Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

Monday, October 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 7. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us a minimum of two weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but if necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any other questions regarding this process or regarding the following questions, please contact: Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

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Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

1. Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.
   SUMMARY: As one of the lowest cost providers in the state, Anna Jaques is pleased that the state is raising awareness through this effort to identify those institutions which are achieving the goal of reducing societal cost of health care. Anna Jaques Hospital has consistently been one of the lowest cost providers in the Commonwealth. According to statewide relative price data, Anna Jaques rates are in the lowest quartile of all providers in the state and 30 to 50 percent less than even the median provider of the upper quartile.
   a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.

      For year to date 2014, Anna Jaques hospital has performed favorably below the targeted rate of 3.6%. Gross revenue has increased 2.5% over prior year. More importantly, net revenue, which in effect is the cost to Massachusetts payors and citizens, has increased only 1.8% as compared to the comparable period a year ago. The hospital has limited its growth in operating costs to 2.1%.
   b. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

      As one of the lowest reimbursed hospitals in the state, Anna Jaques Hospital has been forced to fine tune operations for years to live within the limits of the available revenue. Like many hospitals have done, AJH made every effort to move care to the least costly setting possible while providing measurably high quality care. This is evident in the increases in outpatient surgery and outpatient observation care for cases which only recently were viewed and reimbursed as inpatients at a more costly rate structure.
   c. What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of technology and error reduction) to ensure the Commonwealth will meet the benchmark?

      Anna Jaques Hospital has several initiatives underway that will lead to more care being delivered in low cost venues versus the traditional hospital setting. The expansion of primary care into underserved areas should reduce the utilization of expensive emergency department care as a means to meet primary care demands. AJH is working with Elder Services of the Merrimack Valley on a grant that would focus on the reduction of readmissions. AJH also collaborates closely with the local Whittier IPA and invests significantly in electronic medical records and Meaningful Use achievement. This should assist in providing safer

care and improve efficiency because clinicians will have access to the entirety of the patient experience, thus reducing duplicative or redundant testing.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

The key to the state managing healthcare costs must be the continued existence of the low-cost provider community. If all providers are mandated to exist within a fixed rate increase limit, it simply memorializes the great economic disparities that exist today. The above-average reimbursed provider will get the same increase as the lowest cost provider, in effect widening the gap between the have and have nots which have been operating efficiently for society's benefit all along. A policy change to accomplish that could be that providers that are reimbursed in the upper quartile of all providers would have their increase limited to half the state mandated level while the bottom quartile of providers would be eligible for twice the mandated level until the gap is closed and the overall cost trend reflects the intended declining slope.

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2. C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.
SUMMARY: At this time Anna Jaques Hospital has only fee for service agreements with health plans. AJH does participate in pay for performance efforts but they are elements of the fee for service model
    a. How have alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) affected your organization's overall quality performance, care delivery practices, referral patterns, and operations?
    N/A
    b. Attach and discuss any analyses your organization has conducted on the implementation of APMs and resulting effects on your non-clinical operations (e.g., administrative expenses, resources and burdens).
    N/A
    c. Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid for under APMs and for your overall patient population.
    N/A

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3. Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contracts with payers.
SUMMARY: N/A as referenced in question 2
    a. In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient population acuity, including in particular sub-populations (e.g., pediatric) or those with behavioral health conditions?

N/A

b. How do the health status risk adjustment measures used by different payers compare?
   N/A
c. How does the interaction between risk adjustment measures and other risk contract elements (e.g., risk share, availability of quality or performance-based incentives) affect your organization?
   N/A

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4. A theme heard repeatedly at the 2013 Annual Cost Trends Hearing was the need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs. What types of data are or would be most valuable to your organization in this regard? In your response, please address (i) real time data to manage patient care and (ii) historic data or population-level data that would be helpful for population health management and/or financial modeling.
   SUMMARY: The key to managing the cost of health care and improving the cost curve will be to address the care management needs of the subset of the population who use a disproportionate amount of healthcare resources. Health plans need to identify those patients who are using a higher than expected frequency of care or a disproportionately high per use cost of care. An individual provider is unable to see the entire view of the cost profile of a given patient who may be accessing the healthcare system trough a variety of provider access points. Once those individuals have been identified, a care plan can be constructed with their PCP to assure routine and easily accessible care is available to manage the routine care of the likely chronic conditions as opposed to the very expensive occurrence of acute episodes.
   ANSWER: An APM that provides access to those identified individuals and assists in the creation of the care management plan should differentiate itself in the marketplace

