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Offices In
Maryland
Washington, D.C.
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December 10, 2015

VIA E-MAIL
AND HAND DELIVERY

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Adventist HealthCare, Inc. d/b/a Washington Adventist Hospital, Docket No. 13-15-2349; Responses of Adventist HealthCare, Inc. to Exceptions of the Interested Parties and Participating Entity;
Adventist HealthCare, Inc.'s Opposition to Appeal by MedStar Montgomery Medical Center's from Denial of Request for Evidentiary Hearing

Dear Ladies/Gentlemen:

On behalf of Adventist HealthCare, Inc. d/b/a Washington Adventist Hospital, we are hereby submitting thirty (30) copies of:

1) Responses of Adventist HealthCare, Inc. to Exceptions of the Interested Parties and Participating Entity; and

2) Adventist HealthCare, Inc.'s Opposition to Appeal by MedStar Montgomery Medical Center from Denial of Request for Evidentiary Hearing.

Word copies of both submissions have been transmitted electronically, along with copies of the Affirmations that support the Responses.

I hereby certify that a copy of these submissions has also been forwarded to the appropriate persons and local health planning agency, as noted below.

Respectfully yours,

John F. Morkan III

JFM:pl
Attachments

cc: **(via e-mail) (w/attachments)**
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BEFORE THE MARYLAND HEALTH CARE COMMISSION

IN THE MATTER OF ADVENTIST HEALTHCARE, INC. D/B/A WASHINGTON ADVENTIST HOSPITAL	Docket No. 13-15-2349

RESPONSES OF ADVENTIST HEALTHCARE, INC. TO EXCEPTIONS OF THE INTERESTED PARTIES AND PARTICIPATING ENTITY

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December 10, 2015

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I. INTRODUCTION AND SUMMARY

Applicant Adventist HealthCare, Inc. ("AHC") operates Washington Adventist Hospital ("WAH" or the "Hospital") on a small 13-acre campus in residential Takoma Park. That campus is challenging from both an access standpoint and for the delivery of care. From access to the campus through narrow, traffic-clogged streets, to traffic flow and parking on campus, to limited space, to an aging infrastructure, to small room sizes and to a limited number of private rooms, the challenges to WAH -- which prides itself on the excellent care that it provides -- are considerable. The proposed project -- to relocate WAH to a much larger, more accessible campus 6.5 miles north in White Oak -- is designed to remove barriers to receiving care and to enhance access to modern facilities and services.

As noted by the Reviewer, Commissioner Frances B. Phillips, RN, MHA, AHC first sought a Certificate of Need ("CON") in 2009, but later withdrew that application and "returned with an alternative plan and more solid financial position from which to launch its plans" for relocation of the Hospital (November 18, 2015 Memorandum of Commissioner Phillips at 2). Although it currently is licensed for 230-beds, AHC proposes a smaller replacement hospital of 170-beds and would leave its acute psychiatric inpatient facilities in Takoma Park, to be relicensed as a special hospital that would be operated by Adventist Behavioral Health. Also remaining on the Takoma Park campus would be a currently-operating Federally Qualified Health Clinic ("FHQC"), a women's' care clinic and a 24/7 urgent care center.

The record before the Commission consists of 132 separate items, consisting primarily of submissions by AHC, Interested Parties Holy Cross Hospital ("HCH"), MedStar Montgomery Medical Center ("MMMC") and Laurel Regional Hospital ("LRH"), along with Participating Entity the City of Takoma Park (the "City"). Also part of the record is a November 6, 2015

Memorandum from the Health Services Cost Review Commission (the "HSCRC"), concluding that AHC's overall assumptions regarding financial feasibility of the new facility are reasonable and achievable.

Based upon the voluminous record -- and after having conducted site visits at the existing Hospital and the proposed new site -- Commissioner Phillips issued a December 17, 2015 181-page Recommended Decision (the "Recommended Decision") that thoroughly and thoughtfully assessed the record and recommended approval of AHC's modified CON application.[1]

Exceptions to that Recommended Decision have now been filed by the City, HCH and MMMC.

Both the City and HCH ask that the Commission require AHC to develop a Freestanding Medical Facility (an "FMF") on the Takoma Park campus. AHC, which will operate a 24/7 urgent care center on the campus, respectfully asserts that conditioning approval of WAH's relocation on the development of a facility for which regulations have not yet been promulgated or rates set would be premature and unprecedented. The City's and HCH's exceptions in that regard are unfounded.

MMMC's exceptions are equally unfounded. It argues that AHC's proposed project is neither financially feasible nor viable -- in direct contradiction of the voluminous data and HSCRC analysis that establish otherwise. It contends that relocation of the Hospital would deny access to the indigent and medically vulnerable -- notwithstanding the fact that the services that will remain on the Takoma Park campus will meet the needs of that population and that access in WAH's existing and likely service areas will remain well within the applicable Standard. It

[1] The Recommended Decision, although dated December 17, 2015 (when the Commission next meets), was released on November 18, 2015.

contends that there is no need for a new hospital in White Oak and that the Commission should hire a university professor to conduct an academic study to assess unwarranted adverse impact -- notwithstanding the fact that the Commission itself has long been charged with ensuring that facilities that wish to relocate meet the applicable State Standards and clearly has sufficient expertise to apply those Standards in this instance. And finally, it contends that AHC has failed to explore a cost-effective alternative (remaining in Takoma Park) because it has not asked the State and County to take land through their power of eminent domain -- notwithstanding the fact that no such site has been identified, that an eminent domain taking would involve an expensive, lengthy and likely acrimonious process, and that relocation within Takoma Park itself would neither address nor ameliorate the challenges presented by WAH's current site.

The exceptions of the Interested Parties and Participating Entity do not establish that AHC has failed to meet any of the Standards governing its CON application, nor do they provide any basis for the Commission to disregard Commissioner Phillips' very comprehensive Recommended Decision.

Accordingly, AHC respectfully requests that its application be approved.

II. THE HISTORY OF THE PROJECT

A. AHC's Prior Application

1. The challenges facing WAH on its Takoma Park site.

In 2009, AHC submitted an application for a Certificate of Need by which it proposed to relocate WAH from the Takoma Park campus, where it had been for more than a century, to a 48.8-acre property in White Oak, Maryland, in order to modernize and expand the facility. The proposed new campus was approximately 6.5 miles from the Takoma Park campus, in the heart of WAH's primary service area, and located next to a new facility being developed by the U.S.

Food and Drug Administration ("FDA").

Relocation was sought due to constraints with the Hospital's current site that simply could not be overcome. Specifically, the Takoma Park campus was challenging from both an access standpoint and for the delivery of care. It was (and is) surrounded by narrow, two-lane residential streets on which traffic backups occur regularly. Emergency vehicles compete with normal vehicular and bus traffic for access to the hospital campus. Public transportation options are limited. MetroBus, the region-wide bus system in the Washington metropolitan area, does not travel to the Hospital campus. The only bus access is from the local Montgomery County Ride-On system, creating an additional hurdle for residents who seek and receive care at the hospital. Access challenges continue once on campus where ambulances, automobiles, pedestrians and buses compete for right-of-way.

2. The prolonged application process.

In 2012, Commissioner Barbara Gill McLean issued a Recommended Decision stating that she "regretfully recommend[s] that the Commission deny [the] CON application even though a replacement and relocation of Washington Adventist Hospital . . . may very well offer the best solution for revitalizing the Hospital's performance and prospects for the future." The basis for her decision, she advised, lay in her "strong doubts with respect to the financial feasibility and viability of the specific proposal that [had] been presented to the Commission" and she offered the "hope that AHC and WAH promptly move to develop a new plan to achieve the important objectives addressed in [the] application so that the future of both WAH and AHC can be assured."

3. AHC's withdrawal of the application

AHC voluntarily withdrew its application, advising the Commission that it had "determined that the best course for achieving the important objectives addressed in [the] application [would] be through the development of a new plan that [would] meet with unequivocal Commission approval."

B. Development Of The New Plan

Following withdrawal of the application, the AHC Board of Trustees held a special meeting and developed 19 objectives to consider in selecting the best option for the Hospital's future. Those objectives, which Board members identified as critical to making an informed decision, were divided into the 7 categories listed below:

Financial Consideration:

1. Financial feasibility
2. Financial viability

Facility: Size, Scope and Description

3. Improves access
4. Sufficient parking
5. Improves campus and building aesthetics
6. Improves effectiveness and efficiency of building utility systems

Regulatory Implications

7. Improves patient flow, staff efficiency
8. Improves private bed capacity
9. Ability to achieve regulatory approval

Clinical Experience

10. Opportunity for future inpatient capacity
11. Increases outpatient capacity/accessibility
12. Increases physician recruitment opportunities

Community Implications

13. Impact on community

Adventist HealthCare impacts

14. Minimizes impact on current operations
15. Ability to achieve project completion
16. Impact on AHC and its services
17. Ensures long-term future of Washington Adventist Hospital

Adaptability to Market Changes

18. Potential to expand
19. Provides flexibility for a dynamic market, now and in the future

Utilizing those objectives, the Board directed AHC's executive team to evaluate options for WAH's future that included two options for staying on the Takoma Park campus and two for relocating to White Oak on the earlier-designated site (within the Hospital's existing primary service area).

The four options considered were as follows:

A. Limited capital project on the existing Takoma Park campus, maintaining the current buildings;

B. More significant capital project on the existing Takoma Park campus;

C. Smaller facility in White Oak with non-rate regulated health care services in Takoma Park;

D. Similar sized facility in White Oak with some rate-regulated, acute-care services in Takoma Park.

After analyzing each of the options, the AHC executive team concluded that Option D provided both the best alternative for insuring the long-term future of WAH and was the most cost-effective, being the only option that earned a positive financial margin by the fifth year and would not require on-going subsidy by AHC.

C. AHC's Submission Of Its New Application

1. AHC submitted its October 2013 application

On October 4, 2013, AHC submitted a new CON application, proposing to relocate WAH to the White Oak campus, with eight stories above grade and one below grade, and 201 private patient rooms (a reduction in beds from the Takoma Park facility). The application proposed relocating all current hospital units at the Takoma Park facility, with the exception of behavioral health services, which were to remain on the Takoma Park campus.

After the filing of that application, the State of Maryland negotiated a new waiver with CMS, resulting in a new Global Budget Revenue model for acute-care hospitals for Maryland, including WAH. That change had a substantial impact both on how Maryland hospitals are reimbursed and incentives for hospitals moving forward, and further impacted the size and scope of future capital projects. Accordingly, AHC believed it prudent to re-evaluate options for the future of WAH based upon that new paradigm.

2. AHC refined its options based on the new Global Budget Revenue model.

Given the new health care (and health care reimbursement) landscape, four new options were developed and considered:

1. Limited capital project on the existing Takoma Park campus, maintaining the current buildings;

2. Replacement hospital on the existing Takoma Park campus;

3. Relocation of all existing acute-care hospital services, including behavioral health, to a new facility and campus in White Oak; and

4. Relocation of all existing acute-care hospital services to the new facility in White Oak -- except for behavioral health, which would stay in Takoma Park as a specialty hospital.

AHC then began working to develop both the scope and viability of the various options and a scoring matrix to aid in the decision-making process. The scoring matrix specifically was to identify the degree to which each option met the 19 objectives established by the Board.

Option 1, the limited capital project in Takoma Park, was removed from consideration because it failed materially to address pressing facility infrastructure challenges or access issues.

Scope, programming, budget and schedule data then were developed for each of the other three options, which were evaluated pursuant to the options scoring matrix. Option 2 would have involved a significant reinvestment in the existing hospital with a multi-phased program of demolition and construction at the Takoma Park campus. The resulting hospital in Takoma Park would have taken seven years to complete, beginning with site preparation and demolition. Because it would involve replacing portions of the buildings on campus -- while operating a functioning hospital -- the hospital modernization was divided into three separate phases of construction and corresponding phases of demolition. The capital expenditure would have been $351.2 million.

Option 3, a proposal to build a 210-bed hospital in White Oak, was also considered. The proposal was similar to Option 4 except that, in Option 3, the 40 behavioral health beds would move to White Oak and be operated as acute hospital beds instead of staying in Takoma Park. The capital expenditure for Option 3 would have been $353.2 million.

Option 4 involved the development of a replacement facility with all private rooms on a 48.86-acre campus in White Oak, while retaining the existing Takoma Park campus for various health care services, including the hospital's behavioral health services (which would become part of Adventist Behavioral Health), an FQHC, the services of Adventist Rehabilitation Hospital of Maryland/Takoma Park, the Women's Center clinic, an urgent care clinic, doctors' offices, as

well as lab, radiology and other ancillary services. The new White Oak facility under Option 4 would have 170 inpatient beds, and a total cost of $330.8 million.

Under the options scoring matrix, Option 4 received the highest score, followed by Option 3 and then Option 2.

AHC thus concluded that Option 4 provided the best alternative for ensuring the long-term future of WAH and was the most cost-effective, requiring the lowest amount of capital of the three possible options and earning the highest scores when factoring both the gain in White Oak and loss in Takoma Park.[2]

AHC thereafter modified its application to propose a relocated facility on the White Oak campus with 170-beds and robust health care services (as described below) remaining on the Hospital's current Takoma Park campus.

III. THE PROPOSED PROJECT

AHC has proposed building a 170-bed replacement facility on the 48.86-acre site in White Oak. The new campus is located in WAH's existing primary service area and is within a Maryland state priority funding area. The replacement hospital will include all existing acute-care services -- except for behavioral health services, which will stay in Takoma Park and be licensed as part of Adventist Behavioral Health. The Takoma Park campus will also include other non-acute-care services:

- an FQHC operated by Community Clinic, Inc.;
- the Women's Center, providing prenatal and other services for the community, including low-income women;
- a 24/7 urgent care center;

[2] A chart depicting AHC's overview of those Options is set forth at page 41 of the Reviewer's Recommended Decision.

- the existing rehabilitation unit licensed as part of Adventist Rehabilitation Hospital;
- physician offices;
- Imaging and other ancillary services in support of the clinical care provided on the campus; and
- 55,000 square feet of space to be leased to Washington Adventist University, a college with an adjoining campus.

This plan addresses the need for new facilities in an accessible location, continued health care services for the community around the existing Takoma Park campus, and reflects the changing dynamics of health care.

Specifically, the relocated hospital in White Oak would include the following components:

1) An Emergency Department with 32 treatment bays
2) 8 Operating Rooms (6 for general surgery, 2 special purpose (primarily cardiac surgery)
3) 2 Endoscopy Rooms
4) 1 Cystoscopy Room
5) 6 Cardiac/Vascular Angiography suites
6) 28-bed Critical Care Unit
7) Maternity Unit (18 post-partum rooms, 4 Medical-Surgical patient rooms dedicated to women's care, 7 Labor and Delivery Rooms, 2 C-Section)
8) 8 dedicated Short Stay Observation Beds in the patient tower and 12 Clinical Decision beds adjacent to the Emergency Department.
9) Approximately 750 surface parking spaces

The Hospital will be organized to maximize patient safety and efficiency with a patient tower of medical-surgical floors on a "base" with emergency, radiology, surgery, cardiac, and

maternity services. A cellar level will house support spaces such as lab, central sterile processing, dietary, maintenance, information technology and mechanical-electrical. Because the elevators are critical to hospital circulation for patients, visitors, and staff, they form the primary organizing vertical element that also helps differentiate horizontal functions. Elevator functions are segregated with one bank for the public and a separate bank for service/patients.

Evidence-based architectural methods have been employed in the hospital design to improve patient outcomes, safety, and satisfaction. Additionally, these design methods also improve staff efficiency, satisfaction, and staff retention. The design is consistent with national or jurisdictional codes and guidelines established for hospital design and construction.

After the completion of the White Oak hospital, AHC will re-develop the Takoma Park campus for the non-acute health care services more suited to campus conditions.

The total project cost for the development of the new WAH facility in White Oak would be $330,829,524 million, including interest and an allowance for inflation.

In addition, AHC has a signed Memorandum of Understanding (MOU) with the FDA, located adjacent to the proposed WAH campus in White Oak. That MOU provides: "By sharing resources and talents, the two organizations can open up new areas of discovery, funding and cooperation that are critically important for keeping both organizations on the leading edge and for protecting and promoting our nation's public health." WAH and the FDA have already begun collaborating on several smaller initiatives regarding major FDA regulatory program areas and the collaborative relationship will expand when the hospital moves to White Oak, a relationship that will benefit public health and health care research.

This collaboration between WAH and the FDA is further enhanced by the recent approval by Montgomery County of the White Oak Science Gateway Master Plan. This

emerging White Oak bioscience corridor will be anchored by the FDA, the proposed new WAH, and the Life Sciences Village. White Oak is poised to become one of the most important biotech corridors in the nation. WAH already has all the Montgomery County development approvals necessary to build its new facility at White Oak. The new campus would allow transformational development of the surrounding area that will be a tremendous benefit to WAH, the White Oak area, Montgomery County, the State of Maryland, and the nation.

IV. THE RECOMMENDED DECISION IS THOROUGH, THOUGHTFUL & CORRECT

The Interested Party that has submitted the most vociferous exceptions, MMMC, would have the Commission believe that the "current Recommended Decision is based in large measure on the findings of the September 2012 Recommended Decision regarding WAH's previous application to relocate the hospital to White Oak/Fairland and the health care environment that existed at that time" (MMMC Exceptions at 1). That contention is as outlandish as it is demonstrably false.

