicare Savings

Exhibit 38

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY (REVISED)

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY 2013	FY 2014	FY 2015	FY 2017	FY 2018	FY 2019				
1. REVENUE										
a. Inpatient Services - See Note 1	$ 294,098,900	$ 292,960,600	$ 297,654,040	$ 302,181,942	$ 303,973,116	$ 304,885,277				
b. Outpatient Services	$ 239,409,200	$ 253,443,600	$ 254,587,463	$ 253,953,060	$ 253,956,509	$ 253,960,054				
Gross Patient Service Revenues	***$ 533,508,100***	***$ 546,404,200***	***$ 552,241,503***	***$ 556,135,002***	***$ 557,929,625***	***$ 558,845,331***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 19,750,800	$ 22,623,500	$ 26,145,184	$ 26,303,664	$ 26,366,353	$ 26,398,282				
d. Contractual Allowance	$ 53,366,400	$ 60,024,200	$ 55,603,875	$ 56,115,030	$ 56,317,572	$ 56,420,930				
e. Charity Care	$ 8,912,500	$ 5,721,800	$ 2,774,084	$ 2,796,724	$ 2,805,680	$ 2,810,240				
Net Patient Services Revenue	***$ 451,478,400***	***$ 458,034,700***	***$ 467,718,360***	***$ 470,919,584***	***$ 472,440,020***	***$ 473,215,880***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues	$ 26,036,200	$ 25,995,000	$ 30,197,196	$ 30,157,196	$ 30,157,196	$ 30,157,196				
NET OPERATING REVENUE	***$ 477,514,600***	***$ 484,029,700***	***$ 497,915,556***	***$ 501,076,780***	***$ 502,597,216***	***$ 503,373,076***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 222,592,080	$ 221,047,100	$ 228,259,601	$ 235,991,612	$ 237,393,158	$ 239,600,264				
b. Contractual Services	$ 2,851,345	$ 716,000	$ 245,942	$ 248,167	$ 248,664	$ 249,623				
c. Interest on Current Debt	$ 15,972,794	$ 15,182,000	$ 14,096,925	$ 13,555,176	$ 13,301,038	$ 13,041,376				
d. Interest on Project Debt										
e. Current Depreciation	$27,952,182	$29,211,500	$29,396,532	$ 29,452,079	$ 28,642,928	$ 28,502,319				
f. Project Depreciation				$ 315,319	$ 315,319	$ 315,319				
g. Current Amortization	$ 418,365	$ 392,500	$ 390,407	$ 307,008	$ 307,008	$ 307,008				
h. Project Amortization										
i. Supplies	$ 115,094,050	$ 117,119,100	$ 115,931,587	$ 107,621,203	$ 105,810,629	$ 102,989,400				
j. Other Expenses (Specify/add rows if needed)	$ 91,519,202	$ 88,249,400	$ 89,396,313	$ 84,703,874	$ 82,984,745	$ 80,555,423				
TOTAL OPERATING EXPENSES	**$ 476,400,018**	**$ 471,917,600**	**$ 477,717,307**	**$ 472,194,438**	**$ 469,003,487**	**$ 465,560,733**	**$ -**	**$ -**	**$ -**	**$ -**
3. INCOME										
a. Income From Operation	**$ 1,114,582**	**$ 12,112,100**	**$ 20,198,249**	**$ 28,882,341**	**$ 33,593,728**	**$ 37,812,343**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income	$ 44,226,600	$ 27,091,100	$ (31,684,793)	$ 16,919,694	$ 20,690,944	$ 24,933,376				
SUBTOTAL	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 45,802,036***	***$ 54,284,672***	***$ 62,745,719***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 45,802,036***	***$ 54,284,672***	***$ 62,745,719***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY (REVISED)

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY 2013	FY 2014	FY 2015	FY 2017	FY 2018	FY 2019				

Note 1: Per the HSCRC, revenue can be reallocated from other revenue sources (HSCRC Memorandum of 8/24/16 to MHCC)

	FY 2013	FY 2014	FY 2015	FY 2017	FY 2018	FY 2019				
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY (REVISED)