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5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
   SUMMARY:
   a. Which attribution methodologies most accurately account for patients you care for?
      A combined methodology that takes into account which primary care provider the patient identifies as their provider as well as identifying the providers that they see most frequently. The model that leaves either of these two pieces out of the equation can misrepresent the influence that the primary care provider can have on the cost of care for a patient. When there is a discrepancy between these two indicators occurs, the patient should be notified by the health plan to verify that they are still using the identified PCP. If they indicate that they are still with the identified PCP then the PCP and the patient should be notified that the patient may benefit from a visit to their PCP to help coordinate care.
   b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?

Formulation for attribution was discussed in above question. The suggestion for implementation would be that as part of the process for attribution, that a patient be able to access a care coordination visit with their PCP at least once per year that is covered without any co-pay for the patient, and more frequently based on the number of visits to other providers (perhaps a care coordination visit for every 4 visits to other physicians/providers).

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6. Please discuss the level of effort required to report required quality measures to public and private payers, the extent to which quality measures vary across payers, and the resulting impact(s) on your organization.
   SUMMARY: The hospital manually abstracts measures from electronic and paper medical records to report on the varies measures. The data is then entered into a vendor's database for submission to CMS, TJC and MassHealth. For other payers the information is entered into Excel spreadsheets. The payers and regulatory agencies have many similar required measures for reporting however there are still several that are different.
   ANSWER: The hospital uses Press Ganey for Core Measures and Patient Satisfaction. For MassHealth, the organization utilizies Outcome which will no longer be providing this service. For insurance contracts, Anna Jaques completes a variety of Excel spreadsheets for the individual payors. Leapfrog information is gathered through a variety of sources, some of which require creating numerous reports to then manually calculate the data. The consistent theme for all of these avenues is manual abstaction and then entry into another modality of payor choice. Many of the payors have come into aligment with CMS requirments but not all.
   The hospital recently changed to Premier Quality Advisor software to improve tracking of clinical and financial performance against national benchmarks. This software has interfaces with the CPOE component so it can match patient outcomes with specific evidence-based interventions. It is an important adjunct to our commitment as a hospital and medical staff to practice in a way that benefits patients and that society can afford. The software was fully implemented within the six month grant cycle with the appropriate interfaces with the hospital-based electronic record.

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7. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than average utilization of inpatient care and its reliance on academic medical centers.
   SUMMARY:
   a. Please attach any analyses you have conducted on inpatient utilization trends and the flow of your patients to AMCs or other higher cost care settings.
      See attached supporting schedule of ED transfer volume by facility
   b. Please describe your organization's efforts to address these trends, including, in particular, actions your organization is taking to ensure that patients receive care in lower-cost community settings, to the extent clinically feasible, and the results of these efforts.
      Through AJH's clinical affiliation with BIDMC, a greater number of tertiary affiliated providers will practice within the greater Newburyport community, reducing the need of patients to go to Boston for care. This fosters greater patient satisfaction and reduces overall cost to the Commonwealth.