Commissioner Phillips, assisted by MHCC staff, conducted a detailed, thorough and thoughtful review of the pending application on its independent merits, and her Recommended Decision has analyzed and assessed the data pertinent to that entirely new plan.

MMMC's unfounded insinuation that the Recommended Decision somehow simply "recycles" data submitted in the earlier proceeding completely ignores the voluminous data contained in the record of this application -- 132 separate items, nearly half of which were submitted following Commissioner Phillips' designation as the Reviewer for this matter. That voluminous data painstakingly has been reviewed and analyzed by Commissioner Phillips and MHCC staff, including financial projections, impact calculations, demographic data and other

indicators that are wholly unrelated to the previous, wholly different, project.

This project can -- and must -- be considered on its own merits and in the context of the very comprehensive 181-page Recommended Decision submitted by Commissioner Phillips.

A. Financial Feasibility & Viability

1. The Reviewer is correct that the Project is financially feasible and viable.

MMMC takes exception to the Reviewer's findings regarding financial feasibility and viability on the basis that the Reviewer supposedly "relied heavily on the HSCRC's November 6, 2015 Memorandum reviewing and commenting on the financial feasibility and underlying assumptions of WAH's proposed project," while the Memorandum itself "raised a number of significant concerns with the feasibility and viability of WAH's project and the assumptions made by WAH" (MMMC Exceptions at 4). In that regard, MMMC contends that the "chief concern" expressed by the HSCRC is that WAH's projections are based on an unjustified assumption as to future volume increases.

MMMC is, again, wrong.

As a threshold matter, although the Reviewer rightly cited to and relied on the November 6, 2015 Memorandum from the HSCRC, that hardly was the extent of her review and analysis of pertinent data contained within the record. Commissioner Phillips' review of the parties' and HSCRC's submissions and her independent analysis and findings on financial feasibility alone are comprehensively set forth on 18 pages of single-spaced text; her discussion and analysis of viability consumes another 8 pages of single-spaced text. Clearly, her independent analysis reflects more than just a blind reliance on the HSCRC's assessment.

More significant, however, is the fact that the HSCRC Memorandum concerning financial feasibility -- rather than raising "a number of significant concerns" -- reflected an exceedingly positive assessment throughout its 12-page review, including the following:

- "Staff believes that the assumed increases are reasonable in light of the projected changes in population and approved revenue." (pg. 2)

- "The HSCRC staff also reviewed WAH's projections of other operating revenue. The projected other operating revenue is considered reasonable and achievable." (pg. 2)

- "The average variable cost change averages approximately 90% over the 5 year period. However, since the overall volume change is very small during this period, any change to the variable cost percent would have little impact on the overall projection of expenses. Staff believes that the assumptions used in the projections of ongoing annual expenses are reasonable and achievable." (pg. 4)

- "Based upon these projected ratios, Staff believes that AHC would be able to obtain financing for the project on terms that are consistent with those assumed in the plan of finance." (pg. 5)

- "Given AHC's debt situation, Staff believes that WAH has provided a reasonable amount of equity contribution for the project to be financially feasible." (pg. 7)

- "Staff believes that the overall assumptions regarding the financial viability of the new facility at White Oak are reasonable and achievable depending on WAH attaining the volumes projected in the CON." (pg. 12)[3]

Plainly, the HSCRC Memorandum does not support MMMC's position that the proposed project is not financially feasible.

The HSCRC rightly advised the MHCC carefully to consider overall bed need in the context of current utilization trends. AHC understands this and thus carefully considered bed need and the appropriate sizing of the proposed facility, and specifically reduced its bed capacity to reflect current utilization trends and future expectations. AHC built no volume increases for

[3] A copy of that Memorandum is attached as Attachment A.

MSGA and Observation Visits into its projections until 2019 -- when the new facility opens -- and then it projects growth that is approximately equivalent to population growth estimates. Further, while the HSCRC properly suggested that the MHCC carefully review bed need and apply conservatism, Commissioner Phillips has acknowledged the HSCRC's recommendation in her assessment of the Standard (Table IV-15 of the Recommended Decision) and expressly considered the issue in her analysis:

> The proposed replacement hospital will have 152 MSGA beds, 19 fewer MSGA beds than were licensed in FY 2015 and 17 fewer beds than are currently licensed. This number of beds represents a reduction in physical MSGA bed capacity for WAH of 87 beds. All of the 152 MSGA beds will be located in private rooms.
>
> This standard provides that only beds identified as needed and/or currently licensed shall be developed at an acute-care general hospital, and contains tests that apply to proposed additional beds. This application seeks to replace MSGA bed capacity that is currently licensed, and does not propose any additional beds. WAH currently has a physical capacity for 239 MSGA beds and has allocated 169 beds within its overall acute-care license to MSGA services in FY 2016. AHC is proposing to develop a physical bed capacity for only 152 MSGA beds at White Oak.
>
> I find that AHC has satisfied this standard.

(Recommended Decision at 25).

Moreover, MMMC's contentions regarding WAH's supposed "substantial decreases in volume" are fundamentally flawed. Although WAH did experience a volume decline between 2013 and 2014, that volume change already has been accounted for in current rates; the HSCRC made prospective volume adjustment in WAH's initial FY 2014 GBR setting of 2.18%. Additionally, the volume adjustment for CY 2014 versus CY 2013 also has already been fully addressed in the FY 2016 Rate Adjustment. At this time, WAH's market shift adjustment is -1.14% or $1.4M. So for the total impact for volume changes between CY 2014 and FY 2013, WAH's rates have been reduced by a total of 3.32% (2.18% + 1.14%) -- and yet WAH still

shows increasingly positive margins and the HSCRC has confirmed that Global Budget Revenue increases in its projection are reasonable.

Additionally, MMMC looks at data that only takes into consideration inpatient care, and does not account for the fact that many patients are now being seen in an observation or outpatient status. Thus, MMMC's selective analysis plainly fails to take a comprehensive view of WAH's entire service offerings. When both inpatient and observation cases >23 hours are considered, WAH declined 6.19% in case-mix adjusted discharges between 2013 and 2014, which, as noted, has already been accounted for in its Global Budget Revenue rate structure. Case-mix adjusted discharges from CY 2014 to CY 2015 (January - September Final) annualized have actually increased 2.4%. Further, that increase from CY 2014 to CY 2015 is projected to yield a positive market share adjustment in WAH's FY 2017 GBR rates based on the HSCRC's preliminary 6 month estimate reflected in its September 29, 2015 memorandum.[4]

[4] Attached as Attachment B is the HSCRC final market share calculation for CY 2014 and an excerpt from the September 29, 2015 HSCRC memorandum that contains preliminary CY 2015 first and second quarter market shift data.

Discharges	IP Discharges	OBV <23 hr Discharges	Total Discharges	Variance from Prior Year
2013	13,262	998	14,260	
2014	13,159	940	14,099	-1.13%
2015*	12,446	1,848	14,294	1.38%

CMI	IP CMI	OBV CMI	Total CMI	Variance from Prior Year
2013	0.9866	0.5000	0.9525	
2014	0.9325	0.5021	0.9038	-5.12%
2015*	0.9689	0.5280	0.9119	0.90%

Case-mix Adjusted Discharges	IP Case-mix Adjusted Discharges	OBV >23 Case-mix Adjusted Discharges	Total Case-mix Adjusted Discharges	Variance from Prior Year
2013	13,084	499	13,583	
2014	12,270	472	12,742	-6.19%
2015*	12,059	976	13,035	2.30%

Source: HSCRC Discharge Abstract Data

*January - September Annualized (using final submission data)

2. MMMC erroneously suggests that AHC will be unable to finance the Project.

MMMC contends that AHC's financial ratios will prove to be a barrier to AHC being able to borrow the necessary amount to finance the Project. However, the facts -- as reflected in the record -- belie that contention.

AHC intends to pursue traditional, tax-exempt bond financing for this project. The financing for the proposed project in the anticipated aggregate principal amount of $244.8 million will be secured pursuant to an Amended and Restated Master Trust Indenture. The ratios of the Obligated Group, including the proposed project presented as part of its AHC's Modified CON application, indicate that the Obligated Group will continue to meet all bond covenants.

During the course of the review, MMMC made similarly flawed arguments, and AHC responded with factual data from its consultant, Ziegler, that established that AHC reasonably can expect to obtain bond financing. That advice was based on Ziegler's knowledge of and experience with recent "BBB" and non-rated health care financings. AHC submitted, as part of the review, materials from Ziegler, showing examples of 18 recent financings, including relevant case studies, that supported Ziegler's opinion that the Project not only is financeable, but that (given the favorable environment) borrowing costs may be below those assumed in AHC's application (*see* Attachment C).

In an effort to rebut that data, MMMC cites Moody's medians for "All Hospitals". However, the AHC Obligated Group that will be involved in the bond financing will be compared to peers in its own rating category, not "All Hospitals". Moreover, comparison to rating agency medians is not the only measure that determines ability to finance a project. Institutional investors perform their own due diligence when evaluating financing transactions, relying heavily on qualitative measures such as market share, reputation and leadership team. It is by no means a narrow analysis that would just focus on Moody's medians. Additionally, the approval of AHC's rate application by the HSCRC will be viewed very positively by prospective bondholders because AHC will receive in rates a significant portion of its annual debt service cost, which contrasts favorably with facilities in other states, where hospitals have to earn additional revenue by increasing volume to pay for capital expenditures.

The Reviewer and the HSCRC were correct -- the Project is financially feasible and viable.

B. No Adverse Impact

MMMC takes exception to the Reviewer's determination that WAH's relocation would not inappropriately diminish access to care by the underprivileged population that WAH serves. Specifically, after noting AHC's commitment to maintain outpatient services on the Takoma Park campus -- including an expanded FQHC, a women's clinic serving indigent women in need of obstetric and gynecological services and a 24/7 urgent care center -- the Reviewer concluded:

> In my view, AHC's stated intentions are credible given its historically strong commitment to serving the disadvantaged and indigent population. It has consistently reported high levels of community benefit and charity care. AHC disputed statements by HCH and MMMC that it was leaving a poorer area for one that was better off, providing economic data for its proposed service area that showed only very marginal improvement in the economic and demographic profile of the WAH patient population post-project. Contrary to the opinions expressed by some commenters, I find that this marginal improvement in the economic well-being of the service area population that can be logically assumed for the replacement WAH at White Oak is incidental to the project rather than a strategic objective of the project. The evidence does not indicate that eliminating the level of disadvantage being created through this proposed hospital relocation is so great that MHCC should force AHC to undertake a modernization of WAH on its existing site or force it to find a site for relocation of WAH that will not change access to its hospital facilities in any material way. I find that the impacts are simply not that great and that AHC has committed to responsible actions that will ameliorate those impacts.

(Recommended Decision at 36).

The facts contained within the record establish that the Reviewer clearly was correct in her conclusion.

1. WAH has a long history of serving the community -- particularly its indigent and medically underserved residents -- which will continue both on the Takoma Park campus and in the total community that AHC serves.

MMMC's insinuation that WAH is "abandoning" the community it serves by moving to a state-of-the-art facility only six miles from Takoma Park reflects an ignorance of AHC's strong commitment and contributions to that community. In many respects, AHC's demonstrated

commitment to provide community benefit exceeds that of others, including MMMC.

WAH has a long history of being a leading provider of care for the under-served, and provides a wide array of health and wellness programs for the community, as documented by the significant portion of its income devoted to community benefit services. That is a commitment that will continue with the new campus in White Oak and continued services in Takoma Park.[5]

For State FY 2013, an HSCRC report shows that WAH had the highest level of Community Benefit as a percent of total operating expense of any hospital in Montgomery County, far higher than MMMC (with WAH subsequently reporting an increase to $38.6 million in community benefit activity in calendar year 2013, 17% of the Hospital's operating expense):

Total Community Benefit as a Percent of Operating Expense; FY 2013	
Washington Adventist Hospital:	15.30%
MedStar Montgomery:	9.77%

http://www.hscrc.maryland.gov/init_cb.cfm

AHC's CON application detailed how it plans to maintain the Takoma Park campus and invest in health care services for the benefit of the community. The application details the urgent care center, population health programs, and specialty hospital services that will be maintained on the campus. In fact, AHC already has established an FQHC, operated by Community Clinic, Inc., on the Takoma Park campus, and that FQHC will be doubling its clinical space in the coming months.[6] AHC has committed to other services such as a maternity clinic for low-income women, which is already in operation, and an urgent care center.

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[5] Attached as Attachment D is a document that describes the many community programs offered by AHC that will continue to be offered following the relocation of WAH.

[6] The FQHC currently has 1,443 square feet of space and includes one provider that can handle 4,370 patient visits per year. By the end of this year, the clinic will be expanded to 3,000 square feet, allowing space for an additional three providers and capacity for an estimated 17,480 patient visits; the expansion is being undertaken, in part, using money secured by WAH from a State grant.

As the Reviewer correctly noted, AHC has a "historically strong commitment to serving the disadvantaged and indigent population," and remains committed to meeting the needs of its local community.

2. Access for the population in WAH's existing and likely service areas will remain well within the applicable Standard.

As demonstrated in AHC's filings, 100% of WAH's likely service area population will be able to travel to a hospital within the 30-minute time period established by the applicable Standard. Moreover, AHC's travel time analysis has demonstrated that the likely service area population can travel more quickly to the White Oak location than to the existing location, resulting in a "travel time savings" for the likely population of 1,133,019 minutes traveled. It is inarguable that "access" for the population in WAH's existing and likely service areas will remain well within the State Standard.

3. Additional studies that MMMC asks the MHCC to undertake are neither necessary nor warranted.

MMMC has taken exception to the Recommended Decision on the basis that the Reviewer rejected its suggestion that a study to examine unwarranted adverse impact should be conducted by a professor at Emory University.

There are two reasons why the Reviewer was correct. First, as reflected above and as expressly acknowledged by the Reviewer, WAH has a long history of serving the community, particularly its indigent and medically underserved residents, which will continue in the community that it serves. Second, the Commission long has been charged with ensuring that facilities that wish to relocate meet the applicable State Standards and the Commission and staff clearly have sufficient expertise to apply those Standards in this particular instance without an academic study.

4. The services that will remain on the Takoma Park campus will meet the needs of Takoma Park's underprivileged population.

Throughout its filings, AHC emphasized WAH's long history of serving the community, particularly its indigent and medically under-served residents. AHC's filings further demonstrate that, following relocation, WAH will continue serving such residents, both on the Takoma Park campus and at its new location.

MMMC contends that the underprivileged community that WAH serves needs access to inpatient and outpatient centers to treat chronic medical conditions such as cancer, heart disease, arthritis and diabetes. AHC agrees, which is why its proposal includes a thoughtful, well-planned combination of outpatient and inpatient services on the Takoma Park and the White Oak campuses, both of which are within the Hospital's existing primary service area. As outlined in detail, the Takoma Park campus will include an expanded FQHC designed to provide access to care for patients with routine and chronic conditions who may not have other means of care. The new hospital in White Oak will include a modern, 21st century facility with private rooms and adequate space for inpatient and outpatient services for routine, chronic and tertiary conditions, along with a separate outpatient cancer center -- all on a campus developed with improved transportation access in mind. MMMC seems to suggest that Takoma Park's underprivileged population is best served by relegating the community to aging and crowded facilities. WAH's White Oak campus, which is located in the hospital's existing primary service area, combined with the services on the Takoma Park campus, will strengthen the region's health care infrastructure and ensure continued access to care for all communities served by the

Hospital.[7]

C. The Need For Replacement And Relocation Of WAH

In addition to conducting a detailed analysis of bed need questions called for under COMAR 10.24.01.08G(3)(B), the Reviewer also briefly summarized her other need-related findings, including the following:

> With respect AHC's determination that the relocation of WAH is preferable to alternative approaches to modernization, I found that AHC's conclusions with respect to the inferiority of the on-site replacement alternative are well-founded and that it adequately explained its process for evaluating and selecting the best alternatives. This led me to the conclusion that off-site replacement is the unavoidable preferred choice. The chosen site fits WAH's criteria, which I believe are reasonable.

(Recommended Decision at 131).

MMMC takes exception to the Reviewer's findings concerning need, arguing that WAH should remain in Takoma Park and that a new hospital is not needed in the White Oak area (MMMC Exceptions at 19). In two very well-stated paragraphs, the Reviewer rejected that contention, as the Commission should:

> I disagree with MedStar Montgomery Medical Center's comments that the needs of the population currently served by WAH will not continue to be met if the proposed project goes forward. MMMC contends that the area surrounding the White Oak site is already well served by three acute-care hospitals and that there is no need for additional acute-care service in the proposed location. I find that the White Oak area is actually served by more than three general hospitals, one of which is WAH. I also find that the area surrounding Takoma Park overlaps with the area surrounding White Oak and is also served by several hospitals, one of which is WAH. MMMC characterizes this project as one that removes a general hospital from one distinct and discrete area to another distinct and discrete area, eliminating a hospital from an area where that hospital is needed to a different area where that hospital is not needed. I do not consider this to be a realistic characterization. In all likelihood, a general hospital in White Oak replacing the general hospital in Takoma Park will result in some changes to the catchment

[7] Attached as Attachments E and F are materials submitted as part of the review process that provide an overview of some of AHC's accomplishments and the benefits offered by its Center for Health Equity & Wellness.