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY 2013	FY 2014	FY 2015	FY 2017	FY 2018	FY 2019				
1. REVENUE										
a. Inpatient Services - See Note 1	$ 294,098,900	$ 292,960,600	$ 297,654,040	$ 318,341,878	$ 328,648,242	$ 338,282,901				
b. Outpatient Services	$ 239,409,200	$ 253,443,600	$ 254,587,463	$ 266,809,830	$ 273,484,577	$ 280,326,773				
Gross Patient Service Revenues	***$ 533,508,100***	***$ 546,404,200***	***$ 552,241,503***	***$ 585,151,708***	***$ 602,132,819***	***$ 618,609,674***	$ -	$ -	$ -	$ -
c. Allowance For Bad Debt	$ 19,750,800	$ 22,623,500	$ 26,145,184	$ 27,635,155	$ 28,397,122	$ 29,146,625				
d. Contractual Allowance	$ 53,366,400	$ 60,024,200	$ 55,603,875	$ 57,727,320	$ 58,792,706	$ 59,784,713				
e. Charity Care	$ 8,912,500	$ 5,721,800	$ 2,774,084	$ 2,938,290	$ 3,021,902	$ 3,103,103				
Net Patient Services Revenue	***$ 451,478,400***	***$ 458,034,700***	***$ 467,718,360***	***$ 496,850,944***	***$ 511,921,089***	***$ 526,575,234***	$ -	$ -	$ -	$ -
f. Other Operating Revenues (Specify/add rows if needed)	$ 26,036,200	$ 25,995,000	$ 30,197,196	$ 31,203,328	$ 31,711,634	$ 32,230,107				
NET OPERATING REVENUE	***$ 477,514,600***	***$ 484,029,700***	***$ 497,915,556***	***$ 528,054,271***	***$ 543,632,723***	***$ 558,805,340***	$ -	$ -	$ -	$ -
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 222,592,080	$ 221,047,100	$ 228,259,601	$ 248,737,129	$ 256,786,669	$ 265,897,175				
b. Contractual Services	$ 2,851,345	$ 716,000	245,942	253,155	256,198	259,759				
c. Interest on Current Debt	$ 15,972,794	$ 15,182,000	14,096,925	13,555,176	13,301,038	13,041,376				
d. Interest on Project Debt	$ -	$ -								
e. Current Depreciation	$ 27,952,182	$ 29,211,500	29,396,532	29,452,079	28,642,928	28,502,319				
f. Project Depreciation	$ -	$ -		315,319	315,319	315,319				
g. Current Amortization	$ 418,365	$ 392,500	390,407	307,008	307,008	307,008				
h. Project Amortization	$ -	$ -								
i. Supplies	$ 115,094,050	$ 117,119,100	115,931,587	118,510,331	122,853,218	126,853,721				
j. Other Expenses (Specify/add rows if needed)	$ 91,519,202	$ 88,249,400	89,396,313	92,087,575	94,325,880	96,044,317				
TOTAL OPERATING EXPENSES	**$ 476,400,018**	**$ 471,917,600**	**$ 477,717,307**	**$ 503,217,771**	**$ 516,788,258**	**$ 531,220,993**	$ -	$ -	$ -	$ -
3. INCOME										
a. Income From Operation	**$ 1,114,582**	**$ 12,112,100**	**$ 20,198,249**	**$ 24,836,500**	**$ 26,844,465**	**$ 27,584,347**	$ -	$ -	$ -	$ -
b. Non-Operating Income	$ 44,226,600	$ 27,091,100	$ (31,684,793)	$ 16,716,597	$ 20,162,033	$ 23,870,184				
SUBTOTAL	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 41,553,097***	***$ 47,006,498***	***$ 51,454,531***	$ -	$ -	$ -	$ -
c. Income Taxes										
NET INCOME (LOSS)	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 41,553,097***	***$ 47,006,498***	***$ 51,454,531***	$ -	$ -	$ -	$ -

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY (REVISED)

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY 2013	FY 2014	FY 2015	FY 2017	FY 2018	FY 2019				

Note 1: Per the HSCRC, revenue can be reallocated from other revenue sources (HSCRC Memorandum of 8/24/16 to MHCC)