8. The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially depending upon the discharging hospital.
SUMMARY: It is unclear based on the above comment if the Commission believes an opportunity exists to expand the use of post-acute providers or if there is an overutilization now. The aggregate results for Anna Jaques Hospital over the past five years has been that approximately 30% to 32% of discharged patients have some post-acute service. It is of note that the mix of patients has moved towards more home health related care as opposed to institutional SNF or rehab. SNF and Rehab cases have declined from 14.6% of discharges to 12.2%. During that same five year period of time, home health care has increased from 17.2% to 18.1%
    a. Please describe and attach any analyses your organization has conducted regarding levels of and variation in the utilization and site of post-acute care, as well as your efforts to ensure that patients are discharged to the most clinically appropriate, high-value setting.
    See attached supporting schedule of non home discharge disposition trends
    b. How does your organization ensure optimal use of post-acute care?
    The second project of the CHART phase 1 grant focused on information transfer for patients leaving the facility and being cared for by post-acute care facilities or visiting nurses providers. The case management software is a web-based tool that enables hospitals to fully automate and streamline the discharge planning process and connect automatically with the post-acute care community, decreasing delays in discharge and enhancing communication. This software implementation resulted in improved case management staff productivity, to enable more time on population management interventions to prevent unnecessary readmission. This software transfers discharge information to providers electronically and securely without faxing, resulting in quicker decision regarding appropriate skilled bed offers, and maximizing staff efficiency. The software also provides reports on the effectiveness of the post-acute transfers process, the efficiency of moving patients to the post-acute setting and whether the patient can complete the 30 days without a need for repeat hospitalization. It tracks "avoidable days" in the hospital to monitor appropriate utilization of resources. It also allows tracking of readmissions from individual facilities, to target improvement efforts around avoidable hospitalizations and help with decreasing total medical expenditures. This tool transfers appropriate clinical information to allow for management across the care continuum, which is a central goal and requirement of effective population management and lowered TME.

9. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price

information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.
SUMMARY: Anna Jaques Hospital publicized to the community a hot line to assist people who wanted to better understand their personal cost of care they were expecting to receive at the hospital. Since its operation there have been no queries to the website and three calls to that number or any other direct form of question.

Health Care Service Price Inquiries				
Year		Number of Inquiries via Website	Number of Inquiries via Telephone/In Person	Average (approximate) Response Time to Inquiries*
CY2014	Q1	0	3	6 hours
	Q2	0	0	
	Q3	0	0	
	TOTAL:	0	3	

** Please indicate the unit of time reported.*

ANSWER: See chart above.

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10. Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices, and attach any analyses your organization has conducted on this issue. Describe any actions your organization taken (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.
SUMMARY: Being a high value provider (low cost with measurably high quality), AJH is in the position to be included in all limited network products. Maintaining our focus as a high value provider, we would hope volume will ultimately steer to such providers for the purpose of bending the health care cost curve as volume shifts to lower cost providers.
ANSWER:

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11. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
SUMMARY:
    a. Please describe ways that your organization is collaborating with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.
    Compliance with aftercare is a chronic problem for this population, which results in exacerbation of symptoms and overuse of the ED/inpatient unit. In response to this, Anna Jaques Hospital is corroborating with outpatient providers at time of

admission (with patient permission) to ensure accurate continuity of medication management, medication compliance, and attendance at subsequent outpatient appointments. Throughout the admission AJH will coordinate network meetings with all providers identify areas of weakness/failure in care leading up to the admission and identify interventions to improve. It is strongly recommended that outpatient providers who refuse to make appointments for patients who are consistent no-shows develop a drop-in introductory group intake appointment, therefore maintaining an open door to the more challenging pat

b. Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.

   Avoid unnecessary utilization of emergency department services and psychiatric inpatient care has been an ongoing goal of Anna Jaques Hospital both for the benefit of the patient as well as the total medical expense to the Commonwealth. In collaboration with Lahey's Behavioral Health team educating patients at time of discharge regarding Lahey Behavioral Health's at home crisis evaluation services to avoid ED over usage. AJH supports Lahey's diversion to a CSU when possible rather than in-patient level of care reducing overall cost. Another element of the relationship with Lahey involves setting patients up with Community Based Flexible Support Services (CBFS) to support compliance with out-patient appointments by providing transportation and accompaniment. It will also require a more direct collaboration with payors as well as providers

c. Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.

   Treating this particular population of patients brings with it an inevitable number of successes and challenges. While CBFS (Mass Health Product) is theoretically an excellent service, often we are not able to book these services, and patients leave without the support in place. Mental health patients smoke at a higher rate than non-mental health patients, which is an area that does not receive enough education and support.

   Insurances are assigning intensive case managers for high risk patients, which can be very effective depending on the quality of the case manager.

   Placement in a supervised group home is no longer as an available option as it had once been for our case managers when we have identified a patient that requires this level of care. It would be beneficial to have this access again, which would require more group home s

d. There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organization's willingness and ability to report discharge data.