> areas of the general hospitals in this region; however, it is important to recognize that it is a region with multiple general hospital sites located within reasonable travel times for the vast majority of the region's population.
>
> I also note that Takoma Park will continue to be a hospital campus with acute psychiatric and rehabilitation inpatient services and with outpatient health care services being delivered on both a scheduled and unscheduled basis. Contrary to MMMC's assertion, I find that AHC has addressed, in this application, the basic question of whether the White Oak/Fairland or the Takoma Park location is the more appropriate one to meet the needs of the population that WAH has historically served. While the project will have an impact on availability and accessibility to hospital services that will have both positive and negative ramifications for different subareas of the larger region, I find that the evidence shows that any adverse impacts related to this project cannot be realistically portrayed as dire. CON applications cannot be considered in the absolutist terms suggested by MMMC because, taking this type of logic as a guide, one could rarely if ever permit relocation of a hospital and other health care facilities, because all such moves will invariably reduce physical access to some services for some communities or neighborhoods. The population is not static and health care delivery is not static. I conclude that the Commission cannot approach questions about the supply and distribution of health care facilities from a perspective that the current or historic landscape of facilities must be maintained.

(Recommended Decision at 131-32) (footnote omitted).

In arguing against the Reviewer's analysis, MMMC has acknowledged that her "recommended Decision is consistent with the Commission's traditional bed-need analysis on a County-wide basis," but contends that the Commission should adopt some broader approach that would include the study that it has proposed by the university professor (MMMC Exceptions at 22). However, as discussed above, any such study is wholly unnecessary. Moreover, as also discussed above, WAH is not "shedding volume" in areas with significant indigent and medically underserved populations, as MMMC suggests (MMMC Exceptions at 21); it will continue to have a vital and robust presence in Takoma Park through the medical services that will remain on that campus.

As was established by AHC's filings during the course of the review, the physical challenges that WAH faces on its current site (problems with access, a constraint site, limited

parking, insufficient MOB space on campus and a surrounding residential area) would not and could not be solved under any on-site modernization problem or relocation to a like site within Takoma Park. Modernization and relocation within that residential community simply would not allow the Hospital to achieve its stated objectives for providing the best possible patient care. The Commission necessarily must consider what the effect would be on the region's health care delivery system were AHC's application to be denied.

Conversely, there are numerous examples where the Commission has approved the relocation of an outmoded facility, including Upper Chesapeake, Western Maryland, Meritus and the Anne Arundel Medical Center's relocation out of a residential area in downtown Annapolis. Such relocations prompted performance improvements from rival hospitals, resulting in an increased level of quality and patient care and, ultimately, in a new equilibrium distribution of patients across those facilities -- something that results in an obvious public benefit and a strengthened regional health care delivery system.

D. AHC's Consideration Of Cost-Effective Alternatives

MMMC's final exception concerns the Reviewer's finding that the proposed Hospital in White Oak is the most cost-effective approach to meeting the needs that AHC's project sought to address (MMMC Exceptions at 23). In support of its challenge, MMMC argues that the "City of Takoma Park has repeatedly and adamantly stated that it supports retaining the hospital and would work with WAH to find a solution" (*id.* at 24). The City, however, has said nothing of the sort. Rather, as noted by the Reviewer, the City has stated that it "accepts that to fully realize the goal of a more modern hospital and of higher quality acute-care services, AHC must consider locations outside of Takoma Park" (Recommended Decision at 44).

In its efforts to counter the Reviewer's well-considered findings, MMMC argues that AHC should have taken a so-called "team work approach" that would have involved asking the State and County to exercise their powers of eminent domain to acquire a new site within Takoma Park (MMMC Exceptions at 24). As the Reviewer aptly noted, the suggestion is far from "persuasive", given that the use of eminent domain -- even if a suitable site could be identified within the City -- "is likely to be divisive, litigious, and expensive, and could take years to resolve with an uncertain outcome" (Recommended Decision at 44).

MMMC's exception is wholly unfounded.

E. The Takoma Park Urgent Care Center And the Proposed FMF.

Among the recommended conditions that Commissioner Phillips suggested be attached to approval of AHC's project was one concerning its operation of the proposed 24/7 urgent care center on the Takoma Park campus:

> Adventist HealthCare must open an urgent care center on its Takoma Park campus coinciding with its closure of general hospital operations on that campus. The urgent care center must be open every day of the year, and be open 24 hours a day. Adventist HealthCare may not eliminate this urgent care center or reduce its hours of operation without the approval of the Maryland Health Care Commission.

(Recommended Decision at 38).

In response to that condition, the City asks that the Commission essentially expand upon it by requiring AHC to commit to developing, if appropriate, an FMF on the Takoma Park campus:

1. Adding a condition to the CON requiring that AHC conduct a prompt and thorough exploration of a Freestanding Medical Facility commencing upon the promulgation of the Commission's FMF regulations.

2. Adding a provision authorizing AHC to establish an FMF in Takoma Park, if appropriate, and make any corresponding changes to the proposed project as a modification to the CON in this proceeding.

(City Comments on the Recommended Decision at 6).

For its part, HCH -- contending that WAH's relocation will result in a dramatic increase of emergency department visits to its facility -- goes one step further, arguing that the Commission should "require AHC to provide meaningful and needed emergency services for the Takoma Park community in the form of a freestanding medical facility . . ." (HCH Exceptions at 1).

The relief requested by the City is wholly unnecessary. AHC already, as part of the review process, has committed to meeting the needs of the local community, including evaluating the feasibility of a FMF. Consistent with its establishment of the FQHC (and planned expansion of that facility), AHC committed to participate in the process for evaluating the need for an FMF in Takoma Park. However, the moratorium regarding the creation and development of FMFs was then in place, and regulations concerning possible future development still have not yet been drafted or promulgated. AHC respectfully submits that it would be premature to require AHC to pursue development of a facility when governing regulations have not yet been fully developed and, with the lack of clarity concerning how rates will be structured, under circumstances where it would not have the ability to assess the financial viability of such a facility. To date, AHC has taken a prudent approach toward consideration of an FMF on the Takoma Park campus. Once the regulations have been finalized and published, it will be in a position to conduct a feasibility analysis to assess the appropriateness and viability of such a facility on that campus. That has been, and continues to be, AHC's position. A condition that required AHC to pursue and conduct such a feasibility analysis would be both superfluous and inappropriate.

HCH's request that approval of a CON for WAH's relocation be conditioned on AHC developing an FMF would be unprecedented. As noted, the regulations that will guide the CON process for consideration of such facilities have not been finalized, and it would be unfair to require AHC to develop a facility when regulations have not been developed and there is no means for assessing financial viability. As the Reviewer properly concluded, it would not be "appropriate to require AHC to commit to a more expensive form of urgent and emergent care delivery, the freestanding medical facility model, at this time" (Recommended Decision at 38).

That is especially true given that HCH's request is predicated on the flawed contention that its ED will be overwhelmed following WAH's relocation. Indeed, the Reviewer concluded -- after conducting an exhaustive analysis -- "that it can be reasonably predicted that HCH's Emergency Department may lose volume as a result of the relocation of WAH, rather than gain considerable visit volume, as it predicts" (*id.* at 161).

The Reviewer is correct in that regard, for the reasons previously noted by AHC:

- HCH did not adequately account for the presence of the urgent care center on the WAH campus and previously had stated that it was proposing a pilot program to divert low level EMS calls to alternative locations, including urgent care centers.

- HCH cited public transportation as a key reason patients will visit the HCH campus. ("HCH is on or near the majority of the Montgomery County Ride-on bus routes networked throughout the County that serve both the Takoma Park area and Silver Spring area.") However, WAH's own analysis of ED visits notes that only 1.7% of patients arrived by public transportation to the WAH ED in 2014.

- HCH understated the market share that WAH will retain by having a new ER in White Oak and an urgent care center in Takoma Park.

- HCH claimed its ED would be overwhelmed by the WAH's relocation, but it did not consider that some of the ED cases that currently go to HCH that will instead go to the new WAH ED in White Oak.

- HCH cited proximity as a major reason why patients will flock to the HCH ED, but then discounted that factor as a reason why patients who currently go to HCH might shift to WAH.

- HCH contended that "the HCH ED patients have established relationships, patterns of travel, and the new WAH location is not much closer, accessible or more convenient than the existing HCH ED." That is plainly incorrect. The new WAH has better road access and will have plentiful parking, whereas the current WAH is surrounded by narrow residential streets and has severe parking challenges. Further, the new WAH ED will be a new modern facility, an attractive element for many people.

- HCH claimed that people residing in zip code 20904 will continue to go to HCH because HCH currently has 60% ED market share there. HCH previously argued that proximity is a major factor, yet when it comes to the proximity of the WAH ED in White Oak, which will be a new ED, HCH discounted that. If market share is a deciding factor for EDs, then it would be true not just for HCH, but for the new WAH as well.

    - For example, WAH has 60.3% market share in zip code 20783, 66.2% in zip code 20912, and 53.1% in zip code 20782, yet HCH ignored that market presence and decreased the estimated market share for the relocated hospital to only 3% within each of those zip codes.

    - In zip code 20782, the average drive time will be the exact same for both the relocated WAH and HCH.

    - In zip code 20912, WAH will be the second most proximate hospital and will remain connected as a result of the remaining services in Takoma Park.

- HCH applied unwarranted and extremely aggressive decreases in WAH market share without considering offsetting increases that would occur when moving into the redefined service area.

    - A reduction of 38.5% in market share was applied to zip code 20903 (Silver Spring), in which the drive time was estimated to have improved by 1 minute to the White Oak location.

    - HCH assumed a market share reduction of 20% or greater for 10 zip codes, but did not assume WAH would realize an increase in market share of 20% or greater in any zip code, not even its new home zip code 20904.

- HCH claimed that a large shift from zip code 20904 would be implausible, in part, because the drive time to the zip code market leader, HCH, is only on average 4 minutes longer than to the proposed site for WAH. That argument seemed to discount proximity even though proximity was cited by HCH as a major reason patients will go to HCH over the relocated WAH. HCH's own inconsistency undermines its analysis and reflects its flawed premises.

HCH's premise for insisting that AHC must develop an FMF on the Takoma Park campus because HCH's ED will be overwhelmed following the relocation of WAH is both unsupported and insupportable.

There simply is no precedent or proper basis for the relief sought by the City and HCH with respect to requiring AHC to pursue development of an FMF on the Takoma Park campus.

V. CONCLUSION

Applicant AHC respectfully asserts that the Reviewer's comprehensive and thoughtful Recommended Decision should be adopted by the Commission and that AHC's modified Certificate of Need application should be approved.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY THAT on this 10th day of December, 2015, a copy of the foregoing Responses of Adventist HealthCare, Inc. to Exceptions of the Interested Parties and Participating Entity was sent via email and first class mail to:

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3015745.3

BEFORE THE MARYLAND HEALTH CARE COMMISSION

IN THE MATTER OF ADVENTIST HEALTHCARE, INC. D/B/A WASHINGTON ADVENTIST HOSPITAL	Docket No. 13-15-2349

ADVENTIST HEALTHCARE, INC.'S OPPOSITION TO APPEAL BY MEDSTAR MONTGOMERY MEDICAL CENTER FROM DENIAL OF REQUEST FOR EVIDENTIARY HEARING

Applicant Adventist HealthCare, Inc. ("AHC") submits this opposition to the appeal filed by MedStar Montgomery Medical Center ("MMMC") from the denial of its request for an evidentiary hearing on AHC's application.

It is noteworthy that MMMC has not cited the legal standard under the MHCC regulation for requesting an evidentiary hearing, but presumably it wishes to create the impression that an evidentiary hearing "will assist the reviewer in resolving questions of material fact or witness credibility." *See* COMAR 10.24.01.10D(5). Evidently, the Reviewer -- who considered and analyzed the voluminous filings and data in the record (comprised of 132 entries) and who conducted site visits of both Washington Adventist Hospital's ("WAH") current site and its proposed new site -- believed that an evidentiary hearing was not necessary and would not be of assistance. The Reviewer, Commissioner Frances B. Phillips, RN, MHC, was correct.

MMMC's motives in submitting this appeal are transparent. First, its "appeal" does little more than reargue positions set forth in its Exceptions to the Recommended Decision, which now will afford it additional time to argue its points beyond the ten (10) minute limit for the exceptions hearing. Second, MMMC plainly is unhappy with that Recommended Decision and

wants the opportunity -- through the mechanism of an evidentiary hearing -- to try to convince the Reviewer to change that set forth in her Recommended Decision. However, there is nothing in that Recommended Decision that even suggests that the Reviewer did not understand or did not consider MMMC's submissions and arguments. She just was not persuaded by them. MMMC's failed arguments, however, do not provide a proper basis for the conduct of an evidentiary hearing.

Among MMMC's complaints is its contention that the Reviewer did not address its request that WAH be required to produce patient-specific information that could be utilized by an academician that MMMC hopes to proffer as a witness in an evidentiary hearing, who would design a research study to assess the purported impact of WAH's proposed relocation. In voicing that complaint, MMMC acknowledged that the patient-specific data that WAH would be required to produce and that would be assessed by that university professor is "data that the Commission has not utilized in the past." Indeed, there is no need for such data to be compiled or utilized in this case. The Reviewer and MHCC staff are sufficiently qualified to make determinations regarding unwarranted adverse impact without input from a so-called expert. Such assessments are an integral part of every CON review and the MHCC does not lack the resources or expertise to conduct such evaluations under its own regulation. Moreover, the information submitted by AHC -- and analyzed in depth by the Reviewer -- irrefutably establishes that, as the Reviewer found, "the impacts are simply not that great and . . . AHC has committed to responsible actions that will ameliorate those impacts" (Recommended Decision at 36).

In this CON review, MHCC has been afforded substantial opportunities to present information in the form of comments on the CON application, comments on the completeness

submissions and responses to requests for additional information. The filings and opportunities for input have been many and substantial.

It would indeed be an anomalous result for the Commission to determine that an evidentiary hearing must be held to assist the Reviewer in resolving questions of material fact when the Reviewer herself deemed such a hearing unnecessary, and nothing in her Recommended Decision supports the notion that further fact-finding would be of assistance to her.

AHC respectfully asserts that the Reviewer's decision not to conduct an evidentiary hearing was correct, and that MMMC's appeal is without merit and properly must be denied.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY THAT on this 10th day of December, 2015, a copy of the foregoing Adventist Healthcare, Inc.'s Opposition to Appeal by MedStar Montgomery Medical Center from Denial of Request for Evidentiary Hearing was sent via email and first class mail to:

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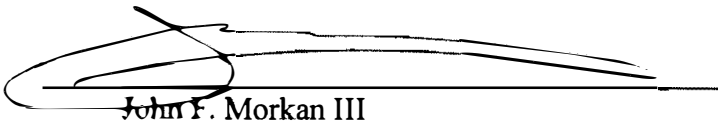

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3017085.2

Responses of Adventist HealthCare, Inc.
To Exceptions of the Interested Parties and
Participating Entity

Attachment List

Attachment No.	Description
A	November 6, 2006 Memorandum from the HSCRC to Commissioner Phillips
B	HSCRC final market share calculation for CY 2014 and an excerpt from a September 29, 2015 HSCRC memorandum that contains preliminary CY 2015 first and second quarter market shift data
C	February 20, 2015 letter from Ziegler to the MHCC, with data concerning recent "BBB" and non-rated health care financings
D	AHC and WAH Community Programs
E	Chart entitled "Overview of Accomplishments"
F	Slides: Center for Health Equity & Wellness

Exhibit A

State of Maryland
Department of Health and Mental Hygiene

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Chairman

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Vice-Chairman

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Deputy Director
Hospital Rate Setting

Sule Gerovich, Ph.D.
Deputy Director
Research and Methodology

Memorandum

Date: November 6, 2015

To: Frances B. Phillips
Commissioner/Reviewer, MHCC

From: Gerard J. Schmith
Deputy Director, Hospital Rate Setting, HSCRC

Subject: Relocation of Washington Adventist Hospital ("WAH") and Establishment of a Special Psychiatric Hospital on the Existing Takoma Park Campus
Docket No. 13-15-2349

On August 31, 2015 you requested that we review and comment on the financial feasibility and underlying assumptions of the relocation of WAH from its existing location in Takoma Park to the White Oak area and establishment of a Special Psychiatric Hospital on the existing Takoma Park Campus. Adventist HealthCare Incorporated, ("AHI"), the owner and operator of WAH, submitted an amended CON on September 29, 2014 with additional supplemental information including a letter dated July 27, 2015 from James Lee, Executive Vice President and CFO of AHI.

This memorandum provides our general comments and addresses your specific questions regarding the project.

General Comments on Financial Feasibility

Data Reviewed

We reviewed the revised financial portions submitted on October 21, 2015 as well as other pertinent supplemental information associated with the CON provided by WAH prior to that date. The information submitted included audited financial data for the fiscal years ending December 31, 2013 and 2014, actual and budgeted data for fiscal year ending 2015, and projected data for the fiscal years ending 2016 through 2020 (the second full year after the completion of the project.)

Along with these financial projections, we have also reviewed WAH's audited financial statements for the year ended December 31, 2014 and the expected financing plan for this project.

Revenue Projections

We have reviewed the assumptions regarding the projections of operating revenue. The assumed annual HSCRC approved revenue increases listed in the CON assumptions provided by WAH that were the basis for the revenue increases shown in the table below are as follows:

Table 1 - Summary of Projected HSCRC Approved Revenue Increases
Washington Adventist Hospital

	Years Ending June 30,					
	2015	2016	2017	2018	2019	2020
Update Factor	2.21%	2.17%	2.30%	2.30%	2.30%	2.30%
Age Adjusted Population Growth	0.00%	.56%	.56%	.56%	.56%	.56%
Population Infrastructure	0.00%	1.05%	0.00%	0.00%	0.00%	0.00%
Market Shift	0.0%	.23%	0.00%	0.00%	0.00%	-.05%
Other Reversals, One Time Adj, etc.	-.75%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	1.46%	4.01%	2.86%	2.86%	2.86%	2.81%

Source: Updated financial information and projections submitted by WAH on October 21, 2015.

