**BEFORE THE MARYLAND HEALTH CARE COMMISSION**

| IN THE MATTER OF<br><br>ADVENTIST HEALTHCARE, INC. D/B/A<br>WASHINGTON ADVENTIST HOSPITAL | Docket No. 13-15-2349 |
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# RESPONSES OF ADVENTIST HEALTHCARE, INC. TO COMMENTS OF THE INTERESTED PARTIES AND PARTICIPATING ENTITY


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## I. INTRODUCTION

Interested Parties Laurel Regional Hospital ("LRH"), MedStar Montgomery Medical Center ("MMMC") and Holy Cross Hospital ("HCH"), along with Participating Entity City of Takoma Park (the "City"), have submitted Comments on the CON application of Adventist HealthCare, Inc. ("AHC") to relocate its Washington Adventist Hospital ("WAH" or the "Hospital"). Not surprisingly, the Interested Parties -- for purely transparent, self-interested commercial reasons -- oppose AHC's application, while the City has provided and relied on incorrect information in commenting on the Hospital's application. Thus, while the reasons for the positions taken by the Interested Parties and Participating Entity may be understandable (at least from their self-interested perspective), the Comments that they have submitted -- whether viewed individually or collectively -- do not establish that AHC has failed to meet any of the Standards governing its CON application. Indeed, as established in AHC's previous filings and in these Responses to the Comments, AHC has met the Standards and its application properly should be approved.

## II. RELOCATION OF WAH WOULD NOT HAVE AN UNDUE NEGATIVE IMPACT ON EXISTING PROVIDERS OR THE HEALTH CARE DELIVERY SYSTEM; TO THE CONTRARY, THE HEALTH CARE DELIVERY SYSTEM WILL BE ENHANCED AND IMPROVED.

### A. The Methodology Relied On For LRH's and MMMC's Claims Of Adverse Impact Is Flawed And Defies Common Sense; Indeed, If Anything, Their "Analysis" Establishes No Adverse Impact.

LRH alleges that both it and MMMC would be adversely impacted by WAH's relocation. However, while it included a narrative describing the approach and methodology purportedly used to define the new service area at White Oak, it did not provide the attendant zip codes and market share. Even more significantly, population within the newly defined service area of

1,749,405 suggested by LRH (LRH Ex. 4 at 5) implies an increase of 48.6% compared to the population of 1,177,484 within WAH's current Takoma Park service area. (*See* Table at Ex. 108 hereto.[1]) Given that LRH used Claritas as the source for its population projections (as has AHC), it would appear that the increase reflected in LRH's data has resulted from expanding the number of zip codes to redefine service area. However, LRH has provided no commentary, reasoning or logic to support its presumption of an expanded service area.

While it is difficult to comment on the validity of the analysis without the underlying detail, the following is clear:

- The analysis supports that there will be no adverse impact from WAH's relocation because the increase in discharges resulting from population increases more than offsets the estimated impact from the move for every identified hospital.

- LRH estimated that the move would cause a reduction of 1,765 discharges at all Maryland hospitals (excluding WAH), which included reductions at hospitals spanning Montgomery, Prince Georges, Howard, Frederick, Anne Arundel, and Baltimore Counties. Of those 1,765 discharges, LRH has estimated that WAH would only gain 549 discharges from the move, while Washington, DC and Virginia would gain the remaining 1,216 discharges; that conclusion defies common sense. It would be patently unreasonable to assume that WAH's relocation 6 miles to the north would cause a significant outmigration of discharges from hospitals in those six Counties to Washington, DC and Virginia, particularly when four of those Counties are not contiguous jurisdictions.

Additionally, LRH's comments wrongly suggest that it and MMMC would be worse off by $10 million and $5 million, respectively. The comment is misleading because (a) market share shifts are considered by the HSCRC at 50% (not 100%, as done by LRH) and (b) these hospitals would also experience a reduction of variable costs. Thus, assuming, as does the HSCRC, 50% variable costs, there would be no impact on those hospitals' profitability.

LRH's "analysis" does not establish any adverse impact.

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[1] AHC has continued the protocol, begun with the filing of its Modified Application, of numbering all of its Exhibits sequentially.

### B. HCH's Claim That Its ED Facilities Will Be Overburdened Following WAH's Relocation Is Unfounded.

HCH has asserted that its ED cases will increase by 15% as a result of a WAH relocation. AHC notes the following shortcomings in the analysis presented in HCH's Ex. 5, which supposedly shows an estimated increase of 13,302 ED visits to HCH:

- 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, including:
    - 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.
    - A reduction of 62.9% in market share was applied to zip code 20912 (Takoma Park), leaving WAH with only a 3.3% market share, when the relocated WAH will be the third most proximate hospital (after taking Providence Hospital into account, as even closer than HCH to areas of Takoma Park and Hyattsville) and WAH will continue to be connected as a result of the remaining services in Takoma Park.
    - 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.
    - HCH also assumed that WAH in White Oak would not have a market share greater than 30% in any zip code.
- HCH's projections indicated that WAH would lose 23,468 annual ED visits (61.6% of current volume in these zip codes) due solely to the move. HCH curiously assumed -- without any substantiation -- that 13,302 of these annual visits lost (56.7% of 23,468) would be gained by HCH.

HCH's projections are extreme and unreasonable and do not establish any undue adverse impact.

### C. Relocation Of WAH Will Enhance And Strengthen The Region's Health Care Delivery System.

As has been established by AHC's filings, the physical challenges that WAH faces on its current site -- problems with access, a constrained site, limited parking, insufficient MOB on campus and a surrounding residential area -- would not and cannot be solved under any on-site modernization program. Modernization 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.

## III. WAH'S PROPOSED RELOCATION PROJECT IS BOTH FINANCIALLY FEASIBLE AND VIABLE.

MMMC and HCH attack the financial feasibility and viability of the relocation Project on similar grounds. The former claims that the Project is neither financially feasible nor viable under COMAR 10.24.01.1B13 and 10.24.01.08G(3)(D) based on five contentions: (1) WAH's current financial status supposedly is "dire"; (2) WAH's assumed financial turnaround is purportedly "unrealistic"; (3) the sources of Project funds allegedly are "questionable"; (4) other factors could worsen AHC's ability to obtain financing; and (5) WAH's projected operating

performance at its new site purportedly is "unsupportable." HCH, for its part, contends that AHC: (1) did not include certain costs allegedly involved with its Central Utility Plant; (2) did not account for certain costs related to decommissioning the Takoma Park site; and (3) did not accurately represent operating results and debt covenant ratios. Each of those contentions is belied by the facts.

### A. WAH Is Profitable, Exceeding Projections, And Can Be Expected To Achieve Its Anticipated Profitability.

Contrary to MMMC's and HCH's apparent expectations, WAH's operating performance in CY 2014 showed a significant turnaround that demonstrates the Hospital's ability to perform as projected. Year-end unaudited financial statements reflect a $4.1 million operating profit for WAH -- a $14.8 million turnaround from the prior year. (*See* Ex. 109.)[2] Based on those results, WAH needs only to achieve an additional $1.6 million in annual improvement to attain the projected 2018 results, which equates to less than 0.8% of non-capital operating expenses.

Thus, not only is WAH's current status not "dire", but given the already significant improvement that WAH made in 2014, its projected turnaround over the next four years is both realistic and eminently achievable. In that regard, it is readily apparent that MMMC's challenges to WAH's assumptions are as off-base as its skepticism that WAH could achieve "a miraculous turnaround in operating performance before the proposed opening of a new hospital." (MMMC Comments at 7.) First, in WAH's July 1, 2014 annual rate update, the HSCRC provided an annual update factor of 2.40%, consistent with what the HSCRC provided to all hospitals in the State under the Global Budget Revenue methodology. Moreover, WAH's inflation assumptions are consistent with the Final Recommendation on Balance Update approved by the HSCRC

[2] These results -- which will be released as audited by April 30 -- already have been reported formally to the HSCRC.

Commissioners on June 11, 2014. That Final Recommendation provides updates for hospitals under Global Budget Revenue agreements by applying the blended Global Insights market basket for non-capital and capital growth. Contrary to MMMC's suggestion, it would be inconsistent with the changing payment landscape and new waiver program to utilize historic update factors that are no longer relevant moving forward. On the issue of market share, WAH expects that the overall market will grow at rates less than the annual population due to reduction in unnecessary utilization, therefore, absent any major change in market dynamics, the market share shift would be immaterial. As a matter of consistency, WAH has applied the same assumption after the opening of the new hospital (*i.e.* that volumes would be constrained in a manner that would not generate a positive market share shift under that methodology).[3]

WAH's projected annual cost (expense) increases properly have assumed aggregate expense inflation consistent with the update factor assumptions, therefore necessarily tying the rate updates to cost increases. However, efficiency gains are also assumed in the years leading up to the opening of the relocated hospital -- many of which were already realized in CY 2014, and not included in projections filed with the application. Indeed, WAH has already realized an additional $5.8 million in 2014 cost reductions, thereby accelerating the necessary efficiency gains to achieve a strong bottom line in 2018.[4] (*See* Ex. 111, outlining various expense reductions.)

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[3] WAH further notes that, although the market share shift methodology has yet to be finalized by the HSCRC staff and approved by the Commission, current discussions at the Payment Workshop on market share shift calculations contemplate applying an algorithm that limits the market share shift to 50% of the lesser of the absolute value of volume decline or market growth.

[4] The Tables set forth in Ex. 110 show the details behind the aggregate expense inflation, as well as a volume variability analysis demonstrating that they are not "unsupportable" assumptions, but, rather, well-thought out and planned.

MMMC's criticisms relating to volume changes are equally misplaced. Indeed, it appears that MMMC took into consideration only the projected change in inpatient admissions, and not aggregate volume change that included outpatient services. The HSCRC has indicated a preference for measuring volume changes for input in the market share shift calculation using an ECMAD (Equivalent Case-Mix Adjusted Discharge) measure.[5] WAH's case-mix adjusted EIPA growth rates, reflected in Table 2 of Ex. 110, include an annual decrease in readmissions of 6.78% between 2014 and 2018, which accounts for nearly 80% of the inpatient admission decline year-over-year, and which WAH believes was a reasonable assumption consistent with the objectives of the new waiver program.

WAH's CY 2014 operating performance not only speaks for itself, but provides a realistic, firm basis for validating the projection of $10.5 million in annual operating income in CY 2018.

### B. The Sources Of Project Funds Are Realistic And Achievable.

#### 1. AHC accurately stated its cash position.

Audited financials are prepared and presented annually for AHC as a consolidated entity, with an unqualified opinion from its auditors rendered in accordance with Generally Accepted Accounting Principles. The final paragraph of the audit opinions states that the supplemental information included in those financial statements "is presented for purposes of additional analysis rather than to present the financial position, result of operations, and cash flows of the individual companies and is not a required part of the consolidated financial statements." Although the consolidated statements are included with the intent to reflect the financial strength

[5] This measure is comparable to a case-mix adjusted EIPA (Equivalent Inpatient Admission) measure, which was the methodology that WAH used in order to project costs associated with volume change.

of the operations of each entity on an individual basis, there is nothing -- from an accounting standpoint or otherwise -- unacceptable or improper about presenting negative cash for those entities whose operations do not currently generate a positive cash flow. Moreover, there is no accounting guidance that suggests that the presentation of negative cash is inappropriate unless an external party funded a liability that AHC could not pay. Thus, the reference to the "going concern" assumption is wholly inapplicable.[6]

HCH is equally wrong in arguments concerning AHC's "Days Cash On Hand". By definition, that term includes all unrestricted cash and investments. Thus, while HCH only has considered the $58,692,102 cash and cash equivalents that AHC and its controlled entities held as of December 31, 2013, the total cash on hand really was $187,334,289 as of December 31, 2013 (reflecting the $58,692,102 in cash and cash equivalents, plus $128,642,187 in short term investments).

There has been no artificial combination or exclusion of controlled entities, nor has there been an overstatement of cash position. The covenants outlined in AHC's various debt agreements relate to the Obligated Group's financials, and ratios are presented as such to demonstrate that the Obligated Group will continue to meet its covenant requirements during all phases of the WAH relocation Project. To that end -- and in accordance with the asset transfer provisions governing the operations of the Obligated Group -- the cash amounts utilized by Adventist Medical Group (as well as any other AHC entity currently operating with negative cash flow) to fund their operations on an annual basis are well within the guidelines prescribed by AHC's covenants with its lenders.

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[6] Indeed, the going concern assumption does not specifically make reference to the presentation of negative cash, and, in issuing AHC's clean audit opinion, its auditors are opining on the entity's ability to continue as a going concern on the basis of its consolidated financial statements.

Based upon the true amount of cash on hand, it should be immediately apparent that AHC will have the financial wherewithal to fund $50.4 million of the Project cost with cash from operations.

**2. AHC's projections do not include the proceeds from the sale of its New Jersey facility.**

Contrary to HCH's contention, AHC included no assumed proceeds from the sale of its New Jersey facility in its projections, as reflected by the note on page 129 of its Modified Application, in which AHC acknowledged that it was not relying on "cash proceeds from the sale . . . ." HCH's criticism simply has no basis in fact.

**3. AHC's operating margins are improving rather than deteriorating.**

HCH also erroneously contends that "AHC's operating margins are decreasing," and that those "margins and the trend documented in the financial statements make AHC's projections for dramatic turnaround in future years unrealistic." (HCH Comments at 17.) Again, HCH's expectations are belied by AHC's actual 2014 results. AHC's hospitals improved operating profitability from slightly more than $7 million to nearly $22 million (an increase of $14.77 million). Operating profitability for all of AHC's services improved from a slight loss in 2013 to an operating profit in excess of $11 million in 2014. As is the case for WAH, there is no reason to believe that AHC's financial turnaround will not continue throughout the period from 2015 to 2019.

AHC's balance sheet also improved along with its operating margins. As reflected by its unaudited CY 2014 results, AHC's total assets grew by nearly $7 million during the year, while its liabilities decreased in excess of $4.2 million. (*See* Ex. 109.)

### 4. AHC reasonably anticipates HSCRC approval of a rate increase.

MMMC questions the financial feasibility and viability of the Project by also challenging WAH's assumption of a $19 million, 7% capital rate increase, which MMMC argues would be historically unprecedented.

First, as a matter of precedent, MMMC simply is wrong in contending that the most the HSCRC has approved in the last 10 years is 50% of the incremental capital costs. In 2013, Garrett County Memorial Hospital ("GCMH") was awarded a rate increase of 100% of incremental capital when it sought an increase in rates exclusively for capital. This equated to a 5.88% increase in GCMH's rate structure. The HSCRC staff's justification for deviating from the 50% standard of incremental capital was due to the fact that, under TPR, the hospital was not able to generate additional revenue with increased volumes as a result of those capital expenditures, and therefore, as a TPR hospital, there was no opportunity to generate necessary revenues to fund capital shortfalls through volume increases. (*See* Ex. 112.) Now that WAH has entered into a Global Budget Revenue agreement, it is similarly constrained by the inability to fund capital through increased volumes. Furthermore, the incentive to fund capital through volumes is in direct conflict with what Maryland hospitals are trying to achieve under the new waiver program. Therefore, it is reasonable to believe that WAH will be given similar consideration to have capital funded above the 50% incremental level that had previously been applied under the fee for service system.

MMMC also contends that "WAH is currently one of the highest charge (cost) hospital [sic] in Maryland." (MMMC Comments at 11.) In making that contention, MMMC does not provide any supporting authority, but whatever data it may be relying on likely is not "current", given that the last published ROC (Reasonableness of Charges) that measured hospital charge

structures was published in June 2011 and used hospital data from FY 2010. More importantly, that published ROC incorporated methodologies that have since been abandoned, such as the charge per case and CPV. Plainly, a reasonableness of charges measure that used data that is now five years old and that was based on reimbursement methodologies that have not been in existence for several years is not "current". MMMC's criticism has no basis in fact.

MMMC also claims that a 7% increase to rates would be a "significant" increase to the Maryland system. That contention, however, is made wholly out-of-context. WAH is requesting $19.7 million. In FY 2014, total hospital regulated revenues was $16.04 billion. WAH's $19.7 million request would equate to 0.12% of the total revenues in the State, which cannot reasonably be viewed as "significant" in the overall context. Indeed, it actually would be less than 25% of the impact of the newly-constructed Holy Cross/Germantown hospital.

**5. AHC has been advised that it reasonably can expect to obtain bond financing.**

AHC's consultant, Ziegler, has advised that AHC reasonably can expect to obtain bond financing. This advice is based on Ziegler's knowledge of and experience with recent "BBB" and non-rated health care financings. Attached are updated materials from Ziegler, showing examples of 18 recent financings, including relevant case studies, that reflect 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* Ex. 113.)

**6. AHC has accounted for costs associated with "decommissioning" hospital space on its Takoma Park campus.**

HCH, without citing any source, expresses supposed concern that WAH has not fully considered "decommissioning" requirements (and their related costs) when the Hospital relocates from Takoma Park to its new site.

In fact, AHC has provided a detailed description of services that will be provided on the Takoma Park campus post-relocation; those services reflect a substantial continued presence on the campus, inhabiting several buildings in nearly a quarter of a million square feet. With that level of activity and presence, it is clear that HCH's supposed concern that the vacated space would not be "appropriately" mothballed has no basis in fact. AHC indeed has considered all necessary actions, and has included them in its technical approach. It similarly has identified the cost of the associated demolition, relocation and renovation and has submitted those costs in the budget information provided in its Takoma Park campus exhibit.

**7. AHC reasonably can expect to raise $20 million in donations.**

MMMC's challenges to AHC's fundraising goals are entirely misplaced and reflect a misunderstanding of standard fundraising practices and strategies. As the attached standard funding principles illustrate (Ex. 114, "*Landmark Philanthropic Fundraising Studies Find Multiple Activities, Long-Term Donor Relationships, Are Keys to Success, AHP Performance Benchmarking Service Says*", Association of Healthcare Philanthropy), MMMC has posed the wrong questions and then criticized the application for not answering them. The comments wrongly presume that the philanthropic goals for the WAH capital campaign are or should be based on the number of hospital beds and the affluence of the surrounding zip codes or patient population, which is not the case. Notably, WAH's fundraising target of $20 Million represents only 6% of the overall cost of the project. The sources of fundraising are not limited to or even necessarily heavily reliant upon the affluence of the constituency served, but rather on the mission and vision of the organization and the impact of the specific project.

### C. AHC Appropriately Has Presented And Accounted For Anticipated Costs Associated With Its Central Utility Plant.

As noted in AHC's CON application and its November 20, 2014 Response to Completeness Questions, the Central Utility Plant ("CUP") for the relocated Hospital will be developed under the requirements of a Power Purchase Agreement ("PPA", also known as a Energy Services Agreement ("ESA")) with an unrelated third party. Such agreements increasingly are used by hospitals and other organizations to provide an improved level of energy service and to avoid the significant capital cost related to a CUP. Indeed, a like agreement was utilized for the delivery of power from a Clark Construction-owned entity to Upper Chesapeake Medical Center, an affiliate of UMMS, beginning in 2014. Under the PPA/ESA, there is no transfer of ownership of equipment in the central plant, and the cost of the plant and maintenance responsibility reside with the third party. Thus, there would be no capital expenditure or debt incurred by AHC to develop the CUP and no source of funds provided by the organization for that purpose. The cost of the utilities purchased would be (and has been) included in the future operating costs of the relocated Hospital, just as would be the purchase of energy from a public utility. For that reason, AHC did not record the cost for the CUP as a capital cost.

HCH, however, has taken issue with AHC's forecasts because they did not include costs relating to a CUP capital lease in debt ratios. (HCH Comments at 11-12.) HCH's position is wrong for four distinct reasons. First, a PPA/ESA is not, by definition, a "lease".[7] Second, the Statement of Financial Accounting Standards relied upon by HCH is only a proposed Standard and has not been formally adopted by the FASB.[8] Third, under the proposed Standard, the

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[7] *See* Ex. 115, *Financing Sustainability Projects on Campus*, American College & University Presidents' Climate Commitment ("ESAs are designed to be treated as a services agreement and not as a lease, potentially allowing for off-balance sheet accounting treatment . . . .").
[8] *See* Ex. 116, *Project Update: Leases-Joint Project of the IASB and FASB.*

FASB has rejected the notion that all leases must be treated as capital leases, and instead has retained a dual approach that recognizes both capital and operating leases; thus, even were the new Standard to be adopted, the arrangement would not be deemed, as HCH claims, "a capital lease." And finally, as noted by attorneys who specialize in energy finance, a PPA/ESA agreement expressly can be structured so it is not categorized as a lease transaction for debt ratio purposes:

> Under the proposed FASB revisions, however, an ESA can be structured to meet the service agreement criteria (which would remain off-balance sheet), avoiding treatment as an on-balance sheet operating lease. ESA providers and providers of emergency energy efficient financing structures such as Managed ESAs are avoiding this potential accounting issue by offering service-based agreements that are not treated as leases under current or proposed FASB standards.[9]

There simply can be no dispute that the services agreement arrangement contemplated for the CUP has been treated properly under both current and potentially prospective accounting standards and need not be included in debt ratios.

## IV. WAH'S RELOCATION WILL NOT ADVERSELY IMPACT ACCESS FOR THE INDIGENT, INCLUDING THOSE IN TAKOMA PARK.

### A. 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.

Comments claiming that WAH is "abandoning" the community it serves by moving to a state of the art facility only six miles from Takoma Park reflect either the ignorance of, or lack of investigation by, the commenters concerning 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 the commenting Interested Parties.

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[9] *See* Ex. 117, Wilson Sonsini Goodrich & Rosati, *Innovations and Opportunities in Energy Efficiency Finance* at 16.

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. (*See* Ex. 118, 119 and 120 for examples of those many community benefit services.) That is a commitment that will continue with the new campus in White Oak and continued services in Takoma Park.

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 Interested Parties HCH and 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% |
| Holy Cross Hospital: | 12.83% |
| MedStar Montgomery: | 9.77% |

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

AHC's CON application details 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.

### B. Medical Access For The Population In WAH's Existing And Likely Service Areas Will Not Decrease With Its Relocation.

#### 1. Access for the population in WAH's existing and likely service areas will remain well within the State Standard.

The City suggests reduced access for the elderly and indigent by virtue of WAH's proposed relocation. As demonstrated in AHC's previous 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 State Standard. (November 20, 2013 Answers to Completeness Questions at 13-14; Modified Application at 31.) 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. Notably, the City did not undertake a travel time study, instead commenting on a single demographic within the City limits -- but shifts in drive time within WAH's current ED PSA are to be expected with relocation. Indisputably, relocation of the Hospital will result in less convenience for some, and more convenience for others. However, "convenience" is not the standard, and it is inarguable that "access" for the population in WAH's existing and likely service areas will remain well within the State Standard.

**2. HCH's insinuation that WAH is "abandoning" the indigent and uninsured population in its service area is not only wrong, but contradicted by data that establishes that WAH serves a larger indigent population than any of the commenting Interested Parties and will continue to do so.**

The assertion that WAH is abandoning the indigent and uninsured population that it currently serves is statistically unsupported and contrary to the mission and programs offered by WAH in its community.

AHC has been unable to locate or verify the income statistics that HCH included in its zip code level analysis and further has been unable to determine whether HCH considered the average household income (HCH Comments at 5) or average salary per worker (HCH Comments, Table 1, at 6). Thus, AHC has undertaken a similar analysis that considered: (i) median household income; (ii) median earnings per worker; and (iii) income per capita published in the United Census Bureau's 5-Year American Community Survey. AHC then ranked the 43 zip codes identified in WAH's current MSGA service area based on the three

metrics identified above and selected those zip codes that had at least two out of the three metrics within the bottom 25th percentile ("Lowest Income Metrics") or top 75th percentile ("Highest Income Metrics"). The Tables at Ex. 121 reflect those results.

Notably, while HCH addressed AHC's anticipated reduction in market share in some of the zip codes with the Lowest Income Metrics, it did not consider that this only represented 9 out of the 25 zip codes with expected market share reductions. Further, the reduction in discharges originating from zip codes outside of those with the Lowest Income Metrics represented 62.2% of the total reduced discharges. The weighted impact on the market share for those zip codes with the Lowest Income Metrics was estimated at only 7.3%. WAH did not expect significant increases in market share in the zip codes with the Highest Income Metrics. With expected increases and decreases in discharges, the overall net impact was an increase of only 10 discharges in the zip codes with the Highest Income Metrics.

Although HCH contends that WAH is "foisting the burden of care for these residents on the other hospitals that currently serve this population", it is WAH that currently serves a higher proportion of the indigent population and a lower proportion of insured patients when compared to both HCH and to the overall market. The Tables in Ex. 122 present the payor mix for patients originating from the zip codes with the Lowest Income Metrics. Specifically, those Tables demonstrate that in 9 of the 10 zip codes with the Lowest Income Metrics, HCH had a higher commercial payor mix when compared to both WAH and to the overall market. Inversely, in 9 out of the same 10 zip codes, WAH is serving a higher portion of Medicaid & Self-Pay patients when compared to both HCH and the overall market. The same trends are found when considering the patient profile within the entire WAH TSA, as reflected in the Tables in Ex. 122.

Perhaps even more significantly, the data demonstrates that, within the current WAH TSA, WAH serves a larger indigent population (Medicaid & Self-Pay) than any of the other commenting Interested Parties, as shown below.

**CY2013 Payor Mix within WAH TP TSA**

| | Medicaid & Self-Pay |
|---|---|
| **WAH** | 26.9% |
| **HCH** | 18.0% |
| **MMMC** | 12.1% |
| **LRH** | 23.1% |
| **Overall** | 20.6% |

The payor mix for WAH's current Takoma Park TSA and the White Oak TSA are not materially different. (Modified Application at 138.) Accordingly, there simply is no truth to the insinuation that WAH is "abandoning" the indigent and uninsured in its service area. Indeed, it has done more -- and anticipates that it will continue doing more -- for that population than any of the commenting Interested Parties.

### C. Additional Studies That MMMC Asks The MHCC To Undertake Are Neither Necessary Nor Warranted.

MMMC has suggested that the Commission properly should "more specifically examine the impact [of relocation] on access on the indigent and medically vulnerable," suggesting that the Commission engage a professor at Emory University who MMMC touts as "a nationally recognized expert in the field of public health policy."

There are two reasons why the Commission should reject MMMC's unusual proposal. First, as reflected above, 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. In that regard -- as also established by AHC's filings -- medical access for the population in WAH's existing service area will not decrease with its relocation. Second, the Commission long has 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 particular instance without the need to engage a supposed expert to undertake a "level of detailed analysis . . . consistent with the research literature . . . ." MMMC's suggestion is misguided.

### D. AHC Is Committed To Meeting The Need Of The Local Community -- Including Evaluating The Feasibility Of An FMF.

Throughout its filings, and as discussed above, AHC has been -- and remains -- committed to meeting the needs of the local community. Nevertheless, HCH contends that AHC's commitments are "unenforceable promises" with "insufficient detail" that will result in clinical services not being available for the first three years after relocation of the Hospital. HCH's criticisms could not be more misguided. In fact, AHC already has established a Federally Qualified Healthcare Center (a "FQHC"), operated by Community Clinics, Inc., on the Takoma Park campus, and that FQHC will be doubling its clinical space in the coming months.[10] Moreover, AHC, in response to a Facility Condition Assessment performed by a third-party expert, committed in mid-2014 to make a substantial investment in the facilities on that campus over an 18 month period, including upgrades to elevators, electrical, mechanical and plumbing systems and roof repair and replacement; it is well on its way to completing that work. AHC intends to revisit the additional capital investment needed on that campus again in 2016, and will not wait until the Hospital relocates to provide the needed funds for additional planned work.

Consistent with its establishment of the FQHC (and planned expansion of that facility), AHC has 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 new FMFs remains

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[10] 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. (*See* Ex. 123.)

in place, and regulations concerning possible future development have not yet been drafted or promulgated. Once regulations have been developed by the MHCC, AHC will carefully evaluate the feasibility of expanding its Takoma Park urgent care services to include an FMF.

## V. THE CITY'S COMMENTS ARE MISGUIDED AND, IN MANY REGARDS, FACTUALLY INCORRECT.

AHC is responding to various of the City's comments in a separate section because they reflect, in many respects, misinterpretation and miscalculation of data and an apparent misunderstanding of the GBR process.

### A. The City Has Misinterpreted AHC's ED Data.

On page 20 of its 36 page submission, the City complains that AHC has provided "inconsistent information about current ED use" and thereafter argues that AHC has proposed almost "doubling" its ED capacity.

Its first argument is that, on page 59 of the CON application, AHC states that the ED unit at WAH was designed for 30,000 annual visits and accommodated just under 49,000 in 2014, which differs from the 50,000 figure on page 20, the 37,677 figure in Ex. 38 and the 46,930 figure in AHC's November 10, 2014 Answers to Completeness Questions.

There is no inconsistency. Actually, page 59 of the application says that WAH accommodated just under 49,000 visits in 2013 (not 2014), when total visits were 48,652. Similarly, the reference to more than 50,000 patients being treated was in 2012, when total visits were 50,840. The 46,930 visits represented total ED visits that were projected as of the time that the Completeness Answers were filed in November 2014, and Ex. 38's 37,677 reported visits were solely outpatient ED visits in 2014. There is no inconsistency; the City has simply misinterpreted the data.

Second, the City incorrectly believes that the clinical decision observation beds that will be located near the ED will be part of the ED; that is not the case. The 12 bed clinical decision area is described in the many AHC filings as a critical element to manage patient through-put and avoidable admissions. It is not treatment space capacity that is included in ED operations, but, rather, is a resource that serves the through-put demands of the entire clinical patient tower. Similarly, as evidenced in its 2013 and 2014 filings, AHC has demonstrated that the proposed addition of six bays is informed by market projections and ACEP guidelines. Accordingly, while the City has made a series of comments about allegedly inconsistent ED data (which, as noted, are wrong), it is important to note that an understanding of the various data tables and the information that they portray is important to appreciating the soundness of AHC's projections for the ED service.[11]

### B. The City Misunderstands AHC's Intentions Concerning Inpatient And Outpatient Cancer Care Services.

The City criticizes AHC's *pro formas* on the basis that its forecast of increasing outpatient visits seems inconsistent with its plans to eliminate inpatient and outpatient cancer care, reasoning that if volumes decline as a result of the elimination of those services, the HSCRC will make a downward adjustment in the total Global Budget Revenue for the facility.