   Anna Jaques Hospital welcomes any opportunity to advance the conversation regarding the impact of behavioral medicine issues on the total medical expenses of the population

12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
    SUMMARY: Anna Jaques Hospital currently doesn't have a patient centered medical home model
    a. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?
       N/A
    b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?
       N/A
    c. Please discuss the results of any analyses your organization has conducted on the impact of PCMH recognition or accreditation, including on outcomes, quality, and costs of care.
       N/A

13. After reviewing the Commission's 2013 Cost Trends Report and the July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.
    SUMMARY: The 2013 report highlighted four main areas of opportunity.
    1. Fostering a value-based market in which payers and providers openly compete to provide services and in which consumers and employers have the appropriate information and incentives to make high-value choices for their care and coverage options
    2. Promoting an efficient, high-quality health care delivery system in which providers efficiently deliver coordinated, patient-centered, high-quality health care that integrates behavioral and physical health and produces better outcomes and improved health status
    3. Advancing alternative payment methods that support and equitably reward providers for delivering high-quality care while holding them accountable for slowing future health care spending increases.
    4. Enhancing transparency and data availability necessary for providers, payers, purchasers, and policymakers to successfully i
    ANSWER: Anna Jaques Hospital does not explicitly disagree with any of the identified opportunities above. However, the above list fails to acknowledge in a sufficiently strong manner that the key to health care cost control in Massachusetts lies in the continued existence of the low cost, high quality community provider. With about a 1% operating margin and an operating income of approximately $500,000 to $1,000,000 annually, there is little room to undertake investments in new programs and systems that would require additional staff to manage and measure on an ongoing basis.
    Health plans alone have the ability, and in our opinion responsibility, to design benefit plans that incent patients to use high quality, low cost (high value) facilities. Part of that ability also includes benefit structures that pass the incremental cost of high cost providers to the patients who make that choice. Transparency is the first step in that regard. If a patient's perspective is limited to their own cost of care, which is often a $100

co-pay regardless of the provider they choose, rather than the thousands of dollars in inequitable rate differential between providers, they won't translate their decisions as significantly impacting healthcare cost trends. Additionally, we appreciate that the high deductable plans offered today are intended to foster more accountability and informed decision-making by the patient. Unfortunately, an unintended consequence experienced by providers is that patients are often unwilling or unable to pay for their share of that high deductable, leaving the provider (not the payor) on the hook for that unpaid balance. The continued existence of low cost, high quality providers is challenged due to the economic inequities that exist in the current market place. If mandated limits on rate increases simply memorialize historical inequities and all providers move equally without some level of rate redistribution, a greater percentage of care with be further concentrated at high cost providers as low cost providers are unable to maintain operations.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for hospitals. To the extent that a hospital submitting pre-filed testimony responses is affiliated with a provider system also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

1. Please submit a summary table showing for each year 2010 to 2013 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as AGO Hospital Exhibit 1 with all applicable fields completed. Please attempt to provide complete answers. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why.

   Completed in Attachment AGO Hospital Exhibit 1

   See attached exhibit

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2. For each year 2010 to present, please submit a summary table showing for each line of business (commercial, government, other, total) your inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as AGO Hospital Exhibit 2 with all applicable fields completed. Please submit separate sheets for pediatric and adult populations, if necessary. If you are unable to provide complete answers, please provide the greatest level of detail possible and explain why your answers are not complete.

   Completed in Attachment AGO Hospital Exhibit 2

   Anna Jaques Hospital currently does not have a cost accounting or decision support system which can accurately address the question posed above

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3. Please explain and submit supporting documents that show how you quantify, analyze and project your ability to manage risk under your risk contracts, including the per member per month costs associated with bearing risk (e.g., costs for human resources, reserves, stop-loss coverage), solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of whether you consider the risk you bear to be significant.

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4. Please explain and submit supporting documents that show how you analyze and track the volume of inpatient and outpatient referrals to your hospital and the associated revenue from those referrals by particular physicians or provider groups. Please include a description and examples of how your organization uses this information.