4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE J-1. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE (REVISED)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE							
a. Inpatient Services	$ 7,557,221	$ 11,147,964	$ 12,980,221				
b. Outpatient Services	$ -	$ -	$ -				
Gross Patient Service Revenues	***$ 7,557,221***	***$ 11,147,964***	***$ 12,980,221***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 264,503	$ 390,178	$ 454,308				
d. Contractual Allowance	$ 853,966	$ 1,259,720	$ 1,466,765				
e. Charity Care	$ 37,786	$ 55,740	$ 64,901				
Net Patient Services Revenue	***$ 6,400,966***	***$ 9,442,326***	***$ 10,994,247***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues							
NET OPERATING REVENUE	***$ 6,400,966***	***$ 9,442,326***	***$ 10,994,247***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 3,042,302	$ 3,397,763	$ 3,582,372				
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	$ 315,319	$ 315,319	$ 315,319				
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 1,687,904	$ 2,466,749	$ 2,873,906				
j. Other Expenses (Specify)	$ 1,899,518	$ 1,830,391	$ 1,702,183				
TOTAL OPERATING EXPENSES	**$ 6,945,043**	**$ 8,010,222**	**$ 8,473,780**	**$ -**	**$ -**	**$ -**	**$ -**
3. INCOME							
a. Income From Operation	**$ (544,076)**	**$ 1,432,104**	**$ 2,520,467**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ (544,076)***	***$ 1,432,104***	***$ 2,520,467***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							

TABLE J-1. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE (REVISED)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY 2017	FY 2018	FY 2019				
NET INCOME (LOSS)	$ (544,076)	$ 1,432,104	$ 2,520,467	$ -	$ -	$ -	$ -

TABLE J-1. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE (REVISED)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	6.8%	6.8%	6.8%				
3) Blue Cross	9.3%	9.3%	9.3%				
4) Commercial Insurance	30.6%	28.9%	27.9%				
5) Self-pay	2.5%	2.5%	2.5%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	7.3%	7.3%	7.3%				
3) Blue Cross	9.0%	9.0%	9.0%				
4) Commercial Insurance	30.0%	28.4%	27.4%				
5) Self-pay	2.9%	2.9%	2.9%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE J-2. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE (REVISED AT 50% VCF)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE							
a. Inpatient Services	$ 3,778,611	$ 5,573,982	$ 6,490,110				
b. Outpatient Services	$ -	$ -	$ -				
Gross Patient Service Revenues	***$ 3,778,611***	***$ 5,573,982***	***$ 6,490,110***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 132,251	$ 195,089	$ 227,154				
d. Contractual Allowance	$ 426,983	$ 629,860	$ 733,383				
e. Charity Care	$ 18,893	$ 27,870	$ 32,450				
Net Patient Services Revenue	***$ 3,200,483***	***$ 4,721,163***	***$ 5,497,124***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues							
NET OPERATING REVENUE	***$ 3,200,483***	***$ 4,721,163***	***$ 5,497,124***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 3,042,302	$ 3,397,763	$ 3,582,372				
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	$ 315,319	$ 315,319	$ 315,319				
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 1,687,904	$ 2,466,749	$ 2,873,906				
j. Other Expenses (Specify)	$ 1,899,518	$ 1,830,391	$ 1,702,183				
TOTAL OPERATING EXPENSES	**$ 6,945,043**	**$ 8,010,222**	**$ 8,473,780**	**$ -**	**$ -**	**$ -**	**$ -**
3. INCOME							
a. Income From Operation	**$ (3,744,559)**	**$ (3,289,059)**	**$ (2,976,657)**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ (3,744,559)***	***$ (3,289,059)***	***$ (2,976,657)***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							

TABLE J-2. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE (REVISED AT 50% VCF)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY 2017	FY 2018	FY 2019				
NET INCOME (LOSS)	$ (3,744,559)	$ (3,289,059)	$ (2,976,657)	$ -	$ -	$ -	$ -