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[11] The City apparently is concerned that the relocation will consume resources that "will drain AHC capacity for future investments at Takoma Park." (City Comments at 20.) As a threshold point, AHC has demonstrated -- and continues to demonstrate -- its commitment to meeting the needs of its local community, including residents of Takoma Park. More importantly, purposefully under-sizing the ED in White Oak solely to reallocate funds for use on the Takoma Park campus would be unnecessary and foolish; the space must be properly-sized. The same is true with respect to the City's criticisms of AHC's proposal for shell space and its projected reduced obstetric and surgical service capacity. As reflected by AHC's many filings, all services proposed for the relocated Hospital have been informed by comprehensive market projections, and provide a "right-sized" hospital capacity based on those market factors.

The City misunderstands both the data and AHC's intentions concerning inpatient and outpatient cancer care services. First, with respect to inpatient cancer care services, there are no plans to discontinue the current level of inpatient cancer care service. Second, outpatient radiation therapy will be moving to a non-rate-regulated building, and the *pro formas* do take into consideration the movement of that service outside of the Global Budget Revenue. Specifically, $3.2 million of radiation therapy revenue is moved outside of the global cap at the 50% variable cost factor in the year that the relocated Hospital opens, and then an additional downward market share adjustment of 0.32% is made in the following year for those services leaving the Hospital premises.

### C. The City Erroneously Has Miscalculated WAH's Change In Revenue Per Admission.

The City, noting that AHC's Answers to Completeness Questions of November 20, 2014 reflect an 8.8% average price increase for inpatient services across the two campuses, argues that the increase actually is 16.1% per admission. Again, the City has misunderstood the relevant data.

The City's calculation, shown in Table 1 on page 10 of its Comments, includes psychiatric services for 2018, while deleting them for 2019. As reflected by the Tables in Ex. 124, if psychiatric admissions are included in both years in order to get a true apples-to-apples comparison, the revenue increase per admission is 9.06%; if they are deleted for both years, as also reflected in that Exhibit, the revenue increase per admission is 8.85%.

### D. The City Has Misunderstood The GBR Process.

At page 19 of its Comments, the City -- again relying on the incorrect belief that WAH rates would increase 16.1% -- argues that such an increase would likely conflict with AHC's Global Budget Revenue agreement. Aside from the fact that its 16.1% figure is flatly wrong (as

demonstrated above), the City's comment reflects a misunderstanding of how the Global Budget Revenue process works. The 5% corridor refers to allowable price increases in a given year to hit the GBR target as utilization is compressed. WAH will be seeking a rate increase and therefore its GBR and unit rates would increase by the 7% sought. The 5% / 10% corridor is a totally unrelated matter.

### E. The City Objects -- Without Basis -- To How WAH Reports And Projects Certain Outpatient Services.

The City quarrels -- without explaining why -- with WAH's methodology for reporting and projecting certain outpatient services, which the City contends results in volume projections that under-represent radiation therapy. First, AHC reports outpatient services, such as radiation therapy, on an episodic basis, rather than discrete visits; the volume projections thus do not under-report, they are just counted differently than if discrete visits were counted. Second, episodes in the *pro formas* are categorized by their primary service, with all of the charges for all of the services related to that episode bundled in projecting future revenues. Therefore, the *pro forma* do take into consideration and make the appropriate adjustments to volumes and revenues. Second, in response to the City's contention that, based on the way it reports such visits, AHC has not accounted for the loss of rehabilitation services, the City apparently has overlooked the fact that such services are not recorded under WAH's license, so there is no need to make any adjustment.

### F. The City Also Inappropriately Questions The Methodology Employed By AHC To Calculate Its Proposed MSGA Primary Service Area.

The City criticizes AHC's application for allegedly failing to describe fully the methodology used to calculate the proposed MSGA Primary Service Area and for not applying

"sufficient logic to substantiate its assumptions for changes in market share by ZIP code." (City Comments at 12.)

AHC's applications and its Answers to Completeness Questions explain its methodology. Indeed, in correspondence dated December 4, 2014, the MHCC confirmed that "Staff understand that there are multiple influences and that the weight attributed to each may vary by zip code and that such projections involve both art and science." AHC thereafter further explained its methodology and rationale to substantiate its assumptions for changes in market share by zip code in the format requested by the MHCC in AHC's answers of January 6, 2015. AHC has performed a thorough analysis and has provided the logic and rationale to support its conclusions.

## VI. CONCLUSION

As noted above, the Comments 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 denial of that application. Accordingly, AHC respectfully requests that its application be approved.

Respectfully submitted,

John F. Morkan III
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A Professional Corporation
100 Light Street
Baltimore, Maryland 21202
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Attorneys for Adventist HealthCare, Inc. d/b/a
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.

02/23/2015

James G. Lee
Executive Vice President & CFO
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.

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

Date 2/23/15

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.

02/23/15

Geoffrey Morgan
Vice President, Expanded Access
Washington Adventist Hospital

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.

Kristen Pulio
Vice President, Revenue Management
Adventist Healthcare

2/23/15
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

2/20/15

Diana Rowny
Director of Finance
Washington Adventist Hospital

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.

Maureen L. Dymond

Maureen L. Dymond
Vice President, Financial Operations
Adventist Healthcare

2/23/2015
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.

R. Lee Piekarz
Deloitte Financial Advisory Services, LLP

2/22/15
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.

Pippa Laundy
Deloitte Financial Advisory Services, LLP

2/23/15
Date

## CERTIFICATE OF SERVICE

I HEREBY CERTIFY THAT on this 24th day of February, 2015, a copy of the foregoing Responses of Adventist Healthcare, Inc. to Comments of the Interested Parties and Participating Entity was sent via email and first class mail to:

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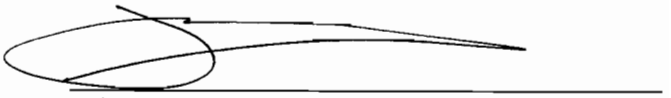

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Washington Adventist Hospital

2896418.1.1

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

## Exhibit List

| Exhibit No. | Description |
|---|---|
| | |
| 108 | Chart: CY 2013 Population Estimates Within WAH MSGA TSA |
| 109 | Adventist HealthCare Financial Report As of December 31, 2014 |
| 110 | Tables titled: Revenue and Expense and Expense Inflation |
| 111 | Washington Adventist Hospital 2014 Operating Expenses; Actual CY 2014 Results Compared to CY 2014 Pro Forma Expenses |
| 112 | HSCRC Staff Recommendation dated February 6, 2013 |
| 113 | Ziegler Materials |
| 114 | April 3, 2008 News Association for Healthcare Philanthropy article: Landmark Philanthropic Fundraising Studies Find Multiple Activities, Long-Term Donor Relationships, Are Keys to Success, AHP Performance Benchmarking Service Says |
| 115 | Article: Financing Sustainability Projects on Campus |
| 116 | Article: Project Update: Leases – Joint Project of the IASB and FASB |
| 117 | Wilson Sonsini Goodrich & Rosati, Innovations and Opportunities in Energy Efficiency Finance |
| 118 | AHD and WAH Community Programs |
| 119 | Chart titled: Overview of Accomplishments: |
| 120 | Slides: Center for Health Equity & Wellness |
| 121 | Tables: Zip Codes with Lowest and Highest Income Metrics in the WAH TP TSA |
| 122 | Charts: Payor Mix in Zip Codes with the Lowest Income Metrics and CY 2013 Payor Mix within WAH TP TSA |
| 123 | June 20, 2014 State Grant documentation |
| 124 | Tables: MSGA and OB (Move to White Oak) and All IP Services (White Oak and Takoma Park) |

# EXHIBIT
# 108

CY2013 Population Estimates Within WAH MSGA TSA

| | 15-44 | 45-64 | 65-74 | 75+ | Total |
|---|---|---|---|---|---|
| 20783 - Hyattsville | 23,816 | 9,241 | 2,183 | 1,542 | 36,782 |
| 20912 - Takoma Park | 10,826 | 6,661 | 1,500 | 847 | 19,834 |
| 20782 - Hyattsville | 14,789 | 7,059 | 1,833 | 1,265 | 24,946 |
| 20903 - Silver Spring | 10,509 | 4,858 | 1,152 | 758 | 17,277 |
| 20901 - Silver Spring | 15,244 | 9,994 | 2,450 | 1,670 | 29,358 |
| 20904 - Silver Spring | 22,007 | 14,782 | 4,008 | 4,933 | 45,730 |
| 20740 - College Park | 17,060 | 4,808 | 1,365 | 1,062 | 24,295 |
| 20910 - Silver Spring | 19,364 | 10,381 | 2,652 | 1,735 | 34,132 |
| 20705 - Beltsville | 11,501 | 7,014 | 1,680 | 1,345 | 21,540 |
| 20011 - Washington | 26,699 | 16,994 | 4,942 | 4,952 | 53,587 |
| 20737 - Riverdale | 10,073 | 4,371 | 968 | 527 | 15,939 |
| 20902 - Silver Spring | 21,528 | 12,685 | 3,315 | 2,515 | 40,043 |
| 20770 - Greenbelt | 11,642 | 6,486 | 1,368 | 853 | 20,349 |
| 20784 - Hyattsville | 12,434 | 6,956 | 1,577 | 825 | 21,792 |
| 20706 - Lanham | 15,938 | 10,248 | 2,656 | 1,615 | 30,457 |
| 20781 - Hyattsville | 5,536 | 2,959 | 626 | 324 | 9,445 |
| 20906 - Silver Spring | 24,581 | 16,259 | 5,666 | 7,926 | 54,432 |
| 20712 - Mount Rainier | 4,290 | 2,248 | 478 | 229 | 7,245 |
| 20785 - Hyattsville | 15,682 | 8,885 | 2,365 | 1,232 | 28,164 |
| 20012 - Washington | 5,153 | 4,208 | 1,401 | 1,226 | 11,988 |
| 20707 - Laurel | 14,479 | 8,730 | 2,179 | 1,321 | 26,709 |
| 20708 - Laurel | 11,869 | 5,911 | 1,281 | 769 | 19,830 |
| 20722 - Brentwood | 2,524 | 1,516 | 399 | 212 | 4,651 |
| 20743 - Capitol Heights | 16,122 | 9,991 | 3,058 | 1,935 | 31,106 |
| 20019 - Washington | 22,631 | 14,809 | 4,094 | 3,270 | 44,804 |
| 20017 - Washington | 7,236 | 4,731 | 1,710 | 2,045 | 15,722 |
| 20020 - Washington | 21,398 | 12,825 | 3,455 | 2,402 | 40,080 |
| 20774 - Upper Marlboro | 17,507 | 13,585 | 3,668 | 1,983 | 36,743 |
| 20002 - Washington | 27,209 | 14,356 | 3,567 | 2,576 | 47,708 |
| 20747 - District Heights | 17,250 | 10,568 | 2,597 | 1,260 | 31,675 |
| 20710 - Bladensburg | 4,514 | 2,009 | 511 | 373 | 7,407 |
| 20018 - Washington | 6,462 | 5,096 | 1,752 | 1,753 | 15,063 |
| 20905 - Silver Spring | 6,311 | 6,410 | 1,796 | 997 | 15,514 |
| 20877 - Gaithersburg | 15,456 | 8,465 | 1,840 | 2,251 | 28,012 |
| 20721 - Bowie | 9,930 | 9,542 | 2,154 | 1,135 | 22,761 |
| 20772 - Upper Marlboro | 17,971 | 13,286 | 2,997 | 1,482 | 35,736 |
| 20866 - Burtonsville | 5,782 | 4,166 | 784 | 440 | 11,172 |
| 20715 - Bowie | 9,162 | 7,741 | 2,194 | 1,813 | 20,910 |
| 20874 - Germantown | 27,243 | 16,017 | 2,792 | 1,122 | 47,174 |
| 20850 - Rockville | 19,557 | 14,189 | 3,880 | 3,308 | 40,934 |
| 20853 - Rockville | 10,666 | 8,891 | 2,816 | 2,097 | 24,470 |
| 20723 - Laurel | 12,901 | 8,831 | 1,501 | 710 | 23,943 |
| 20001 - Washington | 26,147 | 8,340 | 2,077 | 1,461 | 38,025 |
| Total | 628,999 | 377,102 | 97,287 | 74,096 | 1,177,484 |

# EXHIBIT
# 109

Adventist HealthCare

# Financial Report

As of December 31, 2014

# Adventist HealthCare

**Financial Highlights**
**For Period Ended December 31,2014**

## PROFITABILITY SUMMARY
## December 31, 2014
**(in thousands)**

| Month | | | Entities | Year-to-Date | | |
|---|---|---|---|---|---|---|
| Prior Year | Budget | Actual | | Actual | Budget | Prior Year |
| 2013 | 2014 | 2014 | | 2014 | 2014 | 2013 |
| | | | **Hospitals** | | | |
| 2,855 | 2,209 | (1,072) | Shady Grove Adventist Hospital: Consolidated | 18,327 | 19,571 | 15,264 |
| (960) | 14 | 2,531 | Washington Adventist Hospital: Consolidated | 2,626 | (3,679) | (12,231) |
| 280 | (393) | (375) | Hackettstown Regional Medical Center: Consolidated | (560) | (3,436) | (1,141) |
| 37 | 374 | 3,822 | Adventist Behavioral Health : Consolidated | 5,154 | 3,032 | 2,182 |
| (323) | 167 | (3,313) | Adventist Rehabilitation Hospital of MD | (3,094) | 2,667 | 813 |
| 1,889 | 2,371 | 1,593 | **Total: Hospitals** | 22,453 | 18,155 | 4,887 |
| | | | **Clinical Integration Services** | | | |
| 0 | (241) | 227 | Clinical Integration Services Administration | (2,053) | (2,872) | 0 |
| 0 | (391) | (314) | Adventist Medical Group Primary Care | (4,134) | (4,645) | 0 |
| (1,012) | (590) | (904) | Adventist Medical Group Specialty Care | (5,854) | (5,534) | (9,683) |
| 0 | 0 | 0 | Mid Atlantic Primary Care ACO | (1) | 0 | 0 |
| (1,012) | (1,222) | (991) | **Total: Clinical Integration Services** | (12,042) | (13,051) | (9,683) |
| | | | **Home Health Services** | | | |
| (30) | 26 | 271 | Adventist Home Health Services | 739 | 409 | 313 |
| (30) | 26 | 271 | **Total: Home Health Services** | 739 | 409 | 313 |
| | | | **Other Health Services** | | | |
| 40 | 24 | 32 | Capital Choice Pathology Lab | 219 | 324 | 157 |
| 48 | 7 | (268) | Lifework Strategies, Inc | (154) | 98 | 227 |
| 0 | 0 | (121) | AHC Urgent Care Centers, Inc. | (179) | 0 | 0 |
| 88 | 31 | (357) | **Total: Other Health Services** | (114) | 422 | 384 |
| | | | **Support Center** | | | |
| (1,975) | 22 | (86) | Corporate Services | 991 | (1) | 1,655 |
| (2,008) | (6) | 71 | Shared Services | (194) | (62) | (60) |
| 577 | 201 | 338 | Investment Income | 2,527 | 2,175 | 5,563 |
| (3,406) | 217 | 323 | **Total: Support Center** | 3,324 | 2,112 | 7,158 |
| ($2,471) | $1,423 | $839 | **Adventist HealthCare: Total** | $14,360 | $8,047 | $3,059 |

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Adventist HealthCare

Financial Highlights

For Period Ended December 31,2014

# OPERATING PROFITABILITY SUMMARY

## December 31, 2014

(in thousands)

| Month | | | Entities | Year-to-Date | | |
|---|---|---|---|---|---|---|
| Prior Year 2013 | Budget 2014 | Actual 2014 | | Actual 2014 | Budget 2014 | Prior Year 2013 |
| | | | **Hospitals** | | | |
| 2,725 | 2,115 | (1,324) | Shady Grove Adventist Hospital: Consolidated | 17,149 | 18,676 | 15,524 |
| (803) | 120 | 2,649 | Washington Adventist Hospital: Consolidated | 4,127 | (2,407) | (10,721) |
| 243 | (431) | (441) | Hackettstown Regional Medical Center: Consolidated | (1,575) | (3,687) | (918) |
| 52 | 396 | 3,832 | Adventist Behavioral Health : Consolidated | 5,297 | 3,295 | 2,371 |
| (337) | 155 | (3,329) | Adventist Rehabilitation Hospital of MD | (3,198) | 2,544 | 767 |
| 1,880 | 2,355 | 1,387 | **Total: Hospitals** | 21,800 | 18,421 | 7,023 |
| | | | **Clinical Integration Services** | | | |
| 0 | (241) | 227 | Clinical Integration Services Administration | (2,053) | (2,872) | 0 |
| 0 | (391) | (314) | Adventist Medical Group Primary Care | (4,134) | (4,645) | 0 |
| (1,012) | (590) | (904) | Adventist Medical Group Specialty Care | (5,854) | (5,534) | (9,683) |
| 0 | 0 | 0 | Mid Atlantic Primary Care ACO | (1) | 0 | 0 |
| (1,012) | (1,222) | (991) | **Total: Clinical Integration Services** | (12,042) | (13,051) | (9,683) |
| | | | **Home Health Services** | | | |
| (42) | 16 | 255 | Adventist Home Health Services | 637 | 298 | 257 |
| (42) | 16 | 255 | **Total: Home Health Services** | 637 | 298 | 257 |
| | | | **Other Health Services** | | | |
| 40 | 24 | 30 | Capital Choice Pathology Lab | 218 | 324 | 162 |
| 48 | 7 | (268) | Lifework Strategies, Inc | (154) | 98 | 227 |
| 0 | 0 | (121) | AHC Urgent Care Centers, Inc. | (179) | 0 | 0 |
| 88 | 31 | (359) | **Total: Other Health Services** | (115) | 422 | 389 |
| | | | **Support Center** | | | |
| (1,975) | 22 | (86) | Corporate Services | 991 | (1) | 1,655 |
| (2,008) | (6) | 71 | Shared Services | (194) | (62) | (60) |
| (3,983) | 16 | (15) | **Total: Support Center** | 797 | (63) | 1,595 |
| ($3,069) | $1,196 | $277 | **Adventist HealthCare: Total** | $11,077 | $6,027 | ($419) |

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## ADVENTIST HEALTHCARE, INC.: ADVENTIST HEALTHCARE INC

### Balance Sheets

### December 31, 2014 and December 31, 2013

| | December 31, 2014 | December 31, 2013 | Increase (Decrease) |
|---|---|---|---|
| **ASSETS** | | | |
| **Current assets:** | | | |
| Cash, cash equivalents, and investments | $ 194,211,699 | $ 185,461,268 | $ 8,750,431 |
| Patient accounts receivable, less allow. for doubtful accounts totaling $17,921,091 for 2014 and $24,227,074 for 2013 | 105,037,531 | 126,404,865 | (21,367,334) |
| Rate control receivable | 2,228,974 | 1,293,632 | 935,342 |
| Estimated third-party receivables | 3,402,411 | 2,313,438 | 1,088,973 |
| Other receivables, net | 10,811,570 | 13,811,098 | (2,999,529) |
| Due from affiliates | 180 | 180 | 0 |
| Inventories | 10,995,869 | 12,172,222 | (1,176,353) |
| Current portion of trustee-held funds | 1,779,033 | 2,747,528 | (968,495) |
| Prepaid expenses and other current assets | 5,576,816 | 6,377,828 | (801,012) |
| Total current assets | 334,044,083 | 350,582,060 | (16,537,977) |
| **Property and equipment:** | | | |
| Property and equipment | 867,129,155 | 827,950,926 | 39,178,229 |
| Accumulated depreciation | (488,168,775) | (451,101,977) | (37,066,798) |
| | 378,960,380 | 376,848,949 | 2,111,431 |
| Construction in progress | 47,141,287 | 36,964,982 | 10,176,305 |
| Property and equipment, net | 426,101,667 | 413,813,931 | 12,287,736 |
| **Other assets:** | | | |
| Cash and cash equivalents held for capital acquisitions | 2,554,360 | 2,611,538 | (57,179) |
| Investments | 2,967,923 | 779,155 | 2,188,769 |
| Land held for healthcare development | 67,604,975 | 63,173,637 | 4,431,338 |
| Investments in unconsolidated subsidiaries | 8,927,378 | 8,192,394 | 734,983 |
| Interest rate swaps asset | - | - | - |
| Trustee-held funds, excluding current portion | 6,215,093 | 7,045,352 | (830,259) |
| Deferred financing costs | 2,331,701 | 2,622,135 | (290,435) |
| Unamortized intangible assets | 5,181,260 | 5,453,987 | (272,726) |
| Deferred compensation fund | 164,057 | 164,057 | - |
| Professional liability trust fund | 14,081,263 | 10,038,797 | 4,042,466 |
| Deposits and other noncurrent assets | 6,499,909 | 5,225,799 | 1,274,110 |
| Total other assets | 116,527,919 | 105,306,851 | 11,221,068 |
| TOTAL ASSETS | $ 876,673,669 | $ 869,702,842 | $ 6,970,827 |

## ADVENTIST HEALTHCARE, INC.: ADVENTIST HEALTHCARE INC

### Balance Sheets

### December 31, 2014 and December 31, 2013

| | December 31, 2014 | December 31, 2013 | Increase (Decrease) |
|---|---|---|---|
| **LIABILITIES AND NET ASSETS** | | | |
| **Current liabilities:** | | | |
| Accounts payable and accrued expenses | $ 71,461,456 | $ 85,322,897 | $ (13,861,441) |
| Accrued compensation and related items | 36,518,708 | 31,986,275 | 4,532,433 |
| Deferred revenue | 1,244,690 | 421,874 | 822,816 |
| Interest payable | 2,307,800 | 2,222,769 | 85,031 |
| Due to affiliates | - | - | - |
| Estimated third-party payables | 23,989,353 | 24,233,222 | (243,869) |
| Short term financing | - | - | - |
| Current portion of long-term obligations | 27,909,208 | 25,925,595 | 1,983,613 |
| Total current liabilities | 163,431,215 | 170,112,633 | (6,681,418) |
| **Long-term obligations, noncurrent portion:** | | | |
| Construction payable | 191,718 | 116,254 | 75,464 |
| Bonds payable | 235,844,029 | 247,000,919 | (11,156,890) |
| Internal debt | (2) | (3) | 1 |
| Interest rate swaps liability | 21,507,539 | 16,103,581 | 5,403,958 |
| Notes payable | 47,513,025 | 31,916,729 | 15,596,296 |
| Capital lease obligation | 8,549,109 | 16,348,680 | (7,799,572) |
| Deferred gain on sale of land | - | - | - |
| Deferred compensation | 164,057 | 164,057 | - |
| Estimated self-insured professional liabilities | 11,626,223 | 9,324,911 | 2,301,312 |
| Other non-current liabilities | 10,281,405 | 12,251,306 | (1,969,901) |
| Total long-term obligations, noncurrent portion | 335,677,104 | 333,226,436 | 2,450,668 |
| TOTAL LIABILITIES | 499,108,320 | 503,339,070 | (4,230,750) |
| **Net assets:** | | | |
| Unrestricted | 360,222,900 | 359,947,052 | 275,848 |
| Income (loss) summary | 14,360,361 | 3,725,999 | 10,634,361 |
| Temporarily restricted | 2,640,667 | 2,349,299 | 291,368 |
| Permanently restricted | 341,421 | 341,421 | - |
| TOTAL NET ASSETS | 377,565,349 | 366,363,771 | 11,201,577 |
| TOTAL LIABILITIES AND NET ASSETS | $ 876,673,668 | $ 869,702,841 | $ 6,970,827 |

# ADVENTIST HEALTHCARE INC

## Statement of Revenue and Expense

For Period Ending: December 31, 2014

| Month to Date | | | | | | Year to Date | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Prior Year | % | Variance | Budget | Actuals | | Actuals | Budget | Variance | % | Prior Year |
| | | | | | **Patient Revenue** | | | | | |
| 57,984,896 | -3.0% | (1,871,329) | 62,728,664 | 60,857,335 | Inpatient Revenue | 764,077,713 | 750,636,360 | 13,441,353 | 1.8% | 732,878,819 |
| 42,326,781 | 10.4% | 5,084,170 | 49,120,570 | 54,204,739 | Outpatient Revenue | 575,516,248 | 583,745,567 | (8,229,319) | -1.4% | 519,742,524 |
| **100,311,677** | **2.9%** | **3,212,841** | **111,849,234** | **115,062,074** | **Patient Revenue** | **1,339,593,961** | **1,334,381,927** | **5,212,034** | **0.4%** | **1,252,621,344** |
| | | | | | **Deductions From Revenue** | | | | | |
| 31,780,073 | -4.1% | (1,733,178) | 41,859,145 | 43,592,323 | Contractual Adjustments | 520,327,234 | 503,358,522 | (16,968,711) | -3.4% | 464,060,203 |
| 8,285,993 | 17.2% | 584,557 | 3,396,923 | 2,812,366 | Charity Allowance | 35,014,475 | 40,454,394 | 5,439,918 | 13.4% | 38,051,490 |
| **40,066,066** | **-2.5%** | **(1,148,622)** | **45,256,067** | **46,404,689** | **Deductions from Revenue** | **555,341,709** | **543,812,916** | **(11,528,793)** | **-2.1%** | **502,111,693** |
| **60,245,611** | **3.1%** | **2,064,219** | **66,593,166** | **68,657,385** | **Net Patient Revenue Before Bad Debts** | **784,252,252** | **790,569,011** | **(6,316,759)** | **-0.8%** | **750,509,651** |
| **4,143,419** | **-14.3%** | **(565,276)** | **3,952,418** | **4,517,694** | **Provision for Bad Debts** | **43,693,028** | **46,349,489** | **2,656,461** | **5.7%** | **47,795,120** |
| **56,102,192** | **2.4%** | **1,498,943** | **62,640,748** | **64,139,691** | **Net Patient Revenue Less Bad Debts** | **740,559,224** | **744,219,522** | **(3,660,298)** | **-0.5%** | **702,714,530** |
| | | | | | **Other Operating Revenue** | | | | | |
| 0 | 0.0% | 0 | 0 | 0 | Interest On Trustee Held Funds | 2,125 | 0 | 2,125 | 100.0% | 0 |
| 3,306,788 | -4.1% | (173,897) | 4,261,987 | 4,088,090 | Other Operating Income | 42,782,643 | 51,185,984 | (8,403,341) | -16.4% | 46,348,998 |
| **3,306,788** | **-4.1%** | **(173,897)** | **4,261,987** | **4,088,090** | **Other Operating Revenue** | **42,784,768** | **51,185,984** | **(8,401,216)** | **-16.4%** | **46,348,998** |
| **59,408,980** | **2.0%** | **1,325,046** | **66,902,735** | **68,227,781** | **Total Operating Revenue** | **783,343,992** | **795,405,506** | **(12,061,514)** | **-1.5%** | **749,063,529** |
| | | | | | **Operating Expenses** | | | | | |
| 25,783,614 | 1.3% | 378,460 | 29,085,789 | 28,707,329 | Salaries and Wages | 336,953,567 | 345,078,567 | 8,124,999 | 2.4% | 315,365,032 |
| 5,832,311 | 9.6% | 568,783 | 5,897,821 | 5,329,038 | Employee Benefits | 66,831,102 | 71,739,795 | 4,908,694 | 6.8% | 68,073,293 |
| 540,662 | -35.3% | (160,591) | 455,537 | 616,128 | Contract Labor | 8,842,130 | 5,721,874 | (3,120,257) | -54.5% | 8,713,835 |
| 2,037,041 | -11.9% | (239,556) | 2,020,132 | 2,259,688 | Professional Fees | 23,781,762 | 24,810,041 | 1,028,279 | 4.1% | 23,008,949 |
| 8,995,675 | -8.6% | (750,250) | 8,721,983 | 9,472,233 | Medical Supplies | 107,101,358 | 108,039,383 | 938,025 | 0.9% | 105,596,946 |
| 3,113,294 | 37.9% | 1,512,943 | 3,991,971 | 2,479,028 | General & Administrative | 47,443,613 | 47,197,933 | (245,680) | -0.5% | 44,481,345 |
| 8,600,300 | -34.9% | (2,521,401) | 7,215,429 | 9,736,830 | Purchased Services | 83,787,139 | 86,150,691 | 2,363,552 | 2.7% | 92,392,971 |
| 3,173,404 | 9.7% | 354,248 | 3,640,841 | 3,286,593 | Building & Maintenance | 41,511,874 | 44,201,018 | 2,689,145 | 6.1% | 40,307,932 |
| 1,121,234 | -154.7% | (747,006) | 482,892 | 1,229,897 | Insurance | 6,058,599 | 5,651,850 | (406,749) | -7.2% | 5,680,854 |
| 133 | 100.0% | (762,818) | 0 | 762,818 | Bad Debts - Non Patient | 768,682 | 0 | (768,682) | 100.0% | 1,871 |
| 749,028 | 13.4% | 136,176 | 1,017,378 | 881,202 | Interest | 10,923,654 | 12,208,392 | 1,284,738 | 10.5% | 9,753,732 |
| 2,531,968 | -0.4% | (13,807) | 3,176,638 | 3,190,445 | Depreciation & Amortization | 38,262,584 | 38,577,399 | 314,815 | 0.8% | 36,110,262 |
| 0 | 100.0% | (0) | (0) | 0 | IT Depreciation | 0 | 0 | 0 | 100.0% | 0 |
| 0 | 100.0% | 1 | 1 | 0 | Allocation: IT Services | 0 | 0 | 0 | 100.0% | 0 |
| 0 | 0.0% | 0 | 0 | 0 | Allocation: Shared Services | 0 | 0 | 0 | 0.0% | 0 |
| 0 | 81853.0% | 819 | 1 | (818) | AHC Management Fees | 0 | 2 | 2 | 100.0% | 0 |
| **62,478,665** | **-3.4%** | **(2,244,000)** | **65,706,413** | **67,950,413** | **Operating Expenses** | **772,266,064** | **789,376,946** | **17,110,882** | **2.2%** | **749,487,023** |
| **(3,069,685)** | **-76.8%** | **(918,954)** | **1,196,322** | **277,369** | **Income (Loss) from Operations** | **11,077,927** | **6,028,560** | **5,049,368** | **83.8%** | **(423,495)** |
| | | | | | **Non Operating Revenue & Expense** | | | | | |
| 421,235 | 59.3% | 236,246 | 398,541 | 634,787 | Investment Income | 3,775,081 | 4,192,662 | (417,580) | -10.0% | 3,161,318 |
| 306,963 | -187.2% | 320,594 | (171,255) | 149,339 | Non Operating Gains | (270,298) | (2,174,894) | 1,904,596 | 87.6% | 1,695,467 |
| (130,000) | 100.0% | (222,350) | 0 | (222,350) | Loss on Extinguishment of Debt | (222,350) | 0 | (222,350) | 100.0% | (707,292) |
| 0 | 0.0% | 0 | 0 | 0 | Minority Interest | 0 | 0 | 0 | 0.0% | 0 |
| **598,198** | **147.2%** | **334,490** | **227,286** | **561,776** | **Non Operating Revenue & Expense** | **3,282,433** | **2,017,768** | **1,264,665** | **62.7%** | **4,149,494** |
| **(2,471,488)** | **-41.1%** | **(584,464)** | **1,423,608** | **839,144** | **Excess of Revenue over Expense (Expenses over Revenue)** | **14,360,361** | **8,046,328** | **6,314,033** | **78.5%** | **3,725,999** |

ADVENTIST HEALTHCARE, INC.