Anna Jaques Hospital
Count of ED Transfers by Facility
Question 7 Support
FY 2009 to FYTD 2014

	FYTD 2014		FY 2013		FY 2012		FY 2011		FY 2010	
Facility	Count	%	Count	%	Count	%	Count	%	Count	%
BIDMC	277	65.0%	332	63.1%	279	59.1%	274	55.7%	152	29.7%
MGH	66	15.5%	61	11.6%	82	17.4%	79	16.1%	100	19.5%
BRIGHAM & WOMENS	32	7.5%	51	9.7%	38	8.1%	50	10.2%	168	32.8%
LAHEY	32	7.5%	42	8.0%	43	9.1%	47	9.6%	45	8.8%
NEMC	0	0.0%	31	5.9%	11	2.3%	5	1.0%	24	4.7%
MASS EYE & EAR	1	0.2%	4	0.8%	9	1.9%	14	2.8%	9	1.8%
BMC	8	1.9%	4	0.8%	7	1.5%	16	3.3%	9	1.8%
UMASS	3	0.7%	1	0.2%	-	0.0%	2	0.4%	2	0.4%
ST E'S	2	0.5%	-	0.0%	3	0.6%	4	0.8%	2	0.4%
DANA FARBER	0	0.0%	-	0.0%	-	0.0%	1	0.2%	-	0.0%
NE BAPTIST	5	1.2%	-	0.0%	-	0.0%	-	0.0%	1	0.2%
Total Tertiary	426	100.0%	526	100.0%	472	100.0%	492	100.0%	512	100.0%
ED Vistits	25,330		31,627		32,394		32,451		33,374	
% to Tiertiary	1.7%		1.7%		1.5%		1.5%		1.5%	