In addition to the revenue increases shown above, WAH assumed that revenue would increase by $15,391,282 (5.4%) on January 1, 2019 to reflect the HSCRC approved capital increase.

Staff believes that the assumed increases are reasonable in light of the projected changes in population and approved revenue.

WAH projected that charity write offs would equal 6.5% of gross patient revenue from 2015 through 2020, an increase of .5% from the 2014 actual 6.0%. WAH projected that bad debt expenses would equal 5.0% of gross patient revenue less Uncompensated Care Fund payments from 2015 to 2020, which represents a 1.7% decrease from the 2014 actual of 6.7%. WAH attributes these changes to the changes brought about by the Affordable Care Act.

WAH's actual other deductions from revenue equaled 11.8% of gross patient revenue in 2014. WAH projected that its other deductions from revenue would decrease to 9.5% of gross patient revenue in 2015, decreasing to 9.4% from 2016 through 2018, and then decreasing to 9.3% in 2019 and 2020. WAH attributes this improvement to engaging a revenue cycle management firm to manage the revenue cycle operations and the reduction in HSCRC assessments due to the elimination of the Maryland Health Insurance Program (MHIP).

The HSCRC staff also reviewed WAH's projections of other operating revenue. The projected other operating revenue is considered reasonable and achievable. WAH did not project any non-operating revenue associated with this project.

Expense Projections

Staff reviewed the assumptions regarding the projection of expenses. WAH stated that it applied the following variable expense change assumptions in the CON projected financial statements

Table 2 - Summary of Assumed Expense Increases
Washington Adventist Hospital Revised CON Projections

	Years Ending December 31,					
	2015	2016	2017	2018	2019	2020
Salaries Excluding Overhead:						
Inflation	2.3%	2.2%	2.3%	2.2%	2.3%	2.2%
Change in FTE's	2.0%	1.8%	-.2%	-.4%	1.8%	.8%
Supplies Excluding Overhead:						
Inflation	8.2%	2.0%	3.5%	3.5%	3.5%	3.5%
Volume	-.4%	1.8%	0.4%	-.1%	.7%	1.2%
Contract labor Excluding Overhead:						
Inflation	2.3%	2.2%	2.3%	2.2%	2.3%	2.2%
Change in FTE's	17.1%	-12.5%	-.2%	-.4%	1.8%	0.0%
Purchased Services Excluding Overhead:						
Inflation	-10.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Volume	2.6%	0.0%	0.0%	0.0%	-.2%	.7%

Source: Updated financial information and projections submitted by WAH on October 21, 2015.

For fixed expenses, WAH assumed a series of inflation factors for 2016 to 2020 ranging from 0% for professional fees to 2.5% for administrative and general expenses. For 2015 inflation, WAH assumed 0.0% for professional fees, 11.5% for building and maintenance expense, negative (1.9%) for the overhead allocation from AHI, a negative (.2%) for general and administrative costs, and a negative (7.7%) for insurance costs.

WAH assumed that it would reduce building and maintenance operating costs by 20%, or approximately $1,800,000, after the move to the new White Oak facility. WAH has stated that it will contract with an unrelated party to provide utility services to the new White Oak facility through a Centralized Utility Plant (CUP).

WAH is projecting that its number of FTE's per Average Equivalent Occupied Beds (AEOB) will increase from an actual 4.1 in 2014 at the existing WAH facility to a projected 4.7 in 2020 at the new White Oak facility. The reason for the large increase in projected FTE's per AEOB is due to the fact that approximately 16% of WAH's patient days are related to the psychiatric patients who will remain at the existing WAH facility. The 2014 FTE's per AEOB for other neighboring Montgomery and Prince Georges County hospitals range from 5.0 at Montgomery General Hospital to 5.8 at Prince Georges General Hospital. Part of the reason for WAH's lower FTE's per AEOB is due to the fact that WAH does not report FTE's for all of the shared services that it purchases from AHI including patient billing and Information Technology Services.

Staff calculated the projected overall annual expense percentage variability with volume based on the percentage change in uninflated revenue compared to the annual change in total expenses including depreciation and interest depreciation and interest. The results of staff's analyses were as follows:

Table 3 – Projected Expenses Percent Variability with Volume
Washington Adventist Hospital Revised CON Projections

	Years Ending December 31,				
	2016	2017	2018	2019	2020
Including Depreciation and Interest	104.0%	14.2%	97.3%	-11.8%	97.2%

Source: Updated financial information and projections submitted by WAH on October 21, 2015.

The average variable cost change averages approximately 90% over the 5 year period. However, since the overall volume change is very small during this period, any change to the variable cost percent would have little impact on the overall projection of expenses. Staff believes that the assumptions used in the projections of ongoing annual expenses are reasonable and achievable.

In the project budget for capital expenses, WAH made an assumption that it would incur $2,700,000 in relocation costs for the move of the medical/surgical and obstetrics units and practically all outpatient services at the old facility to the new facility. The $2,700,000 estimated relocation costs seem low. WAH may incur cost at the new facility before it opens related to training, staffing, inventories, food, and other items related to relocation. There may also be transportation costs of moving patients and staff from the old facility to the new facility. If WAH needs to maintain some of the medical/surgical and obstetrics units and practically all outpatient services at the old facility after the new facility is open, then costs may be higher than the $2,700,000 WAH has projected.

Financial Ratios

WAH states on Page 128 of the CON that AHI will secure financing for the project pursuant to its amended and restated master trust indenture dated February 1, 2003. WAH provided the projected financial information and ratios for the obligated group of AHI. On a consolidated basis AHI projects that it will meet the ratio levels required under its bond documents.

Listed below are the AHI projected ratios and the required ratios per the bond covenants provided by WAH:

Table 4 - Adventist HealthCare Obligated Group Key Financial Information and Ratios
Washington Adventist Hospital Revised CON Projections

	Years Ending December 31, (in millions)							
	2013	2014	2015	2016	2017	2018	2019	2020
Operating Income	$8.7	$22.5	$34.4	$32.7	$28.4	$29.1	$17.4	$16.0
Operating Margin	1.2%	3.1%	5.1%	4.8%	4.1%	4.1%	2.4%	2.1%
Excess of Revenue over Expenses	$12.1	$25.8	$42.7	$41.8	$37.8	$38.7	$27.2	$25.9
Excess Margin	1.7%	3.5%	6.3%	6.1%	5.5%	5.5%	3.7%	3.4%
Operating Cash Flow	$54.2	$71.1	$74.7	$74.5	$70.9	$72.5	$87.4	$87.9
Operating Cash Flow Margin	7.7%	9.7%	11.1%	10.9%	10.3%	10.3%	11.8%	11.6%
Debt Service Coverage-Projected	1.80x	2.13x	2.39x	2.08x	2.00x	2.04x	2.52x	2.79x
Debt Service Coverage --Required	1.25x	1.25x	1.25x	1.25x	1.25x	1.25x	1.25x	1.25x
Cash and Equivalents	$225.9	$245.1	$213.5	$226.4	$230.3	$196.3	$212.7	$229.2
Days Cash on Hand –Projected	124.6	132.4	127.8	133.8	133.2	111.1	114.8	120.6
Days Cash on Hand-Required	70	70	70	70	70	70	70	70
Long Term Debt	$321.2	$319.8	$299.2	$523.5	$504.7	$502.7	$482.7	$464.1
Net Assets	$396.0	$419.0	$432.8	$480.4	$519.8	$575.4	$587.5	$604.0
Debt to Capitalization-Projected	44.8%	43.3%	40.9%	42.1%	49.3%	46.6%	45.1%	43.4%
Total Liabilities to Unrestricted Net Assets-Projected	1.23x	1.15x	1.03x	1.38x	1.22x	1.11x	1.07	1.03
Total Liabilities to Unrestricted Net Assets-Required	2.50x	2.50x	2.50x	2.50x	2.50x	2.50x	2.50x	2.50x

Source: Data Provided by WAH on November 2, 2015

Based upon these projected ratios, Staff believes that AHI would be able to obtain financing for the project on terms that are consistent with those assumed in the plan of finance.

Projected Volumes

Even though hospital global budgets are fixed and are not sensitive to volume, Staff is concerned about potential declines in volumes that may occur as care models are changed and as population health is improved. Even without these initiatives, there has been a steady decline in inpatient hospital utilization over decades, in spite of an aging population. The introduction of DRGs, technological advances in surgery, radiation therapy, and new medications have contributed to this change. While costs have not decreased, services have moved to outpatient settings. Nationally and in Maryland, payment and delivery models are changing. These models are likely to accelerate these trends toward lower inpatient utilization. Our advice is that attention should be directed to making sure that bed need projections account for these trends and changes while the State is evaluating the size of the facility. There is a risk that excess capacity could develop, and that this excess capacity could affect the feasibility of the WAH project. For example, several of the TPR hospitals saw intensive inpatient volume decreases resulting in excess capacity, including capacity in new facilities.

One measure of the potential for utilization to fall is Potentially Avoidable Utilization (PAU). This is a measurement of categories of unplanned hospital utilization that can be reduced through better care, better care coordination, and other interventions. Staff is measuring several categories of PAUs. Not all PAUs are avoidable, but Staff has not yet identified all categories of utilization that are avoidable. Staff is currently working with recognized national experts to add to the categories of avoidable utilization.

In HSCRC's recent calculations of PAUs used to update statewide revenues as of July 1, 2015, WAH's percentage of PAU's was 16.47% versus a statewide average of 13.65%. This comparison of PAU's has not yet been adjusted for socioeconomic status or other health disparities. In the most recent ROC calculations, WAH had 29.3% of its patients classified as disproportionate share (poor patients) compared to an average of 17.8% for the total hospitals in its comparison group. WAH's significantly higher than average percentage of disproportionate share patients is likely contributing to its higher than average percentage of PAU's.

On a combined basis, the hospitals in Prince Georges County had 18.50% of their patients classified as PAU's, while Montgomery County hospitals had 14.43% of their patients classified as PAUs. Therefore, not only does WAH have a high proportion of PAU's but the hospitals surrounding WAH also have high proportions of PAU's. Staff believes th potential for volume declines in WAH's service area related to future reductions in PAUs should be considered when evaluating bed need projections as potentially affecting feasibility. We understand that MHCC carries the responsibility for this effort and that it is difficult to predict the exact impact of change. Nevertheless, Staff believes conservatism is warranted. WAH is projecting the following discharges and observation patient volumes for CYs 2015 through 2020:

Table 5 – Projected Volumes
Washington Adventist Hospital Revised CON Projections

	Year Ended December 31,						
	Actual	Projected					
	2014	2015	2016	2017	2018	2019	2020
Inpatient Discharges Excl. Psych.	9,892	9,131	9,558	9,567	9,576	9,672	9,768
Outpatient Observation Patients	1,185	2,299	1,881	1,881	1,881	1,900	1,919
Totals	11,077	11,430	11,439	11,448	11,457	11,572	11,687

Source: Updated financial information and projections submitted by WAH on October 21, 2015.

Included in WAH's construction plans are 8 dedicated Short Stay Observation Beds in the lower tower and 12 Clinical Decision beds adjacent to the Emergency Department for a total of 20 additional beds to treat patients classified as observation patients. WAH is projecting 76,132 observation hours in 2020, the second year of operations at the new White Oak facility. Dividing these hours by 24 hours per day results in 3,172 days of observation care, or an average daily census of 8.7 patients. Many patients stay less than 24 hours, so we are not certain how this translates into bed need or occupancy.
Adding the 20 observation beds to the 152 proposed medical surgical (MSGA) beds results in a total of 172 beds to take care of patients requiring inpatient MSGA services at the new White Oak facility. Adding the projected 3,172 observation patient days to the projected 41,763 MSGA days projected

for 2020 results in a total of 44,935 patient days to be treated in the 172 total MSGA beds for an average occupancy rate of 71.6% in 2020. For the 152 proposed MSGA inpatient beds only, WAH is projecting an occupancy rate of 75.3% in 2020. The State Health Plan calls for a minimum occupancy level of 80% for hospitals with 100 to 299 medical surgical beds. The use of all private rooms may increase the level of occupancy that can occur. We understand that MHCC will evaluate occupancy in its review of bed need.
Staff is concerned about future inpatient volume levels in the service area. If WAH is unable to achieve the projected volumes, the Hospital would be less efficient and would have higher rates, which in turn could affect the overall feasibility of the project. In summary, Staff is suggesting that conservatism in bed need projection is warranted relative to project feasibility and efficiency, given the level of change in the delivery system that is underway nationally and in Maryland.

Responses to Specific Questions:

1. Are the sources of funds assumed by the applicant appropriate? In your opinion, is the equity contribution and the proportion of other non-debt sources of project funding adequate?

WAH intends to finance the total project costs of $330,829,524 by incurring $244,750,000 in debt, fund raising $20,000,000, contributing cash of $50,575,175, and earning $4,504,349 in interest income during construction. All of the $330,829,524 project cost is related to capital costs with no allowance made for working capital costs or transition costs.

In addition to the $20,000,000 assumed fund raising and $50,575,175 cash contribution, WAH is assuming that the $11,000,000 previously expended for the purchase of the land for the project will also be a source of funds leaving the total equity contribution at $81,575,175, or approximately 25% of the project costs.

Staff spoke with representatives of the Maryland Health and Higher Educational Facilities Authority (MHHEFA) who stated that AHI has a Baa2 debt rating. WAH has assumed an interest rate of 6% for the debt associated with this project, which seems to be high given current interest rates. If the actual interest rate is less than that assumed, the rate adjustment approved by the HSCRC would be modified to reflect the lower interest rate.

Additionally, while the estimated annual depreciation, amortization, and interest is $24.6 million, the HSCRC only approved an additional $15.4 million revenue increase. Therefore, AHI will be financing a significant portion of the borrowing.

Given AHI's debt situation, staff believes that WAH has provided a reasonable amount of equity contribution for the project to be financially feasible. Ideally staff would like to see higher equity contributions so that the interest rate might be lower on the debt issued for the project resulting in overall lower costs to the patients.

2. As you know, one of the applicant's assumptions is that it will obtain a 7% increase in the hospital's global budget revenue to account for the increased capital costs resulting from this project. In your opinion, is this increase necessary for this project to be feasible and for the replaced and relocated WAH to be financially viable? If, in your opinion, this increase is not

necessary for project feasibility and the viability of WAH, please provide the basis for this opinion.

The 7.0% rate increase assumed by WAH represents approximately 80% of the additional depreciation and interest related to the new project. As stated above, Staff has recommended a $15.4 million (5.4%) increase to revenue instead of the 7.0% requested. WAH had used projected operating results for FY 2014 in its original CON submission. Its actual operating results for that year were much better than projected. These results were incorporated in its projections submitted on October 21, 2015. This improvement significantly offsets the impact of the lower approved revenue increase.

3. Based on your analysis and the experience of HSCRC to date in implementing the new payment model for hospitals, what is the ability of the proposed replacement hospital to be competitively priced, when compared with general hospitals in its region of the state and when compared with similar (peer-group) hospitals throughout the state, if the project is implemented as proposed and the applicant's utilization projections are realized?

Competitive rates for proposed hospital – In order to evaluate the proposed rates of the relocated hospital, we developed a comparison of how WAH's inpatient and outpatient hospital charges compared to its local competitors for the year ended June 30, 2014. Staff's analyses compared average inpatient charges per case by APRDRG broken down between the 4 severity levels within each APRDRG. Staff's analyses also compared average outpatient charges per case broken down by APG.

Listed below are the percentage variances between WAH's average charges per inpatient case and outpatient case and its neighboring hospitals for the year ended June 30, 2014:

Table 6
Comparison of Average Inpatient and Outpatient Charges per Case
Washington Adventist Hospital and Neighboring Competitors
Using Actual Charge Data
Year Ended June 30, 2014

Hospital	Percent Variance from WAH Average Inpatient Charges per Case	Percent Variance from WAH's Average Outpatient Charges per Case	Combined Percent Variance from WAH's Average Charges per Case
Doctors Hospital	(8.4%)	(4.3%)	(7.5%)
Howard County	(13.6%)	(21.9%)	(17.9%)
Montgomery Medical Center	(13.1%)	(8.4%)	(12.3%)
Suburban Hospital	(18.4%)	(4.3%)	(14.4%)
Holy Cross Hospital	(14.1%)	(7.8%)	(12.8%)
Laurel Regional Medical Center	(12.0%)	6.6%	(5.7%)
Average Difference	(13.3%)	(6.1%)	(11.6%)

Source: HSCRC Market share data base. Percentages were determined by first comparing to statewide averages and then comparing to WAH variances from statewide average.

As this table indicates, the charges at WAH's competitors were on average 13.3% below WAH's charges for inpatients and 6.1% below for outpatients based on actual charge data for the year ended June 30, 2014. Once WAH is granted an additional 5.4% rate increase for capital its competitors will have rates on average that may be more than 15% less than WAH's new rates based on the comparisons of actual FY 2014 charges. However, these comparisons do not take into account the cost differences that may be attributable to taking care of populations with lower socioeconomic status. The ROC comparison discussed below includes an adjustment to estimate the impact on costs of these population differences.