TABLE J-2. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE (REVISED AT 50% VCF)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	6.8%	6.8%	6.8%				
3) Blue Cross	9.3%	9.3%	9.3%				
4) Commercial Insurance	30.6%	28.9%	27.9%				
5) Self-pay	2.5%	2.5%	2.5%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	7.3%	7.3%	7.3%				
3) Blue Cross	9.0%	9.0%	9.0%				
4) Commercial Insurance	30.0%	28.4%	27.4%				
5) Self-pay	2.9%	2.9%	2.9%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE K-1. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE (REVISED)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE							
a. Inpatient Services	$ 7,935,082	$ 11,984,062	$ 14,278,243				
b. Outpatient Services	$ -	$ -	$ -				
Gross Patient Service Revenues	***$ 7,935,082***	***$ 11,984,062***	***$ 14,278,243***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 277,728	$ 419,442	$ 499,739				
d. Contractual Allowance	$ 896,664	$ 1,354,199	$ 1,613,442				
e. Charity Care	$ 39,676	$ 59,921	$ 71,391				
Net Patient Services Revenue	***$ 6,721,015***	***$ 10,150,500***	***$ 12,093,672***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)							
NET OPERATING REVENUE	***$ 6,721,015***	***$ 10,150,500***	***$ 12,093,672***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 3,163,994	$ 3,601,628	$ 3,868,962				
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	$ 315,319	$ 315,319	$ 315,319				
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 1,228,148	$ 2,095,246	$ 2,585,649				
j. Other Expenses (Specify/add rows of needed)	$ 2,442,273	$ 2,372,968	$ 2,251,816				
TOTAL OPERATING EXPENSES	***$ 7,149,734***	***$ 8,385,161***	***$ 9,021,745***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							

TABLE K-1. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE (REVISED)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
a. Income From Operation	**$ (428,720)**	**$ 1,765,339**	**$ 3,071,926**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ (428,720)***	***$ 1,765,339***	***$ 3,071,926***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ (428,720)***	***$ 1,765,339***	***$ 3,071,926***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE K-1. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE (REVISED)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	6.8%	6.8%	6.8%				
3) Blue Cross	9.3%	9.3%	9.3%				
4) Commercial Insurance	30.6%	28.9%	27.9%				
5) Self-pay	2.5%	2.5%	2.5%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	7.3%	7.3%	7.3%				
3) Blue Cross	9.0%	9.0%	9.0%				
4) Commercial Insurance	30.0%	28.4%	27.4%				
5) Self-pay	2.9%	2.9%	2.9%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE K-2. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE (REVISED AT 50% VCF)

<u>INSTRUCTION</u>: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE							
a. Inpatient Services	$ 3,967,541	$ 5,852,681	$ 6,814,616				
b. Outpatient Services	$ -	$ -	$ -				
Gross Patient Service Revenues	***$ 3,967,541***	***$ 5,852,681***	***$ 6,814,616***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 138,864	$ 204,844	$ 238,512				
d. Contractual Allowance	$ 448,332	$ 661,353	$ 770,052				
e. Charity Care	$ 19,838	$ 29,264	$ 34,073				
Net Patient Services Revenue	***$ 3,360,507***	***$ 4,957,221***	***$ 5,771,980***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)							
NET OPERATING REVENUE	***$ 3,360,507***	***$ 4,957,221***	***$ 5,771,980***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 3,163,994	$ 3,601,628	$ 3,868,962				
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	$ 315,319	$ 315,319	$ 315,319				
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 1,228,148	$ 2,095,246	$ 2,585,649				
j. Other Expenses (Specify/add rows of needed)	$ 2,442,273	$ 2,372,968	$ 2,251,816				
TOTAL OPERATING EXPENSES	**$ 7,149,734**	**$ 8,385,161**	**$ 9,021,745**	**$ -**	**$ -**	**$ -**	**$ -**
3. INCOME							

TABLE K-2. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE (REVISED AT 50% VCF)

<u>INSTRUCTION</u>: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
a. Income From Operation	$ (3,789,227)	$ (3,427,940)	$ (3,249,766)	$ -	$ -	$ -	$ -
b. Non-Operating Income							
SUBTOTAL	$ (3,789,227)	$ (3,427,940)	$ (3,249,766)	$ -	$ -	$ -	$ -
c. Income Taxes							
NET INCOME (LOSS)	$ (3,789,227)	$ (3,427,940)	$ (3,249,766)	$ -	$ -	$ -	$ -

TABLE K-2. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE (REVISED AT 50% VCF)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	6.8%	6.8%	6.8%				
3) Blue Cross	9.3%	9.3%	9.3%				
4) Commercial Insurance	30.6%	28.9%	27.9%				
5) Self-pay	2.5%	2.5%	2.5%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	7.3%	7.3%	7.3%				
3) Blue Cross	9.0%	9.0%	9.0%				
4) Commercial Insurance	30.0%	28.4%	27.4%				
5) Self-pay	2.9%	2.9%	2.9%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