Consolidating Schedule - Balance Sheet Information

December 31, 2014

| | Consolidated Adventist HealthCare, Inc. | Eliminating Entries | Shady Grove Adventist Hospital | Washington Adventist Hospital | Hackettstown Regional Medical Center | Adventist Behavioral Health |
|---|---|---|---|---|---|---|
| **ASSETS** | | | | | | |
| Current assets: | | | | | | |
| Cash, cash equivalents and investments | $ 194,211,699 | $ - | $ 111,865,070 | $ (5,780,692) | $ 38,379,126 | $ (6,819,393) |
| Patient accounts receivable | 198,947,750 | - | 67,412,196 | 50,992,643 | 46,692,811 | 12,698,108 |
| Less: Allowance for contractual | (75,989,128) | - | (18,235,445) | (13,721,753) | (34,251,833) | (3,407,627) |
| Less: Allowance for uncollectible accounts | (17,921,091) | - | (3,065,282) | (8,406,635) | (4,047,658) | (1,012,854) |
| Net patient accounts receivable | 105,037,531 | - | 46,111,469 | 28,864,254 | 8,393,320 | 8,277,626 |
| Rate control receivable | 2,228,974 | - | 1,339,855 | 1,555,180 | - | (666,021) |
| Estimated third-party receivables | 3,402,411 | - | - | - | - | 2,504,193 |
| Other receivables, net | 10,811,570 | (917,637) | 2,459,348 | 4,020,238 | 773,389 | 1,807,619 |
| Due from affiliates | 180 | - | (0) | (0) | - | 0 |
| Inventories | 10,995,869 | - | 5,352,907 | 3,533,318 | 1,771,971 | 84,592 |
| Current portion of trustee-held funds | 1,779,033 | - | - | - | - | - |
| Prepaid expenses and other current assets | 5,576,816 | - | 770,284 | 768,418 | 314,462 | 199,572 |
| Total current assets | **334,044,083** | **(917,637)** | **167,898,933** | **32,960,717** | **49,632,268** | **5,388,189** |
| Property and equipment: | | | | | | |
| Property and equipment | 867,129,155 | - | 365,277,928 | 179,426,053 | 125,838,301 | 25,028,710 |
| Accumulated depreciation | (488,168,775) | - | (187,113,155) | (147,308,591) | (86,679,486) | (12,183,395) |
| | 378,960,380 | - | 178,164,773 | 32,117,461 | 39,158,816 | 12,845,315 |
| Construction in progress | 47,141,287 | - | 4,864,289 | 25,652,802 | 1,634,710 | 82,321 |
| Property and equipment, net | **426,101,667** | **-** | **183,029,062** | **57,770,263** | **40,793,526** | **12,927,636** |
| Other assets: | | | | | | |
| Cash and cash equivalents held for capital acquisitio | 2,554,360 | - | 330,905 | - | 1,484,292 | 528,279 |
| Investments | 2,967,923 | - | - | - | - | - |
| Land held for healthcare development | 67,604,975 | - | - | 399,575 | - | - |
| Investments in unconsolidated subsidiaries | 8,927,378 | - | 2,946,268 | - | 1,342,168 | (0) |
| Interest rate swaps asset | - | - | - | - | - | - |
| Trustee-held funds, excluding current portion | 6,215,093 | - | 843,581 | 867,088 | 2,788,505 | 492,089 |
| Deferred financing costs | 2,331,701 | - | 693,088 | 417,924 | 426,095 | 75,982 |
| Unamortized intangible assets | 5,181,260 | - | 1,324,452 | - | 867,660 | 1,756,588 |
| Deferred compensation fund | 164,057 | - | - | 164,057 | - | - |
| Professional liability trust fund | 14,081,263 | - | - | - | - | - |
| Deposits and other noncurrent assets | 6,499,909 | - | 2,743,111 | 31,351 | 2,336,515 | 31,728 |
| Total other assets | **116,527,919** | **-** | **8,881,404** | **1,879,996** | **9,245,235** | **2,884,665** |
| TOTAL ASSETS | **$ 876,673,669** | **$ (917,637)** | **$ 359,809,399** | **$ 92,610,976** | **$ 99,671,029** | **$ 21,200,490** |

ADVENTIST HEALTHCARE, INC.

Consolidating Schedule - Balance Sheet Info

December 31, 2014

| | Adventist Rehabilitation Hospital of Maryland | Clinical Integration Services | Adventist Home Health Services | Other Health Services | Support Center |
|---|---|---|---|---|---|
| **ASSETS** | | | | | |
| Current assets: | | | | | |
| Cash, cash equivalents and investments | $ 8,854,418 | $ (52,848,880) | $ 5,062,630 | $ (1,855,324) | $ 97,354,742 |
| Patient accounts receivable | 12,043,565 | 5,536,585 | 3,571,847 | (4) | - |
| Less: Allowance for contractual | (4,897,589) | (1,299,126) | (175,755) | - | 0 |
| Less: Allowance for uncollectible accounts | (871,722) | (340,142) | (176,797) | - | - |
| Net patient accounts receivable | 6,274,253 | 3,897,317 | 3,219,295 | (4) | 0 |
| Rate control receivable | (40) | - | - | - | - |
| Estimated third-party receivables | 897,725 | - | - | 493 | - |
| Other receivables, net | 91,648 | 27,230 | 9,149 | 615,503 | 1,925,083 |
| Due from affiliates | 180 | (0) | (0) | 0 | 0 |
| Inventories | 78,532 | - | - | 174,548 | - |
| Current portion of trustee-held funds | - | - | - | - | 1,779,033 |
| Prepaid expenses and other current assets | 110,766 | 138,401 | 50,768 | 261,785 | 2,962,359 |
| Total current assets | **16,307,483** | **(48,785,931)** | **8,341,842** | **(802,999)** | **104,021,217** |
| Property and equipment: | | | | | |
| Property and equipment | 17,312,377 | 265,929 | 1,897,869 | 1,276,306 | 150,805,682 |
| Accumulated depreciation | (8,881,792) | (193,775) | (1,496,796) | (757,120) | (43,554,665) |
| | 8,430,586 | 72,153 | 401,072 | 519,186 | 107,251,017 |
| Construction in progress | 411,507 | 318,702 | 25,580 | 18,409 | 14,132,966 |
| Property and equipment, net | **8,842,092** | **390,856** | **426,652** | **537,595** | **121,383,984** |
| Other assets: | | | | | |
| Cash and cash equivalents held for capital acquisitio | 210,884 | - | - | - | - |
| Investments | - | - | - | - | 2,967,923 |
| Land held for healthcare development | - | - | - | - | 67,205,399 |
| Investments in unconsolidated subsidiaries | - | - | - | - | 4,638,942 |
| Interest rate swaps asset | - | - | - | - | - |
| Trustee-held funds, excluding current portion | 445,223 | - | - | - | 778,607 |
| Deferred financing costs | 63,309 | - | - | - | 655,303 |
| Unamortized intangible assets | 942,124 | - | 175,280 | 76,748 | 38,408 |
| Deferred compensation fund | - | - | - | - | - |
| Professional liability trust fund | - | - | - | - | 14,081,263 |
| Deposits and other noncurrent assets | 32,000 | 6,887 | 30,828 | 109,799 | 1,177,689 |
| Total other assets | **1,693,541** | **6,887** | **206,108** | **186,547** | **91,543,535** |
| TOTAL ASSETS | **$ 26,843,117** | **$ (48,388,188)** | **$ 8,974,603** | **$ (78,857)** | **$ 316,948,736** |

ADVENTIST HEALTHCARE, INC.

Consolidating Schedule - Balance Sheet Information

December 31, 2014

| | Consolidated Adventist HealthCare, Inc. | Eliminating Entries | Shady Grove Adventist Hospital | Washington Adventist Hospital | Hackettstown Regional Medical Center | Adventist Behavioral Health |
|---|---|---|---|---|---|---|
| **LIABILITIES AND NET ASSETS** | | | | | | |
| Current liabilities: | | | | | | |
| Accounts payable and accrued expenses | $ 71,461,456 | $ - | $ 24,716,218 | $ 14,393,555 | $ 6,343,950 | $ 2,488,157 |
| Accrued compensation and related items | 36,518,708 | (917,637) | 12,307,642 | 8,737,353 | 3,218,034 | 2,796,228 |
| Deferred revenue | 1,244,690 | - | - | - | - | - |
| Interest payable | 2,307,800 | - | - | 691 | - | 821 |
| Due to affiliates | - | - | - | - | - | - |
| Estimated third-party payables | 23,989,353 | - | 13,296,133 | 8,001,574 | 2,718,702 | 1 |
| Short term financing | - | - | - | - | - | - |
| Current portion of long-term obligations | 27,909,208 | - | 9,778,494 | 5,994,385 | 48,196 | 764,688 |
| Total current liabilities | 163,431,215 | (917,637) | 60,098,487 | 37,127,557 | 12,328,881 | 6,049,896 |
| Long-term obligations, noncurrent portion: | | | | | | |
| Construction payable | 191,718 | - | - | - | 191,718 | - |
| Bonds payable | 235,844,029 | - | 3,642,000 | 33,482,029 | - | - |
| Internal debt | (2) | - | 114,087,672 | 37,354,785 | 32,229,053 | 5,809,634 |
| Interest rate swaps liability | 21,507,539 | - | - | - | - | - |
| Notes payable | 47,513,025 | - | 10,500,000 | - | - | 166,729 |
| Capital lease obligation | 8,549,109 | - | 160,711 | 83,481 | - | - |
| Deferred gain on sale of land | - | - | - | - | - | - |
| Deferred compensation | 164,057 | - | - | 164,057 | - | - |
| Estimated self-insured professional liabilities | 11,626,223 | - | - | - | - | - |
| Other non-current liabilities | 10,281,405 | - | 3,170,906 | 1,158,698 | 1,076,128 | - |
| Total long-term obligations, noncurrent portion | 335,677,104 | - | 131,561,288 | 72,243,051 | 33,496,899 | 5,976,363 |
| TOTAL LIABILITIES | 499,108,320 | (917,637) | 191,659,776 | 109,370,608 | 45,825,781 | 12,026,259 |
| Net assets: | | | | | | |
| Unrestricted | 360,222,900 | - | 149,517,208 | (19,932,429) | 53,037,500 | 3,506,608 |
| Income (loss) summary | 14,360,361 | - | 18,326,967 | 2,625,943 | (559,992) | 5,153,767 |
| Temporarily restricted | 2,640,667 | - | 305,448 | 546,854 | 1,367,741 | 172,436 |
| Permanently restricted | 341,421 | - | - | - | - | 341,421 |
| TOTAL NET ASSETS | 377,565,349 | - | 168,149,623 | (16,759,632) | 53,845,248 | 9,174,232 |
| TOTAL LIABILITIES AND NET ASSETS | $ 876,673,668 | $ (917,637) | $ 359,809,399 | $ 92,610,976 | $ 99,671,029 | $ 21,200,490 |

ADVENTIST HEALTHCARE, INC.

Consolidating Schedule - Balance Sheet Info

December 31, 2014

| | Adventist Rehabilitation Hospital of Maryland | Clinical Integration Services | Adventist Home Health Services | Other Health Services | Support Center |
|---|---|---|---|---|---|
| **LIABILITIES AND NET ASSETS** | | | | | |
| Current liabilities: | | | | | |
| Accounts payable and accrued expenses | $ 721,487 | $ 1,519,217 | $ 112,718 | $ 976,237 | $ 20,189,917 |
| Accrued compensation and related items | 2,128,923 | 559,813 | 1,398,551 | 229,335 | 6,060,466 |
| Deferred revenue | - | - | 577,962 | 0 | 666,728 |
| Interest payable | - | - | - | - | 2,306,288 |
| Due to affiliates | - | - | - | - | - |
| Estimated third-party payables | (27,057) | - | - | - | - |
| Short term financing | - | - | - | - | - |
| Current portion of long-term obligations | (0) | - | - | - | 11,323,446 |
| Total current liabilities | 2,823,353 | 2,079,029 | 2,089,231 | 1,205,572 | 40,546,845 |
| Long-term obligations, noncurrent portion: | | | | | |
| Construction payable | - | - | - | - | - |
| Bonds payable | - | - | - | - | 198,720,000 |
| Internal debt | 4,347,854 | - | - | - | (193,829,000) |
| Interest rate swaps liability | - | - | - | - | 21,507,539 |
| Notes payable | - | - | - | - | 36,846,296 |
| Capital lease obligation | - | - | - | - | 8,304,916 |
| Deferred gain on sale of land | - | - | - | - | - |
| Deferred compensation | - | - | - | - | - |
| Estimated self-insured professional liabilities | - | - | - | - | 11,626,223 |
| Other non-current liabilities | 166,740 | - | - | - | 4,708,934 |
| Total long-term obligations, noncurrent portion | 4,514,594 | - | - | - | 87,884,909 |
| TOTAL LIABILITIES | 7,337,947 | 2,079,029 | 2,089,231 | 1,205,572 | 128,431,754 |
| Net assets: | | | | | |
| Unrestricted | 22,626,459 | (38,425,019) | 6,145,889 | (1,170,119) | 184,916,803 |
| Income (loss) summary | (3,094,062) | (12,042,198) | 739,483 | (114,310) | 3,324,762 |
| Temporarily restricted | (27,227) | - | - | - | 275,416 |
| Permanently restricted | - | - | - | - | - |
| TOTAL NET ASSETS | 19,505,169 | (50,467,217) | 6,885,373 | (1,284,429) | 188,516,981 |
| TOTAL LIABILITIES AND NET ASSETS | $ 26,843,117 | $ (48,388,188) | $ 8,974,603 | $ (78,857) | $ 316,948,735 |

# ADVENTIST HEALTHCARE, INC.

## Consolidating Statement of Operations Information

### Twelve Months Ended December 31, 2014

| | Consolidated Adventist HealthCare, Inc. | Eliminating Entries | Shady Grove Adventist Hospital | Washington Adventist Hospital | Hackettstown Regional Medical Center | Adventist Behavioral Health |
|---|---|---|---|---|---|---|
| **PATIENT REVENUE** | | | | | | |
| Inpatient Revenue | $ 764,077,713 | $ (51,150) | $ 229,638,726 | $ 174,007,371 | $ 259,152,349 | $ 46,668,535 |
| Outpatient Revenue | 575,516,248 | - | 176,730,651 | 99,959,435 | 222,169,778 | 3,902,584 |
| **PATIENT REVENUE** | 1,339,593,961 | (51,150) | 406,369,376 | 273,966,806 | 481,322,127 | 50,571,120 |
| **DEDUCTIONS FROM REVENUE** | | | | | | |
| Contractual Adjustments | 520,327,234 | 174,000 | 45,059,606 | 30,828,060 | 391,705,664 | 3,090,576 |
| Charity Allowance | 35,014,475 | - | 10,238,461 | 15,717,136 | 5,971,485 | 850,928 |
| **DEDUCTIONS FROM REVENUE** | 555,341,709 | 174,000 | 55,298,066 | 46,545,195 | 397,677,149 | 3,941,505 |
| **NET PATIENT REVENUE BEFORE BAD DEBTS** | 784,252,252 | (225,150) | 351,071,310 | 227,421,611 | 83,644,978 | 46,629,615 |
| **PROVISION FOR BAD DEBTS** | 43,693,028 | - | 17,069,199 | 17,511,787 | 1,502,665 | 3,932,498 |
| **NET PATIENT REVENUE LESS BAD DEBTS** | 740,559,224 | (225,150) | 334,002,111 | 209,909,824 | 82,142,313 | 42,697,117 |
| **OTHER OPERATING REVENUE** | | | | | | |
| Other Operating Income | 42,784,768 | (6,813,099) | 9,401,412 | 4,926,597 | 6,670,290 | 13,892,847 |
| **OTHER OPERATING REVENUE** | 42,784,768 | (6,813,099) | 9,401,412 | 4,926,597 | 6,670,290 | 13,892,847 |
| **TOTAL OPERATING REVENUE** | 783,343,992 | (7,038,248) | 343,403,524 | 214,836,421 | 88,812,603 | 56,589,964 |
| **OPERATING EXPENSES** | | | | | | |
| Salaries and Wages | 336,953,567 | - | 120,895,666 | 80,898,052 | 37,732,460 | 27,816,309 |
| Employee benefits | 66,831,102 | - | 25,317,498 | 16,404,680 | 8,918,501 | 6,192,939 |
| Contract labor | 8,842,130 | (102,772) | 4,289,028 | 2,319,915 | 968,707 | 626,468 |
| Professional Fees | 23,781,762 | - | 7,796,248 | 12,079,658 | 1,712,323 | 1,053,083 |
| Medical supplies | 107,101,358 | (100,956) | 52,790,148 | 35,407,823 | 12,980,776 | 1,902,089 |
| General and administrative | 47,443,613 | (64,589) | 14,580,273 | 10,924,554 | 3,824,318 | 1,994,375 |
| Purchased Services | 83,787,139 | (4,240,014) | 25,959,896 | 15,921,612 | 4,962,768 | 2,753,185 |
| Building and maintenance | 41,511,874 | (2,529,917) | 23,705,315 | 8,535,981 | 5,321,963 | 3,476,367 |
| Insurance | 6,058,599 | - | 2,464,722 | 1,707,869 | 632,446 | 246,218 |
| Provision for bad debts - non patient | 768,682 | - | - | - | - | 440,227 |
| Interest | 10,923,654 | - | 5,578,666 | 2,536,990 | 1,296,380 | 268,532 |
| Depreciation and Amortization | 38,262,584 | - | 14,933,093 | 5,657,317 | 4,993,586 | 1,149,434 |
| IT Depreciation | 0 | - | 4,525,324 | 2,931,899 | 1,294,397 | 240,044 |
| Allocation: IT Services | (0) | - | 16,029,191 | 9,995,337 | 3,495,766 | 1,511,005 |
| Allocation: Shared Services | - | - | - | - | - | - |
| AHC Management Fees | (0) | - | 7,389,529 | 5,388,043 | 2,253,111 | 1,622,366 |
| **TOTAL EXPENSES** | 772,266,064 | (7,038,248) | 326,254,597 | 210,709,730 | 90,387,501 | 51,292,639 |

# ADVENTIST HEALTHCARE, INC.

## Consolidating Statement of Operations Information

### Twelve Months Ended December 31, 2014

| | Consolidated Adventist HealthCare, Inc. | Eliminating Entries | Shady Grove Adventist Hospital | Washington Adventist Hospital | Hackettstown Regional Medical Center | Adventist Behavioral Health |
|---|---|---|---|---|---|---|
| INCOME (LOSS) FROM OPERATIONS | 11,077,927 | - | 17,148,927 | 4,126,691 | (1,574,898) | 5,297,326 |
| OTHER INCOME | | | | | | |
| Investment income | 3,775,081 | - | 2,031,034 | (968,821) | 825,838 | (104,321) |
| Loss on extinguishment of debt | (222,350) | - | (147,664) | (74,686) | - | - |
| Other | (270,298) | - | (705,329) | (457,241) | 189,068 | (39,238) |
| TOTAL OTHER INCOME | 3,282,433 | - | 1,178,040 | (1,500,747) | 1,014,906 | (143,559) |
| PORTION OF EARNINGS RELATED TO MINORITY INTEREST | - | - | - | - | - | - |
| REVENUE AND GAINS IN EXCESS (DEFICIENT) OF EXPENSES AND LOSSES | $ 14,360,361 | $ - | $ 18,326,967 | $ 2,625,943 | $ (559,992) | $ 5,153,767 |

# ADVENTIST HEALTHCARE, INC.

## Consolidating Statement of Operations Inform

### Twelve Months Ended December 31, 2014

| | Adventist Rehabilitation Hospital of Maryland | Clinical Integration Services | Adventist Home Health Services | Other Health Services | Support Center | Consolidated Adventist Physician Services |
|---|---|---|---|---|---|---|
| **PATIENT REVENUE** | | | | | | |
| Inpatient Revenue | $ 54,661,882 | $ - | $ - | $ - | $ - | $ - |
| Outpatient Revenue | 8,521,202 | 42,889,525 | 21,343,074 | - | - | 28,841,891 |
| **PATIENT REVENUE** | 63,183,084 | 42,889,525 | 21,343,074 | - | - | 28,841,891 |
| **DEDUCTIONS FROM REVENUE** | | | | | | |
| Contractual Adjustments | 28,092,820 | 20,685,080 | 691,429 | - | - | 14,940,326 |
| Charity Allowance | 2,086,400 | 71,941 | 78,123 | - | - | 29,871 |
| **DEDUCTIONS FROM REVENUE** | 30,179,220 | 20,757,021 | 769,552 | - | - | 14,970,198 |
| **NET PATIENT REVENUE BEFORE BAD DEBTS** | 33,003,864 | 22,132,504 | 20,573,521 | - | - | 13,871,693 |
| **PROVISION FOR BAD DEBTS** | 1,759,900 | 1,666,572 | 129,724 | 120,684 | - | 1,423,488 |
| **NET PATIENT REVENUE LESS BAD DEBTS** | 31,243,963 | 20,465,932 | 20,443,798 | (120,684) | - | 12,448,206 |
| **OTHER OPERATING REVENUE** | | | | | | |
| Other Operating Income | 2,535,163 | 122,904 | 240,626 | 7,038,819 | 4,769,206 | 117,600 |
| **OTHER OPERATING REVENUE** | 2,535,163 | 122,904 | 240,626 | 7,038,819 | 4,769,206 | 117,600 |
| **TOTAL OPERATING REVENUE** | 33,779,126 | 20,588,836 | 20,684,424 | 6,918,135 | 4,769,206 | 12,565,806 |
| **OPERATING EXPENSES** | | | | | | |
| Salaries and Wages | 21,171,197 | 21,454,217 | 14,090,392 | 2,284,410 | 10,610,865 | 12,908,979 |
| Employee benefits | 4,381,269 | 613,964 | 2,429,675 | 441,630 | 2,130,946 | 477,343 |
| Contract labor | 746,484 | 120,565 | 128,329 | 256,572 | (511,165) | 109,365 |
| Professional Fees | 243,809 | 369,376 | 4,006 | 510,211 | 13,048 | 341,834 |
| Medical supplies | 1,427,317 | 1,184,860 | 251,368 | 1,297,202 | (39,269) | 611,575 |
| General and administrative | 980,362 | 6,319,419 | 744,128 | 518,778 | 7,621,995 | 2,873,131 |
| Purchased Services | 2,551,808 | 1,220,518 | 216,100 | 433,915 | 34,007,352 | 470,342 |
| Building and maintenance | 1,278,096 | 46,779 | 674,295 | 579,110 | 423,886 | - |
| Insurance | 128,265 | 713,280 | 87,571 | 16,790 | 61,437 | 542,479 |
| Provision for bad debts - non patient | - | - | 1,888 | 326,423 | 145 | - |
| Interest | 185,778 | - | - | - | 1,057,308 | - |
| Depreciation and Amortization | 674,371 | 322,200 | 133,206 | 93,597 | 10,305,779 | 84,958 |
| IT Depreciation | 397,976 | - | 41,969 | 15,310 | (9,446,918) | - |
| Allocation: IT Services | 1,693,195 | - | 570,240 | 110,776 | (33,405,511) | - |
| Allocation: Shared Services | - | - | - | - | - | - |
| AHC Management Fees | 1,116,924 | 265,857 | 674,703 | 147,722 | (18,858,254) | - |
| **TOTAL EXPENSES** | 36,976,851 | 32,631,034 | 20,047,871 | 7,032,445 | 3,971,644 | 18,420,006 |

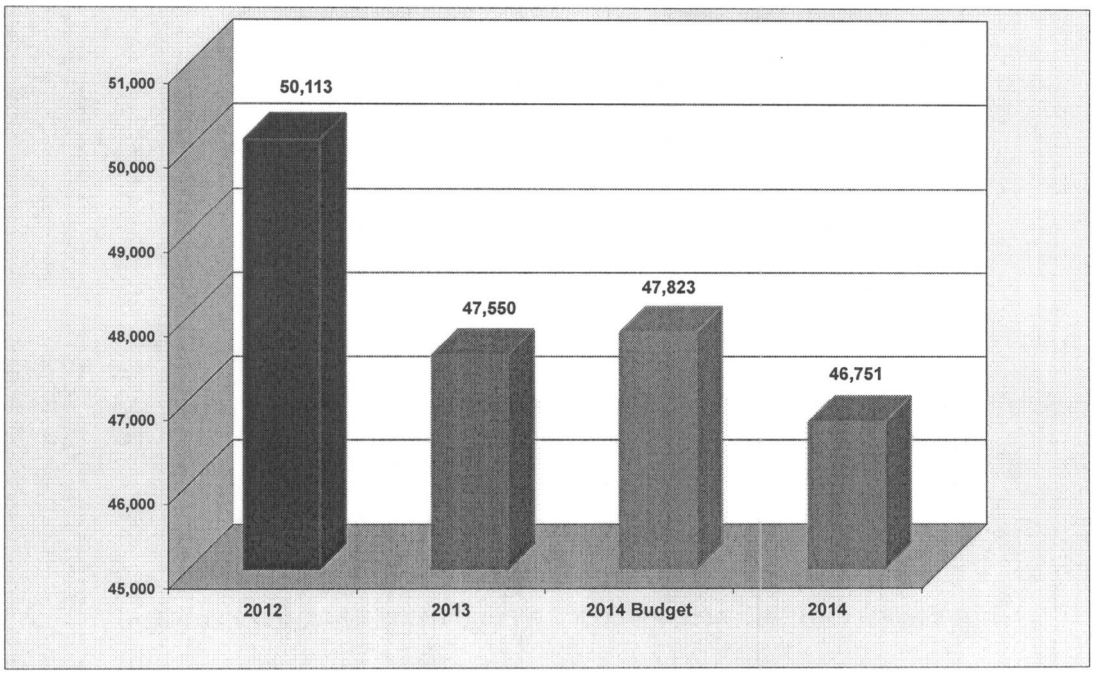
# ADVENTIST HEALTHCARE, INC.