Staff compared adjusted charges using information from the most recent ROC calculation, which utilized data from 2013 adjusted for revenue changes to 2014. The adjusted charge comparison from the ROC data is as follows:

Table 7
Comparison of Average Combined Inpatient and Outpatient Charges per Case
Washington Adventist Hospital and Neighboring Competitors
Using Adjusted ROC Charges
Year Ended June 30, 2014

Hospital	Percent Variance from WAH's Average Combined Adjusted Charges per Case
Doctors Hospital	12.5%
Howard County	.5%
Montgomery Medical Center	10.4%
Suburban Hospital	9.9%
Holy Cross Hospital	(9.5%)
Laurel Regional Medical Center	(6.4%)
Average Difference	7.5%

Source: HSCRC ROC data. Percentages were determined by first comparing to statewide averages and then comparing to WAH variances from statewide average.

As noted above, the ROC analysis takes into account that WAH has a greater percentage of poor patients than the average of the hospitals in its peer group, which tends to cause higher costs and rates.

Other requests:

You also asked to receive comments on the financial feasibility of providing acute psychiatric hospital services in Takoma Park as a 40-bed special hospital. The project budget, five year pro forma schedule of revenues and expenses, and assumptions for this proposed special hospital

were submitted on December 12, 2014. Note that the project budget erroneously indicated that the source of funds for renovating space for behavioral health would be cash. The correct source of funds is debt, as specified in Exhibit 6 of the September 29, 2014 replacement application. This was confirmed by WAH in its response to my April 29, 2015 request for additional information.

Financial Feasibility of 40 bed special psychiatric hospital on Takoma Park campus.

Staff reviewed the pro forma income statement provided by WAH in the December 12, 2014 supplemental submission letter for the 40 bed psychiatric unit that will remain at WAH after the relocation of the other beds to White Oak. The 40 bed unit will be owned and operated by Adventist Behavioral Health (ABH), a psychiatric specialty hospital owned by AHI that is located in Rockville Maryland. The pro forma is only for the 40 bed psychiatric unit and does not include any information on the other services that will exist at WAH after the relocation such as the 24-hour urgent care clinic and the Women's Health Clinic.

On August 24, 2015, the Maryland Medicaid program reduced reimbursements to free-standing psychiatric facilities larger than 16 beds because CMS withdrew a waiver that had been approved for the State of Maryland, which had allowed Maryland Medicaid to reimburse these facilities for acute psychiatric services. Maryland's Department of Health and Mental Hygiene is currently seeking a new federal waiver that would significantly expand the scope of treatment options available to Medicaid enrollees with substance abuse and mental health disorders. WAH provided documentation showing that ABH has not been impacted by the reduction in Medicaid reimbursement, and that WAH, for a variety of reasons including the pending new waiver request, does not anticipate any reduction in projected Medicaid payments for the 40 bed psychiatric unit remaining in Takoma Park. Staff believes that the projected net revenues for the 40 bed psychiatric unit are reasonable, assuming that Medicaid does not reduce payments to free-standing psychiatric hospitals in the future.

Staff performed reasonableness tests of the direct costs for salaries and benefits and other expenses included in the December 12, 2014 pro forma for the 40 bed psychiatric unit. Staff compared the projected 2019 costs per patient day in the pro forma to the regulated costs per patient day that ABH incurred during the year ended December 31, 2014 based on ABH's HSCRC Annual Report provided to the HSCRC. Staff inflated the actual ABH expenses for the year ended 2014 by 2.3% per year to 2019 based on the inflation assumptions included in WAH's CON.

The results of staff's analysis are presented below:

Table 8 - Comparison of Projected Takoma Park Psychiatric Unit Costs to Adventist Behavioral Health Actual Costs on a per Equivalent Inpatient day Basis

	Cost per Equivalent Inpatient Day		
Expense Category	Takoma Park Psychiatric Unit Projected FY 2019	Adventist Behavioral Health YE 12/31/2014 Inflated to 2019	Percent Variance
Salaries and benefits	$574	$600	4.5%
Depreciation and interest	186	27	(85.5%)
Other	352	229	(65.1%)
Total Costs	$1,112	$837	(24.7%)
Equivalent inpatient days	10,578	32,467	

Sources: HSCRC Annual Report for the Year Ended December 31, 2014 and additional WAH CON information submitted December 12, 2014.

Although Staff would expect that there would be economies of scale causing lower salary and benefits per patient day at ABH than at the Takoma Park site, the overall expenses per day appear reasonable. Staff believes that ABH's management team will be able to bring cost in line where appropriate.

The income statements in the CON include projected net income of $5,465,000 in 2019 and $6,897,000 in 2020 for the new White Oak facility. The pro forma for the 40 bed psychiatric unit included a $210,000 projected profit in the first year of operations after the White Oak facility opens. The projected income statements provided by WAH in the July 27, 2015 letter from James Lee for both the White Oak facility and the services remaining at WAH show projected net income of only $747,000 in 2019 and $1,770,000 in 2020. The approximate annual $5,000,000 difference between the two sets of projected financial statements represents the annual projected loss on the other services that will remain at Takoma Park.

Staff reviewed additional information provided by WAH regarding the projected financial operations of services remaining at Takoma Park. This financial information appears reasonable.

Finally, you asked that we comment on Laurel Regional Hospital's and MedStar Montgomery Medical Center's submission of an analysis of the impact of the relocation on their discharges and the impact of such a reduction in volume on their revenues and bottom line profit. While you did not necessarily agree with the hospitals' assessments of the impact on volume and you did not ask for our opinion on their calculation of the expected loss in discharges, you did ask for our comments on the methodology used to convert such losses in volume to reductions in revenue and impact on the hospitals' bottom line profit (the relevant analysis submitted by the interested parties on May 29, 2015 was attached).

Laurel Regional Hospital and MedStar Montgomery Medical Center Comments

The major issue with the analysis prepared on behalf of Laurel Regional Hospital (LRH) and MedStar Montgomery Medical Center (MMC) is that LRH and MMC are projecting a far greater number of discharges moving from their facilities than WAH has projected. WAH is projecting that 95 discharges will move to their new White Oak facility from LRH, while 91 discharges will move from MMC to the new White Oak facility. LRH is projecting that it will lose 582 discharges to the new WAH facility at White Oak. MMC is projecting that it will lose 284 discharges to the new WAH facility.

Assuming that all of LRH's and MMC's assumptions regarding revenue, collection percentages, and variability of expenses are accurate, but substituting WAH's projected changes in discharges, the estimated impact at LRH would then decrease from ($1,123,000) annually to ($183,000.) At MMC, the impact would be reduced from ($952,000) annually to ($305,000) if WAH's projected changes in discharges are accurate.

Another less important issue is the assumption of variability in expenses for supply and drug costs. Both LRH and MMC assume that supply and drug costs would vary at a 60% rate with changes in volumes. Normally supplies and drugs should vary at or near 100% with changes in volumes. Assuming a higher variability factor for supplies and drugs would also reduce the projected impact on LRH and MMC.

We also note that the submission by LRH may be irrelevant, given its recent announcement of facility reconfiguration and plans to eliminate much of the acute inpatient capacity of the hospital.

Summary

Staff believes that the overall assumptions regarding the financial viability of the new facility at White Oak are reasonable and achievable depending on WAH attaining the volumes projected in the CON. The current environment of change in health care financing and delivery increase the probability that inpatient volumes will decline. WAH and the surrounding hospitals in the area presently have substantial volumes of f PAUs. Staff recommends conservatism in evaluating need. If WAH does not attain the projected volumes in the CON its overall rate and revenue structure may be viewed as inefficient and may affect the overall financial viability of the project.

Exhibit B

Table 1: The Global Budget Market Shift Adjustments for Rate Year 2016 by Hospital								✓
Hospital Name	Total Discharge/Visits July-Dec 2014	Total Discharge/Visits July-Dec 2015	Total Discharge/Visit Growth	ECMAD July-Dec 2014	ECMAD July-Dec 2015	ECMAD GROWTH	ECMAD Market Shift	Market Shift Adjustment
ANNE ARUNDEL	101,761	106,320	4,559	19,871	20,492	621	69	$396,143
ATLANTIC GENERAL	42,762	44,132	1,370	2,927	3,054	127	(19)	-$108,402
BALTIMORE WASHINGTON MEDIC	72,835	75,080	2,245	12,845	12,992	147	(117)	-$799,826
BON SECOURS	20,431	20,184	(247)	2,681	2,475	(206)	(172)	-$1,562,367
BOWIE HEALTH	16,340	17,544	1,204	540	583	43	14	$97,155
CALVERT	32,783	32,992	209	4,249	4,232	(17)	(68)	-$401,728
CARROLL COUNTY	42,128	41,377	(751)	7,259	7,028	(230)	(70)	-$396,380
CHARLES REGIONAL	34,821	37,948	3,127	4,730	4,696	(35)	(43)	-$37,376
CHESTERTOWN	18,295	18,532	237	1,466	1,457	(9)	(37)	-$341,212
DOCTORS COMMUNITY	34,265	37,569	3,304	6,200	6,439	239	40	$373,537
DORCHESTER	18,141	18,178	37	1,335	1,410	76	22	$202,127
EASTON	28,377	29,608	1,231	5,155	5,090	(64)	(48)	-$430,911
FRANKLIN SQUARE	90,274	89,939	(335)	15,037	15,506	469	245	$1,420,348
FREDERICK MEMORIAL**	55,030	59,622	4,592	10,389	11,292	903	259	$1,347,105
FT. WASHINGTON	20,464	20,299	(165)	1,463	1,396	(66)	(58)	-$383,283
G.B.M.C.	80,801	81,477	676	14,014	13,689	(325)	(437)	-$2,278,961
GARRETT COUNTY**	23,174	23,902	728	1,237	1,534	297	49	$188,050
GERMANTOWN	16,232	16,446	214	618	622	3	(13)	-$72,215
GOOD SAMARITAN	68,320	60,163	(8,157)	9,286	8,663	(623)	(518)	-$3,085,321
HARBOR	42,157	41,499	(658)	6,102	6,038	(64)	(129)	-$905,499
HARFORD	34,419	35,001	582	3,195	3,166	(29)	(18)	-$125,166
HOLY CROSS	69,503	71,215	1,712	16,144	16,958	814	272	$1,039,213
HOLY CROSS GERMANTOWN	-	6,654	6,654	-	782	782	379	$0
HOPKINS BAYVIEW MED CTR	189,358	195,830	6,472	15,099	15,781	683	250	$1,795,780
HOWARD COUNTY	61,847	63,850	2,003	10,395	10,752	357	38	$395,457
JOHNS HOPKINS	299,913	320,772	20,859	36,137	38,180	2,043	921	$7,714,776
LAUREL REGIONAL	20,109	19,637	(472)	3,308	3,096	(212)	(267)	-$1,937,225
MCCREADY	10,000	10,417	417	423	436	13	2	-$40,155
MERCY	135,022	133,919	(1,103)	15,632	15,513	(120)	(74)	-$601,739
MERITUS	44,621	44,362	(259)	9,195	8,987	(208)	(124)	-$709,616
MONTGOMERY GENERAL	25,466	26,431	965	5,112	5,261	149	(64)	-$461,212
NORTHWEST	49,807	48,786	(1,021)	6,604	6,463	(141)	(225)	-$1,385,014
PENINSULA REGIONAL	70,441	71,246	805	11,029	11,218	189	(3)	-$55,102
PRINCE GEORGE	27,789	28,002	213	6,217	6,902	685	186	$1,396,315
QUEEN ANNES	6,800	7,625	825	243	280	38	4	$18,298
REHAB & ORTHO	20,859	20,962	103	3,468	3,374	(95)	(99)	-$704,634
SHADY GROVE	55,371	55,979	608	13,074	12,857	(218)	(458)	-$2,846,113
SINAI	104,282	104,965	683	18,647	18,497	(151)	(274)	-$1,977,215
SOUTHERN MARYLAND	35,468	33,991	(1,477)	7,090	6,848	(242)	(255)	-$1,493,265
ST. AGNES	75,264	80,905	5,641	12,031	12,413	382	104	$656,125
ST. MARY	49,059	50,469	1,410	5,463	5,920	457	173	$972,173
SUBURBAN	29,315	29,700	385	9,544	9,840	295	76	$333,569
UM ST. JOSEPH*	54,895	56,203	1,308	12,027	13,304	1,277	758	$4,161,524
UMMC MIDTOWN	42,015	56,741	14,726	4,111	4,702	591	305	$3,249,062
UNION HOSPITAL OF CECIL COUN	46,095	42,029	(4,066)	4,324	3,990	(334)	(140)	-$1,041,023
UNION MEMORIAL	73,678	72,498	(1,180)	12,396	13,061	665	280	$1,735,895
UNIVERSITY OF MARYLAND	137,529	136,820	(709)	28,506	28,361	(145)	(280)	-$1,822,357
UPPER CHESAPEAKE HEALTH	67,086	68,901	1,815	9,608	9,193	(415)	(232)	-$1,029,914
WASHINGTON ADVENTIST	33,359	33,668	309	7,110	7,020	(90)	(256)	-$1,464,523
WESTERN MARYLAND HEALTH SYS	40,177	41,841	1,664	6,655	6,619	(36)	45	$248,759
Grand Total	2,768,938	2,842,230	73,292	420,192	428,462	8,270	0	-$756,341
HSCRC Casemix Data- Updated 7/7/2015								
Notes:								
Shifts within systems for service movements between system hospitals have not been reflected in these figures.								
*Market shift adjustment for St. Joseph Medical Center was implemented concurrently during FY2015.								
** Market shift adjustments will be revised due to data accuracy issues.								

Accessed at: http://www.hscrc.state.md.us/hsp-gbr-tpr-update.cfm on 12/4/2015.

Table 1: CY2015 Q1 Q2 Preliminary Market Shift Calculations

Hospital Name/Serviceline/Zipcode	Total Discharge/Visits CY14Q1Q2	Total Discharge/Visits CY15Q1Q2	Total Discharge/Visit Growth	ECMAD CY14Q1Q2	ECMAD CY15Q1Q2	ECMAD GROWTH	Market Shift	Market Shift Adjustment
HOLY CROSS GERMANTOWN	-	14,727	14,727	-	2,107	2,107	1,394	
SOUTHERN MARYLAND	33,398	34,679	1,281	6,574	7,085	511	401	$2,739,841
JOHNS HOPKINS	313,126	322,751	9,625	37,141	37,429	288	395	$2,829,546
ANNE ARUNDEL	102,499	103,844	1,345	19,497	19,980	484	392	$2,108,999
UMMC MIDTOWN	47,374	52,808	5,434	4,331	4,629	298	309	$3,445,227
MERCY	137,040	130,571	(6,469)	15,185	15,489	304	299	$1,359,541
ST. MARY	49,509	51,167	1,658	5,579	5,833	254	154	$795,354
HOPKINS BAYVIEW MED CTR	191,604	192,400	796	15,231	15,337	106	124	$1,394,275
HOWARD COUNTY	61,278	61,176	(102)	10,301	10,529	227	115	$595,841
UM ST. JOSEPH	56,993	53,519	(3,474)	12,625	12,637	12	91	$569,994
PRINCE GEORGE	26,930	26,165	(765)	6,261	6,591	330	82	$230,376
CARROLL COUNTY	40,547	40,201	(346)	6,873	7,077	205	74	$475,000
WASHINGTON ADVENTIST	32,181	31,854	(327)	7,007	7,060	54	71	$613,299
UPPER CHESAPEAKE HEALTH	66,739	69,263	2,524	9,248	9,271	24	68	$482,988
UNIVERSITY OF MARYLAND	135,795	131,434	(4,361)	26,799	26,796	(3)	39	$272,197
GARRETT COUNTY	23,423	23,924	501	1,490	1,566	76	36	$163,562
FRANKLIN SQUARE	89,880	89,810	(70)	15,290	15,349	59	34	$114,869
PENINSULA REGIONAL	69,596	70,101	505	10,847	10,735	(112)	25	-$893
BALTIMORE WASHINGTON MEDICAL CENTER	73,743	72,761	(982)	12,941	12,737	(204)	21	$73,957
BOWIE HEALTH	17,200	16,910	(290)	567	616	50	15	$108,053
BON SECOURS	19,487	20,376	889	2,455	2,420	(36)	14	-$503,726
ATLANTIC GENERAL	41,788	40,531	(1,257)	2,836	2,879	43	14	$58,350
MERITUS	43,944	42,777	(1,167)	8,961	8,921	(40)	6	$32,968
MCCREADY	10,093	9,972	(121)	414	431	17	6	$64,347
EASTON	29,035	29,299	264	4,986	4,973	(13)	1	$17,686
WESTERN MARYLAND HEALTH SYSTEM	41,968	41,400	(568)	6,600	6,482	(118)	(0)	$32,567
QUEEN ANNES	7,394	7,510	116	277	281	4	(0)	-$1,603
CHESTERTOWN	17,437	18,362	925	1,468	1,421	(47)	(12)	-$145,599
REHAB & ORTHO	20,204	20,606	402	3,363	3,310	(53)	(15)	-$6,481
UNION HOSPITAL OF CECIL COUNT	43,000	40,346	(2,654)	3,978	3,851	(126)	(24)	-$213,302
FT. WASHINGTON	20,583	19,781	(802)	1,492	1,408	(84)	(24)	-$12,438
HARFORD	33,935	32,984	(951)	3,275	3,108	(167)	(30)	-$238,457
DORCHESTER	18,009	18,210	201	1,429	1,376	(53)	(41)	-$352,073
ST. AGNES	77,003	77,531	528	12,197	12,121	(75)	(61)	-$342,454
LAUREL REGIONAL	19,447	18,998	(449)	3,169	3,162	(8)	(86)	-$723,927
SUBURBAN	29,214	28,372	(842)	9,581	9,513	(67)	(98)	-$741,521
GERMANTOWN	17,115	14,268	(2,847)	656	549	(107)	(107)	-$570,133
CALVERT	32,670	32,956	286	4,186	4,100	(86)	(131)	-$820,007
FREDERICK MEMORIAL	56,850	55,180	(1,670)	10,402	10,198	(204)	(144)	-$1,166,124
UNION MEMORIAL	74,219	67,896	(6,323)	12,579	12,217	(363)	(158)	-$901,362
DOCTORS COMMUNITY	35,117	37,506	2,389	6,387	6,288	(99)	(172)	-$1,251,701
NORTHWEST	48,381	46,141	(2,240)	6,512	6,228	(284)	(184)	-$1,170,036
CHARLES REGIONAL	35,999	37,000	1,001	4,767	4,489	(278)	(199)	-$967,498
HOLY CROSS	68,904	66,562	(2,342)	15,914	15,791	(123)	(241)	-$1,260,771
MONTGOMERY GENERAL	25,817	24,967	(850)	5,242	4,995	(247)	(288)	-$1,656,436
HARBOR	41,697	39,322	(2,375)	5,932	5,403	(529)	(298)	-$2,540,452
G.B.M.C.	81,186	78,133	(3,053)	13,596	12,979	(618)	(319)	-$1,979,731
GOOD SAMARITAN	65,387	58,775	(6,612)	8,831	8,143	(688)	(327)	-$2,190,771
SHADY GROVE	55,627	52,330	(3,297)	12,853	11,988	(866)	(571)	-$3,328,487
SINAI	105,894	100,141	(5,753)	18,363	17,397	(966)	(646)	-$5,033,989
Grand Total	2,786,259	2,768,297	(17,962)	416,488	415,279	(1,209)	(0)	-$9,541,136