Exhibit 39

REVISED AAMC Cardiac Surgery Program System Savings Projection

EXHIBIT 39

	FY 2018 - Charges[1]				
	Cases	CPC	Revenue	VCF	Revenue @ VCF
AAMC Projected Open Heart Cases	337	$37,501	$12,637,820	50%	$6,318,910
Transfers	178	(8,370)	(1,489,856)	50%	(744,928)
Incremental Revenue	337	33,080	$11,147,964	50%	$5,573,982
Impact on OHS Hospitals:					
DC Hospitals[2,4]	(227)	$58,681	($13,320,587)	100%	($13,320,587)
Johns Hopkins Hospital	(69)	68,174	(4,704,001)	50%	(2,352,001)
University of Maryland Medical Center	(29)	69,878	(2,026,455)	50%	(1,013,227)
Washington Adventist Hospital	(6)	47,107	(282,643)	50%	(141,322)
Sinai Hospital	(3)	48,313	(144,938)	50%	(72,469)
MedStar Union Memorial Hospital	(2)	49,124	(98,249)	50%	(49,124)
UM St. Joseph Medical Center	(1)	38,659	(38,659)	50%	(19,330)
Total Estimated Charges	(337)	$61,174	($20,615,533)	82%	($16,968,060)
Net Savings to the Health Care System			**($9,467,568)**	**120%**	**($11,394,078)**

	FY 2018 - Payments[3]				
	Cases	Average Payment	Total Payment	VCF	Payment @ VCF
AAMC Projected Open Heart Cases	337	$37,501	$12,637,820	50%	$6,318,910
Transfers	178	(8,370)	(1,489,856)	50%	(744,928)
Incremental Revenue	337	33,080	$11,147,964	50%	$5,573,982
Estimated Payment @ 95.6% [3]		31,624	$10,657,454	50%	$5,328,727
Impact on Existing Cardiac Surgery Hospitals:					
DC Hospitals[2,4]	(227)	$58,681	($13,320,587)	100%	($13,320,587)
Maryland Hospitals					
Johns Hopkins Hospital	(69)	65,174	(4,497,025)	50%	(2,248,513)
University of Maryland Medical Center	(29)	66,803	(1,937,291)	50%	(968,645)
Washington Adventist Hospital	(6)	45,034	(270,207)	50%	(135,103)
Sinai Hospital	(3)	46,187	(138,561)	50%	(69,281)
MedStar Union Memorial Hospital	(2)	46,963	(93,926)	50%	(46,963)
UM St. Joseph Medical Center	(1)	36,958	(36,958)	50%	(18,479)
Total Estimated Payment	-337	$60,221	($20,294,555)	83%	($16,807,571)
Net Savings on Total Healthcare Spend			**($9,637,101)**	**119%**	**($11,478,844)**

Notes:

[1] MD Hospital CPC calculated as Hospital-specific total CPC @ CMI 1.00 (excluding categoricals and ODS, except for OB/normal newborns) multiplied by the

[2] DC Hospitals defined as Washington Hospital Center (221 cases) and George Washington University Hospital (6 cases)

[3] Payment discount is calculated at 4.4%, a blend of the 8% discount for Medicare (55.3% of cases) and no discount for non-Medicare cases (44.7%

[4] DC hospital payments estimated as a blend of payments for Medicare and non-Medicare payments in the same proportion. The Medicare

Exhibit 40

REVISED AAMC vs. BWMC System Savings Comparison - EXHIBIT 40

Aggregate Reduction in Charges to the System

	AAMC-CON	BWMC	Notes
GBR Target Budget Adjustment			
Hospital CPC @ CMI 1.00	$10,962	$11,911	FY2014 CPC @ CMI 1.00, using RY2013 CMI weights, v.29 (excludes 1-day stays and normal newborns)
Estimated Cardiac Surgery CMI	3.42	3.40	Per AAMC & BWMC CONs
Imputed Charge per OHS Case	$37,501	$40,490	
Total OHS Cases	337	228	Per AAMC & BWMC CONs
Subtotal: Incremental Charges	$12,637,820	$9,231,720	
Less: Existing Transfer Revenue	(1,489,856)	-	Per AAMC CON
Total Incremental Charges	$11,147,964	$9,231,720	
VCF	50%	50%	
GBR Adjustments	**$5,573,982**	**$4,615,860**	
Reduction of Maryland Hospital Target Budgets			
Hospital CPC @ CMI 1.00	$19,386	$19,412	
Estimated Cardiac Surgery CMI	3.42	3.40	
Imputed Charge per OHS Case	$66,318	$65,990	Weighted average of shifting hospital OHS CPCs (See System Savings Calculations)
OHS Cases Shifting from Maryland Hospitals	(110)	(198)	Per AAMC & BWMC CONs
Incremental Charge Reduction	($7,294,946)	($13,066,028)	
VCF	50%	50%	
GBR Adjustments	**($3,647,473)**	**($6,533,014)**	
Net Reduction in Charges at Maryland Hospitals	**$1,926,509**	**($1,917,154)**	All Payer Test
Reduction of Washington, D.C. Hospitals			
Payment per Case	$58,681	$58,681	
OHS Cases Shifting from DC Hospitals	(227)	(30)	Per AAMC & BWMC CONs
Incremental Charge Reduction	($13,320,587)	($1,760,430)	
VCF	100%	100%	
Reduction in Payments at DC Hospitals	**($13,320,587)**	**($1,760,430)**	
Total Reduction in Hospital Spending	**($11,394,078)**	**($3,677,584)**	Impact to total Healthcare Spend