## Consolidating Statement of Operations Inform

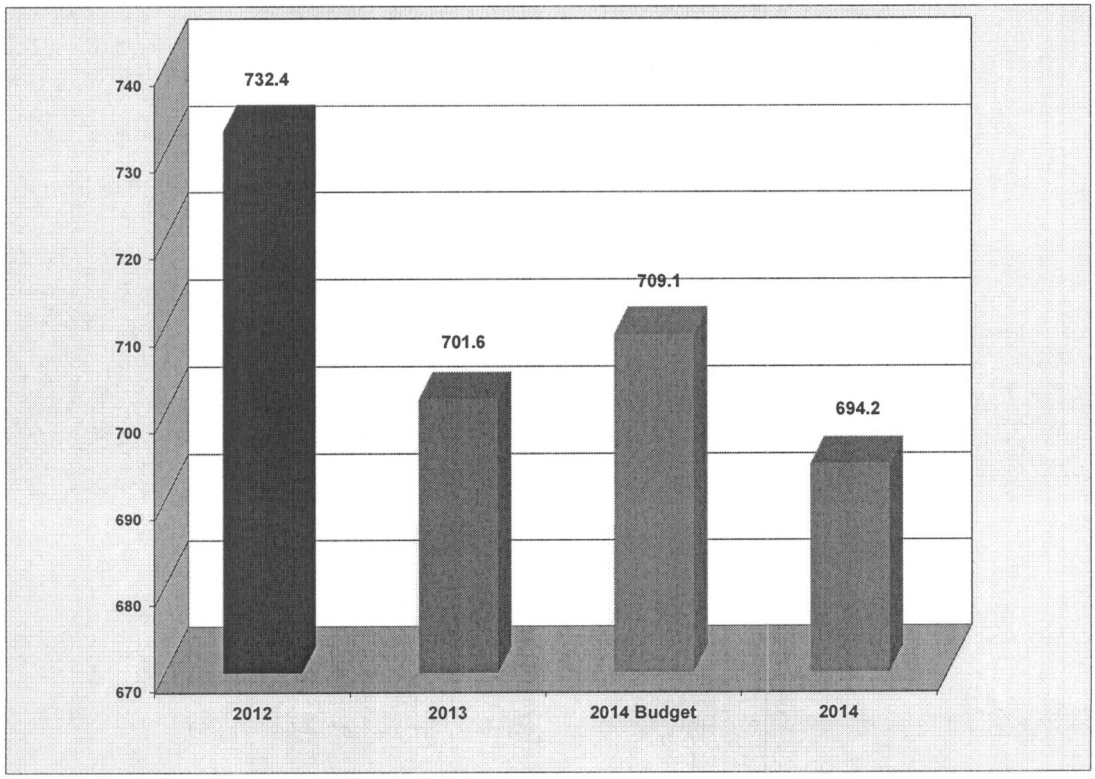
### Twelve Months Ended December 31, 2014

| | Adventist Rehabilitation Hospital of Maryland | Clinical Integration Services | Adventist Home Health Services | Other Health Services | Support Center | Consolidated Adventist Physician Services |
|---|---|---|---|---|---|---|
| INCOME (LOSS) FROM OPERATIONS | (3,197,724) | (12,042,198) | 636,553 | (114,310) | 797,562 | (5,854,201) |
| OTHER INCOME | | | | | | |
| Investment income | 133,005 | - | 102,930 | - | 1,755,416 | - |
| Loss on extinguishment of debt | - | - | - | - | - | - |
| Other | (29,343) | 0 | - | - | 771,785 | 0 |
| TOTAL OTHER INCOME | 103,662 | 0 | 102,930 | - | 2,527,201 | 0 |
| PORTION OF EARNINGS RELATED TO MINORITY INTEREST | - | - | - | - | - | - |
| REVENUE AND GAINS IN EXCESS (DEFICIENT) OF EXPENSES AND LOSSES | $ (3,094,062) | $ (12,042,198) | $ 739,483 | $ (114,310) | $ 3,324,762 | $ (5,854,201) |

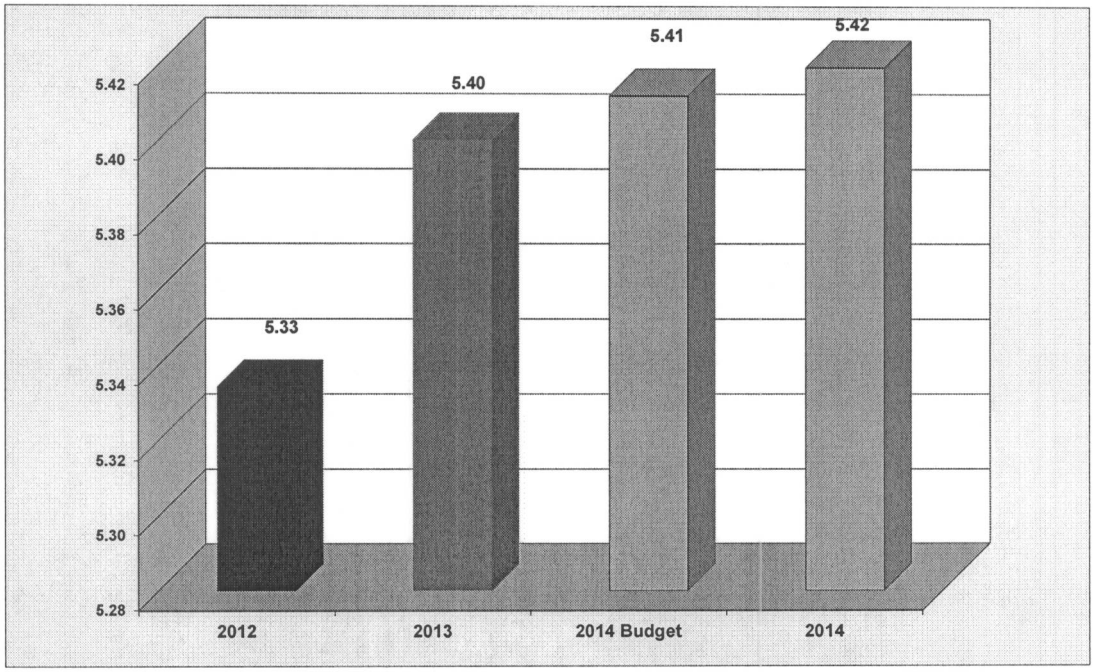
## AHC CONSOLIDATED HOSPITAL ADMISSIONS & BIRTHS (YTD)



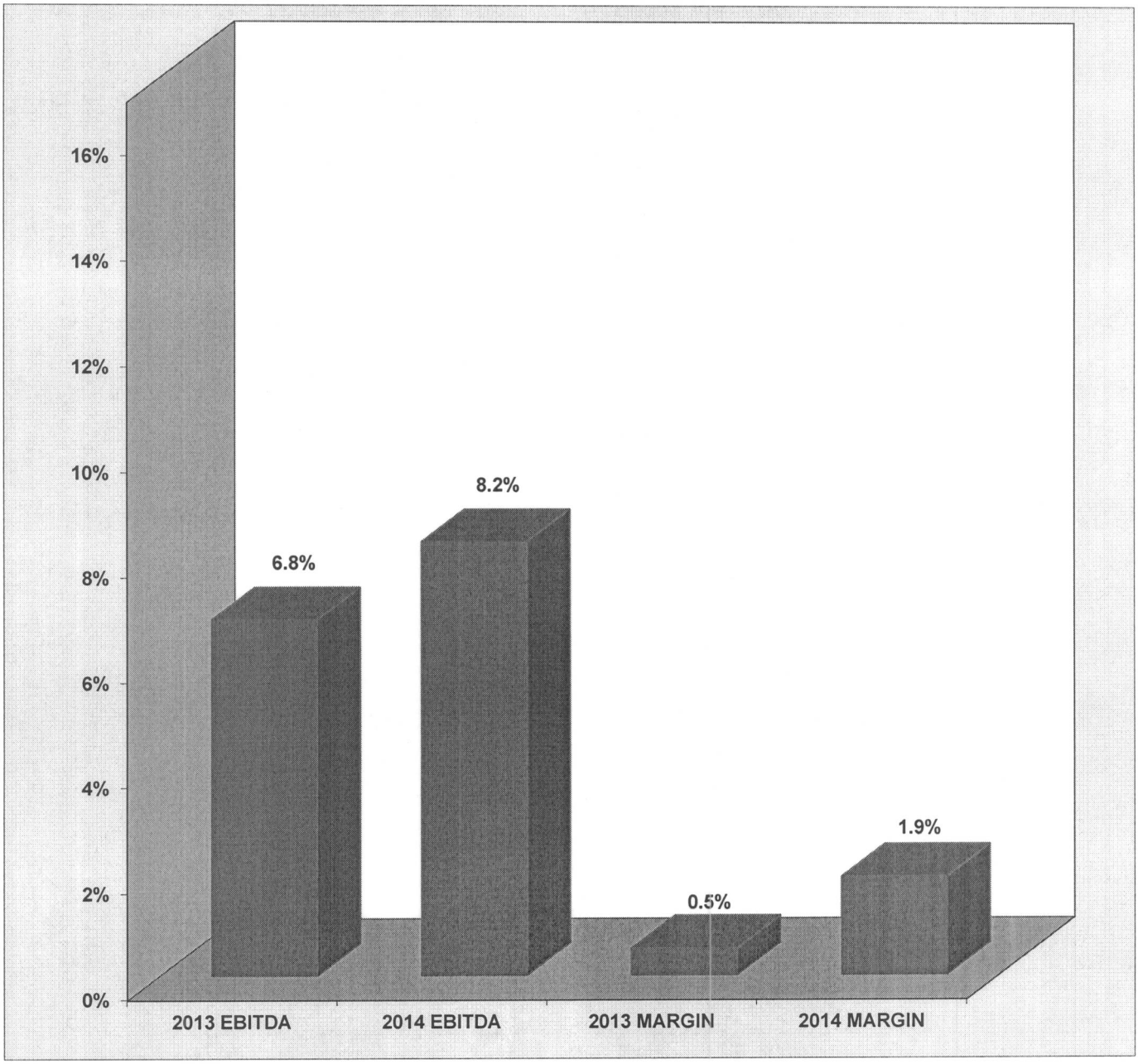

## AHC CONSOLIDATED HOSPITAL AVERAGE DAILY CENSUS (ADC)



# AHC CONSOLIDATED AVERAGE LENGTH OF STAY (YTD)



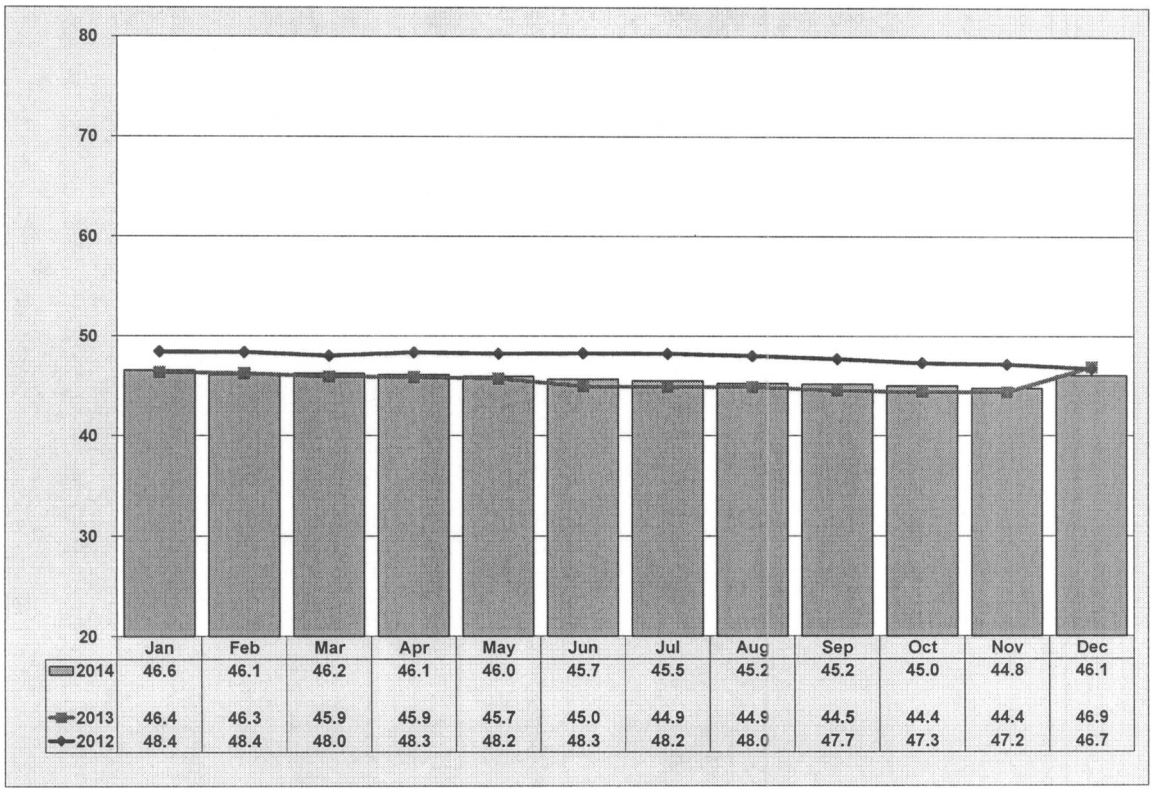
## AHC CONSOLIDATED EBITDA AND MARGIN AS % OF TOTAL OPERATING REVENUE




| YTD | 2014 Actual | 2014 Budget | 2013 Actual |
|---|---|---|---|
| EBITDA | 8.2% | 7.6% | 6.8% |
| MARGIN | 1.9% | 1.0% | 0.5% |

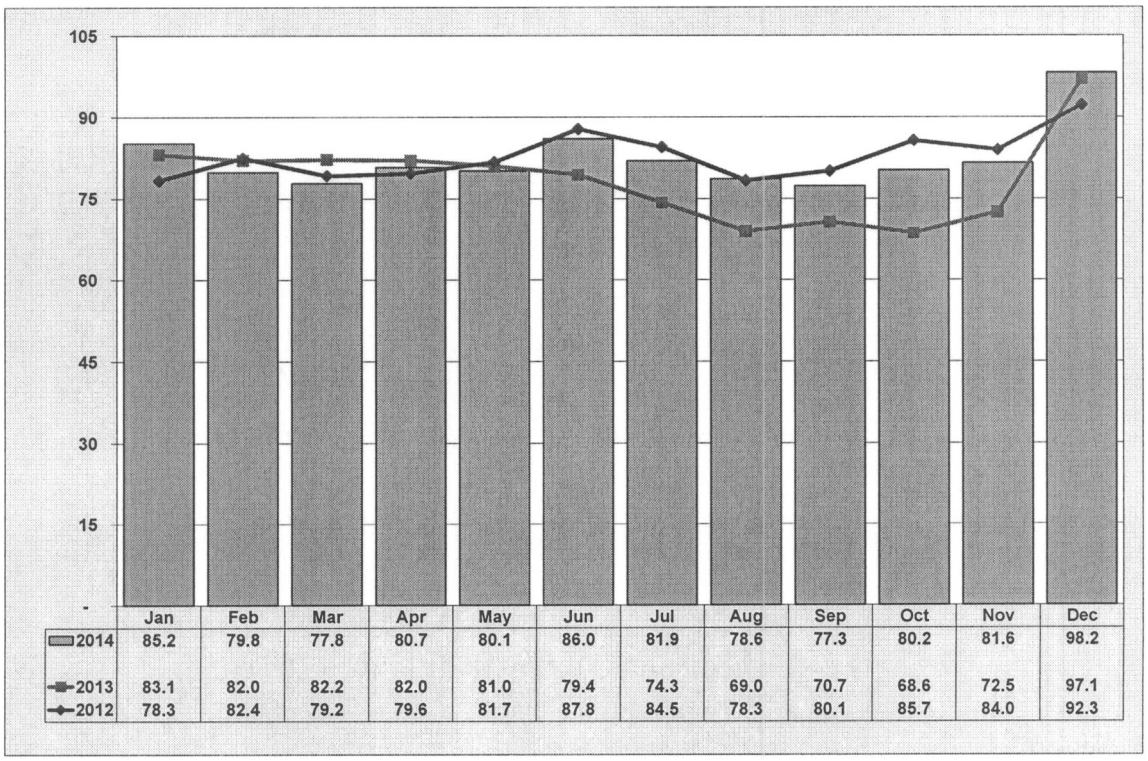
# AHC CONSOLIDATED

## DEBT TO CAPITALIZATION




| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 46.6 | 46.1 | 46.2 | 46.1 | 46.0 | 45.7 | 45.5 | 45.2 | 45.2 | 45.0 | 44.8 | 46.1 |
| 2013 | 46.4 | 46.3 | 45.9 | 45.9 | 45.7 | 45.0 | 44.9 | 44.9 | 44.5 | 44.4 | 44.4 | 46.9 |
| 2012 | 48.4 | 48.4 | 48.0 | 48.3 | 48.2 | 48.3 | 48.2 | 48.0 | 47.7 | 47.3 | 47.2 | 46.7 |

## DAYS CASH ON HAND

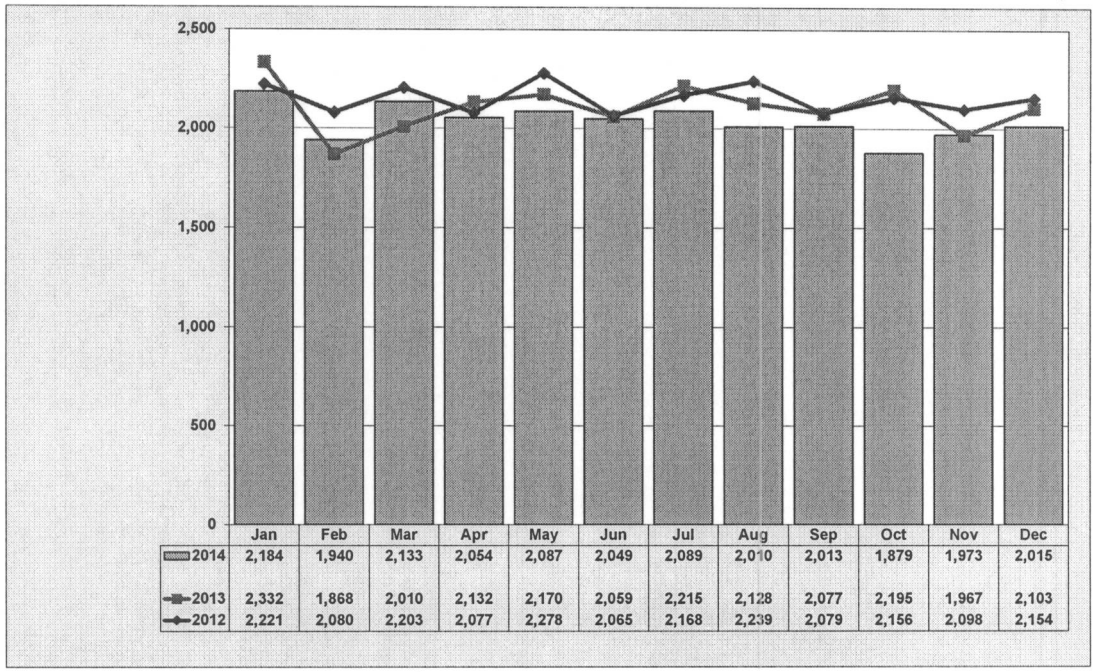



| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 85.2 | 79.8 | 77.8 | 80.7 | 80.1 | 86.0 | 81.9 | 78.6 | 77.3 | 80.2 | 81.6 | 98.2 |
| 2013 | 83.1 | 82.0 | 82.2 | 82.0 | 81.0 | 79.4 | 74.3 | 69.0 | 70.7 | 68.6 | 72.5 | 97.1 |
| 2012 | 78.3 | 82.4 | 79.2 | 79.6 | 81.7 | 87.8 | 84.5 | 78.3 | 80.1 | 85.7 | 84.0 | 92.3 |

## SGAH TOTAL ADMISSIONS & BIRTHS

YTD Act: 24,426
YTD Bud: 25,347

YTD 2013 25,256
YTD 2012 25,818

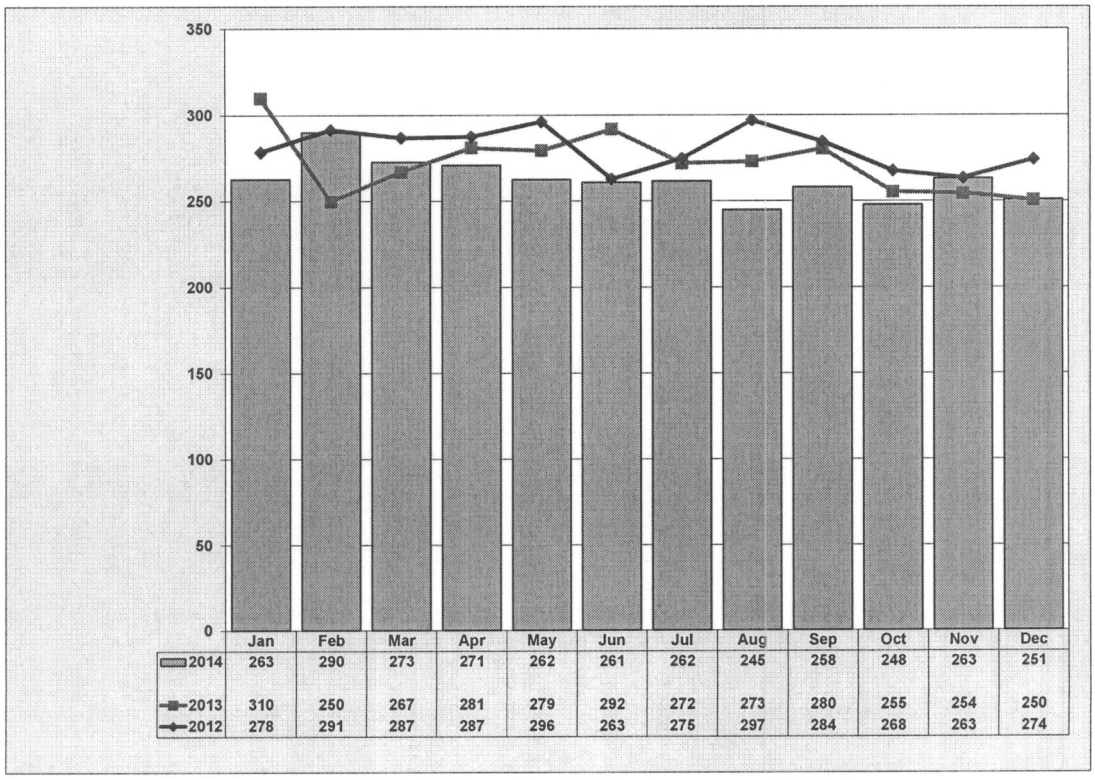



| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 2,184 | 1,940 | 2,133 | 2,054 | 2,087 | 2,049 | 2,089 | 2,010 | 2,013 | 1,879 | 1,973 | 2,015 |
| 2013 | 2,332 | 1,868 | 2,010 | 2,132 | 2,170 | 2,059 | 2,215 | 2,128 | 2,077 | 2,195 | 1,967 | 2,103 |
| 2012 | 2,221 | 2,080 | 2,203 | 2,077 | 2,278 | 2,065 | 2,168 | 2,239 | 2,079 | 2,156 | 2,098 | 2,154 |

## SGAH TOTAL AVERAGE DAILY CENSUS (ADC)

YTD Act: 261.9
YTD Bud: 277.3

YTD 2013 272.0
YTD 2012 280.3

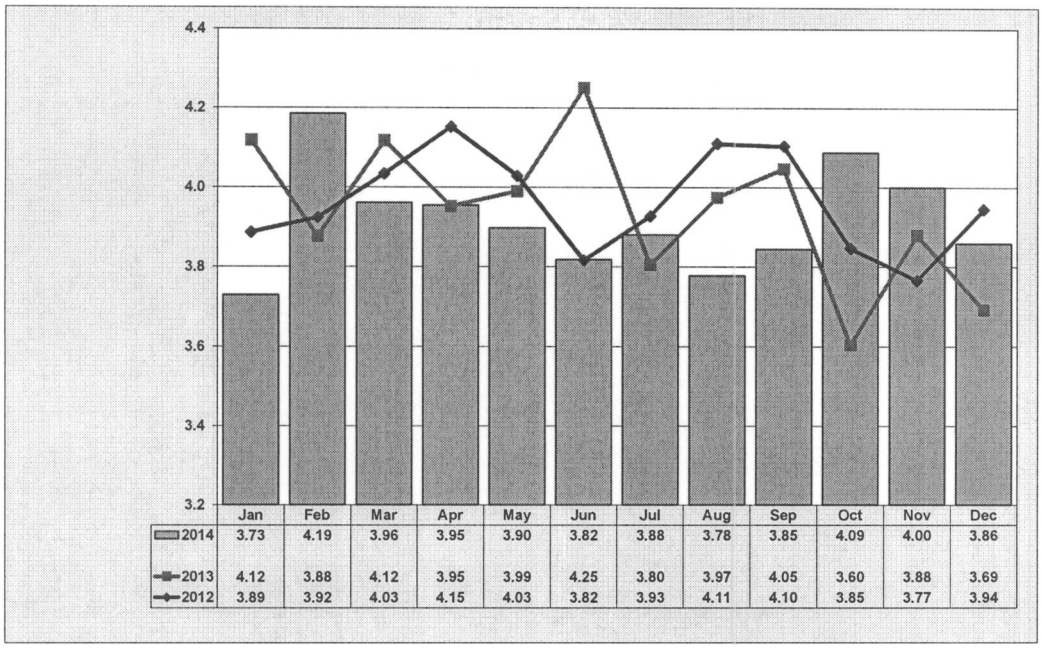



| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 263 | 290 | 273 | 271 | 262 | 261 | 262 | 245 | 258 | 248 | 263 | 251 |
| 2013 | 310 | 250 | 267 | 281 | 279 | 292 | 272 | 273 | 280 | 255 | 254 | 250 |
| 2012 | 278 | 291 | 287 | 287 | 296 | 263 | 275 | 297 | 284 | 268 | 263 | 274 |

# SGAH AVERAGE LENGTH OF STAY

YTD Act: 3.9
YTD Bud: 4.0

YTD 2013 3.9
YTD 2012 4.0

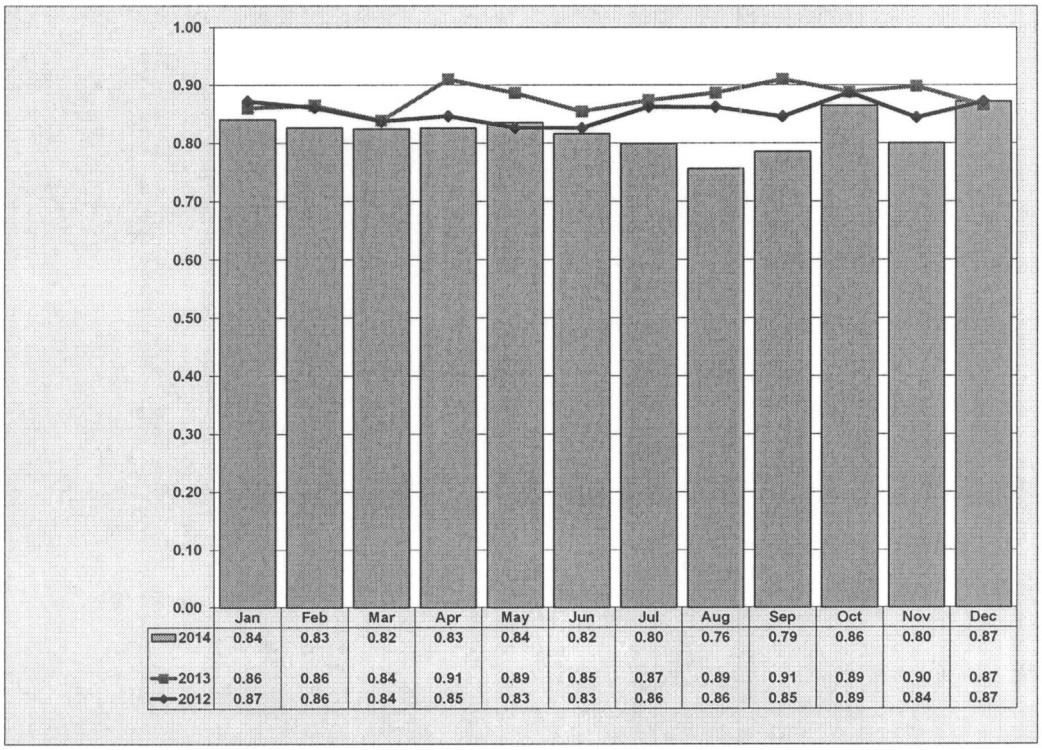



| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 3.73 | 4.19 | 3.96 | 3.95 | 3.90 | 3.82 | 3.88 | 3.78 | 3.85 | 4.09 | 4.00 | 3.86 |
| 2013 | 4.12 | 3.88 | 4.12 | 3.95 | 3.99 | 4.25 | 3.80 | 3.97 | 4.05 | 3.60 | 3.88 | 3.69 |
| 2012 | 3.89 | 3.92 | 4.03 | 4.15 | 4.03 | 3.82 | 3.93 | 4.11 | 4.10 | 3.85 | 3.77 | 3.94 |

# SGAH CASE MIX INDEX (CMI)

YTD Avg 2014 Actual: 0.82
YTD Avg 2012 Actual: 0.85

YTD Avg 2013 Actual: 0.88



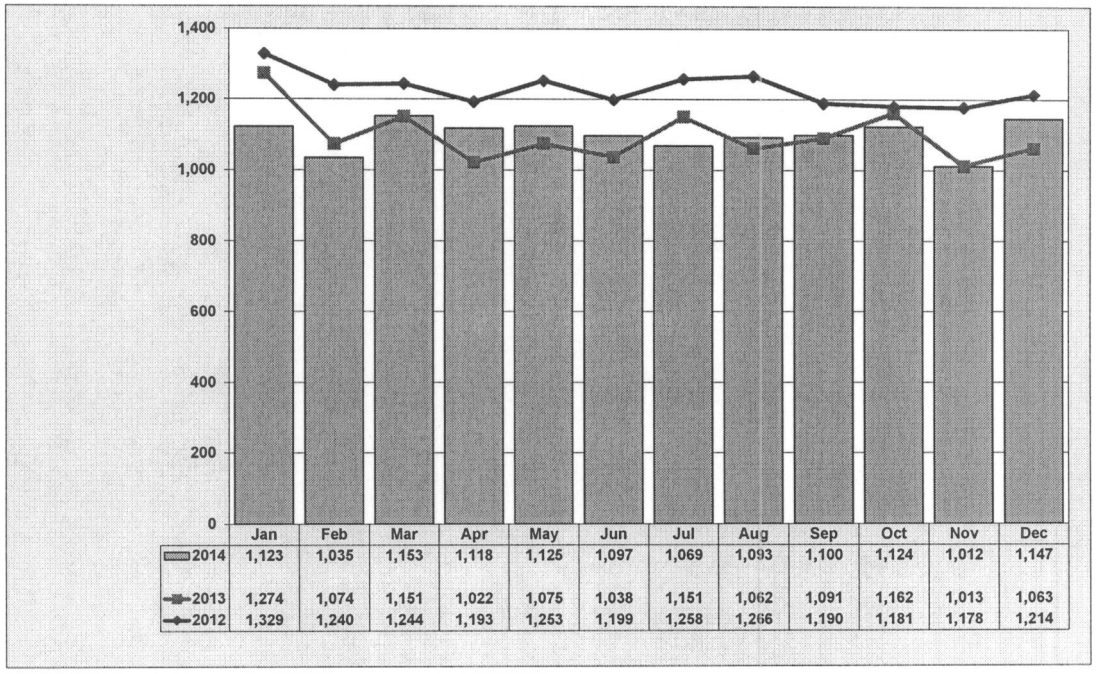

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 0.84 | 0.83 | 0.82 | 0.83 | 0.84 | 0.82 | 0.80 | 0.76 | 0.79 | 0.86 | 0.80 | 0.87 |
| 2013 | 0.86 | 0.86 | 0.84 | 0.91 | 0.89 | 0.85 | 0.87 | 0.89 | 0.91 | 0.89 | 0.90 | 0.87 |
| 2012 | 0.87 | 0.86 | 0.84 | 0.85 | 0.83 | 0.83 | 0.86 | 0.86 | 0.85 | 0.89 | 0.84 | 0.87 |

Note: Prior to January 1, 2014, Shady Grove Adventist Hospital was operating under a revenue reimbursement model referred to as "Admission/Readmission Revenue". Under this methodology, readmissions and one day stays were excluded for purposes of calculating the case mix index. Effective January 1, 2014, however, Shady Grove Adventist Hospital started operating under a new revenue reimbursement model referred to as "Global Revenue Budget". Under this model, readmissions and one day stays are included for purposes of calculating the case mix index. The case mix indices in the graph above properly reflect this change.