Exhibit C

Ziegler
CAPITAL :: INVESTMENTS :: ADVICE

200 South Wacker Drive
Suite 2000
Chicago, IL 60606

www.Ziegler.com

February 20, 2015

Mr. Ben Steffan
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Steffan,

As one of the leading investment banks in the nation for tax-exempt healthcare financing, Ziegler is intimately familiar with all aspects of the bond markets as they relate to hospitals and health systems. The financing assumptions included in the modified CON application, submitted on September 29, 2014, were based on best available capital markets information at the time, with relatively conservative assumptions on credit and interest rate environment. Ziegler's credit opinion of Adventist HealthCare ("AHC") is based on how external credit parties, including rating agencies, credit lenders and investors, would view AHC's credit profile, reflective of the proposed Washington Adventist Hospital project and financing. As represented in Exhibits 1-3, attached to this letter, various "BBB" and lower rated hospital and health system financings are being completed at historically low borrowing costs. During 2014, the average BBB and non-rated healthcare borrowers' borrowing cost were approximately 4.57% vs. 6.0% assumed in the CON application. In addition, the interest rate environment for tax-exempt financing continues to be favorable with the 30-Year MMD, a benchmark for long-term tax-exempt borrowing cost, hovering around the near historical lows, as shown in Exhibit 4. The 30-Year MMD is currently at 2.88% (vs. 2.95% when the CON application was submitted). Financing assumptions made in the CON application were conservative assumptions based on current market environment, and it is Ziegler's view that the project is financeable and important to the future of AHC.

Sincerely,

Donald A. Carlson, Jr.
Vice Chairman

EXHIBIT 1: RECENT "BBB" AND NON-RATED HEALTHCARE FINANCINGS

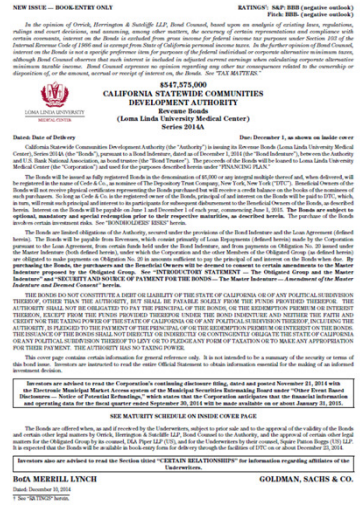
- A large number of BBB and non-rated healthcare deals are being completed at historically low borrowing costs
- Borrowing costs, represented by the Yield, decreased by more than 0.25%-0.50% from the beginning of 2014 to the end of 2014
- In 2014, BBB and non-rated healthcare borrowers achieved long-term borrowing cost at or around 4.57% Yield compared to a 6.0% Yield assumed in the modified CON application for the Washington Adventist Hospital project financing

Sale Date	Borrower	State	Moodys	S&P	Fitch	Par Amount (Millions)	Final Term	Years	Coupon	Yield
12/16/14	Washington Regional Med Ctr	AR	Baa1	NR	NR	$ 107.75	2/1/2038	23.1	4.00%	4.21%
12/10/14	Loma Linda University Medical Center	CA	NR	BBB	BBB-	$ 547.58	12/1/2054	40.0	5.50%	4.96%
11/18/14	Erlanger Health System	TN	Baa2	NR	BBB	$ 149.92	10/1/2044	29.9	5.00%	4.29%
10/21/14	Western Maryland Health System	MD	NR	BBB	NR	$ 236.17	7/1/2035	20.7	4.00%	4.02%
10/16/14	Cooper Health System	NJ	Baa2	BBB	NR	$ 139.73	2/15/2035	20.3	5.00%	3.53%
10/02/14	Karnes Co Hospital Dt	TX	NR	NR	BBB	$ 43.82	2/1/2044	29.3	5.00%	4.65%
09/24/14	Major Hospital	IN	Baa2	NR	BBB+	$ 53.51	10/1/2044	30.0	5.00%	4.40%
09/10/14	Madonna Rehabilitation Hospital	NE	NR	BBB+	NR	$ 80.17	5/15/2044	29.7	5.00%	4.11%
08/20/14	Mt. Sinai Medical Center	FL	Baa1	NR	BBB	$ 170.90	11/15/2044	30.2	5.00%	4.20%
06/17/14	St. Alexius Medical Center	ND	NR	BBB+	BBB+	$ 46.48	7/1/2035	21.0	5.00%	4.35%
06/04/14	Wise Regional Health System	TX	NR	BB+	BB+	$ 93.73	9/1/2044	30.2	5.25%	5.30%
05/20/14	Centegra Health System	IL	NR	BBB	BBB	$ 134.72	9/1/2042	28.3	5.00%	4.74%
05/14/14	St. Francis Hospital - NY	NY	Baa1	BBB+	BBB+	$ 77.73	7/1/2034	20.1	5.00%	4.07%
04/23/14	Denver Health	CO	NR	BBB	BBB+	$ 67.87	12/1/2045	31.6	5.25%	4.75%
02/26/14	Leesburg Regional Medical Center	FL	Baa1	BBB+	NR	$ 50.00	7/1/2044	30.3	5.25%	5.42%
01/28/14	Lawrence General Hospital	MA	NR	BBB-	BBB	$ 43.49	7/1/2044	30.4	5.50%	5.62%
01/22/14	Henry Mayo Newhall Mem Hospital	CA	NR	BBB-	NR	$ 70.00	10/1/2043	29.7	5.25%	5.30%
01/16/14	Milford Regional Medical Center	MA	Baa3	NR	NR	$ 45.66	7/15/2043	29.5	5.75%	5.80%
							Weighted Average		**5.03%**	**4.57%**

Source: Bloomberg - List includes "BBB" and non-rated health care financings with more than $40 million in borrowing amount and borrowing term longer than 20 years

EXHIBIT 2: LOMA LINDA UNIVERSITY MEDICAL CENTER 2014 FINANCING CASE STUDY

- Loma Linda University Medical Center (aka Loma Linda University Health System, "Loma Linda") is a California, non-profit health system composed of 3 hospitals with net patient revenue of approximately $1.4B
- Loma Linda issued $547M tax-exempt revenue bonds on Dec. 23, 2014 to fund new projects and refund existing debt
- Loma Linda is rated BBB with a negative outlook from Standard and Poor's Financial Services and BBB- with a negative outlook from Fitch Ratings
- Adventist HealthCare, Inc. (AHC) has stronger key financial ratios as depicted below. In addition, Loma Linda is experiencing declining performance, unlike AHC who had strong operating performance for FY 2014
- Loma Linda financing was completed with weighted average coupon of 5.41% to yield 4.76%
- Despite the negative outlook by rating agencies, more than 70 investors placed order for the bonds and interest level exceeded the borrowing amount by more than 6x



NEW ISSUE — BOOK-ENTRY ONLY

RATINGS†: S&P: BBB (negative outlook)
Fitch: BBB- (negative outlook)

$547,575,000
CALIFORNIA STATEWIDE COMMUNITIES DEVELOPMENT AUTHORITY
Revenue Bonds
(Loma Linda University Medical Center)
Series 2014A

Dated: Date of Delivery — Due: December 1, as shown on inside cover

BofA MERRILL LYNCH — GOLDMAN, SACHS & CO.

	AHC OG FY 2014	Loma Linda FY 2013
Net Patient Revenue (in 000s)	$ 699,289	$ 1,396,247
Days Cash on Hand	133	102
Long-Term Debt-to-Cap	41.1%	55.0%
Cash-to-Long Term Debt	83.8%	52.3%
Max Ann. DS Coverage	2.17x	2.15x

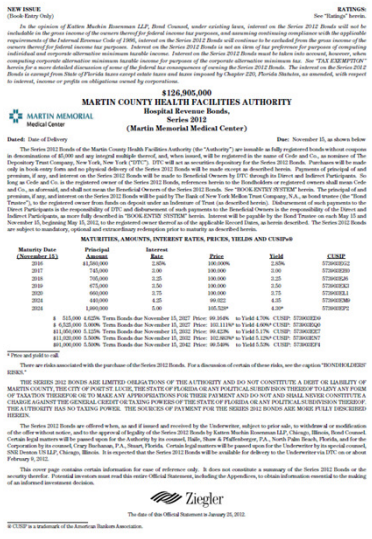
Final Pricing Summary

Maturity	Par (000s)	Coupon	Yield
12/1/2029	$ 43,580	5.25%	4.18%
12/1/2034	56,280	5.25%	4.44%
12/1/2044	166,575	5.25%	4.70%
12/1/2054	281,140	5.50%	4.96%
	$ 547,575	5.41%	4.76%

Source: AHC Unaudited FY 2014 financials; Loma Linda 2014A Bond Offering Document; S&P and Fitch rating reports (Dec 2014)

EXHIBIT 3: MARTIN MEDICAL CENTER NEW HOSPITAL FINANCING CASE STUDY

- Martin Memorial Medical Center (Martin Memorial), a Florida not-for-profit health system with 2 hospitals was looking to finance a greenfield hospital construction in its neighboring community and borrow approximately $127M to fund a portion of the $160M project
- At the time of financing, Martine Memorial was rated BBB with a stable outlook from Standard and Poor's Ratings and Baa 1 (equivalent to BBB+) with a stable outlook from Moody's Investor Services
- Given the relative size of the financing compared to the size of the organization, Martin Memorial completed an independent feasibility study to be included in the bond offering document
- Both rating agencies and investors factored in the feasibility study in their rating and investment decisions
- More than 25 investors participated in the pricing, providing weighted average cost of 5.43% (Coupon) to yield 5.40%. The transaction was priced during the period when the 30-Year MMD was at 3.36% compared to current rate of 2.88%



NEW ISSUE
(Book-Entry Only)

RATINGS:
See "Ratings" herein.

In the opinion of Kutten Mushin Rosenman LLP, Bond Counsel, under existing laws, interest on the Series 2012 Bonds will not be includable in the gross income of the owners thereof for federal income tax purposes, and assuming continuing compliance with the applicable requirements of the Internal Revenue Code of 1986, interest on the Series 2012 Bonds will continue to be excluded from the gross income of the owners thereof for federal income tax purposes. Interest on the Series 2012 Bonds is not an item of tax preference for purposes of computing individual and corporate alternative minimum taxable income. Interest on the Series 2012 Bonds must be taken into account, however, when computing corporate alternative minimum taxable income for purposes of the corporate alternative minimum tax. See "TAX EXEMPTION" herein for a more detailed discussion of some of the federal tax consequences of owning the Series 2012 Bonds. The interest on the Series 2012 Bonds is exempt from State of Florida taxes except estate taxes and taxes imposed by Chapter 220, Florida Statutes, as amended, with respect to interest, income or profits on obligations owned by corporations.

$126,905,000

MARTIN COUNTY HEALTH FACILITIES AUTHORITY

Hospital Revenue Bonds,
Series 2012
(Martin Memorial Medical Center)

MARTIN MEMORIAL
Medical Center

Dated: Date of Delivery

Due: November 15, as shown below

The Series 2012 Bonds of the Martin County Health Facilities Authority (the "Authority") are issuable as fully registered bonds without coupons in denominations of $5,000 and any integral multiple thereof, and, when issued, will be registered in the name of Cede and Co., as nominee of The Depository Trust Company, New York, New York ("DTC"). DTC will act as securities depository for the Series 2012 Bonds. Purchases will be made only in book-entry form and no physical delivery of the Series 2012 Bonds will be made except as described herein. Payments of principal of and premium, if any, and interest on the Series 2012 Bonds will be made to Beneficial Owners by DTC through its Direct and Indirect Participants. So long as Cede and Co. is the registered owner of the Series 2012 Bonds, references herein to the Bondholders or registered owners shall mean Cede and Co., as aforesaid, and shall not mean the Beneficial Owners of the Series 2012 Bonds. See "BOOK-ENTRY SYSTEM" herein. The principal of and premium, if any, and interest on the Series 2012 Bonds will be paid by The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Bond Trustee"), to DTC, which is obligated in turn to remit such principal and interest to its Direct Participants, for subsequent disbursement to the Beneficial Owners. The disbursement of such payments to the Beneficial Owners is the responsibility of DTC and disbursement of such payments to the Beneficial Owners is the responsibility of the Direct and Indirect Participants, as more fully described in "BOOK-ENTRY SYSTEM" herein. Interest will be payable by the Bond Trustee on each May 15 and November 15, beginning May 15, 2012, to the registered owner thereof as of the applicable Record Dates, as herein described. The Series 2012 Bonds are subject to mandatory, optional and extraordinary redemption prior to maturity as described herein.

MATURITIES, AMOUNTS, INTEREST RATES, PRICES, YIELDS AND CUSIPs®

Maturity Date (November 15)	Principal Amount	Interest Rate	Price	Yield	CUSIP
2016	$1,560,000	2.00%	100.000%	2.00%	573065DL2
2017	745,000	3.00	100.000	3.00	573065DM0
2018	765,000	3.25	100.000	3.25	573065DN8
2019	675,000	2.50	100.000	2.50	573065DK3
2020	660,000	2.75	100.000	2.75	573065DL1
2024	140,000	4.25	99.022	4.35	573065DM9
2024	1,090,000	5.00	105.529†	4.30†	573065DP2
	$ 515,000 4.625% Term Bonds due November 15, 2027 Price: 99.164% to Yield 4.70% CUSIP: 573065DQ0				
	$ 6,525,000 5.000% Term Bonds due November 15, 2027 Price: 101.111%† to Yield 4.00%† CUSIP: 573065DQ0				
	$11,450,000 5.125% Term Bonds due November 15, 2032 Price: 99.422% to Yield 5.17% CUSIP: 573065DS7				
	$11,820,000 5.500% Term Bonds due November 15, 2032 Price: 102.865%† to Yield 5.128%† CUSIP: 573065DT5				
	$91,090,000 5.500% Term Bonds due November 15, 2042 Price: 99.548% to Yield 5.53% CUSIP: 573065DP4				

† Price and yield to call.

There are risks associated with the purchase of the Series 2012 Bonds. For a discussion of certain of these risks, see the caption "BONDHOLDERS' RISKS."

THE SERIES 2012 BONDS ARE LIMITED OBLIGATIONS OF THE AUTHORITY AND DO NOT CONSTITUTE A DEBT OR LIABILITY OF MARTIN COUNTY, THE CITY OF PORT ST. LUCIE, THE STATE OF FLORIDA OR ANY POLITICAL SUBDIVISION THEREOF TO LEVY ANY FORM OF TAXATION THEREFOR OR TO MAKE ANY APPROPRIATIONS FOR THEIR PAYMENT AND DO NOT AND SHALL NEVER CONSTITUTE A CHARGE AGAINST THE GENERAL CREDIT OR TAXING POWERS OF THE STATE OF FLORIDA OR ANY POLITICAL SUBDIVISION THEREOF. THE AUTHORITY HAS NO TAXING POWER. THE SOURCES OF PAYMENT FOR THE SERIES 2012 BONDS ARE MORE FULLY DESCRIBED HEREIN.

The Series 2012 Bonds are offered when, as and if issued and received by the Underwriter, subject to prior sale, to withdrawal or modification of the offer without notice, and to the approval of legality of the Series 2012 Bonds by Kutten Mushin Rosenman LLP, Chicago, Illinois, Bond Counsel. Certain legal matters will be passed upon for the Authority by its counsel, Hale, Shaw & Pfaffenberger, P.A., North Palm Beach, Florida, and for the Corporation by its counsel, Crary Buchanan, P.A., Stuart, Florida. Certain legal matters will be passed upon for the Underwriter by its special counsel, SNR Denton US LLP, Chicago, Illinois. It is expected that the Series 2012 Bonds will be available for delivery to the Underwriter via DTC on or about February 8, 2012.