Exhibit 41

EXHIBIT 41

Medicare Waiver Assumptions and Calculations – Revised AAMC Projections

1. Increased AAMC Revenue under the Project – All-Payers: $5,573,982

AAMC estimates that its GBR target budget will increase **$5,573,982** in FY 2018. AAMC derived this estimate by (a) calculating the total charges for its FY 2018 cardiac surgery cases (multiplying its charge per case by the estimated number of cases), (b) subtracting existing budgeted revenue for those patients[1], and (c) applying a 50% market share adjustment.

Chart 50 – REVISED

FY 2018 AAMC BUDGET INCREASE – TOTAL

	Step	Result
1	Estimated Cardiac Surgery Cases	337
2	Charge Per Case	$37,501
3	Aggregate Charges: (1) x (2)	$12,637,820
4	Existing Revenue from Transferred Patients	($1,489,856)
5	Incremental Budget Increase before MSA: (3) – (4)	$11,147,964
6	Market Share Adjustment	***50%***
7	Actual Incremental Budget Increase (5) x (6)	$5,573,982

[1] That is, for patients who are admitted to AAMC but are ultimately transferred to another hospital for cardiac surgery, AAMC's budget still includes revenue to provide care to those patients from admission through the time of transfer. So, for that subset of patients (admitted to AAMC then transferred for surgery), the estimated $37,501 charge per case is not all an incremental increase in revenue.

2. Increased AAMC Revenue – Medicare only: $2,835,823

AAMC estimates that the $5,573,991 increase in its FY 2018 target budget will include **$2,835,823** of additional expenditures by Medicare. This is based on the following analysis:

First, AAMC projected the total number of cardiac surgery cases at AAMC in FY 2018 if the Project is approved.

Second, AAMC projected the number of *Medicare* cardiac surgery cases at AAMC in FY 2018 if the Project is approved based on the projected volume shifts, by hospital, and projected population growth.

Third, AAMC applied case mix indexes (CMIs) for Medicare and for all payers to estimate the severity of Medicare cases, and thus the portion of the FY 2018 target budget increase attributable to Medicare patients.[2] AAMC multiplied the Medicare CMI by the estimated total number of FY 2018 Medicare cardiac surgery cases at AAMC to generate the case mix adjusted discharges (CMADs) for Medicare patients at AAMC. AAMC similarly multiplied the general CMI for all cardiac surgery cases – Medicare or non-Medicare – by the projected number of FY 2018 cardiac surgery cases at AAMC to generate the CMADs for all patients at AAMC.

Fourth, AAMC used the ratio of Medicare CMADs to total CMADs as the ratio of charges attributable to Medicare vs. total charges to derive the portion of AAMC's FY 2018 incremental budget increase attributable to Medicare.

Finally, AAMC applied Medicare's discount of 8% (6% HSCRC discount plus 2% sequestration discount) to derive Medicare's incremental increase in actual expenditures at AAMC.[3] The results are displayed on the chart below.

Chart 51 – REVISED

FY 2018 AAMC BUDGET INCREASE – MEDICARE

	Step	Result
1	Estimated Medicare Cardiac Surgery Cases	172
2	Medicare CMI	3.71
3	Medicare CMADs: (1) x (2)	638
4	Estimated Total Cardiac Surgery Cases	337
5	Total CMI	3.4209
6	Total CMADs: (4) x (5)	1152

[2] It would be incorrect to assume that Medicare cases would generate charges in portion to their number (i.e., 172 /337 = 51%). Although AAMC will have an *average* charge per case, Medicare cases will be more severe, requiring more resources and thus generating higher charges, while non-Medicare cases will be less severe, requiring fewer resources and thus generating lower charges.