Anna Jaques Hospital
Question 8 support
FY10- FYTD Jul14

Dischage Dispostion	FYTD Jul 14		FY 2013		FY 2012		FY 2011		FY 2010	
SNF AMESBURY VILLAGE	22	0.3%	40	0.5%	63	0.8%	70	0.9%	96	1.2%
INTERMEDIATE CARE FACILIT	5	0.1%	5	0.1%	13	0.2%	18	0.2%	9	0.1%
SKILLED NURSING FACILITY	50	0.8%	62	0.8%	66	0.9%	101	1.3%	158	2.0%
SNF BRIGHAM MANOR	87	1.4%	130	1.7%	118	1.5%	123	1.6%	135	1.7%
SNF COUNTRY MANOR	-	0.0%	348	4.5%	-	0.0%	-	0.0%	-	0.0%
SNF COUNTRY CTR HLTH & RE	289	4.5%	-	0.0%	419	5.5%	409	5.3%	409	5.3%
SNF HANNAH DUSTIN	10	0.2%	3	0.0%	12	0.2%	9	0.1%	11	0.1%
SNF HARBORSIDE HEALTHC	-	0.0%	-	0.0%	116	1.5%	130	1.7%	121	1.6%
SNF MAPLEWOOD CARE & REHA	117	1.8%	117	1.5%	7	0.1%	-	0.0%	-	0.0%
SNF MERRIMACK VALLEY HLTH	30	0.5%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
SNF OXFORD MANOR	13	0.2%	10	0.1%	10	0.1%	20	0.3%	12	0.2%
SNF PORT REHABILITATION	71	1.1%	94	1.2%	96	1.3%	78	1.0%	116	1.5%
SNF SEA VIEW RETREAT	11	0.2%	16	0.2%	24	0.3%	28	0.4%	-	0.0%
WHITTIER REHAB	73	1.1%	103	1.3%	114	1.5%	89	1.2%	70	0.9%
Nursing Home Subtotal	778	12.2%	928	12.1%	1,058	13.8%	1,075	14.0%	1,137	14.6%
HOME HEALTH AGENCY	1,150	18.1%	1,233	16.1%	1,367	17.9%	1,245	16.2%	1,336	17.2%
TRAN TO BETH ISRAEL DEACO	95	1.5%	102	1.3%	63	0.8%	58	0.8%	50	0.6%
TRAN TO BOSTON MEDICAL CE	1	0.0%	1	0.0%	3	0.0%	4	0.1%	3	0.0%
TRAN TO BRIGHAM & WOMENS	14	0.2%	9	0.1%	25	0.3%	19	0.2%	13	0.2%
TRAN TO DEACONESS	1	0.0%	1	0.0%	1	0.0%	-	0.0%	2	0.0%
TRAN TO LAHEY	24	0.4%	40	0.5%	32	0.4%	42	0.5%	64	0.8%
TRAN TO MASS GENERAL	16	0.3%	33	0.4%	30	0.4%	27	0.4%	38	0.5%
TRAN TO NEW ENGLAND BAPTI	-	0.0%	2	0.0%	-	0.0%	-	0.0%	-	0.0%
TRAN TO N E MEDICAL CT	-	0.0%	2	0.0%	2	0.0%	7	0.1%	3	0.0%
TRAN TO ST ELIZABETHS	1	0.0%	1	0.0%	2	0.0%	3	0.0%	3	0.0%
TRAN TO TUFTS MEDICAL CTR	10	0.2%	1	0.0%	-	0.0%	-	0.0%	-	0.0%
TRAN TO UMASS MEMORIAL ME	-	0.0%	-	0.0%	-	0.0%	1	0.0%	-	0.0%
Tiertiary Subtotal	162	2.5%	192	2.5%	158	2.1%	161	2.1%	176	2.3%
TRAN TO ACUTE CARE FACILI	17	0.3%	15	0.2%	11	0.1%	17	0.2%	12	0.2%
TRAN TO BEVERLY HOSPITAL	-	0.0%	1	0.0%	2	0.0%	2	0.0%	2	0.0%
TRAN TO CHILDRENS HOSPITA	16	0.3%	11	0.1%	14	0.2%	10	0.1%	22	0.3%
TRAN TO HOLY FAMILY	-	0.0%	3	0.0%	3	0.0%	-	0.0%	-	0.0%
TRAN TO LAWRENCE GENERAL	12	0.2%	10	0.1%	7	0.1%	4	0.1%	1	0.0%
TRAN TO LOWELL GENERAL HO	1	0.0%	-	0.0%	-	0.0%	1	0.0%	-	0.0%
TRAN TO LYNN/UNION	-	0.0%	1	0.0%	-	0.0%	-	0.0%	-	0.0%
TRAN TO PORTSMOUTH HOSPIT	24	0.4%	80	1.0%	93	1.2%	81	1.1%	75	1.0%
TRAN TO SALEM HOSPITAL	2	0.0%	1	0.0%	4	0.1%	3	0.0%	2	0.0%
Other Acute Subtotal	72	1.1%	122	1.6%	134	1.8%	118	1.5%	114	1.5%
Other Dis Dis Subtotal	4,194	66.0%	5,176	67.7%	4,936	64.5%	5,065	66.1%	5,021	64.5%
Grand Total	6,356	100%	7,651	100%	7,653	100%	7,664	100%	7,784	100%

Exhibit 1 AGO Questions to Hospitals

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. For hospitals, please include professional and technical/facility revenue components.
3. Please include POS payments under HMO.
4. Please include Indemnity payments under PPO.
5. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
6. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that subject you to very limited or minimal "downside" risk.
7. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.
8. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
9. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.
10. **Incentive-Based Revenue** is the total revenue a provider received under a P4P Contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.
11. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.
12. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

2010

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	X	X	X	X	X	X	X	X	X	X	25.96 M	X	X	X	X
Tufts Health Plan	X	X	X	X	X	X	X	X	X	X	4.28 M	X	X	X	X
Harvard Pilgrim Health Care	X	X	X	X	X	X	X	X	X	X	3.84 M	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	.38 M	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	1.50 M	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	2.07 M	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	2.0 M	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	8.03 M	X	X	X	X
Total Commercial	X	X	X	X	X	X	X	X	X	X	48.07 M	X	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	1.48 M	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	1.38 M	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	.87 M	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	1.64 M	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	5.37 M	X	X	X	X
MassHealth	X	X	X	X	X	X	X	X	X	X	6.95 M	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	.85 M	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	.01 M	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	1.68 M	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	2.55 M	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	35.68 M	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	1.79 M	X	X	X	X
GRAND TOTAL	X	X	X	X	X	X	X	X	X	X	100.40 M	X	X	X	X