This cover page contains certain information for ease of reference only. It does not constitute a summary of the Series 2012 Bonds or the security therefor. Potential investors must read this entire Official Statement, including the Appendices, to obtain information essential to the making of an informed investment decision.

Ziegler

The date of this Official Statement is January 25, 2012.

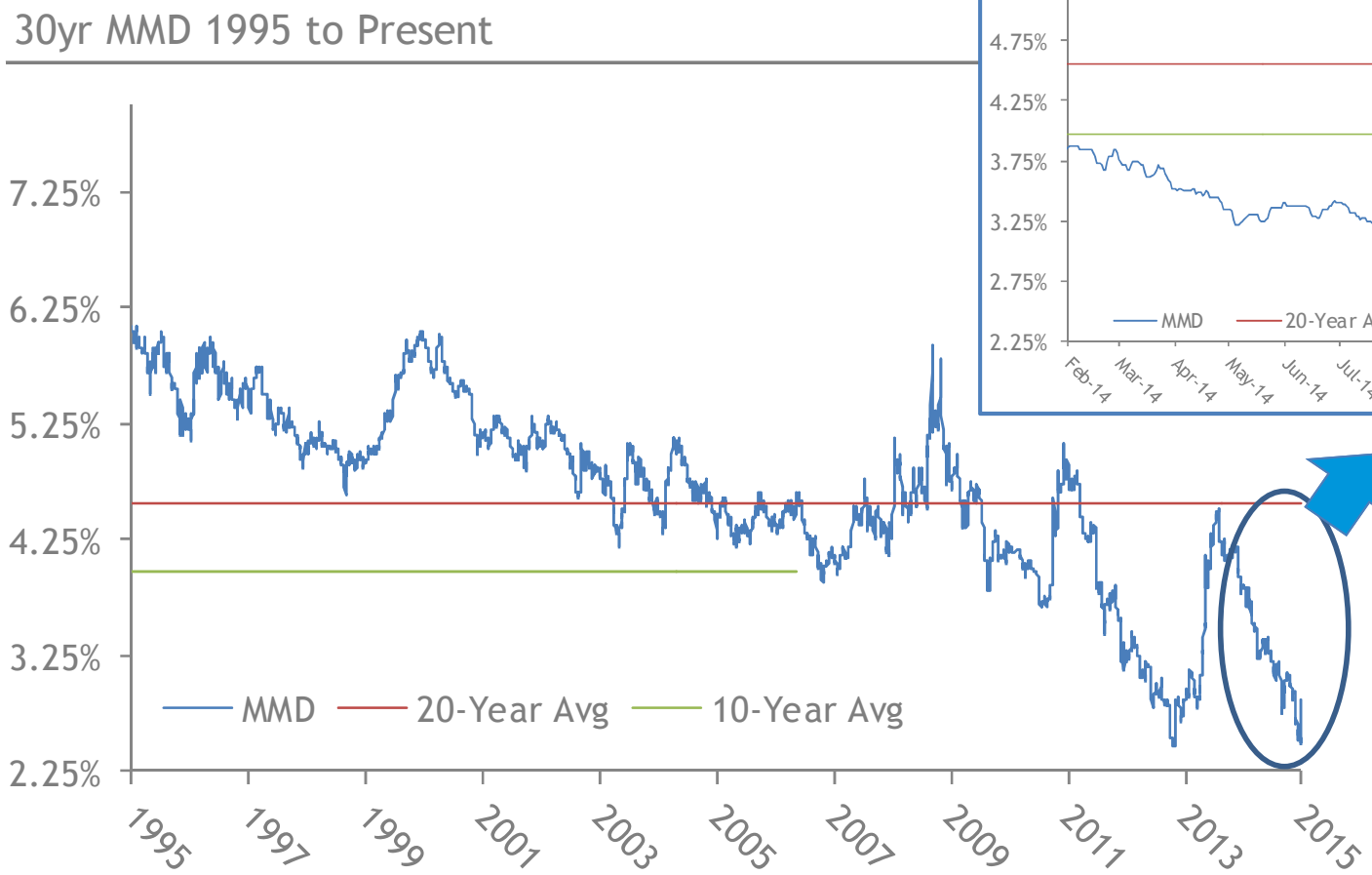
® CUSIP is a trademark of the American Bankers Association.

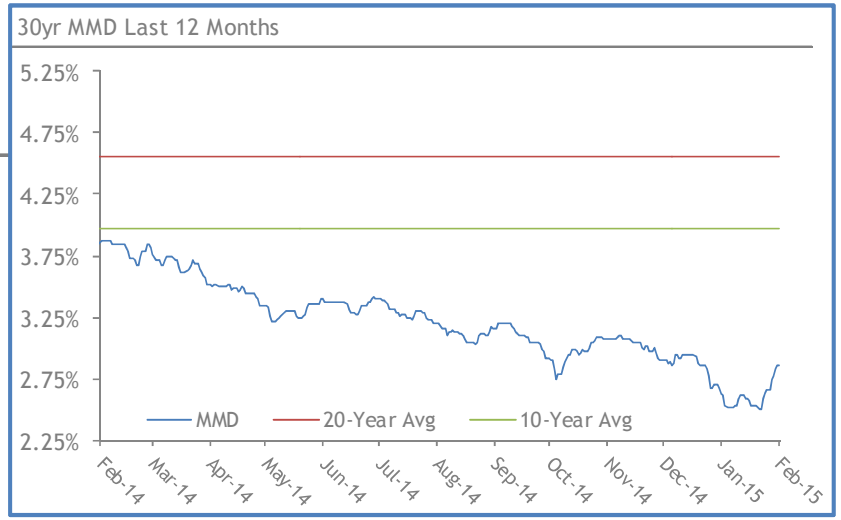
	Martin Memorial	
	FY 2011	Hist. Pro Forma
Net Patient Revenue (in 000s)	$ 328,260	$ 328,260
Days Cash on Hand	126	112
Long-Term Debt-to-Cap	48.2%	65.6%
Cash-to-Long Term Debt	85.7%	41.8%
Max Ann. DS Coverage	3.37x	2.50x

Source: Martin Memorial Medical Center 2012 Bond Offering Document; S&P and Moody's rating reports (Dec 2012)

EXHIBIT 4: TAX-EXEMPT FIXED RATE INTEREST RATE

- The 30-YR MMD (tax-exempt long-term borrowing cost benchmark) is currently at 2.88% vs 2.95% when CON application was submitted
- Interest rate environment continues to be favorable for borrowers, hovering near the all-time low of 2.47% which occurred on 11/29/2012
- The average 30-YR MMD for CY 2014 was 3.36% and the YTD 2015 is at 2.68%



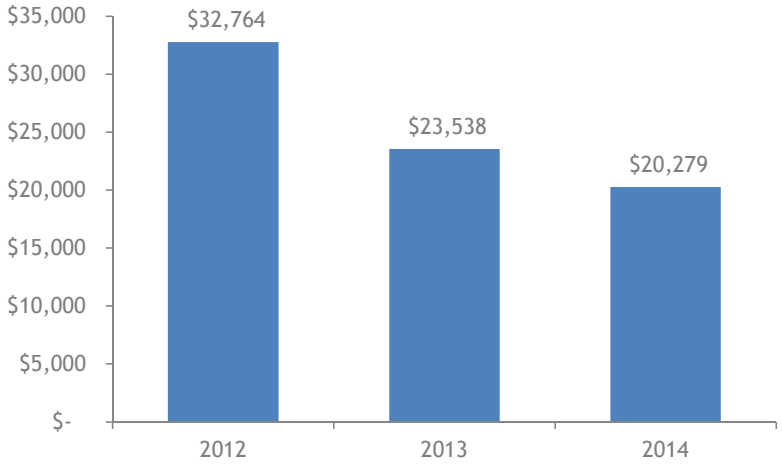


Current	2.88%
10-Year Ave	3.97%
20-Year Ave	4.56%
20-Year Max	6.10%
20-Year Min	2.47%

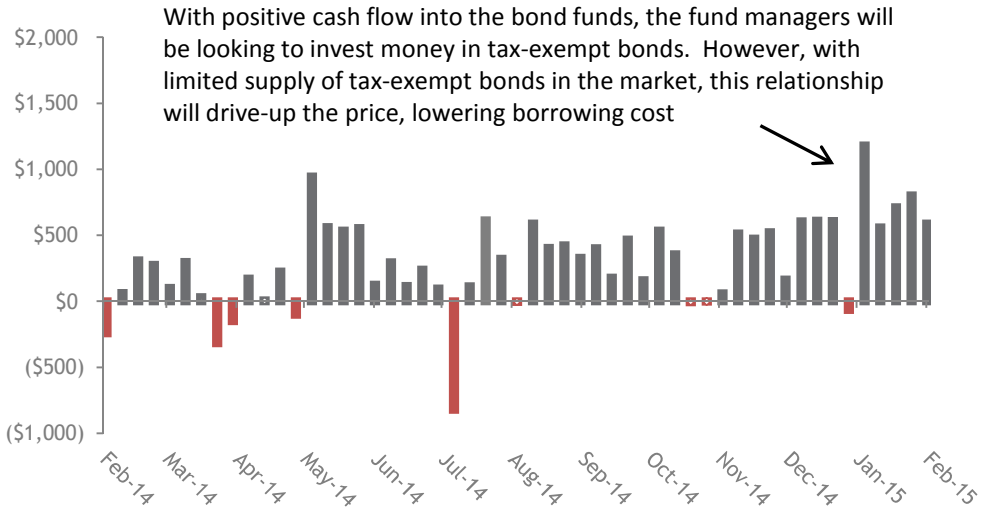
Source: Bloomberg, As of February 20, 2015

EXHIBIT 5: SUPPLY AND DEMAND IMBALANCE IN TAX-EXEMPT PAPERS WILL CONTINUE TO PRESSURE BORROWING COST

Hospital and Health System New Money Financing (in Millions)



Municipal Bond Fund Cash Flow (in Millions)



- Amount of hospitals and health systems tax-exempt debt issuance volume decreased by more than 38% between 2012 and 2014 as hospitals and health systems utilized direct bank lending programs to fund capital projects
- Meanwhile, cash continues to follow into the municipal bond funds increasing demand for tax-exempt bonds. This imbalance between demand and supply puts downward pressure on interest rates

Source: SDC and Bloomberg, As of February 20, 2015

Exhibit D

AHC AND WAH COMMUNITY PROGRAMS

In addition to the services that will remain on the Takoma Park campus once WAH relocates to White Oak -- and consistent with its long-standing commitment to providing health and wellness programs for the community -- AHC will continue to offer a number of community programs. Among the types of programs currently offered are the following.

Center for Health Equity and Wellness

AHC has a Center for Health Equity and Wellness (the "Center"), specifically focused on the delivery of needed, culturally competent services to communities that are often subject to health disparities. In 2007, the Adventist HealthCare Center on Health Disparities was created to raise community awareness, develop solutions to eliminate local disparities in health care and improve access to quality health care, especially for minorities, women, and people who have language barriers or other communications needs. In 2012, the Center on Health Disparities and the Adventist HealthCare Health and Wellness Department joined together to form the Center, to addresses disease prevention and management and to promote health equity in the communities served by AHC. The Center collaborates with hospitals and other community stakeholders to promote community outreach and improve cancer, cardiovascular disease, diabetes, maternal/child health, and other health outcomes especially among minority and vulnerable populations. In the community, it raises awareness of health issues and disparities, screens for various conditions, and offers educational and support programs to residents in Montgomery County. Also, the Center coordinates language services to eliminate barriers among minority, limited English proficient, and vulnerable populations. In addition, the Center provides cultural competence training to clinical and non-clinical healthcare professionals and coordinates language access services (i.e., interpretation) to eliminate barriers to effective communication between healthcare providers and limited English-proficient patients.

Exhibit 120 is a print-out of a presentation given by the Center concerning its population health strategies, including: (a) collection of data and research; (b) fostering of cultural competence in the delivery of health care, (c) providing multi-lingual support, (d) conducting cancer screenings, (e) supporting smoking cessation, (f) providing breast cancer screening to low income populations, (g) providing cardiac screening, (h) providing comprehensive diabetes education and support, and (i) providing support for childbearing families.

Cardiac and Vascular Outreach Services Program

The Center also offers a Cardiac and Vascular Outreach Services Program (Cardiac Program) to promote and support positive cardiovascular health in the community. The Cardiac Program, fully implemented since 1996, grew out of AHC's concern to provide increased health care access to underserved populations, including racial/ethnic minorities and older adults. The Cardiac Program emphasizes the prevention of heart disease through healthy lifestyle habits, including (but not limited to) proper nutrition, fitness and exercise, cessation of smoking and stress reduction. The program creates awareness of health issues facing the targeted population; educates them about risk factor identification, reduction and management; assesses needs in the area of cardiac and vascular health; provides education, tools and support to assist with behavior

change; and identifies diseases early through screenings. At-risk patients identified through screenings are linked with health care providers who are sensitive to their cultural, linguistic, and physical needs.

A registered nurse and health educator with 20+ years of experience runs the Cardiac Program, and collaborations with various community agencies and groups (senior centers, low-income housing, etc.) have increased both the outreach and the effectiveness of the program to those at risk for heart disease. Partnerships include, but are not limited to: the African American Health Program, Senior Centers, Complete Health Improvement Plan, Plus 15, The Eden Experience, American Heart Association, Sister to Sister, and Women and Heart. Selected components of the Cardiac Program are described below.

Heart Health Screening Program

This screening program is offered to assist people in being proactive regarding heart health and to work with their physician in tracking their "numbers". At the event, individuals choose from a menu of cardiac related screening tests and also speak one-on-one with a clinician regarding personal risk factors. Results from the screenings are sent both to the participant and their personal physician. Approximately 20-30 screenings are offered annually, at eight (8) Montgomery County locations. Screening tests offered include: Lipid Profile, Vertical Auto Profile, Homocysteine, HsCRP, Fasting Blood Sugar, A1c, Body Fat Analysis, BMI, Blood Pressure and PSA for men to be done in conjunction with physician examination.

Blood Pressure Screening and Counseling

In addition to the Heart Health Screening described above, AHC separately offers free monthly blood pressure screenings and counseling session at 10 Montgomery County sites.

Community Classes/Lectures on Cardiac and Vascular Topics

AHC offers several classes in the community on topics relating to cardiovascular health (by request). These classes include, but are not limited to: Heart Attack Recognition, Don't Wait, Call 9-1-1; Women and Heart Disease (HD); Cholesterol and HD; Nutrition and HD; Stroke; and Spirituality and Health.

Cardiovascular Support and Activity Groups

Groups meet at least monthly to promote both disease prevention and disease management. Groups include: Heart to Heart, Stroke Club, Implantable Defibrillator, Diabetes Support Group, Walking Club, Congestive Heart Failure, and DVT (Deep Vein Thrombosis).

Complete Health Improvement Program

The Complete Health Improvement Program (CHIP) is a 32-hour lifestyle enrichment program designed to reduce disease risk factors (primarily cardiovascular and diabetes risk factors, which contribute to many other conditions as well) through the adoption of better health habits and

appropriate lifestyle modifications. The goal is to lower blood lipids, blood pressure, blood sugar levels, and reduce excess weight, which are all risk factors for more serious conditions. This is done by improving dietary choices (primarily through adopting a plant based diet), enhancing daily exercise, increasing support systems and decreasing stress, thus aiding in preventing and reversing disease. At the end of the formal class, there is an on-going support group, called Club CHIP to help the participants' sustain their efforts in continuing the healthy lifestyle habits learned. This evidence-based program is endorsed by the Physicians Committee for Responsible Medicine, the Center for Science in the Public Interest and the International Nutrition Research Foundation. Further, results from CHIP programs have been published extensively in peer-reviewed journals, including Advances in Preventive Medicine, the American Journal of Cardiology, the British Medical Journal, and Preventing Chronic Disease.

In the pilot CHIP program conducted at WAH between August 1 and September 12, 2013 results showed an average drop in total cholesterol from 174 mg/dL to 142 mg/dL, and average weight loss of 8 lbs, and an average drop in body fat from 43.0% to 41.9%.

Other Programs and Special Events

In addition to the many programs listed above, the Center also offers many special events, such as a Heart Health Education and Health Fair in collaboration with the African American Health Program at WAH, and Vascular Screenings (Carotid Artery Screening, Ankle Brachial Index, and Abdominal Aortic Aneurysm). An Advisory Board has been established to help guide efforts to reduce and eliminate health disparities, to identify community needs, and to help assess and direct AHC's responses to those needs. The Advisory Board is comprised of both internal and external (community) leaders which include clinicians, researchers, administrators and other hospital staff, community-based organizations, local and state health departments, the University of Maryland, the National Institutes of Health (specifically, the National Institute of Minority Health and Health Disparities), and other public health stakeholder organizations. All of the Community Health Needs Assessment and Implementation Strategy reports were reviewed and approved by the AHC Board of Trustees, as well as the board of each entity, both of which consist of leaders from community-based organizations, local safety net clinics, physicians, and health care leaders. These reports are all available to the public through the AHC website.