## WAH TOTAL ADMISSIONS & BIRTHS

YTD Act: 13,196
YTD Bud: 13,105

YTD 2013 13,176
YTD 2012 14,745

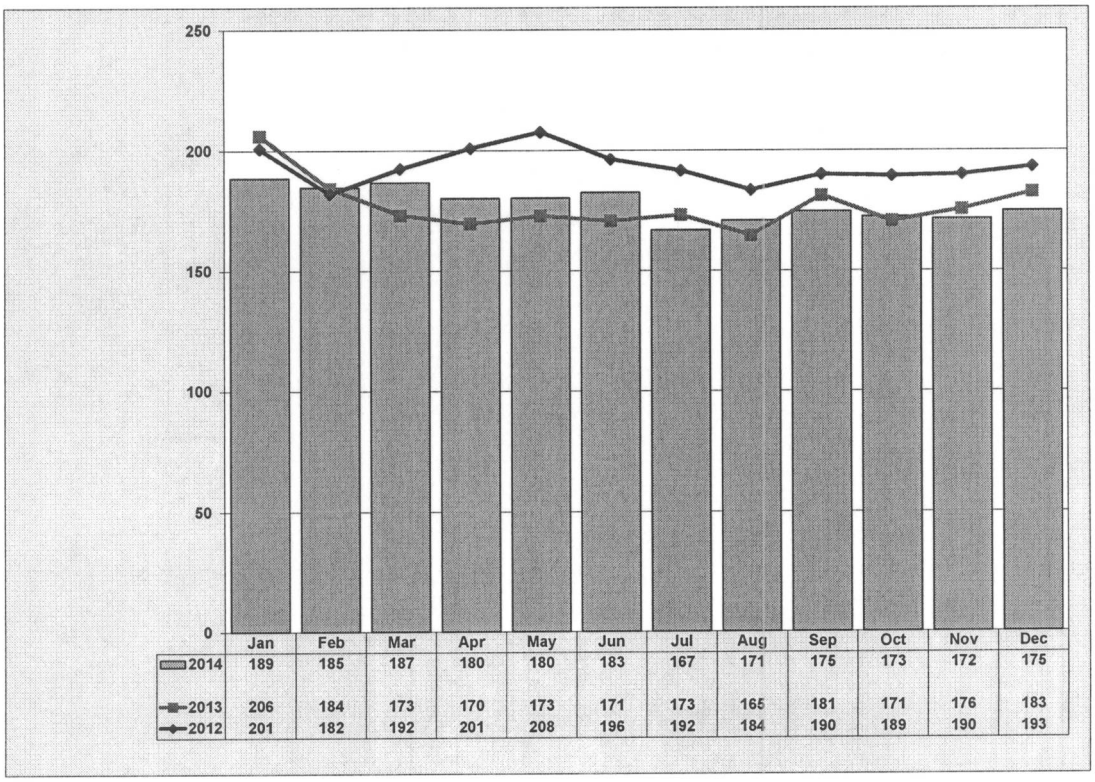



| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 1,123 | 1,035 | 1,153 | 1,118 | 1,125 | 1,097 | 1,069 | 1,093 | 1,100 | 1,124 | 1,012 | 1,147 |
| 2013 | 1,274 | 1,074 | 1,151 | 1,022 | 1,075 | 1,038 | 1,151 | 1,062 | 1,091 | 1,162 | 1,013 | 1,063 |
| 2012 | 1,329 | 1,240 | 1,244 | 1,193 | 1,253 | 1,199 | 1,258 | 1,266 | 1,190 | 1,181 | 1,178 | 1,214 |

## WAH TOTAL AVERAGE DAILY CENSUS (ADC)

YTD Act: 177.8
YTD Bud: 167.1

YTD 2013 177.0
YTD 2012 193.2

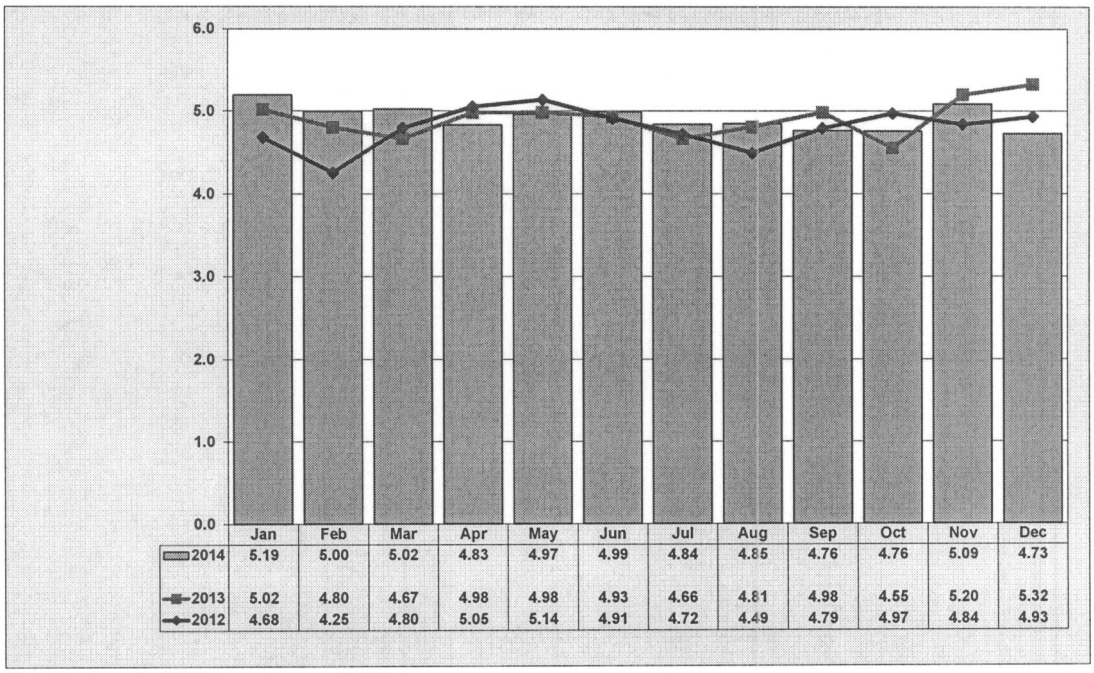



| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 189 | 185 | 187 | 180 | 180 | 183 | 167 | 171 | 175 | 173 | 172 | 175 |
| 2013 | 206 | 184 | 173 | 170 | 173 | 171 | 173 | 165 | 181 | 171 | 176 | 183 |
| 2012 | 201 | 182 | 192 | 201 | 208 | 196 | 192 | 184 | 190 | 189 | 190 | 193 |

# WAH AVERAGE LENGTH OF STAY

YTD Act: 4.9
YTD Bud: 4.7

YTD 2013 4.9
YTD 2012 4.8

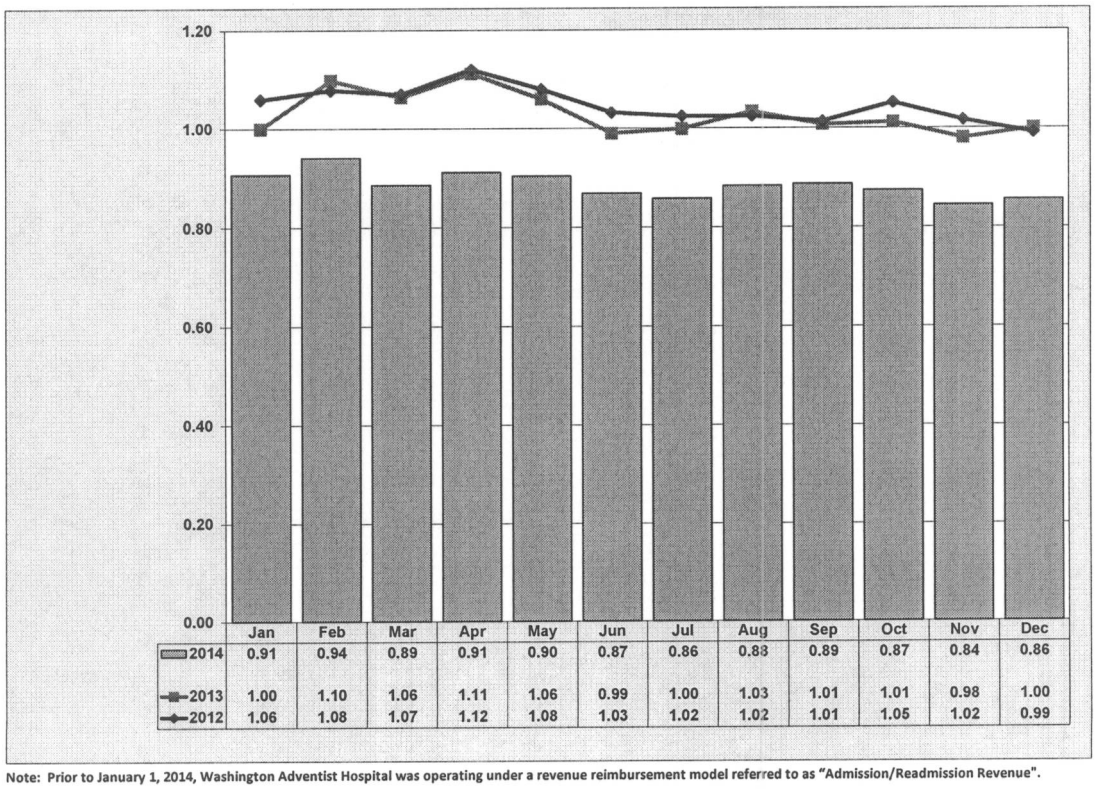



| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 5.19 | 5.00 | 5.02 | 4.83 | 4.97 | 4.99 | 4.84 | 4.85 | 4.76 | 4.76 | 5.09 | 4.73 |
| 2013 | 5.02 | 4.80 | 4.67 | 4.98 | 4.98 | 4.93 | 4.66 | 4.81 | 4.98 | 4.55 | 5.20 | 5.32 |
| 2012 | 4.68 | 4.25 | 4.80 | 5.05 | 5.14 | 4.91 | 4.72 | 4.49 | 4.79 | 4.97 | 4.84 | 4.93 |

# WAH CASE MIX INDEX (CMI)

YTD Avg 2014 Actual: 0.81

YTD Avg 2013 Actual: 1.03

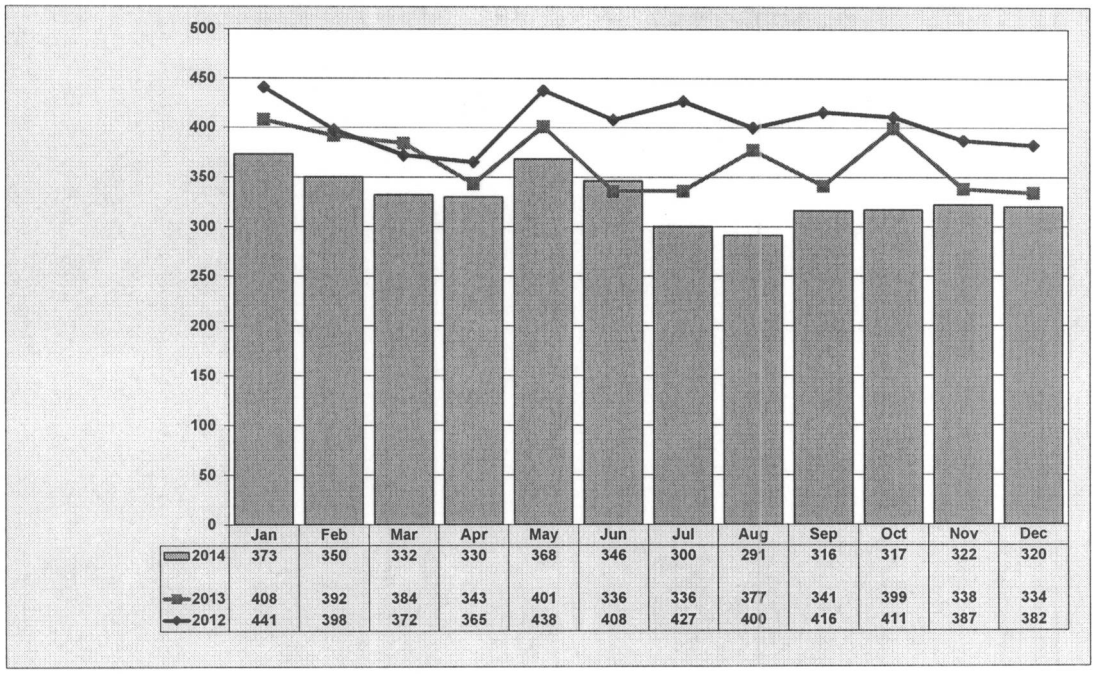



| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 0.91 | 0.94 | 0.89 | 0.91 | 0.90 | 0.87 | 0.86 | 0.88 | 0.89 | 0.87 | 0.84 | 0.86 |
| 2013 | 1.00 | 1.10 | 1.06 | 1.11 | 1.06 | 0.99 | 1.00 | 1.03 | 1.01 | 1.01 | 0.98 | 1.00 |
| 2012 | 1.06 | 1.08 | 1.07 | 1.12 | 1.08 | 1.03 | 1.02 | 1.02 | 1.01 | 1.05 | 1.02 | 0.99 |

Note: Prior to January 1, 2014, Washington Adventist Hospital was operating under a revenue reimbursement model referred to as "Admission/Readmission Revenue". Under this methodology, readmissions and one day stays were excluded for purposes of calculating the case mix index. Effective January 1, 2014, however, Washington Adventist Hospital started operating under a new revenue reimbursement model referred to as "Global Revenue Budget". Under this model, readmissions and one day stays are included for purposes of calculating the case mix index. The case mix indices in the graph above properly reflect this change.

## HRMC TOTAL ADMISSIONS & BIRTHS

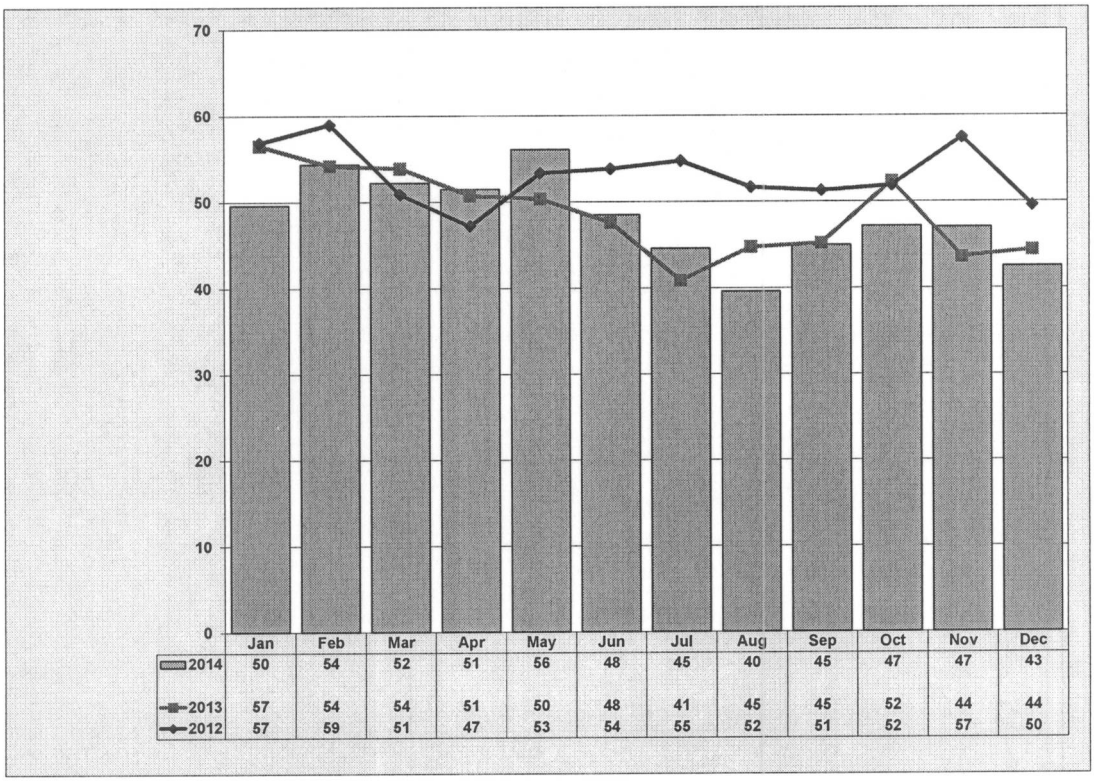
| | | | |
|---|---|---|---|
| YTD Act: | 3,965 | YTD 2013 | 4,389 |
| YTD Bud: | 4,424 | YTD 2012 | 4,845 |




| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 373 | 350 | 332 | 330 | 368 | 346 | 300 | 291 | 316 | 317 | 322 | 320 |
| 2013 | 408 | 392 | 384 | 343 | 401 | 336 | 336 | 377 | 341 | 399 | 338 | 334 |
| 2012 | 441 | 398 | 372 | 365 | 438 | 408 | 427 | 400 | 416 | 411 | 387 | 382 |

## HRMC TOTAL AVERAGE DAILY CENSUS (ADC)

| | | | |
|---|---|---|---|
| YTD Act: | 48.1 | YTD 2013 | 48.7 |
| YTD Bud: | 47.2 | YTD 2012 | 53.1 |

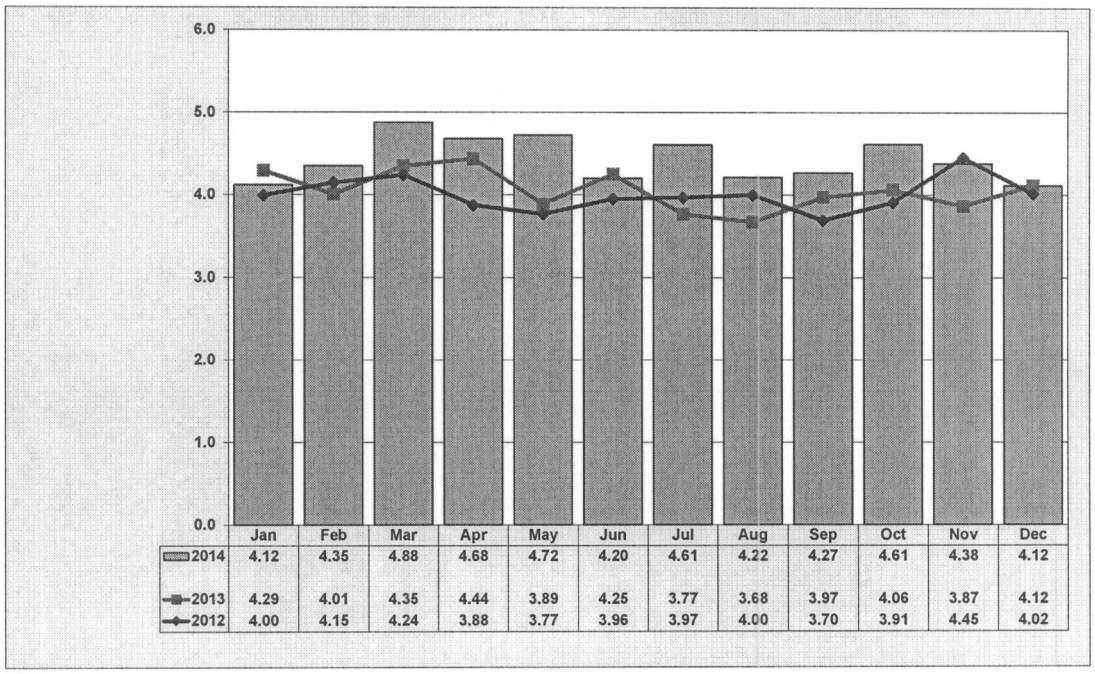



| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 50 | 54 | 52 | 51 | 56 | 48 | 45 | 40 | 45 | 47 | 47 | 43 |
| 2013 | 57 | 54 | 54 | 51 | 50 | 48 | 41 | 45 | 45 | 52 | 44 | 44 |
| 2012 | 57 | 59 | 51 | 47 | 53 | 54 | 55 | 52 | 51 | 52 | 57 | 50 |

# HRMC AVERAGE LENGTH OF STAY

YTD Act: 4.4
YTD Bud: 3.9

YTD 2013 4.1
YTD 2012 4.0

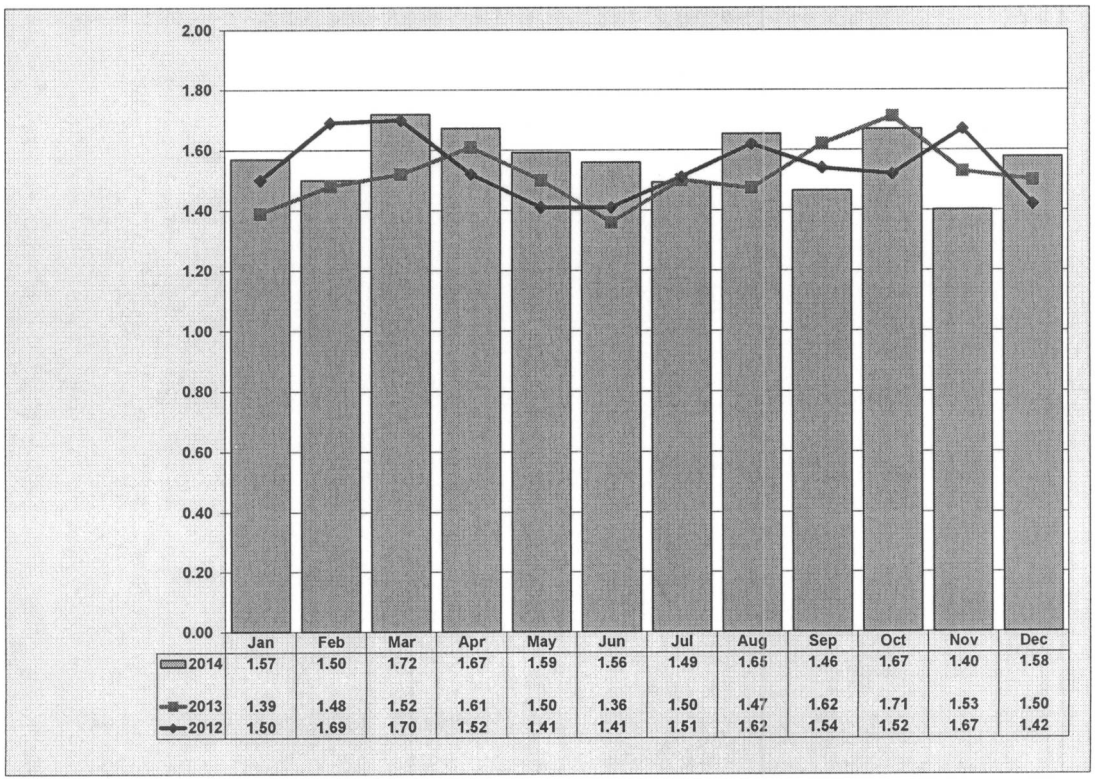



| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 4.12 | 4.35 | 4.88 | 4.68 | 4.72 | 4.20 | 4.61 | 4.22 | 4.27 | 4.61 | 4.38 | 4.12 |
| 2013 | 4.29 | 4.01 | 4.35 | 4.44 | 3.89 | 4.25 | 3.77 | 3.68 | 3.97 | 4.06 | 3.87 | 4.12 |
| 2012 | 4.00 | 4.15 | 4.24 | 3.88 | 3.77 | 3.96 | 3.97 | 4.00 | 3.70 | 3.91 | 4.45 | 4.02 |

# HRMC CASE MIX INDEX (CMI)

YTD Avg 2014 Actual: 1.57

YTD Avg 2013 Actual: 1.51

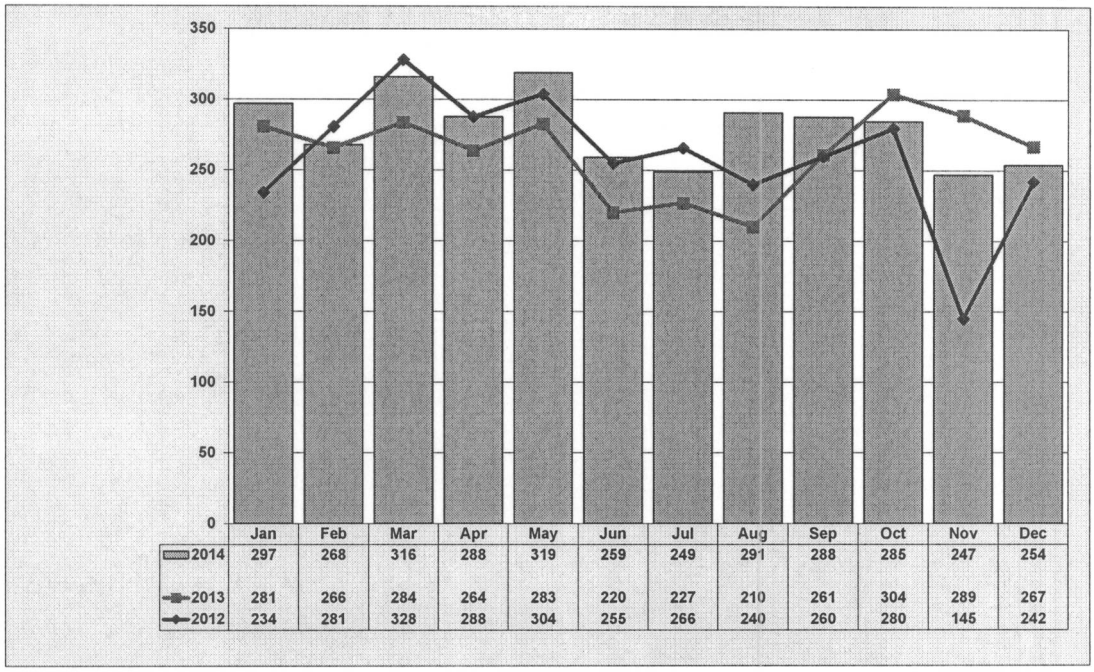



| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 1.57 | 1.50 | 1.72 | 1.67 | 1.59 | 1.56 | 1.49 | 1.65 | 1.46 | 1.67 | 1.40 | 1.58 |
| 2013 | 1.39 | 1.48 | 1.52 | 1.61 | 1.50 | 1.36 | 1.50 | 1.47 | 1.62 | 1.71 | 1.53 | 1.50 |
| 2012 | 1.50 | 1.69 | 1.70 | 1.52 | 1.41 | 1.41 | 1.51 | 1.62 | 1.54 | 1.52 | 1.67 | 1.42 |

## ABH TOTAL ADMISSIONS

YTD Act: 3,361
YTD Bud: 3,237

YTD 2013 3,156
YTD 2012 3,123

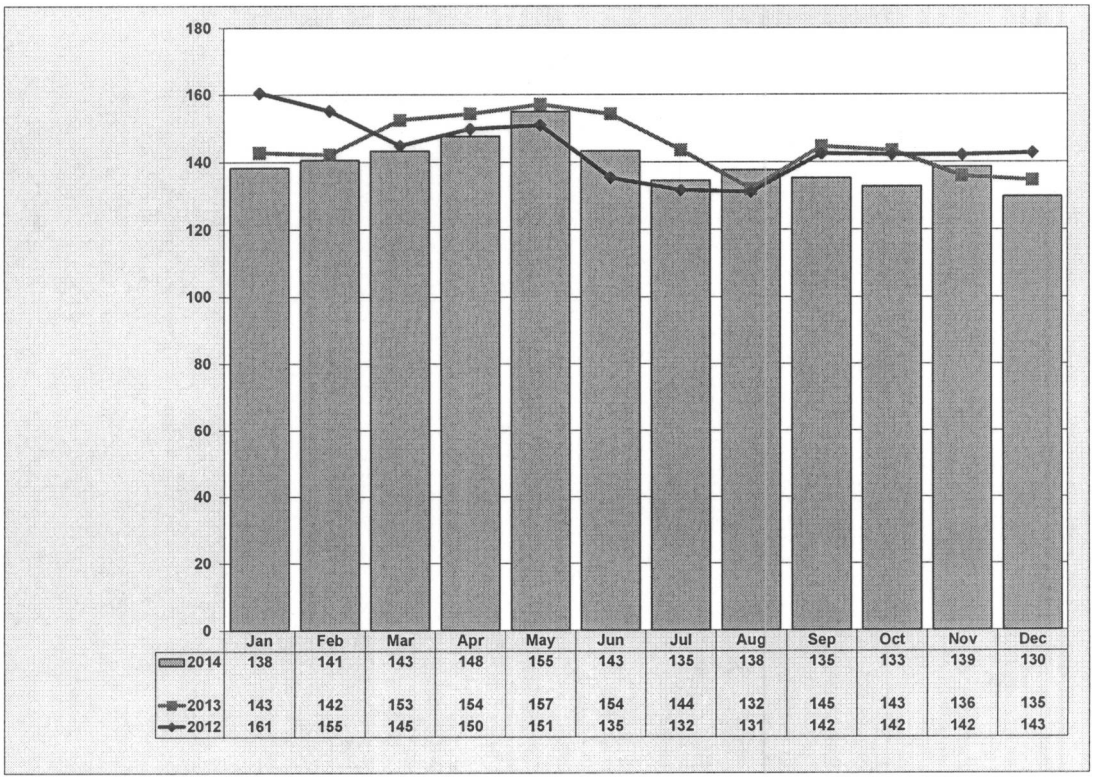



| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 297 | 268 | 316 | 288 | 319 | 259 | 249 | 291 | 288 | 285 | 247 | 254 |
| 2013 | 281 | 266 | 284 | 264 | 283 | 220 | 227 | 210 | 261 | 304 | 289 | 267 |
| 2012 | 234 | 281 | 328 | 288 | 304 | 255 | 266 | 240 | 260 | 280 | 145 | 242 |

## ABH TOTAL AVERAGE DAILY CENSUS (ADC)

YTD Act: 139.7
YTD Bud: 152.5

YTD 2013 144.8
YTD 2012 144.0

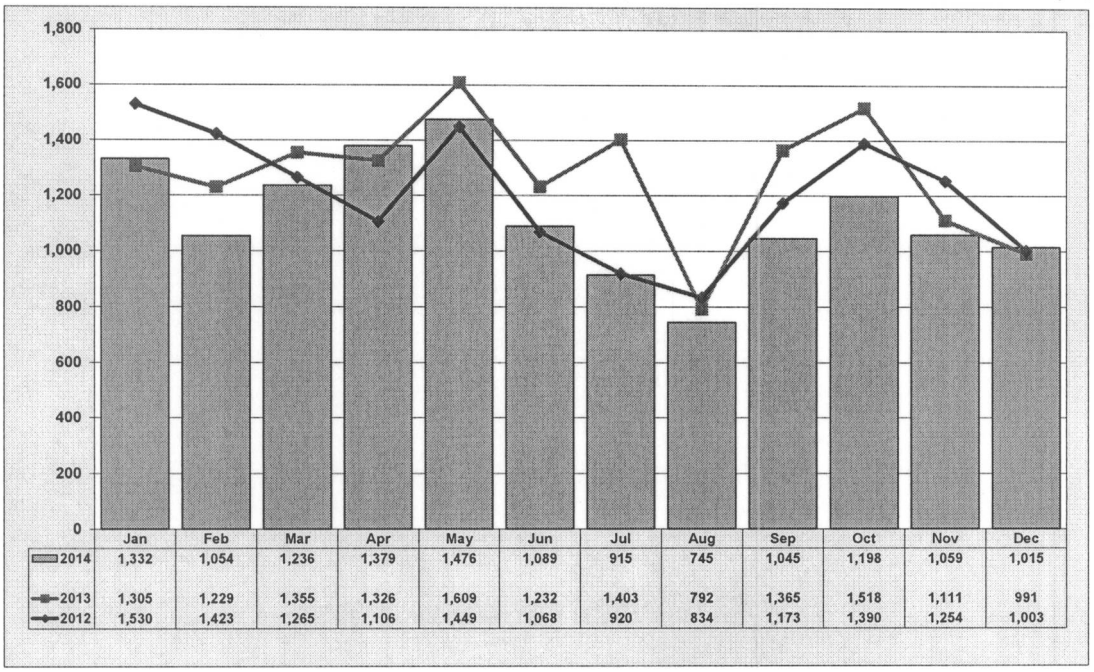



| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 138 | 141 | 143 | 148 | 155 | 143 | 135 | 138 | 135 | 133 | 139 | 130 |
| 2013 | 143 | 142 | 153 | 154 | 157 | 154 | 144 | 132 | 145 | 143 | 136 | 135 |
| 2012 | 161 | 155 | 145 | 150 | 151 | 135 | 132 | 131 | 142 | 142 | 142 | 143 |