2011

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	X	X	1.15 M	X	X	X	X	X	X	X	23.17 M	X	X	X	X
Tufts Health Plan	X	X	0.05 M	X	X	X	X	X	X	X	4.01 M	X	X	X	X
Harvard Pilgrim Health Care	X	X	0.11 M	X	X	X	X	X	X	X	4.05 M	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	0.44 M	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	1.63 M	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	2.13 M	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	1.94 M	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	8.57 M	X	X	X	X
Total Commercial	X	X	1.31 M	X	X	X	X	X	X	X	45.95 M	X	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	1.46 M	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	1.87 M	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	1.08 M	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	1.88 M	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	6.29 M	X	X	X	X
MassHealth	X	X	0.30 M	X	X	X	X	X	X	X	5.36 M	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	1.24 M	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	0.01 M	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	0.89 M	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	2.15 M	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	35.82 M	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	2.0M	X	X	X	X
GRAND TOTAL	X	X	1.61 M	X	X	X	X	X	X	X	97.54 M	X	X	X	X

2012

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	X	X	1.14 M	X	X	X	X	X	X	X	22.38 M	X	X	X	X
Tufts Health Plan	X	X	0.03 M	X	X	X	X	X	X	X	4.10 M	X	X	X	X
Harvard Pilgrim Health Care	X	X	0.14 M	X	X	X	X	X	X	X	4.77 M	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	.28 M	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	1.61 M	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	1.68 M	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	1.70 M	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	10.0 M	X	X	X	X
Total Commercial	X	X	1.31 M	X	X	X	X	X	X	X	46.53 M	X	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	1.58 M	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	1.92 M	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	0.76 M	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	2.19 M	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	6.45 M	X	X	X	X
MassHealth	X	X	0.45 M	X	X	X	X	X	X	X	5.53 M	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	1.80 M	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	.03 M	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	1.45 M	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	3.28 M	X	X	X	X
Medicare	X	X	0.26 M	X	X	X	X	X	X	X	36.29 M	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	1.72 M	X	X	X	X
GRAND TOTAL	X	X	2.02 M	X	X	X	X	X	X	X	99.35 M	X	X	X	X

2013

		P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
		Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
		HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
A	Blue Cross Blue Shield	X	X	1.20 M	X	X	X	X	X	X	X	22.67 M	X	X	X	X
B	Tufts Health Plan	X	X	0.03 M	X	X	X	X	X	X	X	3.84 M	X	X	X	X
C	Harvard Pilgrim Health Care	X	X	X	X	X	X	X	X	X	X	4.4 M	X	X	X	X
D	Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	0.28 M	X	X	X	X
E	CIGNA	X	X	X	X	X	X	X	X	X	X	2.13 M	X	X	X	X
F	United Healthcare	X	X	X	X	X	X	X	X	X	X	1.39 M	X	X	X	X
G	Aetna	X	X	X	X	X	X	X	X	X	X	1.37 M	X	X	X	X
H	Other Commercial	X	X	X	X	X	X	X	X	X	X	11.61 M	X	X	X	X
	Total Commercial	X	X	1.23 M	X	X	X	X	X	X	X	47.70 M	X	X	X	X
I	Network Health	X	X	X	X	X	X	X	X	X	X	2.01 M	X	X	X	X
J	Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	1.55 M	X	X	X	X
K	BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	.8 M	X	X	X	X
L	Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
M	Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	.01 M	X	X	X	X
N	Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	2.51 M	X	X	X	X
	Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	6.89 M	X	X	X	X
O	***MassHealth***	X	X	0.17 M	X	X	X	X	X	X	X	6.16 M	X	X	X	X
P	Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	1.43 M	X	X	X	X
Q	Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	.02 M	X	X	X	X
R	Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	2.0 M	X	X	X	X
	Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	3.45 M	X	X	X	X
S	***Medicare***	X	X	0.31 M	X	X	X	X	X	X	X	35.13 M	X	X	X	X
T	***Other***	X	X	X	X	X	X	X	X	X	X	1.87 M	X	X	X	X
	GRAND TOTAL	X	X	1.99 M	X	X	X	X	X	X	X	100.74 M	X	X	X	X