[3] Under the Medicare differential, Medicare receives a 6% discount on charges. An additional 2% is withheld under the Budget Control Act of 2011 (sequestration).

7	Ratio of Medicare CMADs to Total CMADs: (3) / (6)	55.3%
8	Actual Incremental Budget Increase (Previous Table)	$5,573,982
9	Medicare Share of Incremental Increase in Budget: (7) x (8)	$3,082,412
10	Medicare Responsibility after 8% Discount	92%
11	Actual Increase in Medicare Expenditure: (9) x (10)	$2,835,819

3. <u>Decreased Maryland Hospital Revenue (AAMC Excluded) – All-Payers: **$3,635,059**</u>

AAMC estimates that other Maryland hospitals performing cardiac surgery will have an aggregate **$3,635,059** decrease in their FY 2018 GBR target budgets as a result of the projected volume shifts. AAMC derived this estimate for each hospital by: (a) calculating the average charge for each case shifting to AAMC (the product of AAMC's projected CMI times the after hospital's FY 2014 charge per CMAD), (b) multiplying that average charge per case by the number of cases shifted, and then (c) applying a market share adjustment of 50%.

Chart 52

FY 2018 MARYLAND HOSPITAL BUDGET DECREASE - TOTAL

	Step	UMMS	JHH	Other	Total
1	Average Charge per CMAD	$20,427	$19,929	$13,145	
2	CMI of Cases Lost to AAMC	3.4209	3.4209	3.4209	
3	Average Charge per Case Shifted: (1) x (2)	$69,878	$68,174	$44,971	
4	Cases Shifted	29	69	12	
5	Incremental Budget Decrease before MSA: (3) x (4)	$2,026, 462	$4,704,006	$539,649	
6	Market Share Adjustment	50%	50%	50%	
7	Actual Incremental Budget Decrease: (5) x (6)	$1,013, 231	$2,352,003	$269,825	$3,635,059

4. Decreased Maryland Hospital Revenue (AAMC Excluded) – Medicare only: **$1,849,373**

AAMC estimates that the $3,635,059 aggregate decrease in the FY 2018 target budgets of the other Maryland hospitals performing cardiac surgery will result in **$1,849,373 savings** in expenditures by Medicare. AAMC derived that estimate by applying the same ratio of Medicare vs. total charges to the $3.6 million aggregate decrease that is projected, and then applying the same Medicare discount.[4]

Chart 53

FY 2018 MARYLAND HOSPITAL BUDGET DECREASE - MEDICARE

	Step	Result
1	Actual Incremental Budget Decrease (Previous Table)	$3,635,059
2	Ratio of Medicare CMADs Lost to Total CMADs Lost	55.3%
3	Medicare Share of Incremental Decrease in Budget: (1) x (2)	$2,010,188
4	Medicare Responsibility after 8% Discount	92%
5	Actual Decrease in Medicare Expenditure: (3) x (4)	$1,849,373

[4] This symmetry makes sense. By definition, the CMADs of the Medicare cases gained by AAMC from other hospitals equal the CMADs of the Medicare cases lost by the other hospitals to AAMC.

5. Decreased Medicare Expenditure – Washington Hospital Center: **$5,113,280**

AAMC estimates that Medicare will *save* **$5,113,280** on cardiac surgery cases at Washington Hospital Center (WHC) in FY 2018 as volume is shifted to AAMC. AAMC derived this estimate by (a) calculating the average payment for each Medicare case shifted to AAMC (multiplying AAMC's projected CMI by WHC's payment per CMAD as derived from the MedPar data), then (b) multiplying that average payment per case by the number of cases projected to shift to AAMC.

Chart 54

FY 2018 MEDICARE SAVINGS - WASHINGTON HOSPITAL CENTER

	Step	Result - WHC
1	Average Payment per CMAD	$12,885.50
2	CMI of Cases Shifted to AAMC	3.4209
3	Average Payment per Case Shifted: (1) x (2)	$44,080
4	Cases Shifted	116
5	Medicare Savings	$5,113,280