# ABH SCHOOL DAYS

YTD Act: 13,543
YTD Bud: 16,165

YTD 2013 15,236
YTD 2012 14,415

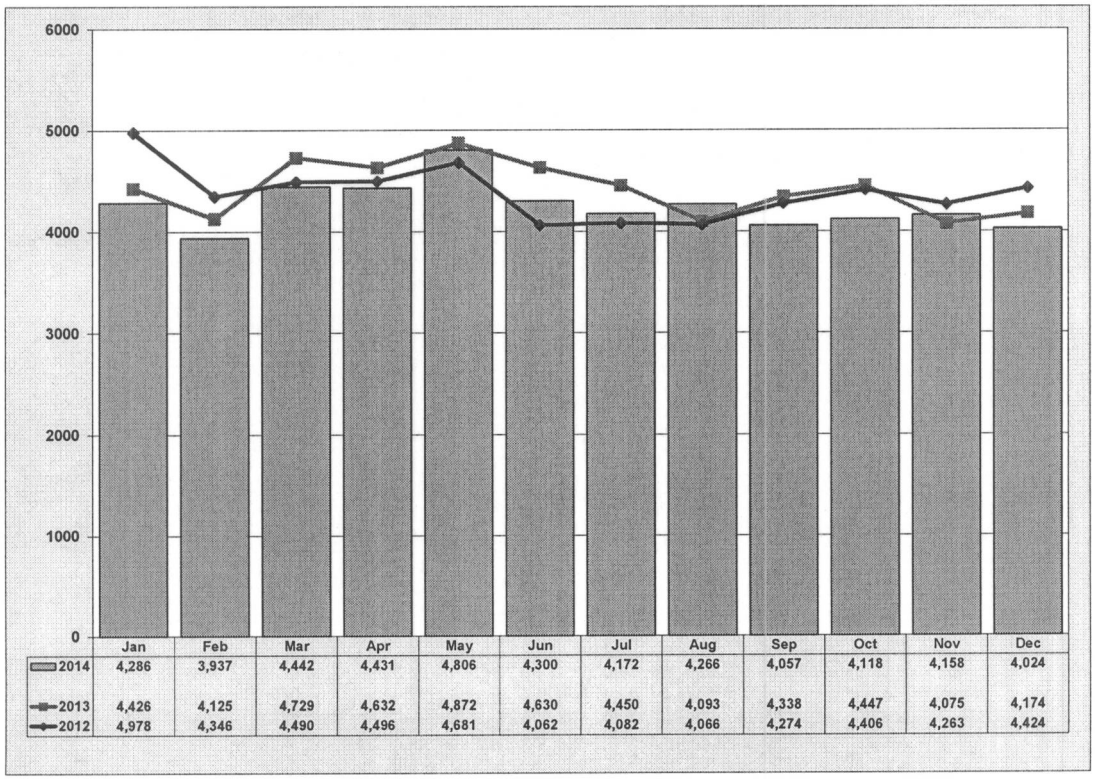



| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 1,332 | 1,054 | 1,236 | 1,379 | 1,476 | 1,089 | 915 | 745 | 1,045 | 1,198 | 1,059 | 1,015 |
| 2013 | 1,305 | 1,229 | 1,355 | 1,326 | 1,609 | 1,232 | 1,403 | 792 | 1,365 | 1,518 | 1,111 | 991 |
| 2012 | 1,530 | 1,423 | 1,265 | 1,106 | 1,449 | 1,068 | 920 | 834 | 1,173 | 1,390 | 1,254 | 1,003 |

# ABH PATIENT DAYS

YTD Act: 50,997
YTD Bud: 55,661

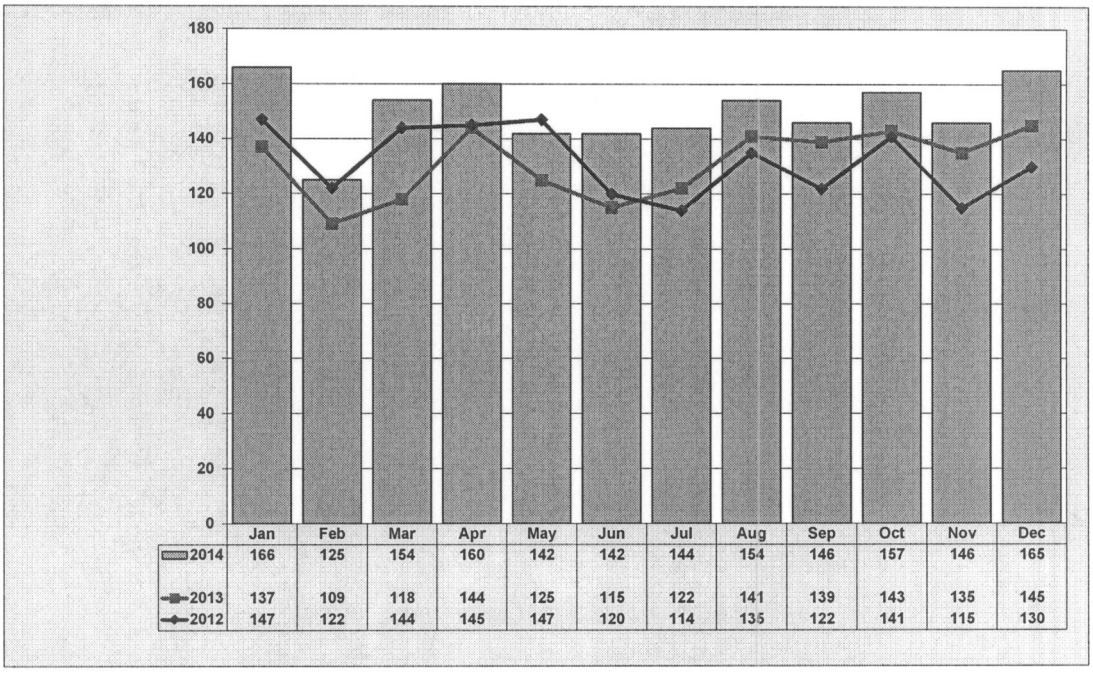
YTD 2013 52,991
YTD 2012 52,568




| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 4,286 | 3,937 | 4,442 | 4,431 | 4,806 | 4,300 | 4,172 | 4,266 | 4,057 | 4,118 | 4,158 | 4,024 |
| 2013 | 4,426 | 4,125 | 4,729 | 4,632 | 4,872 | 4,630 | 4,450 | 4,093 | 4,338 | 4,447 | 4,075 | 4,174 |
| 2012 | 4,978 | 4,346 | 4,490 | 4,496 | 4,681 | 4,062 | 4,082 | 4,066 | 4,274 | 4,406 | 4,263 | 4,424 |

## ARHM TOTAL ADMISSIONS & BIRTHS

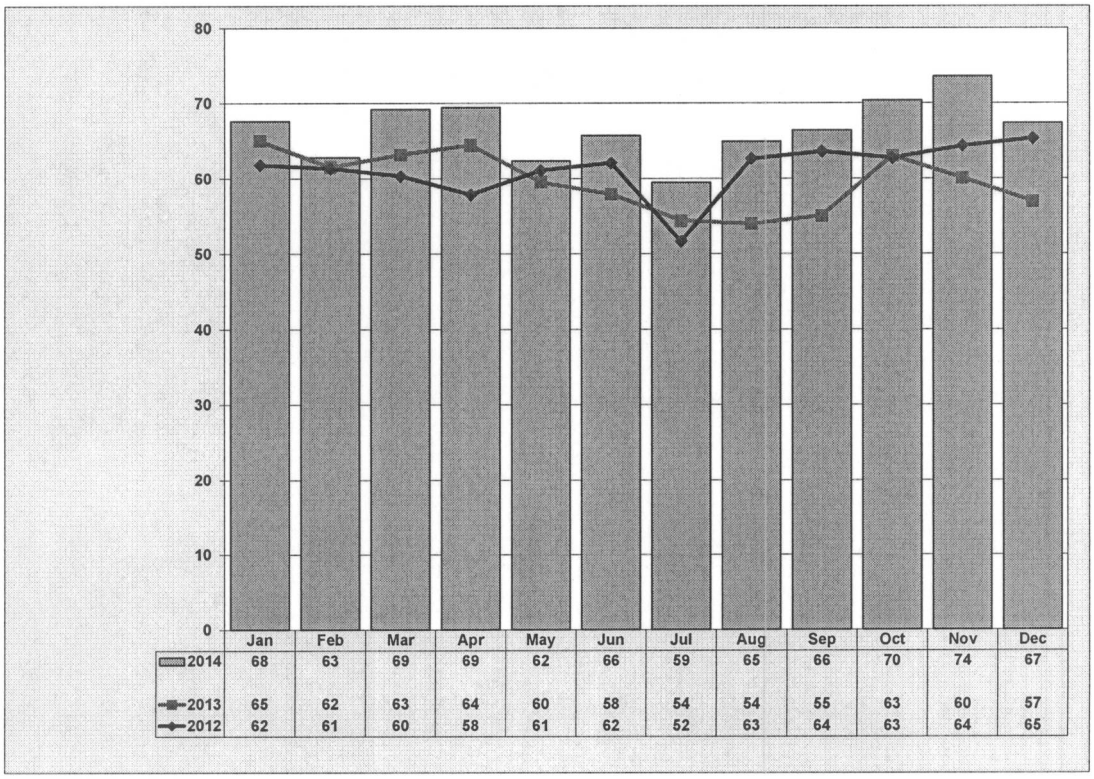
| | | | |
|---|---|---|---|
| YTD Act: | 1,801 | YTD 2013 | 1,573 |
| YTD Bud: | 1,710 | YTD 2012 | 1,582 |




| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 166 | 125 | 154 | 160 | 142 | 142 | 144 | 154 | 146 | 157 | 146 | 165 |
| 2013 | 137 | 109 | 118 | 144 | 125 | 115 | 122 | 141 | 139 | 143 | 135 | 145 |
| 2012 | 147 | 122 | 144 | 145 | 147 | 120 | 114 | 135 | 122 | 141 | 115 | 130 |

## ARHM TOTAL AVERAGE DAILY CENSUS (ADC)

| | | | |
|---|---|---|---|
| YTD Act: | 66.6 | YTD 2013 | 59.6 |
| YTD Bud: | 65.0 | YTD 2012 | 61.2 |

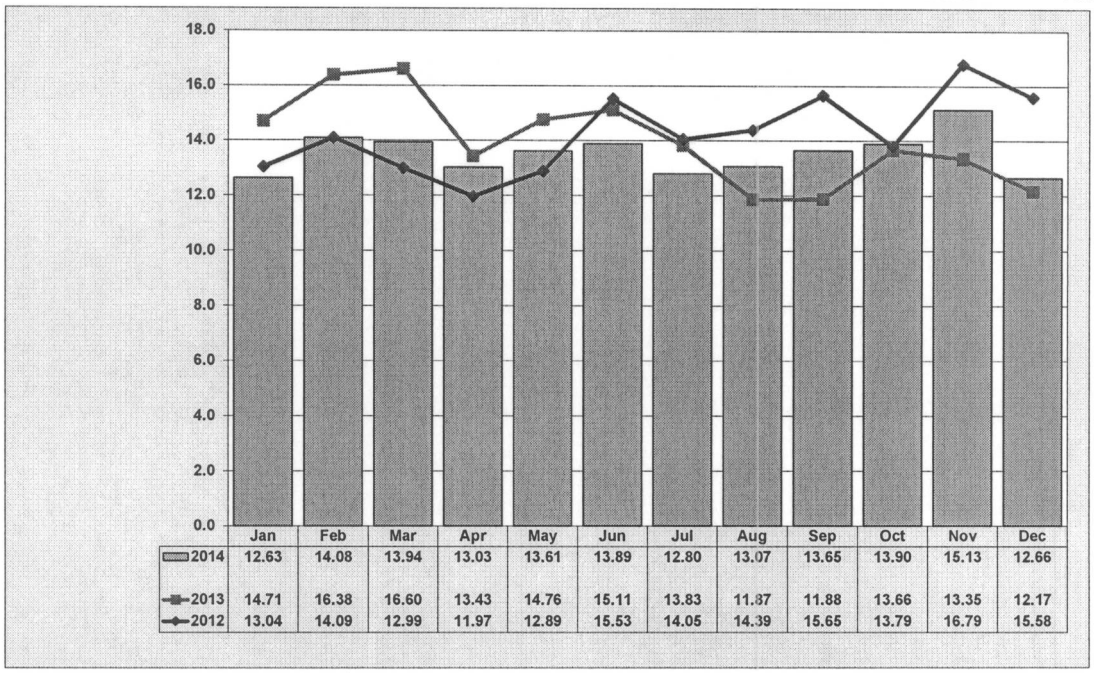



| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 68 | 63 | 69 | 69 | 62 | 66 | 59 | 65 | 66 | 70 | 74 | 67 |
| 2013 | 65 | 62 | 63 | 64 | 60 | 58 | 54 | 54 | 55 | 63 | 60 | 57 |
| 2012 | 62 | 61 | 60 | 58 | 61 | 62 | 52 | 63 | 64 | 63 | 64 | 65 |

# ARHM AVERAGE LENGTH OF STAY

YTD Act: 13.5
YTD Bud: 13.9

YTD 2013 13.9
YTD 2012 14.1




| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014 | 12.63 | 14.08 | 13.94 | 13.03 | 13.61 | 13.89 | 12.80 | 13.07 | 13.65 | 13.90 | 15.13 | 12.66 |
| 2013 | 14.71 | 16.38 | 16.60 | 13.43 | 14.76 | 15.11 | 13.83 | 11.87 | 11.88 | 13.66 | 13.35 | 12.17 |
| 2012 | 13.04 | 14.09 | 12.99 | 11.97 | 12.89 | 15.53 | 14.05 | 14.39 | 15.65 | 13.79 | 16.79 | 15.58 |

# EXHIBIT
# 110

Revenue and Expense

## Washington Adventist Hospital

Proposed CON Project

Calendar Year 2014 - 2023

| **Gross Revenues:** | | CY 2014 | CY 2015 | CY 2016 | CY 2017 | CY 2018 | CY 2019 | CY 2020 | CY 2021 | CY 2022 | CY 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total Volume Change (Unadjusted CMAEDs)** | **A** | **-1.92%** | **0.36%** | **0.11%** | **-0.02%** | **-0.61%** | **-10.31%** | **1.26%** | **1.29%** | **1.27%** | **1.30%** |
| **Expenses (Not including Capital):** | | | | | | | | | | | |
| Aggregate Base Operating Expense Inflation | | 1.59% | 2.01% | 2.29% | 2.30% | 2.30% | 2.36% | 2.37% | 2.38% | 2.39% | 2.39% |
| Expense Increase/Decrease above inflation | B | -1.16% | -0.59% | -0.12% | -0.19% | -0.35% | -4.88% | 0.74% | 0.60% | 0.70% | 0.66% |
| **Overall Expense Growth** | | **0.43%** | **1.42%** | **2.17%** | **2.10%** | **1.95%** | **-2.51%** | **3.12%** | **2.98%** | **3.09%** | **3.06%** |
| **Expense Variability Factor** | **B/A** | **60.40%** | **-161.80%** | **-107.72%** | **888.37%** | **57.81%** | **47.30%** | **59.32%** | **46.30%** | **54.92%** | **50.94%** |

# Expense Inflation

## Washington Adventist Hospital

### Summary of Aggregate Inflation

CY 2015 - CY 2023

| | Volume Factor before Inflation | 2012 | 2013 Inflation | 2013 | 2014 Inflation | 2014 | 2015 Inflation | 2015 | 2016 Inflation | 2016 | 2017 Inflation | 2017 | 2018 Inflation | 2018 | 2019 Inflation | 2019 | 2020 Inflation | 2020 | 2021 Inflation | 2021 | 2022 Inflation | 2022 | 2023 Inflation | 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Salaries & Wages | Average Salary per FTE based on FTE per Adjusted Occupied Bed | 84,386 | *0.0%* | 82,831 | *1.5%* | 81,773 | 2.3% | 83,457 | 2.3% | 85,176 | 2.3% | 86,849 | 2.3% | 88,471 | 2.3% | 85,946 | 2.3% | 88,661 | 2.3% | 91,189 | 2.3% | 93,967 | 2.3% | 96,750 |
| Benefits | 21% of Salaries & Wages | 17,421 | *0.0%* | 17,330 | *1.5%* | 17,472 | 2.3% | 17,526 | 2.3% | 17,887 | 2.3% | 18,238 | 2.3% | 18,579 | 2.3% | 18,049 | 2.3% | 18,619 | 2.3% | 19,150 | 2.3% | 19,733 | 2.3% | 20,318 |
| Supplies | Expense per Adjusted Admission | 39,987 | *3.5%* | 36,700 | *2.0%* | 37,175 | 2.0% | 38,054 | 3.5% | 39,434 | 3.5% | 40,801 | 3.5% | 41,969 | 3.5% | 43,277 | 3.5% | 45,335 | 3.5% | 47,489 | 3.5% | 49,749 | 3.5% | 52,118 |
| Contract Labor | | 1,100 | *2.0%* | 2,627 | *2.0%* | 1,559 | 2.3% | 1,037 | 2.3% | 1,060 | 2.3% | 1,084 | 2.3% | 1,108 | 2.3% | 850 | 2.3% | 869 | 2.3% | 889 | 2.3% | 909 | 2.3% | 929 |
| Purchase Services | Admission (29% fixed/71% variable) | 15,026 | *2.0%* | 14,308 | *2.0%* | 14,962 | 2.0% | 15,165 | 2.0% | 15,371 | 2.0% | 15,581 | 2.0% | 15,793 | 2.0% | 15,239 | 2.0% | 15,655 | 2.0% | 16,083 | 2.0% | 16,522 | 2.0% | 16,974 |
| G&A | Fixed plus inflation | 13,906 | *1.5%* | 13,116 | *1.5%* | 12,307 | 2.5% | 12,615 | 2.5% | 12,930 | 2.5% | 13,253 | 2.5% | 13,585 | 2.5% | 13,254 | 2.5% | 13,585 | 2.5% | 13,925 | 2.5% | 14,273 | 2.5% | 14,630 |
| Professional Fees | Fixed plus inflation | 9,768 | *3.0%* | 11,052 | *0.0%* | 12,146 | 0.0% | 11,963 | 0.0% | 11,963 | 0.0% | 11,963 | 0.0% | 11,963 | 1.0% | 11,699 | 1.0% | 11,816 | 1.0% | 11,934 | 1.0% | 12,053 | 1.0% | 12,174 |
| Building & Maintenance | Fixed plus inflation | 8,309 | *1.1%* | 9,031 | *2.5%* | 9,175 | 2.5% | 9,404 | 2.5% | 9,640 | 2.5% | 9,880 | 2.5% | 10,128 | 2.5% | 8,350 | 2.5% | 8,559 | 2.5% | 8,773 | 2.5% | 8,992 | 2.5% | 9,217 |
| Insurance | Fixed plus inflation | 1,747 | *1.0%* | 1,853 | *1.0%* | 1,562 | 1.0% | 1,578 | 1.0% | 1,594 | 1.0% | 1,610 | 1.0% | 1,626 | 1.0% | 1,566 | 1.0% | 1,582 | 1.0% | 1,598 | 1.0% | 1,614 | 1.0% | 1,630 |
| Other - OH Alloc | Fixed plus inflation | 14,758 | *0.8%* | 14,597 | *1.5%* | 16,184 | 1.5% | 16,427 | 1.5% | 16,673 | 1.5% | 16,923 | 1.5% | 17,177 | 1.5% | 16,629 | 1.5% | 16,878 | 1.5% | 17,131 | 1.5% | 17,388 | 1.5% | 17,649 |
| **Total Weighted Inflation** | | 206,409 | *1.19%* | 203,445 | *1.59%* | 204,315 | 2.01% | 207,226 | 2.29% | 211,728 | 2.30% | 216,182 | 2.30% | 220,398 | 2.36% | 214,858 | 2.37% | 221,558 | 2.38% | 228,159 | 2.39% | 235,200 | 2.39% | 242,388 |

# EXHIBIT
# 111

Washington Adventist Hospital 2014 Operating Expenses

Actual CY 2014 Results Compared to CY 2014 Pro Forma Expenses

| | CY 2014 Pro Forma | CY 2014 Actual | Variance |
|---|---|---|---|
| **EXPENSES** | | | |
| a. Salaries & Wages (including benefits) | 99,245 | 97,303 | (1,942) |
| b. Contractual Services | 28,667 | 29,167 | 500 |
| c. Interest on Current Debt | 2,684 | 2,537 | (147) |
| d. Interest on Project Debt | - | | - |
| e. Current Depreciation | 9,467 | 8,589 | (878) |
| f. Project Depreciation | - | | - |
| g. Current Amortization | | | - |
| h. Project Amortization | | | - |
| i. Supplies | 37,175 | 35,408 | (1,767) |
| j. Other Expenses | 39,228 | 37,706 | (1,522) |
| ***TOTAL OPERATING EXPENSES*** | ***$ 216,466*** | ***$ 210,710*** | ***$ (5,756)*** |

Salaries and Wages were favorable to the pro forma, due to less than expected shared service expense. Employee Benefits were favorable to the pro forma as AHC experienced lower costs for health insurance, retirement and other employee benefits.

Contractual Services costs were unfavorable to the pro forma as WAH absorbed one-time costs for transition to a new IT vendor. Contract labor exceeded the pro forma as WAH experienced a higher need for contract nurses in certain specialties.

Medical Supplies were well controlled and finished favorable to the pro forma. WAH achieved significant savings in cardiac rhythm devices, pharmaceuticals and surgical supplies.

General and Administrative costs were significantly lower than the pro forma. WAH reduced consulting expenditures by half, while also reducing advertising and other administrative costs. Building and Maintenance costs were favorable to the pro forma, as WAH achieved savings in equipment service contracts. Professional Fees were on target with the pro forma.

# EXHIBIT
# 112

| | | |
|---|---|---|
| IN RE: THE FULL | * | BEFORE THE HEALTH SERVICES |
| RATE REVIEW OF | * | COST REVIEW COMMISSION |
| GARRETT COUNTY | * | DOCKET: 2012 |
| MEMORIAL HOSPITAL | * | FOLIO: 1958 |
| OAKLAND, MARYLAND | * | PROCEEDING: 2168R |

* * * * * * * * * * * * *

STAFF RECOMMENDATION

February 6, 2013
Approved

## I. INTRODUCTION

On July 6, 2012 Garrett County Memorial Hospital ("Hospital," or "GCMH") submitted a full rate application to the Health Services Cost Review Commission ("HSCRC," or "Commission"). GCMH is a 55-bed acute care community hospital located in Oakland, Maryland.

GCMH has operated under the HSCRC's Total Patient Revenue (TPR) System since the early 1980's. Under the TPR System, the Hospital is provided a fixed revenue (CAP) amount under which it must operate each year. The CAP is updated each year for inflation based on the same inflation factor applied to all other hospitals. The CAP is also adjusted each year for a change in the Hospital's payer mix and approved uncompensated care (mark-up), as is the case with all other hospitals. However, the Hospital does not receive an adjustment for actual case mix change or an adjustment for actual volume changes as do other hospitals. Instead, the CAP is increased based on a fixed adjustment for volume changes each year. The volume adjustment provides the Hospital with the lesser of 25% of the percentage change in the population of the County, or a flat 1% increase, whichever is less. The TPR System attempts to deter unnecessary admissions by providing the Hospital with an incentive to control both the charge per inpatient case and the number of cases.

## II. THE HOSPITAL REQUEST AND JUSTIFICATION

The Hospital has requested combined overall rate increases, exclusively for capital, of $789,019 at July 1, 2014, $761,429 at July 1, 2015, and $827,723 at July 1, 2016. The total amount requested over the three year period is $2,378,171. The capital costs are related to a $23.5 million project for a New Wing Expansion and Renovations. GCMH expects to receive

Certificate of Need (CON) approval from the Maryland Health Care Commission (MHCC) for the Project.

## III. HOSPITAL RATE HISTORY

As stated above, GCMH has operated under the TPR system since the early 1980's, and for years was the only hospital utilizing this fixed revenue methodology. GCMH continues to be unique even with the new TPR group, which consists primarily of hospitals in larger and more suburban areas.

Under the TPR rate setting structure, a hospital's unit rates may change significantly throughout a given year depending on fluctuations in volumes. The revenue CAP places pressure on hospitals to control costs during periods of rising volumes and acts as a safety net during periods of declining volumes. While the TPR structure does provide for a predictable operating revenue stream, the TPR system does not readily address the funding of infrequent large capital building projects.

Since 2008, GCMH has applied for and received two full rate adjustments – in 2008 and 2009. In 2008, the Hospital received a $2.1 million (6%) increase of which nearly one-third was related to West Virginia Medicaid, which refused to pay HSCRC-approved rates. The other two-thirds were used to hire additional staffing and for certain technological advances.

In 2009, GCMH received a $1.9 million (5%) increase to its TPR, which was used for additional staffing and increased group health benefits.

Both the 2008 and 2009 applications were predicated on GCMH's favorable Reasonableness Of Charges (ROC) position.

## IV. HOSPITAL FINANCIAL SITUATION

The Hospital's fiscal year end is June 30. For the past three fiscal years, the Hospital has reported the following audited operating results:

| **Garrett County Memorial** | Net Operating Revenue (Regulated) | Net Operating Profit/(Loss) (Regulated) | Operating Margin (Regulated) | Net Profits |
|---|---|---|---|---|
| FYE June 2012 | $33,733,500 | $1,755,400 | 5.20% | $1,621,900 |
| FYE June 2011 | $32,531,200 | $2,237,600 | 6.90% | $2,815,100 |
| FYE June 2010 | $32,921,200 | $3,800,100 | 11.5% | $4,973,000 |

## V. STAFF ANALYSIS

### a. Timing of Rate Request

The total costs of the Wing Expansion and Renovation Project are $23.5 million. The Hospital plans to fund 32%, or $7.5 million, through equity and $1.0 million through contributions. Project debt is expected to equal $15.0 million at 5.25% interest over 20 years. GCMH has requested a phased-in approach for the rate adjustment. The requested effective dates of July 1, 2014, 2015, and 2016 are reflective of when the depreciation and interest expense related to the Project are projected to be realized.

### b. Baseline ICC Calculation

The HSCRC's ICC methodology for full rate reviews was applied to GCMH's rate request. While the ICC methodology produced a 0.46% rate increase, GCMH's 3-year phased-in revenue request of $2,378,171 results in a 5.88% rate increase when applied to GCMH's current revenue base. In its application, GCMH requests that the difference between the 5.88% and 0.46% (or 5.42%) be provided as a special adjustment to rates.

**c. Rate Methodology for Capital**

The current HSCRC policy for funding capital in rates (either through a full or partial application[1]) limits the amount of funding to the lesser of 50% of the project capital costs or the peer group average capital costs. Hospitals are expected to generate the shortfall in capital funding through increased volumes related to the Project. Prior to this application, GCMH has never requested HSCRC funding for a major capital project.

TPR vs. Non-TPR Hospitals

While it is equitable for many HSCRC policies to be applied across-the-board to all Maryland hospitals, certain criteria should be considered when evaluating capital cost requests from hospitals with extreme circumstances such as GCMH.

A hospital's rate methodology and the related incentives of that methodology should be considered in addition to the reasonableness of costs and charges with respect to the request.

While non-TPR hospitals are able to generate additional revenue with increased volumes as a result of capital expenditures, there is no opportunity for GCMH, as a TPR hospital, to generate necessary revenues to fund capital shortfalls through volume increases.

Lack of TPR Transition Adjustment

While GCMH has been on the TPR rate system since the early 1980's, eight of the current ten TPR hospitals entered into their TPR agreements during fiscal 2011, at a time when rate adjustments were given ("Transition Adjustments") to hospitals that transitioned from the Charge Per Case ("CPC") rate methodology to TPR. These adjustments ranged between $1.1 million and $10.6 million and averaged $6.5 million per TPR hospital spread over 2 years.

[1] A partial application using the relaxed ICC (ICC adding back 2% productivity) would have resulted in funding of $978,000, or 41% of GCMH capital costs.

GCMH has no Transition Adjustment to assist with the funding of the capital project which could be used to offset a portion of this rate request. With no Transition Adjustment, GCMH has to rely on its TPR revenue and prudent spending to maintain a viable bottom line.

Reasonable Charges

A hospital's existing charge structure should be taken into account prior to the HSCRC's granting capital funding, whether it is a TPR hospital or not. There should be some offset to capital funding for TPR hospitals above the peer average on the ROC methodology. On the last published ROC in the spring of 2011, GCMH was 6.58% below its peers and had been consistently well below the average on previous ROCs.

Reasonable Cost Structure

In addition to a review of charges, staff analyzed GCMH's cost structure compared to its ROC peer group as well as the other TPR hospitals. A comparison of capital costs per EIPA and non-capital costs per case mix adjusted EIPA resulted in GCMH's costs being significantly below its peers as follows:

| | GCMH (Below) Peers | |
|---|---|---|
| | v. TPR | v. ROC Group |
| Capital per EIPA | (47.8%) | (31.9%) |
| Non-capital per CMAEIPA | (5.7%) | (3.5%) |
| Combined | (9.5%) | (6.1%) |

Adding the $2.1 million in Project costs to GCMH's capital costs results in GCMH remaining 6.0% below the TPR hospitals' combined average and at the ROC peer group average.

## VI. FINAL RATES SUMMARIZED

Based on the analysis outlined in Section V and the unique circumstances of GCMH, the staff recommends the following:

1. That the Hospital's CAP be adjusted by $2,378,171 as follows, provided that the assets are available for use at that time:

| | | |
|---|---|---|
| July | 1, 2014 | $789,019 |
| July | 1, 2015 | $761,429 |
| July | 1, 2016 | $827,723 |

If the assets are not available for use at the times stated above, the staff recommends that the adjustments be made when the assets become available for use.

2. That these adjustments be contingent on the approval of the CON before the MHCC without any material changes.

3. That any material difference between the Hospital's assumed interest rate and the actual interest rate secured be appropriately adjusted for at the time this adjustment is to be made.