2010

	Commercial				Government				All Other				Total			
Service Category	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cardiology Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Invasive	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cardiac Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dental	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dermatology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Endocinology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gastroenterology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
General Medicine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
General Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gynecology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hematology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Infectious Disease	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Neonatology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nephrology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Neurology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Neurosurgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Normal Newborns	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Obstetrics	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Oncology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ophthalmology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Orthopedics	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Otolaryngology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Psychiatry	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pulmonary	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Rehab	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Rheumatology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transplant Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Trauma	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Urology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Vascular Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Inpatient	0	0			0	0			0	0			0	0		
Imaging			0	0			0	0			0	0			0	0
Other Treatments			0	0			0	0			0	0			0	0
Laboratory			0	0			0	0			0	0			0	0
Ambulatory Surgery			0	0			0	0			0	0			0	0
Therapies			0	0			0	0			0	0			0	0
Office Visits			0	0			0	0			0	0			0	0
Observation			0	0			0	0			0	0			0	0
Other Outpatient			0	0			0	0			0	0			0	0
GRAND TOTAL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

2011

	Commercial				Government				All Other				Total			
Service Category	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**
Burns	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cardiology Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Invasive	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cardiac Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dental	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dermatology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Endocinology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gastroenterology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
General Medicine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
General Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gynecology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hematology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Infectious Disease	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Neonatology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nephrology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Neurology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Neurosurgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Normal Newborns	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Obstetrics	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Oncology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ophthalmology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Orthopedics	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Otolaryngology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Psychiatry	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pulmonary	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Rehab	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Rheumatology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transplant Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Trauma	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Urology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Vascular Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Inpatient	0	0			0	0			0	0			0	0		
Imaging			0	0			0	0			0	0			0	0
Other Treatments			0	0			0	0			0	0			0	0
Laboratory			0	0			0	0			0	0			0	0
Ambulatory Surgery			0	0			0	0			0	0			0	0
Therapies			0	0			0	0			0	0			0	0
Office Visits			0	0			0	0			0	0			0	0
Observation			0	0			0	0			0	0			0	0
Other Outpatient			0	0			0	0			0	0			0	0
GRAND TOTAL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

2012

	Commercial				Government				All Other				Total			
Service Category	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**
Burns	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cardiology Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Invasive	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cardiac Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dental	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dermatology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Endocinology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gastroenterology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
General Medicine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
General Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gynecology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hematology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Infectious Disease	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Neonatology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nephrology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Neurology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Neurosurgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Normal Newborns	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Obstetrics	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Oncology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ophthalmology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Orthopedics	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Otolaryngology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Psychiatry	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pulmonary	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Rehab	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Rheumatology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transplant Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Trauma	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Urology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Vascular Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Inpatient	0	0			0	0			0	0			0	0		
Imaging			0	0			0	0			0	0			0	0
Other Treatments			0	0			0	0			0	0			0	0
Laboratory			0	0			0	0			0	0			0	0
Ambulatory Surgery			0	0			0	0			0	0			0	0
Therapies			0	0			0	0			0	0			0	0
Office Visits			0	0			0	0			0	0			0	0
Observation			0	0			0	0			0	0			0	0
Other Outpatient			0	0			0	0			0	0			0	0
GRAND TOTAL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

2013

	Commercial				Government				All Other				Total			
Service Category	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**
Burns	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cardiology Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Invasive	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cardiac Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dental	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dermatology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Endocinology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gastroenterology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
General Medicine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
General Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gynecology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hematology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Infectious Disease	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Neonatology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nephrology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Neurology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Neurosurgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Normal Newborns	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Obstetrics	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Oncology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ophthalmology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Orthopedics	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Otolaryngology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Psychiatry	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pulmonary	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Rehab	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Rheumatology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transplant Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Trauma	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Urology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Vascular Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Inpatient	0	0			0	0			0	0			0	0		
Imaging			0	0			0	0			0	0			0	0
Other Treatments			0	0			0	0			0	0			0	0
Laboratory			0	0			0	0			0	0			0	0
Ambulatory Surgery			0	0			0	0			0	0			0	0
Therapies			0	0			0	0			0	0			0	0
Office Visits			0	0			0	0			0	0			0	0
Observation			0	0			0	0			0	0			0	0
Other Outpatient			0	0			0	0			0	0			0	0
GRAND TOTAL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0