The Center maintains a close partnership with the Montgomery County Department of Health and Human Services to provide training and education to employees as well as deliver The Center's annual fall conferences. Since 2008, The Center has served as a consulting partner with the LifeBridge Health System in Baltimore to implement a health equity strategy. During the six year relationship, The Center has assisted LifeBridge Health System in assessing culturally competent practices and creating a Health Equity Task Force and Community Advisory Panel at Sinai Hospital of Baltimore and is currently undertaking similar tasks with two other hospitals within the LifeBridge Health System (e.g., Northwest Hospital and Levindale Hebrew Geriatric Center). The Center is also at the heart of implementing and evaluating several successful evidence-based wellness programs for AHC, including the Tobacco Cessation Program, and the American Association of Diabetes Educators Endorsed Diabetes Education Program. In addition to the activities described, The Center is responsible for hosting and implementing numerous community health and screening fairs reaching more than 20,000 individuals annually, health

education classes enrolling more than 15,000 people per year, and an annual conference on health disparities that engages 250 community leaders from health, education, policy, and urban development sectors.

Focus on Continental African Communities

A particular highlight of the Center's activities with this community is Project BEAT IT! (Becoming Empowered Africans Through Improved Treatment of Diabetes, Hepatitis B, and HIV/AIDS). Originally funded by the federal Office of Minority Health Resource Center in 2012, Project BEAT IT! seeks to improve the health of African immigrants and refugees through health education to the patient community and cultural competence training for their healthcare providers in chronic and infectious disease management. During the 20-month pilot program, The Center established an advisory panel of 26 members, 23 of whom are African-born, to assist in reviewing health education content and engage the African community to participate in Project BEAT IT! The Center also hosted community focus groups with African-born individuals and healthcare providers to review health education materials. Separate curricula for chronic (e.g., type 2 diabetes) and infectious (e.g., HIV/AIDS and hepatitis B) diseases were developed using the Culturally Competent Model of Care created by Campinha-Bacote (2002) to teach prevention and treatment strategies from a culturally appropriate perspective. The Center employed two African immigrant experts in chronic and infectious disease management to facilitate two hour course instruction to African consumers and healthcare providers. For providers, the instruction focused on general cultural information (e.g., common diets, traditions, and religious practices) and reviewing case studies. Classes for African consumers involved debunking disease myths using a deck of cards, role playing, reviewing treatment and prevention strategies, and enjoying a nutritious catered meal featuring common African dishes. Over the course of the six month implementation period (2012-13), The Center hosted 15 courses, including two webinars, and trained over 800 healthcare providers in effective communication strategies for the African patient and 40 African immigrants and refugees through Project BEAT IT! In addition, the Center formed many community partnerships with African immigrant serving entities, including: the Dennis Avenue Health Clinic; Immanuel's Church; Maryland Department of Health and Mental Hygiene; Montgomery College—Takoma Park Campus; and the African American Health Program.

Other WAH Population Health Initiatives

WAH has initiated a number of innovative programs designed to provide socioeconomic support to patients discharged from the Hospital and to prevent unnecessary hospital admissions. These programs are offered irrespective of geographic location and are consistent with the goals of the new Global Budget Revenue model implemented in Maryland.

ED U-Turn Program

This program is focused on decreasing unnecessary admissions/readmission at WAH by assessing patients for discharge needs (both medical and social) at the point of entry into the hospital. Staff partners with WAH's 911 skilled nursing facilities to allow for increased

communication regarding the plan of care for the patient. This will expedite treatment and allow for appropriate and timely admissions. Through the ED U-Turn Program WAH also provides intensive case management and multidisciplinary care planning for many patients.

QIO Partnership

WAH has partnered with the Virginia Health Quality Center and other community partners to provide consulting services geared towards improving care transitions across the healthcare continuum by applying the latest quality improvement tools and techniques.

High Risk Discharge program

Patients who are identified as high risk through the use of WAH's screening tool, as well as any diabetic patient, can be a part of this program, which involves a high risk discharge checklist that is reviewed with the patient at time of discharge.

Senior Peer Hea
Wholesome Wave

WAH is initiating a program beginning in March 2015 to provide a "prescription" for healthy foods for its underinsured/uninsured diabetic patients. We have commitments from 22 vendors at local farmers markets to accept these and provide their goods at a reduced cost. This is a partnership with Long Branch Health Enterprise.

Remote Patient Monitoring Program

This program places remote tele-scales and blood pressure cuffs in the patient's home to evaluate for increasing signs/symptoms of congestive heart failure. Early interventions are taken for patients who are at risk for readmission. The program will launch in March 2015 and expand to diabetic and COPD patients in mid-2015.

Exhibit E

Overview of Accomplishments:

Accomplishments	Strategy	Outcome
1. Implemented best practices that promote Patient- and Family-Centered Care within Adventist HealthCare and the state hospital association.	Maryland Hospital Association (MHA) partnership in Race, Ethnicity, Age, Language & Gender (REALG) Demographic Data Collection	Trained 80 individuals from 30 hospital systems
	AHC Health Equity Report	7 reports
	Cultural Competence in End of Life Conference	Held Nov. 2014 with over 200 participants
2. Through the Center for Health Equity and Wellness, we have been recognized as a state and national leader in the utilization of culturally competent approaches to care and provision of linguistic services guided by the CLAS Standards (Culturally and Linguistically Appropriate Service Standards develop by Federal DHHS).	Recognition	Health Equity Award from National Dialogue on Diversity, Inc.
		Health Care Heroes Award from Daily Record Newspaper
	Annual National Conferences	Addressed ~1400 community memebers
	Qualified Bilingual Staff Program	Trained a total of 676 people
	Cultural Competence Training for Providers and Staff	Trained ~9,660 people
	MultiCare Health System	
	LifeBridge Health	Conducted Cultural Competence Organizational Assessment; develeoped a Health Equity Task Force of hospital employees; and developed a Community Advisory Board
	Maryland Health Quality and Cost Council	Chair the Cultural Competence Committee for MHQCC; Influenced the development of Health Enterprise Zones in Maryland
3. Successfully partnered with local government, state, safety net clinics and others to address needs of vulnerable populations in line with state goals to reduce health disparities in our communities	Low-Income Breast Cancer Program	Screened ~6,800 women in the past 4 years
	Primary Care Coalition Clinics Partnerships	Partner with 8 out of the 12 safety net clinics in Montgomery County
4. The Center spearheaded Adventist HealthCare entities' alignment of community benefit resources with the community health needs assessed by our local county government	Focus areas for 2014, 2015, 2015: Behavioral Health, Immunizations, Diabetes Management, Cancer Screening, Concussion Care	
5. Advanced Prevention and Wellness strategies that improved access and health outcomes for our most vulnerable populations	Community Influenza Vaccination Program	Provided ~ 6,400 vaccines at 182 flu shot clinics in past 4 years
		2011 – 1,800 vaccines at 50 clinics; 2012 – 1,700 vaccines at 65 clinics; 2013 – 1,400 vaccines at 32 clinics; 2014 – 1,500 vaccines at 35 clinics
	Tobacco Cessation Counseling	Offered to ~1,400 patients (at WAH) per year (or about 5,600 patients in past 4 years)
	Outreach events/activities (e.g. community health screenings, health fairs)	~400 events/activities per year or 1,600 in past 4 years
	Health Education Classes:	~400 total classes per year or 1,600 classes in past 4 years
	o Maternal/Child/Family Health Classes/Support Groups (breastfeeding classes & support groups, childbirth classes, baby care basics classes, fatherhood support group, motherhood support group, grandparent classes, & sibling classes)	o ~ 210 classes & support groups/year
	o Diabetes (self-management & pre-diabetes classes)	o ~50 classes/year
	o Youth Health (babysitting and home alone classes)	o ~ 40 classes/year
	o CPR/First Aid (Infant and Adult)	o ~ 85 classes/year
	o Cardiac classes (i.e., CHIP) & lectures	o ~30/year
6. Partner with academic institutions to provide meaningful Public Health Internships to over 25 undergraduate and graduate students yearly to develop the next generation of diverse health professionals	University of Maryland School of Public Health, School of Pharmacy, Johns Hopkins, Towson University, and more	Trained ~ 100 health professionals in past 4 years

Exhibit F

www.AdventistHealthCare.com

Center for Health Equity & Wellness

Population Health
Care Coordination Meeting
January 23, 2015

Adventist HealthCare

Center for Health Equity & Wellness

Identifying patient and community needs…	…addressing identified needs…	…working toward population health.
Health Equity Report	Health Programs Delivery	Health Equity
Community Health Needs Assessment (CHNA)	Community Health Outreach	Access to Care
Community Partnerships	Linguistic Services	Culturally Competent Care
Health Outreach & Program Evaluation Data	Cultural Competence Training	Social Determinants of Health
Organizational Assessments	Community Partnership Fund	
	Implementation Strategy Initiatives	

Adventist HealthCare

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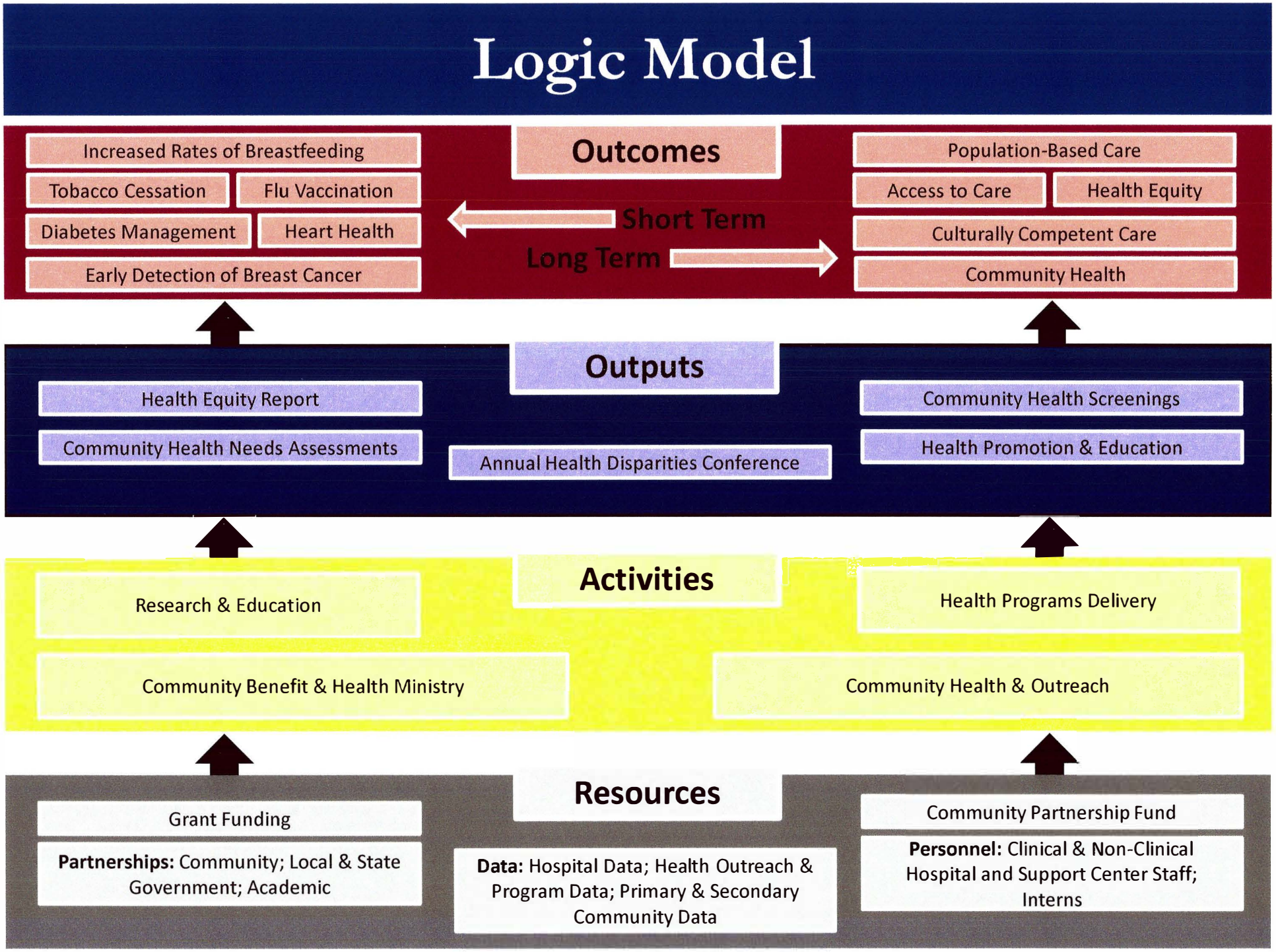
Logic Model


Outcomes
Increased Rates of Breastfeeding
Tobacco Cessation
Flu Vaccination
Diabetes Management
Heart Health
Early Detection of Breast Cancer
Short Term
Long Term
Population-Based Care
Access to Care
Health Equity
Culturally Competent Care
Community Health
Outputs
Health Equity Report
Community Health Needs Assessments
Annual Health Disparities Conference
Community Health Screenings
Health Promotion & Education
Activities
Research & Education
Community Benefit & Health Ministry
Health Programs Delivery
Community Health & Outreach
Resources
Grant Funding
Partnerships: Community; Local & State Government; Academic
Data: Hospital Data; Health Outreach & Program Data; Primary & Secondary Community Data
Community Partnership Fund
Personnel: Clinical & Non-Clinical Hospital and Support Center Staff; Interns

Population Demographics

- Data Collection and Reporting
  - Accuracy and ability to report process of care and outcomes stratified by R, E, A, L, G and SES
  - MHA / HSCRC Partnership
- Cultural Competence Capacity Building
  - Web-based training / Classroom
  - Cultural Competence Organizational Assessments
- Linguistic Access Support
  - Qualified Bilingual Staff Program
  - CyraCom, VRI, Sign Language

Cancer Prevention

- Cancer Screening Days
  - WAH & SGMC
  - Colorectal, throat, skin, breast, prostate
- Smoking Cessation Programs
  - WAH: # of patients counseled/Success Rate/Follow-up
  - SGMC: Starting January 2015
- Low-Income Breast Cancer Program
  - WAH & SGMC

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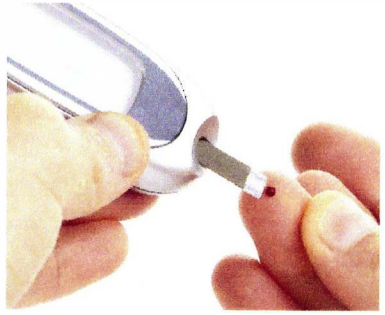
Cardiac & Diabetes Outreach

- Cardiac Outreach
  - Love Your Sweetheart: Multiple local events scheduled in February including 2 large events at WAH & SGMC
  - Support Groups
  - Low cost heart health screenings: WAH & SGMC

- Diabetes Outreach
  - Pre-Diabetes Class: WAH & SGMC
  - Comprehensive Diabetes Education Classes
  - Mobile Med: Education during joint medical appointments
  - Complete Health Improvement Plan (CHIP)



Baby Friendly Support

- Childbirth & Baby Care
- Breastfeeding Class
- Maternity Tours
- Lactation Services
- The BEST breastfeeding support group
- Discovering Motherhood support group
- Gestational Diabetes
- Fatherhood 101

Adventist HealthCare

www.AdventistHealthCare.com

Addressing Social Determinants

- Community Partnership Fund
  - Grants for improving the health of the community
- Community Clinics Partnerships
  - Mercy Health Clinic
  - Community Clinic Inc.
- Hard to reach populations
  - Low Income Housing Outreach
  - Health Ministry

Adventist HealthCare

www.AdventistHealthCare.com

AFFIRMATION

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

Linda Beth Berman 12/9/15

Linda Beth Berman
Grants Manager
Adventist HealthCare

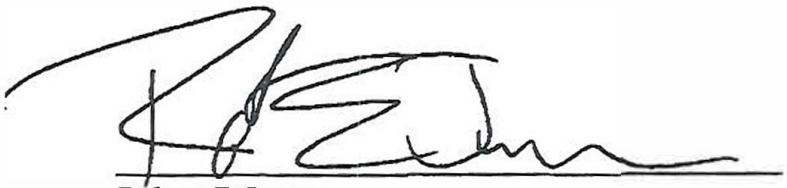
AFFIRMATION

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

Maureen L. Dymond
Vice President, Financial Operations
Adventist Healthcare

AFFIRMATION

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



Robert E. Jepson
Vice President, Business Development
Washington Adventist Hospital

AFFIRMATION

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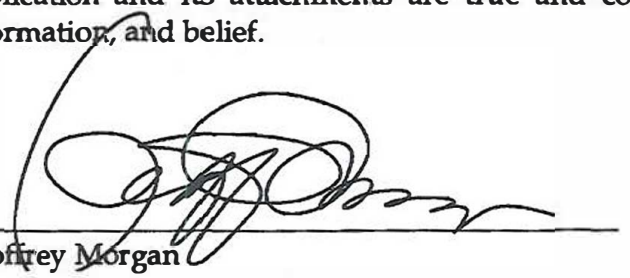

Geoffrey Morgan
Vice President, Expanded Access
Washington Adventist Hospital

AFFIRMATION

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

R. Lee Piekarz
Deloitte Financial Advisory Services, LLP

AFFIRMATION

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

Kristen M. Pulio

12/9/15

Kristen M. Pulio
Vice President, Revenue Management
Adventist HealthCare, Inc.

Date

AFFIRMATION

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

Diana Rowny
Director of Finance
Washington Adventist Hospital