# 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 | |
| | Community Influenza Vaccination Program | Provided ~ 6,400 vaccines at 182 flu shot clinics in past 4 years |
| | | 2011 – 1,800 vaccines at 50 clinics;<br>2012 – 1,700 vaccines at 65 clinics;<br>2013 – 1,400 vaccines at 32 clinics;<br>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) |

| | | |
|---|---|---|
| 5. Advanced Prevention and Wellness strategies that improved access and health outcomes for our most vulnerable populations | 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 | 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
# 113

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

Ziegler

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

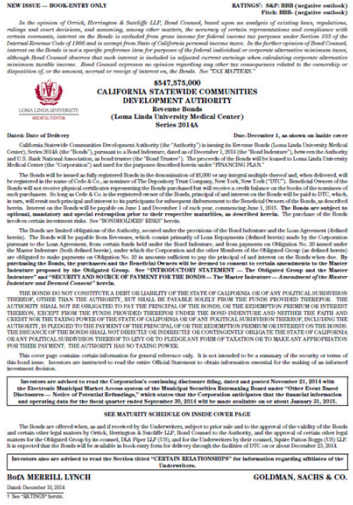
- A large number of BBB and non-rated healthcare deals are being completed at historically low borrowing costs
- Borrowing costs, represented by the Yield, decreased by more than 0.25%-0.50% from the beginning of 2014 to the end of 2014
- In 2014, BBB and non-rated healthcare borrowers achieved long-term 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[1]: S&P: BBB (negative outlook)
Fitch: BBB- (negative outlook)

*In the opinion of Orrick, Herrington & Sutcliffe LLP, Bond Counsel, based upon an analysis of existing laws, regulations, rulings and court decisions, and assuming, among other matters, the accuracy of certain representations and compliance with certain covenants, interest on the Bonds is excluded from gross income for federal income tax purposes under Section 103 of the Internal Revenue Code of 1986 and is exempt from State of California personal income taxes. In the further opinion of Bond Counsel, interest on the Bonds is not a specific preference item for purposes of the federal individual or corporate alternative minimum taxes, although Bond Counsel observes that such interest is included in adjusted current earnings when calculating corporate alternative minimum taxable income. Bond Counsel expresses no opinion regarding any other tax consequences related to the ownership or disposition of, or the amount, accrued or receipt of interest on, the Bonds. See "TAX MATTERS."*

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

LOMA LINDA UNIVERSITY MEDICAL CENTER

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

California Statewide Communities Development Authority (the "Authority") is issuing its Revenue Bonds (Loma Linda University Medical Center), Series 2014A (the "Bonds"), pursuant to a Bond Indenture, dated as of December 1, 2014 (the "Bond Indenture"), here on the Authority and U.S. Bank National Association, as bond trustee (the "Bond Trustee"). The proceeds of the Bonds will be loaned to Loma Linda University Medical Center (the "Corporation") and used for the purposes described herein under "FINANCING PLAN."

The Bonds will be issued as fully registered Bonds in the denomination of $5,000 or any integral multiple thereof and, when delivered, will be registered in the name of Cede & Co., as nominee of The Depository Trust Company, New York, New York ("DTC"). Beneficial Owners of the Bonds will not receive physical certificates representing the Bonds purchased but will receive a credit balance on the books of the nominees of such purchasers. So long as Cede & Co. is the registered owner of the Bonds, principal of and interest on the Bonds will be paid to DTC, which, in turn, will remit such principal and interest to the participants for subsequent disbursement to the Beneficial Owners of the Bonds, as described herein. Interest on the Bonds will be payable on June 1 and December 1 of each year, commencing June 1, 2015. **The Bonds are subject to optional, mandatory and special redemption prior to their respective maturities, as described herein.** The purchase of the Bonds involves certain investment risks. See "BONDHOLDERS' RISKS" herein.

The Bonds are limited obligations of the Authority, secured under the provisions of the Bond Indenture and the Loan Agreement (defined herein). The Bonds will be payable from Revenues, which consist primarily of Loan Repayments (defined herein) made by the Corporation pursuant to the Loan Agreement, from certain funds held under the Bond Indenture, and from payments on Obligation No. 20 issued under the Master Indenture (both defined herein), under which the Corporation and the other Members of the Obligated Group (as defined herein) are obligated to make payments on Obligation No. 20 in amounts sufficient to pay the principal of and interest on the Bonds when due. **By purchasing the Bonds, the purchasers and the Beneficial Owners will be deemed to consent to certain amendments to the Master Indenture proposed by the Obligated Group. See "INTRODUCTORY STATEMENT — The Obligated Group and the Master Indenture" and "SECURITY AND SOURCE OF PAYMENT FOR THE BONDS — The Master Indenture — *Amendment of the Master Indenture and Deemed Consent*" herein.**

THE BONDS DO NOT CONSTITUTE A DEBT OR LIABILITY OF THE STATE OF CALIFORNIA OR OF ANY POLITICAL SUBDIVISION THEREOF, OTHER THAN THE AUTHORITY, BUT SHALL BE PAYABLE SOLELY FROM THE FUNDS PROVIDED THEREFOR. THE AUTHORITY SHALL NOT BE OBLIGATED TO PAY THE PRINCIPAL OF THE BONDS, OR THE REDEMPTION PREMIUM OR INTEREST THEREON, EXCEPT FROM THE FUNDS PROVIDED THEREFOR UNDER THE BOND INDENTURE AND NEITHER THE FAITH AND CREDIT NOR THE TAXING POWER OF THE STATE OF CALIFORNIA OR OF ANY POLITICAL SUBDIVISION THEREOF, INCLUDING THE AUTHORITY, IS PLEDGED TO THE PAYMENT OF THE PRINCIPAL OF OR THE REDEMPTION PREMIUM OR INTEREST ON THE BONDS. THE ISSUANCE OF THE BONDS SHALL NOT DIRECTLY OR INDIRECTLY OR CONTINGENTLY OBLIGATE THE STATE OF CALIFORNIA OR ANY POLITICAL SUBDIVISION THEREOF TO LEVY OR TO PLEDGE ANY FORM OF TAXATION OR TO MAKE ANY APPROPRIATION FOR THEIR PAYMENT. THE AUTHORITY HAS NO TAXING POWER.

This cover page contains certain information for general reference only. It is not intended to be a summary of the security or terms of this bond issue. Investors are instructed to read the entire Official Statement to obtain information essential for the making of an informed investment decision.

**Investors are advised to read the Corporation's continuing disclosure filing, dated and posted November 21, 2014 with the Electronic Municipal Market Access system of the Municipal Securities Rulemaking Board under "Short Based Disclosure." Investors are also advised to read the financial information and notice that the Corporation anticipates that the financial information and operating data for the fiscal quarter ended September 30, 2014 will be made available on or about January 31, 2015.**

**SEE MATURITY SCHEDULE ON INSIDE COVER PAGE**

The Bonds are offered when, as and if received by the Underwriters, subject to prior sale and to the approval of the validity of the Bonds and certain other legal matters by Orrick, Herrington & Sutcliffe LLP, Bond Counsel to the Authority, and the approval of certain other legal matters for the Obligated Group by its counsel, DLA Piper LLP (US), and for the Underwriters by their counsel, Squire Patton Boggs (US) LLP. It is expected that the Bonds will be available in book-entry form for delivery through the facilities of DTC on or about December 23, 2014.

**Investors also are advised to read the Section titled "CERTAIN RELATIONSHIPS" for information regarding affiliates of the Underwriters.**

**BofA MERRILL LYNCH** — **GOLDMAN, SACHS & CO.**

Dated: December 10, 2014
[1] See "RATINGS" herein.

| | 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 |

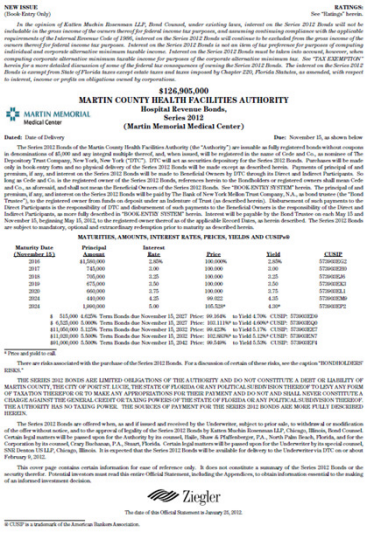
**Final Pricing Summary**

| 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 Muskin Bonneman 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 Cede and Co., as aforesaid, so long as Cede and Co. is the registered owner of the Series 2012 Bonds. Payments by DTC to its Direct and Indirect Participants 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 | $1,580,000 | 2.00% | 100.000% | 2.00% | 573903XL2 |
| 2017 | 745,000 | 2.00 | 100.000 | 2.00 | 573903XM0 |
| 2018 | 795,000 | 2.25 | 100.000 | 2.25 | 573903XN8 |
| 2019 | 675,000 | 2.50 | 100.000 | 2.50 | 573903XK3 |
| 2020 | 660,000 | 2.75 | 100.000 | 2.75 | 573903XL1 |
| 2024 | 440,000 | 4.25 | 99.022 | 4.35 | 573903XM9 |
| 2024 | 1,990,000 | 5.00 | 105.529* | 4.30* | 573903XP2 |
| $ 515,000 | 4.625% | Term Bonds due November 15, 2027 | Price: 99.164% | to Yield 4.70% | CUSIP: 573903XQ0 |
| $ 6,525,000 | 5.000% | Term Bonds due November 15, 2027 | Price: 101.119*# | to Yield 4.68*# | CUSIP: 573903XQ0 |
| $11,695,000 | 5.125% | Term Bonds due November 15, 2032 | Price: 99.412% | to Yield 5.17% | CUSIP: 573903XR7 |
| $11,920,000 | 5.500% | Term Bonds due November 15, 2032 | Price: 102.863*# | to Yield 5.12*# | CUSIP: 573903XR7 |
| $91,000,000 | 5.500% | Term Bonds due November 15, 2042 | Price: 99.549% | to Yield 5.53% | CUSIP: 573903XP4 |

* 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 Muskin Bonneman LLP, Chicago, Illinois, Bond Counsel. Certain legal matters will be passed upon for the Authority by its counsel, Hallo, 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 26, 2012.

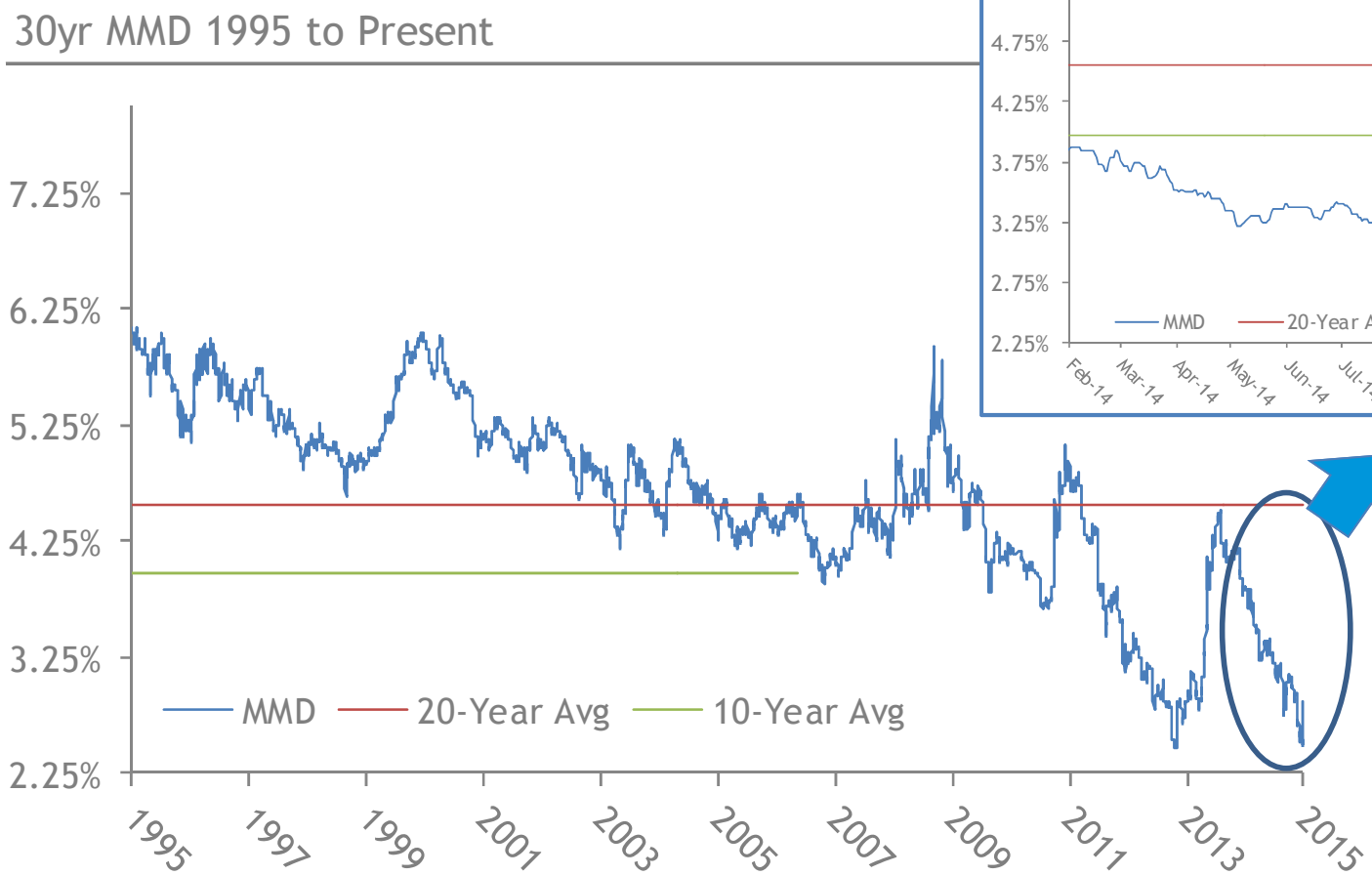
® CUSIP is a trademark of the American Bankers Association.

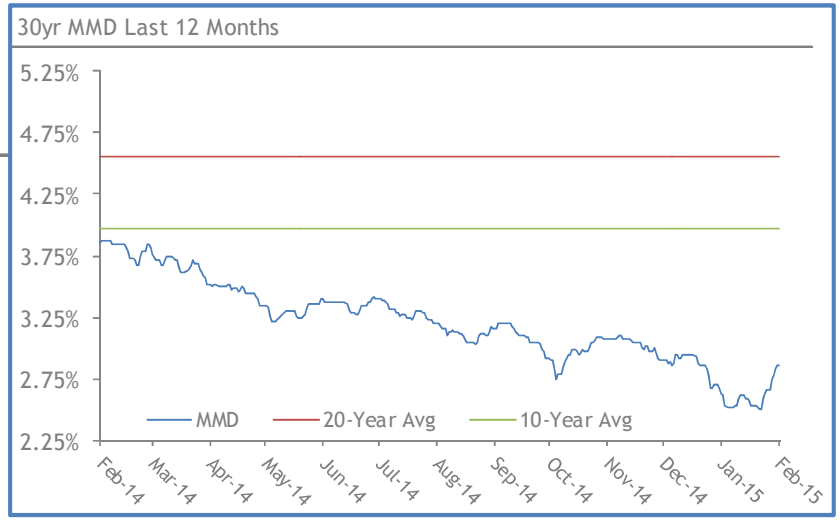
| | Martin Memorial | |
|---|---|---|
| | FY 2011 | Hist. Pro Forma |
| Net Patient Revenue (in 000s) | $ 328,260 | $ 328,260 |
| Days Cash on Hand | 126 | 112 |
| Long-Term Debt-to-Cap | 48.2% | 65.6% |
| Cash-to-Long Term Debt | 85.7% | 41.8% |
| Max Ann. DS Coverage | 3.37x | 2.50x |

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%



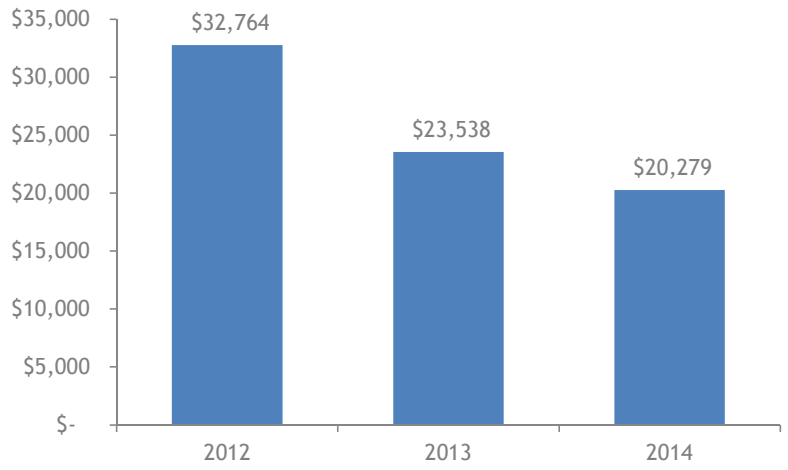




| Current | 2.88% |
|---|---|
| 10-Year Ave | 3.97% |
| 20-Year Ave | 4.56% |
| 20-Year Max | 6.10% |
| 20-Year Min | 2.47% |

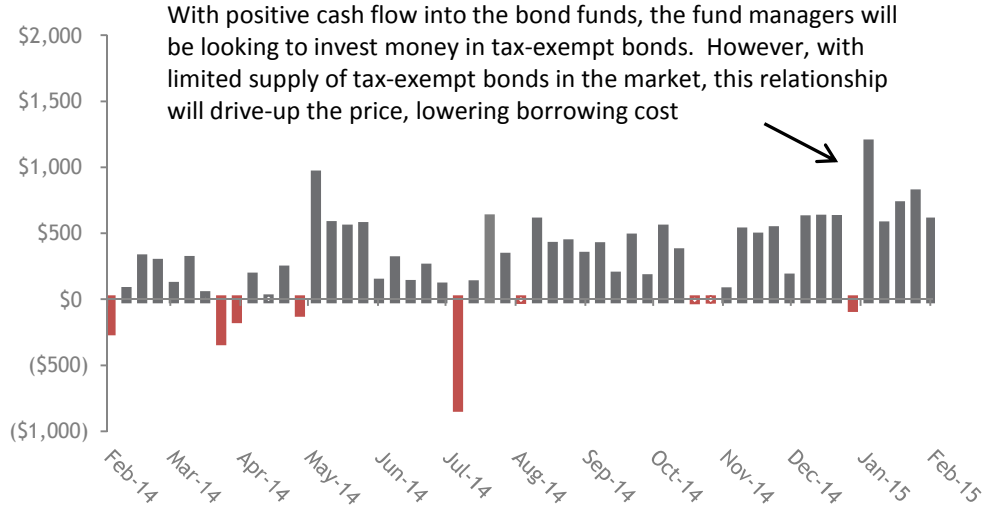
Source: Bloomberg, As of February 20, 2015

# 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
# 114

# NEWS Association for Healthcare Philanthropy

**April 3, 2008**
Contact: Kathy Renzetti (703) 532-6243, (571) 216-0146 or kathy@ahp.org
313 Park Avenue Falls Church, VA 22046
www.ahp.org

## Landmark Philanthropic Fundraising Studies Find Multiple Activities, Long-Term Donor Relationships, Are Keys to Success, AHP Performance Benchmarking Service Says

**WASHINGTON, D.C.**, (April 3, 2008) – A landmark new series of studies on philanthropic practices has found that today's most effective fundraisers use a variety of well-rounded programs and activities to raise money, shattering the myth that big ticket galas, golf tourneys and telethons are the only way to attract donors. The most successful fundraising programs have a sustained emphasis on building relationships and cultivating and maintaining major gift donors.

These are findings from The Association for Healthcare Philanthropy's (AHP) initial series of studies based on initial results of its Performance Benchmarking Service, which for the first time allows participating nonprofit hospitals and health care systems to systematically compare and contrast their fundraising efforts. Data were gathered from 31 U.S. and Canadian organizations.

"To meet the serious challenges placing financial strains on nonprofit health care systems, it is critical that philanthropic fundraisers adopt modern business practices such as benchmarking," said William McGinly, Ph.D, CAE, president and chief executive officer of AHP, whose members direct philanthropic programs in 2,200 of North America's not-for-profit health care providers.

"Effective and efficient fundraising is more important than ever. Americans are facing a recessionary economy in 2008 and nonprofits are facing heightened scrutiny by government agencies to justify their tax-exempt status," McGinly noted. "Meanwhile, the gap continues to grow between the costs hospitals must expend to treat the uninsured and under-insured and the level of reimbursement they can recover from public and private sources."

The benchmarking studies underscore the importance of a hospital or health care system's fundraising arm or foundation as a profit center worthy of appropriate resources that yield high net returns and balanced efficiency. Among the chief findings from the data:

- A wide assortment of fundraising programs, such as annual giving, special events, public support, major gifts and planned giving, yields higher charitable revenue. Conversely, when foundations emphasize only one or two programs, revenues are comparably lower.

- It takes time for investments in new fundraising programs to pay off. The lower and even negative returns reported for individual fundraising programs are largely a result of fresh upfront

investment in staff, materials and relationship-building activity that will yield higher returns and lower costs after three to five years.

- Major gifts and planned giving programs are at the core of successful fundraising programs. Hospitals and systems that have invested time and resources in major gifts from individuals, corporations and foundations, and through planned giving, yield higher overall returns than those who do not.

- High performers have a balanced approach to the full scope of fundraising programs. Strong focus and investment in high return/lower cost programming, paired with moderate focus on expensive but important programs that attract new donors, is part of the wisdom of this balancing act.

- Uncontrollable factors, such as geography, demographics and the size or structure of the health care facility, do not impact overall returns to the extent many previously believed.

- High performers stand out from the crowd based on their emphasis on high return fundraising programs. Data also paint of picture of leanness among high performing foundations that employ fewer professionals, while giving them greater responsibilities.

About the AHP Benchmarking Service

AHP ASSOCIATION FOR HEALTHCARE PHILANTHROPY
Connecting People • Enriching Lives

The AHP Performance Benchmarking Service is designed to improve corporate compliance and transparency for fundraising efforts and to ensure that dollars donated by grateful patients, their families and members of the community, are accounted for and spent effectively. Basic financial and program data are transformed into useful information that enables hospital CEOs and boards of directors to integrate philanthropy into their overall strategic planning for their health care organizations.

"The forward-looking hospitals and systems and their dedicated staffs who played a part in these initial studies invested a great deal of time and resources to demonstrate the value of benchmarking as a vital and exciting management tool," McGinly said.

Using benchmarking data, participating nonprofit hospitals, clinics and health care systems can compare their fundraising efforts with those of other facilities across the country. They can exchange and adopt the best ideas to encourage philanthropy and avoid pitfalls. Systematic data-gathering techniques and standard definitions eliminate "apples-vs.-oranges" problems that can arise when gauging one system's practices against another's.

AHP benchmarking participants are located in Alabama, Arizona, California, Florida, Georgia, Illinois, Maryland, Minnesota, Nebraska, New Jersey, New York, Oklahoma, Pennsylvania, Tennessee, Virginia, Washington, Wisconsin and the Canadian provinces of Ontario and Saskatchewan.

The Association for Healthcare Philanthropy, established in 1967, is a not-for-profit organization whose 4,600+ members direct philanthropic programs in 2,200 of North America's not-for-profit health care providers. AHP members provide essential service such as wellness programs; mobile

health vans; mammography screenings; hearing and eye exams; and other health care services. AHP is comprised of professionals in the fields of fundraising, development, public relations and marketing, as well as trustees, administrators, and executives interested in health care fundraising.

For a copy of the AHP Performance Benchmarking Service studies, a list of participating members, or to learn more about the program, visit the AHP Web site at www.ahp.org.

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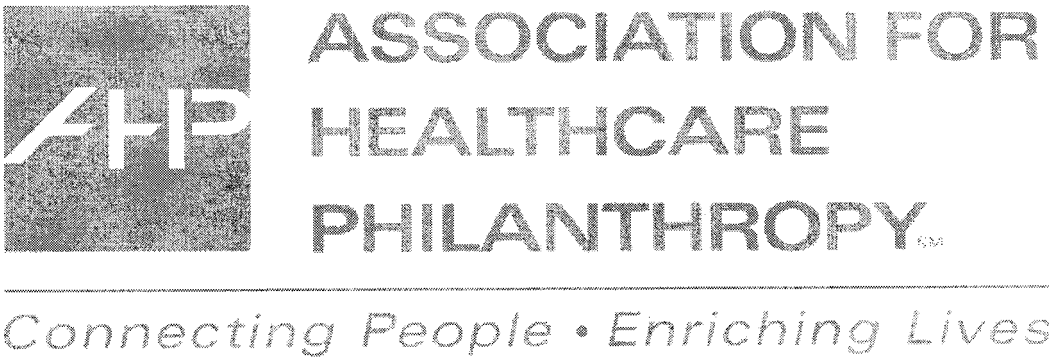


# EXHIBIT
# 115

# Financing Sustainability Projects on Campus

## Efficiency Services Agreements

An **Efficiency Services Agreement** (ESA) is a pay-for-performance financing solution that allows building owners to implement energy efficiency projects without any upfront capital expenditure. Under this power purchase agreement (PPA)-like structure for energy efficiency, an ESA provider pays for all development and construction costs. After a project is operational, the building owner uses a portion of the cost savings associated with reduced energy consumption to make periodic service payments over the ESA term. ESA payments vary by billing period according to the actual amount of achieved savings. Like a typical utility bill, ESA service payments are based on a measured quantity of energy units, i.e. kilowatt-hours of electricity and therms of natural gas. However, ESA service payments are based on energy units that are saved, enabling building owners to implement and repay energy efficiency measures with no additional capital or operational costs. The price per unit of energy savings is an output-based charge (e.g. $.08 per kWh of electricity saved) that is set at or below existing utility prices.

For each project, the ESA provider enters into the ESA directly with the building owner and pays a third-party contractor (for example, an ESCO) to engineer, implement and maintain the energy efficiency project. Although most ESA projects to date have been implemented with large ESCOs, the emergence of independent energy savings insurance products have opened the door for ESA providers to work with a broader range of contractors and energy service providers.

### Key features of an ESA generally include:

- ESA provider funds 100% of all design, engineering, and construction costs
- Projects can include a broad range of energy efficiency technologies and measures
- ESA provider owns and is responsible for ongoing maintenance services for all equipment, with customer buyout options available
- ESA provider recommends efficiency improvement projects during the ESA term (i.e., the ESA provider adds in new sources of savings/efficiency measures over time)
- After the ESA term expires, the customer has the option to purchase the equipment at fair market value

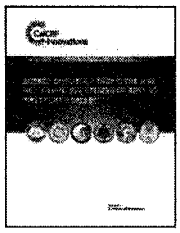
ESAs are designed to be treated as a services agreement and not as a lease, potentially allowing for off-balance sheet accounting treatment for the owner. Properly crafted ESAs are expected to maintain this treatment under future potential changes to lease accounting standards. However, each customer is responsible for making their own accounting review.

The ESA is similar to the **shared savings model**, in which an ESCO funds the cost of an energy efficiency project and the owner agrees to repay the ESCO using an agreed-upon percentage of measured and verified savings from the project. This model is not widely offered by ESCOs today.

### Benefits

- Owner can implement comprehensive efficiency upgrades with no upfront cost
- Cost of maintaining equipment (as well as measurement and verification of savings) is borne by ESA provider

## Resources



**Energy Efficiency Paying the Way: New Financing Strategies Remove First-Cost Hurdles** (p.23)
California Clean Energy Fund
Download the PDF

## Subtopics

- Revolving Loan Funds
- Tax Exempt Lease Purchase Agreements
- Power Purchase Agreements
- Efficiency Services Agreements
- Managed Utility Services Contracts

## External Resources

**Campus as a Living Lab: Using the Built Environment to Revitalize College Education**

**AASHE Financing Resources**

View all

- Owner has a significant degree of flexibility in negotiating the specific terms (e.g. contract length) of their ESA
- Turnkey approach in which the ESA provider is responsible for the time and resources required to develop a comprehensive project
- Owner is only responsible for making payments on savings that are realized
- ESA payments are an operating expense similar in nature to a regular utility bill, although each owner is responsible for conducting their own accounting review
- Treats energy efficiency as a resource; owners can redirect current utility expenses to cover ESA payments

**Challenges**

- Limited number of ESA providers in the market; model still in the proof of concept stage
- ESA terms generally do not exceed 12 years
- Projects generally need to be greater than $1mm
- Efficiency projects do not receive the same attractive tax benefits given to renewable energy projects
- Limited available sources of debt for ESA projects
- Lenders require a large ESCO performance guarantee or equivalent energy savings insurance

Back to Financing main page

*The proper role of colleges and universities is to lead the way by committing to climate neutrality, developing smart and farsighted plans to execute that goal, and equipping students for leadership in the challenges and opportunities ahead.*
—David W. Orr, Sears Professor, Oberlin College

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# EXHIBIT
# 116

*Project Roster & Status*

# PROJECT UPDATE

**Leases—Joint Project of the FASB and the IASB**

**Last updated on January 28, 2015. Please refer to the Current Technical Plan for information about the expected release dates of exposure documents and final standards.**

**(Updated sections are indicated with an asterisk *)**

*This project update summarizes the project activities and decisions of the FASB and the IASB (Boards). It was prepared by the staff and is for the information and convenience of their constituents. All decisions of the Boards are tentative, may change at future Board meetings, and do not change current accounting and reporting requirements. Decisions of the Boards become final only after extensive due process.*

Due Process Documents
Project Objective and Summary of the Proposed Model
Outreach/Field Work
*Decisions Reached at the Last Meeting
*Summary of Decisions Reached to Date
Next Steps
*Board/Other Public Meeting Dates
Background Information
*Contact Information

## DUE PROCESS DOCUMENTS

On May 16, 2013, the FASB issued a proposed Accounting Standards Update, *Leases (Topic 842): a revision of the 2010 proposed Accounting Standards Update, Leases (Topic 840).*

- Download the revised Exposure Draft.
- Read the press release introducing the proposed Update.
- Read the FAQ on the proposed Update.
- Listen Now or Download the Videocast on the proposed Update.
- Download the revised IASB Exposure Draft.
- Read the FASB In Focus and the IASB Snapshot, which provide summaries of the proposals contained in the revised proposals.
- Read the Exposure Draft Comment Letters.
- Read the Exposure Draft Feedback Summary.

## PROJECT OBJECTIVE AND SUMMARY OF THE PROPOSED MODEL

Leasing is an important activity for many organizations—whether a public or private company, or a not-for-profit organization. It is a means of gaining access to assets, obtaining financing, and reducing an organization's exposure to the risks of asset ownership. Many organizations lease assets such as real estate, airplanes, trucks, ships, and construction and manufacturing equipment. Because of the prevalence of leasing, it is important for users of financial statements to have a complete and understandable picture of an organization's leasing activities.

The existing accounting models for leases require lessees and lessors to classify their leases as either capital leases or operating leases and to account for those leases differently. Those models have been criticized for failing to meet the needs of users of financial statements because they do not always

provide a faithful representation of leasing transactions.

As a result, there has been a widespread request from users of financial statements and other stakeholders to change the accounting guidance so that lessees would be required to recognize assets and liabilities arising from leases.

In addition, the U.S. Securities and Exchange Commission (SEC) issued a report on off-balance sheet activities in 2005 and recommended that changes be made to the existing lease accounting requirements to ensure greater transparency in financial reporting. A number of academic studies have made similar recommendations.

The objective of the project is to increase transparency and comparability among organizations by recognizing lease assets and liabilities on the balance sheet and disclosing key information. This represents an improvement over existing leases standards, which do not require lease assets and lease liabilities to be recognized by many lessees.

A lessee would recognize assets and liabilities for leases with a lease term of more than 12 months.

**OUTREACH/FIELD WORK**

*Preparer Outreach*

The Boards and staff participated in fieldwork meetings, where members of the Boards and staff visited financial statement preparers, both public and nonpublic, lessees and lessors. During these meetings, the members of the Boards and staff met with more than 20 different companies, who provided detailed information about the types and volume of leases that they enter into, as well as the systems that they currently use to track their leases. The purpose of these meetings was for the Boards and staff to use the information provided by the preparers to obtain a detailed understanding of the practical application of the 2013 revised Exposure Draft to help them evaluate the costs of implementation and any potential ongoing compliance costs.

*Investor/Analyst Outreach*

The Boards and staff conducted outreach with investors and analysts in the months of May through September 2013. This outreach mainly focused on the lessee proposals, but the Boards and staff also received feedback on the lessor proposals. For a summary of investor and analyst feedback on the lessee proposals, click here.

*Public Roundtable Meetings*

The Boards hosted several public roundtable meetings on their revised joint proposals on leases that were published in May 2013: the revised proposed FASB Accounting Standards Update, *Leases* (Topic 842) and the IASB's Exposure Draft, *Leases*.

The roundtable meetings are an important part of the Boards' due process. The meetings provided an opportunity for those that submitted a comment letter to discuss the proposals with the Boards and staff in further detail. To ensure that they received input covering a variety of perspectives, the Boards and staff sought participation from preparers, auditors, investors, and others.

The public roundtable meetings were scheduled as follows:

- Tuesday, September 10th at Conselho Regional de Contabilidade do Estado de Sao Paulo in Sao Paulo, Brazil (one session)
  - An audio replay is available here.
- Monday, September 16th at the IASB Office in London, UK (two sessions)
  - An audio replay is available here.
- Monday, September 23rd at the FASB Office in Norwalk, Connecticut, USA (two sessions)

- An audio replay is available here.
- Thursday, October 3rd at Sheraton Gateway in Los Angeles, California, USA (two sessions, one of which was focused on nonpublic entities)
  - An audio replay is available here.
- Friday, October 4th at Suntec Singapore Convention & Exhibition Centre in Singapore (one session)
  - An audio replay is available here.

*Webcast*

On Monday, May 20, the Boards and staff hosted IN FOCUS: THE LEASES PROJECT, a live webcast taking place from 10:30 to 11:30 a.m. EDT (3:30 to 4:30 p.m. GMT). The webcast featured FASB member Russell Golden, IASB member Darrel Scott, and FASB and IASB staff members discussing the proposal and answering questions submitted by viewers.

***DECISIONS REACHED AT THE LAST MEETING (JANUARY 21, 2015)**

*Overall Disclosure Objective*

The Boards decided that the final leases standard should include a disclosure objective, which would be to enable users of financial statements to assess the amount, timing, and uncertainty of cash flows arising from leases. The Boards also decided to retain the 2013 ED proposal requiring a lessee to consider the level of detail necessary to satisfy the disclosure objective.

*Quantitative Disclosure Requirements*

The Boards decided not to retain the 2013 ED proposal requiring a lessee to disclose a reconciliation of the opening and closing balances of its lease liabilities. The IASB also decided not to retain the 2013 ED proposal requiring a lessee to disclose a reconciliation of the opening and closing balances of its right-of-use (ROU) assets.

The FASB decided to require a lessee to disclose the following quantitative items:

1. Type A lease expense, segregated between amortization of ROU assets and interest on lease liabilities.
2. Type B lease expense.
3. Short-term lease expense, excluding expenses relating to leases with a lease term of one month or less.
4. Variable lease expense.
5. Sublease income.
6. Cash paid for amounts included in the measurement of lease liabilities, segregated between operating and financing cash flows and between Type A and Type B leases.
7. Supplemental noncash information on lease liabilities arising from obtaining ROU assets, segregated between Type A and Type B leases.
8. Weighted-average remaining lease term, disclosed separately for Type A and Type B leases.
9. Weighted-average discount rate for Type B leases as of the reporting date.
10. Gains and losses arising from sale and leaseback transactions.

The FASB decided not to require a lessee to present lessee disclosures in a tabular format.

The FASB decided to clarify that the expense items disclosed would also include any amounts capitalized as part of the cost of another asset.

The IASB decided to require a lessee to disclose the following quantitative items:

1. Amortization of ROU assets, split by class of underlying asset.

2. Interest on lease liabilities.
3. Short-term lease expense, excluding expenses relating to leases with a lease term of one month or less.
4. Small asset lease expense.
5. Variable lease expense.
6. Income from subleasing ROU assets.
7. Total cash outflow for leases.
8. Additions to ROU assets.
9. Gains and losses arising from sale and leaseback transactions.
10. Closing carrying amount of ROU assets, split by class of underlying asset.

The IASB decided to require a lessee to present all lessee disclosures in a single note or separate section in its financial statements. The IASB also decided to require a lessee to present the quantitative lessee disclosures in a tabular format, unless another format is more appropriate.

The FASB decided to retain the 2013 ED proposal for a lessee to disclose a maturity analysis of its lease liabilities, showing the undiscounted cash flows on an annual basis for a minimum of each of the first five years and a total of the amounts for the remaining years, and reconciling the undiscounted cash flows to the discounted lease liabilities recognized in the statement of financial position.

The FASB decided not to retain the 2013 ED proposal requiring a lessee to disclose a maturity analysis of commitments for nonlease components related to a lease.

The FASB decided not to require a lessee to provide qualitative disclosures about the existence, and terms and conditions, of significant nonlease commitments it has taken on as a result of entering lease contracts.

The IASB decided that a lessee should be required to disclose a maturity analysis of its lease liabilities in accordance with paragraphs 39 and B11 of IFRS 7, *Financial Instruments: Disclosures*. A lessee would be required to disclose this maturity analysis separately from the maturity analyses of other financial liabilities.

*Qualitative Disclosure Requirements*

The FASB decided to retain the qualitative disclosure requirements proposed in the 2013 ED, requiring a lessee to disclose the following qualitative items:

1. Information about the nature of its leases (and subleases), including:
   a. A general description of those leases;
   b. The basis, and terms and conditions, on which variable lease payments are determined;
   c. The existence, and terms and conditions, of options to extend or terminate the lease. A lessee should provide narrative disclosure about the options that are recognized as part of the ROU assets and lease liabilities and those that are not;
   d. The existence, and terms and conditions, of residual value guarantees provided by the lessee; and
   e. The restrictions or covenants imposed by leases.
2. Information about leases that have not yet commenced but that create significant rights and obligations for the lessee.
3. Information about significant assumptions and judgments made in applying the requirements of the leases standards, which may include the following:
   a. The determination of whether a contract contains a lease;
   b. The allocation of the consideration in a contract between leases and nonlease components; and

c. The determination of the discount rate.

4. The main terms and conditions of any sale and leaseback transactions.
5. Whether an accounting policy election was made for the short-term lease exemption.

The FASB decided not to include disaggregation guidance, similar to the guidance in Topic 606 on revenue from contracts with customers, when describing the level of detail with which qualitative disclosures should be presented.

The IASB decided not to retain the qualitative disclosure requirements proposed in the 2013 ED and, instead, require a lessee to disclose sufficient additional information to satisfy the overall disclosure objective. The IASB decided to supplement this requirement with a list of specific disclosure objectives and to include illustrative examples in the final leases standard to demonstrate how a lessee might comply with this requirement.

*Nonpublic Business Entity Considerations*

The FASB decided not to provide any specified reliefs from the disclosure requirements for nonpublic business entities (that is, all other entities besides public business entities). Therefore, the lessee disclosure package is equally applicable to both public and nonpublic business entities.

***SUMMARY OF TENTATIVE DECISIONS REACHED TO DATE (AS OF JANUARY 21, 2015)**
**Accounting Models**

Lessee Accounting Model

The FASB decided on a dual approach for lessee accounting, with lease classification determined in accordance with the principle in existing lease requirements (that is, determining whether a lease is effectively an installment purchase by the lessee). Under this approach, a lessee would account for most existing capital/finance leases as Type A leases (that is, recognizing amortization of the right-of-use (ROU) asset separately from interest on the lease liability) and most existing operating leases as Type B leases (that is, recognizing a single total lease expense). Both Type A leases and Type B leases result in the lessee recognizing a ROU asset and a lease liability.

The IASB decided on a single approach for lessee accounting. Under that approach, a lessee would account for all leases as Type A leases (that is, recognizing amortization of the ROU asset separately from interest on the lease liability).

Lessor Accounting Model

The Boards decided that a lessor should determine lease classification (Type A versus Type B) on the basis of whether the lease is effectively a financing or a sale, rather than an operating lease (that is, on the concept underlying existing U.S. GAAP and on IFRS lessor accounting). A lessor would make that determination by assessing whether the lease transfers substantially all the risks and rewards incidental to ownership of the underlying asset. In addition, the FASB decided that a lessor should be precluded from recognizing selling profit and revenue at lease commencement for any Type A lease that does not transfer control of the underlying asset to the lessee. This requirement aligns the notion of what constitutes a sale in the lessor accounting guidance with that in Topic 606, which evaluates whether a sale has occurred from the customer's perspective.

*Lessor Type A Accounting*

For all Type A leases, a lessor will be required to apply an approach substantially equivalent to existing IFRS finance lease accounting (and U.S. GAAP sales type/direct financing lease accounting).

**Scope**

Definition of a Lease

The Boards decided that a lease should be defined as "a contract that conveys the right to use an asset (the underlying asset) for a period of time in exchange for consideration." An entity would determine whether a contract contains a lease by assessing whether:

1. The use of an identified asset is either explicitly or implicitly specified. A contract would not involve the use of an identified asset if a supplier has the substantive right to substitute the asset used to fulfill the contract. A supplier would have the substantive right to substitute an asset if:
   a. It has the practical ability to substitute the asset; and
   b. It can benefit from exercising that right of substitution.
2. The customer controls the use of the identified asset. A contract conveys the right to control the use of an identified asset if, throughout the period of use, the customer has the right to:
   a. Direct the use of the identified asset; and
   b. Obtain substantially all of the economic benefits from directing the use of the identified asset.

The Boards decided that a customer has the right to direct the use of an identified asset whenever it has the right to direct how and for what purpose the asset is used, including the right to change how and for what purpose the asset is used, throughout the period of use. If neither the customer nor the supplier controls how and for what purpose the asset is used throughout the period of use, the customer is considered to have the right to direct the use of the identified asset in *either* of the following circumstances:

1. The customer has the right to operate the asset or to direct others to operate the asset in a manner that it determines (with the supplier having no right to change those operating instructions); or
2. The customer designed the asset, or caused the asset to be designed, in a way that predetermines during the period of use:
   a. How and for what purpose the asset will be used; or
   b. How the asset will be operated.

In addition, the Boards decided that a supplier's protective rights over the identified asset typically define the scope of the customer's use of the asset but do not, in isolation, prevent the customer from having the right to direct the use of the asset.

Small-Ticket Leases

The Boards decided to permit the leases guidance to be applied at a portfolio level by lessees and lessors. The FASB decided to include the portfolio guidance in the basis for conclusions; the IASB decided to include the portfolio guidance in the application guidance.

The IASB decided to provide an explicit recognition and measurement exemption for leases of small assets for lessees.

Short-Term Leases (Lessee)

The Boards decided to retain the recognition and measurement exemption for a lessee's short-term leases. The Boards also decided that the short-term lease threshold should remain at 12 months or less. Additionally, the Boards decided to change the definition of a short-term lease so that it is consistent with the definition of lease term.

**Measurement**

Lease Term and Purchase Options

The Boards decided that, when determining the lease term, an entity should consider all relevant factors that create an economic incentive to exercise an option to extend, or not to terminate, a lease. An entity should include such an option in the lease term only if it is reasonably certain that the lessee will exercise the option having considered the relevant economic factors. Reasonably certain is a high threshold substantially the same as reasonably assured in existing U.S. GAAP. The Boards decided that a lessee should reassess the lease term only upon the occurrence of a significant event or a significant change in circumstances that are within the control of the lessee.

The Boards decided that a lessor should not be required to reassess the lease term.

The Boards decided that an entity should account for purchase options in the same way as options to extend, or not to terminate, a lease.

Variable Lease Payments

The Boards decided that only variable lease payments that depend on an index or a rate should be included in the initial measurement of lease assets and lease liabilities and that an entity should measure those payments using the index or rate at lease commencement.

The FASB decided that a lessee should reassess variable lease payments that depend on an index or a rate only when the lessee remeasures the lease liability for other reasons (for example, because of a reassessment of the lease term).

The IASB decided that a lessee should reassess variable lease payments that depend on an index or a rate when the lessee remeasures the lease liability for other reasons (for example, because of a reassessment of the lease term) and when there is a change in the cash flows resulting from a change in the reference index or rate (that is, when an adjustment to the lease payments takes effect).

The Boards decided that a lessor should not be required to reassess variable lease payments that depend on an index or a rate.

*In-Substance Fixed Payments*

The Boards decided (1) to retain the principle that variable lease payments that are in-substance fixed payments should be included in the definition of lease payments and provide additional clarifying guidance and (2) to note in the Basis for Conclusions that the concept that some variable lease payments are in-substance fixed payments exists under current practice.

Discount Rate

With respect to the determination of the discount rate, the Boards decided:

1. To clarify in the implementation guidance what "value" refers to in the definition of the lessee's incremental borrowing rate, but otherwise make no changes to the definition in the May 2013 Exposure Draft.
2. To describe the rate the lessor charges the lessee as the rate implicit in the lease, consistent with existing lessor guidance.
3. To include initial direct costs of the lessor in determining the rate implicit in the lease.

With respect to reassessment of the discount rate, the Boards decided:

1. To require a lessee to reassess the discount rate only when there is a change to either the lease term or the assessment of whether the lessee is (or is not) reasonably certain to exercise an option to purchase the underlying asset.
2. Not to require a lessor to reassess the discount rate.

Nonpublic Business Entity Discount Rate Considerations

The FASB decided to retain the accounting policy election to use the risk-free rate for nonpublic business entities (that is, all other entities beside public business entities).

Lease Modifications and Contract Combinations

The Boards decided to define a lease modification as any change to the contractual terms and conditions of a lease that was not part of the original terms and conditions of the lease and that the substance of the modification should govern over its form.

The Boards decided that both a lessee and a lessor should account for a lease modification as a new lease, separate from the original lease, when (1) the lease grants the lessee an additional right-of-use not included in the original lease and (2) the additional right-of-use is priced commensurate with its standalone price (in the context of that particular contract).

For lease modifications that are not accounted for as separate new leases, the Boards decided that:

1. When a lease modification results in a change in the scope or consideration of the lease, a lessee should remeasure the lease liability using a discount rate determined at the effective date of the modification. For modifications that increase the scope of, or change the consideration paid for, the lease, the lessee should make a corresponding adjustment to the right-of-use asset. For modifications that decrease the scope of the lease, the lessee should decrease the carrying amount of the right-of-use asset to reflect the partial or full termination of the lease and should recognize a gain or a loss on a proportionate basis to the decrease in scope.
2. A lessor should account for (a) modifications to a Type B lease as, in effect, a new lease from the effective date of the modification, considering any prepaid or accrued lease rentals relating to the original lease as part of the lease payments for the modified lease and (b) modifications to a Type A lease in accordance with IFRS 9, *Financial Instruments* (IFRS), or Topic 310, Receivables (U.S. GAAP).

The Boards decided to include contract combination guidance in the final leases standard, similar to that which is included in Topic 606, that would indicate when two or more contracts should be considered a single transaction.

Separating Lease and Nonlease Components

The Boards decided to retain guidance similar to that proposed in the 2013 Exposure Draft for both lessees and lessors on identifying separate lease components.

The Boards decided to retain guidance similar to that proposed in the 2013 Exposure Draft for lessors on separating lease components from nonlease components and allocating consideration in the contract to those components. That is, a lessor should apply the guidance in Topic 606 on allocating the transaction price to separate performance obligations. A lessor also should reallocate the consideration in a contract when there is a contract modification that is not accounted for as a separate, new contract.

The Boards decided to change the proposals in the 2013 Exposure Draft for lessees regarding separating lease components from nonlease components and allocating consideration in a contract to those components as follows:

1. A lessee should separate lease components from nonlease components unless it applies the accounting policy election discussed below.
2. A lessee should allocate the consideration in a contract to the lease and nonlease components on a relative standalone price basis. Activities (or costs of the lessor) that do not transfer a good or service to the lessee are not components in a contract. A lessee also should reallocate the consideration in a contract when (a) there is a reassessment of either the lease term or a lessee's purchase option or (b) there is a contract modification that is not accounted for as a separate, new contract.

3. A lessee should use observable standalone prices, if available, and otherwise it would use estimates of the standalone price for lease and nonlease components (maximizing the use of observable information).

The Boards decided to permit a lessee, as an accounting policy election by class of underlying asset, to not separate lease components from nonlease components. Instead, a lessee should account for lease and nonlease components together as a single lease component.

Initial Direct Costs

The Boards decided that only incremental costs should qualify as initial direct costs.

The Boards decided that initial direct costs should include only incremental costs that an entity would not have incurred if the lease had not been obtained (executed) (for example, commissions or payments made to existing tenants to obtain the lease).

The Boards decided that both lessees and lessors should apply the same definition of initial direct costs.

The Boards decided the following regarding the accounting for initial direct costs:

1. A lessor in a Type A lease (except those who recognize selling profit at lease commencement) should include initial direct costs in the initial measurement of the lease receivable by taking account of those costs in determining the rate implicit in the lease. A lessor who recognizes selling profit at lease commencement should recognize initial direct costs associated with a Type A lease as an expense at lease commencement.
2. A lessor in a Type B lease should recognize initial direct costs as an expense over the lease term on the same basis as lease income.
3. A lessee should include initial direct costs in the initial measurement of the right-of-use asset and amortize those costs over the lease term.

Subleases

The Boards decided that an intermediate lessor (that is, an entity that is both a lessee and a lessor of the same underlying asset) should account for a head lease and a sublease as two separate contracts (accounting for the head lease in accordance with the lessee accounting proposals and the sublease in accordance with the lessor accounting proposals), unless those contracts meet the contract combinations guidance adopted by the Boards at the April 2014 joint Board meeting.

The FASB decided that, when classifying a sublease, an intermediate lessor should determine the classification of the sublease with reference to the underlying asset (for example, the item of property, plant, and equipment that is the subject of the lease), rather than with reference to the ROU asset arising from the head lease.

The IASB decided that, when classifying a sublease, an intermediate lessor should determine the classification of the sublease with reference to the ROU asset arising from the head lease. The Boards decided that an intermediate lessor should not offset lease assets and lease liabilities arising from a head lease and a sublease that do not meet the respective IFRS and GAAP financial instruments requirements for offsetting.

The Boards decided that an intermediate lessor should not offset lease income and lease expense related to a head lease and a sublease, unless it recognizes sublease income as revenue and acts as an agent (assessed in accordance with the "principal-agent" guidance in Topic 606 on revenue from contracts with customers).

Sale and Leaseback Transactions

*Determining Whether a Sale Has Occurred*

The Boards decided to retain the guidance in the 2013 Exposure Draft that in order for a sale to occur in the context of a sale and leaseback transaction, the sale must meet the requirements for a sale in Topic 606. The Boards reaffirmed that the presence of the leaseback does not, in isolation, preclude the seller-lessee from concluding that it has sold the underlying asset to the buyer-lessor.

The FASB decided that if the seller-lessee determines that the leaseback is a Type A lease, assessed from the seller-lessee's perspective, then no sale has occurred.

The IASB decided not to include any additional application guidance in the final leases standard regarding the determination of the sale. The IASB clarified, however, that if the seller-lessee has a substantive repurchase option with respect to the underlying asset, then no sale has occurred.

*Accounting for the Sale/Purchase*

The Boards decided to retain the guidance in the 2013 Exposure Draft that a buyer-lessor should account for the purchase of the underlying asset consistent with the guidance that would apply to any other purchase of a nonfinancial asset (that is, without the presence of the leaseback).

The Boards decided to retain the guidance in the 2013 Exposure Draft that a seller-lessee should account for any loss on a completed sale in a sale and leaseback transaction consistent with the guidance that would apply to any other similar sale.

The FASB decided to retain the guidance in the 2013 Exposure Draft that a seller-lessee should account for any gain on a completed sale in a sale and leaseback transaction consistent with the guidance that would apply to any other similar sale.

The IASB decided that the gain recognized by a seller-lessee on a completed sale in a sale and leaseback transaction should be restricted to the amount of the gain that relates to the residual interest in the underlying asset at the end of the leaseback.

*Repurchase Options in a Sale and Leaseback Transaction*

The FASB decided to follow the guidance in Topic 606 and clarify that a repurchase option exercisable only at the then-prevailing fair market value would not preclude sale treatment, provided that the underlying asset is nonspecialized and readily available in the marketplace. The repurchase option must be substantive in order to affect the accounting for the transaction. In reaching this decision, some FASB members thought that this application was consistent with language provided in the basis for conclusions of Topic 606.

*Application Guidance for Determining Whether a Sale Has Occurred*

The FASB decided to include application guidance, with respect to determining whether a sale occurs in the context of a sale and leaseback transaction, in the final leases standard.

*Accounting for the Leaseback*

The Boards decided to retain the guidance in the 2013 Exposure Draft that if a sale is completed, the seller-lessee and the buyer-lessor should account for the leaseback in the same manner as any other lease.

*Accounting for "Off-Market" Terms*

The Boards decided that an entity should determine any potential "off-market" adjustment on the basis of the difference between either (1) the sale price and the fair value of the underlying asset or (2) the present value of the contractual lease payments and the present value of fair market value lease payments, whichever is more readily determinable.

For sale and leaseback transactions entered into at "off-market" terms, the Boards decided that an entity should account for:

1. Any deficiency in the same manner as a prepayment of rent.
2. Any excess as additional financing provided by the buyer-lessor to the seller-lessee.

*Accounting for Failed Sale and Leaseback Transactions*

The IASB decided to retain the guidance proposed in the 2013 Exposure Draft that both a seller-lessee and a buyer-lessor would account for a "failed" sale and leaseback transaction as a financing transaction.

The FASB decided that if a sale and leaseback transaction does not result in a sale, the "failed" sale should be accounted for as a financing transaction by the seller-lessee and buyer-lessor.

Related Party Leasing Transactions

The FASB decided to retain the related party leases guidance proposed in the 2013 Exposure Draft. The FASB reaffirmed that lessees and lessors should be required to account for their related party leases on the basis of the legally enforceable terms and conditions of the lease.

Leveraged Leases

The FASB reaffirmed the proposal in the 2013 Exposure Draft that leveraged lease accounting should be eliminated. That is, the lessor should account for leases that currently qualify as leveraged leases consistent with all other leases within the new leases guidance.

The FASB decided that existing leveraged leases should be grandfathered during transition.

**Presentation**

Balance Sheet Presentation

*Lessee ROU Asset*

The FASB decided that a lessee should either present as separate line items on the balance sheet or disclose in the notes Type A ROU assets (which are effectively purchases of the underlying asset) and Type B ROU assets. If a lessee does not present Type A ROU assets or Type B ROU assets as separate line items on the balance sheet, the lessee should disclose in the notes which line items in the balance sheet include Type A ROU assets and Type B ROU assets. A lessee is prohibited from presenting Type A ROU assets within the same line item as Type B ROU assets.

The IASB decided that a lessee should either present as a separate line item on the balance sheet or disclose in the notes ROU assets. If a lessee does not present ROU assets as a separate line item on the balance sheet, the lessee should present ROU assets within the same line item as the corresponding underlying assets would be presented if they were owned, and disclose in the notes which line item in the balance sheet includes ROU assets.

*Lessee Lease Liability*

The FASB decided that a lessee should either present as separate line items on the balance sheet or disclose in the notes Type A lease liabilities and Type B lease liabilities. If a lessee does not present Type A lease liabilities or Type B lease liabilities as separate line items on the balance sheet, the lessee should disclose in the notes which line items in the balance sheet include Type A lease liabilities and Type B lease liabilities. A lessee is prohibited from presenting Type A lease liabilities within the same line item as Type B lease liabilities.

The IASB decided that a lessee should either present as a separate line item on the balance sheet or

disclose in the notes lease liabilities. If a lessee does not present lease liabilities as a separate line item on the balance sheet, the lessee should disclose in the notes which line item in the balance sheet includes lease liabilities.

Cash Flow Presentation

*Lessee*

The FASB decided to retain the guidance in the 2013 Exposure Draft requiring a lessee to classify:

1. Cash payments for the principal portion of the lease liability arising from Type A leases within financing activities
2. Cash payments for the Interest portion of the lease liability arising from Type A leases within operating activities
3. Cash payments arising from Type B leases within operating activities.

The IASB decided to retain the guidance in the 2013 Exposure Draft for Type A leases requiring a lessee to classify:

1. Cash payments for the principal portion of the lease liability within financing activities
2. Cash payments for the interest portion of the lease liability in accordance with the requirements relating to interest paid in IAS 7, Statement of Cash Flows.

The IASB also decided to require a lessee to disclose a single figure for lease cash outflows elsewhere in the financial statements.

*Lessor*

The Boards decided to retain the guidance in the 2013 Exposure Draft requiring a lessor to classify cash receipts from leases within operating activities.

***Disclosures***

Lessee

*Overall Disclosure Objective*

The Boards decided that the final leases standard should include a disclosure objective, which would be to enable users of financial statements to assess the amount, timing, and uncertainty of cash flows arising from leases. The Boards also decided to retain the 2013 ED proposal requiring a lessee to consider the level of detail necessary to satisfy the disclosure objective.

*FASB Qualitative Disclosure Requirements*

The FASB decided to retain the qualitative disclosure requirements proposed in the 2013 ED, requiring a lessee to disclose the following qualitative items:

1. Information about the nature of its leases (and subleases), including:
    a. A general description of those leases;
    b. The basis, and terms and conditions, on which variable lease payments are determined;
    c. The existence, and terms and conditions, of options to extend or terminate the lease. A lessee should provide narrative disclosure about the options that are recognized as part of the ROU assets and lease liabilities and those that are not;
    d. The existence, and terms and conditions, of residual value guarantees provided by the lessee; and
    e. The restrictions or covenants imposed by leases.

2. Information about leases that have not yet commenced but that create significant rights and obligations for the lessee.
3. Information about significant assumptions and judgments made in applying the requirements of the leases standards, which may include the following:
   a. The determination of whether a contract contains a lease;
   b. The allocation of the consideration in a contract between leases and nonlease components; and
   c. The determination of the discount rate.
4. The main terms and conditions of any sale and leaseback transactions.
5. Whether an accounting policy election was made for the short-term lease exemption.

The FASB decided if the short-term lease expense does not reflect the lessee's short-term lease commitments, a lessee should disclose that fact and the amount of its short-term lease commitments.

*IASB Qualitative Disclosure Requirements*

The IASB decided not to retain the qualitative disclosure requirements proposed in the 2013 ED and, instead, require a lessee to disclose sufficient additional information to satisfy the overall disclosure objective. The IASB decided to supplement this requirement with a list of specific disclosure objectives and to include illustrative examples in the final leases standard to demonstrate how a lessee might comply with this requirement.

*FASB Quantitative Disclosure Requirements*

The FASB decided not to retain the 2013 ED proposal requiring a lessee to disclose a reconciliation of the opening and closing balances of its lease liabilities.

The FASB decided to require a lessee to disclose the following quantitative items:

1. Type A lease expense, segregated between amortization of ROU assets and interest on lease liabilities.
2. Type B lease expense.
3. Short-term lease expense, excluding expenses relating to leases with a lease term of one month or less.
4. Variable lease expense.
5. Sublease income.
6. Cash paid for amounts included in the measurement of lease liabilities, segregated between operating and financing cash flows and between Type A and Type B leases.
7. Supplemental noncash information on lease liabilities arising from obtaining ROU assets, segregated between Type A and Type B leases.
8. Weighted-average remaining lease term, disclosed separately for Type A and Type B leases.
9. Weighted-average discount rate for Type B leases as of the reporting date.
10. Gains and losses arising from sale and leaseback transactions.

The FASB decided to clarify that the expense items disclosed would also include any amounts capitalized as part of the cost of another asset.

The FASB decided to retain the 2013 ED proposal for a lessee to disclose a maturity analysis of its lease liabilities, showing the undiscounted cash flows on an annual basis for a minimum of each of the first five years and a total of the amounts for the remaining years, and reconciling the undiscounted cash flows to the discounted lease liabilities recognized in the statement of financial position.

The FASB decided not to retain the 2013 ED proposal requiring a lessee to disclose a maturity analysis of commitments for nonlease components related to a lease.

*IASB Quantitative Disclosure Requirements*

The IASB decided not to retain the 2013 ED proposal requiring a lessee to disclose a reconciliation of the opening and closing balances of its lease liabilities. The IASB decided not to retain the 2013 ED proposal requiring a lessee to disclose a reconciliation of the opening and closing balances of its ROU assets.

The IASB decided to require a lessee to disclose the following quantitative items:

1. Amortization of ROU assets, split by class of underlying asset.
2. Interest on lease liabilities.
3. Short-term lease expense, excluding expenses relating to leases with a lease term of one month or less.
4. Small asset lease expense.
5. Variable lease expense.
6. Income from subleasing ROU assets.
7. Total cash outflow for leases.
8. Additions to ROU assets.
9. Gains and losses arising from sale and leaseback transactions.
10. Closing carrying amount of ROU assets, split by class of underlying asset.

The IASB decided to require a lessee to present all lessee disclosures in a single note or separate section in its financial statements. The IASB also decided to require a lessee to present the quantitative lessee disclosures in a tabular format, unless another format is more appropriate.

The IASB decided that a lessee should be required to disclose a maturity analysis of its lease liabilities in accordance with paragraphs 39 and B11 of IFRS 7, *Financial Instruments: Disclosures*. A lessee would be required to disclose this maturity analysis separately from the maturity analyses of other financial liabilities.

*Nonpublic Business Entity Considerations*

The FASB decided not to provide any specified reliefs from the disclosure requirements for nonpublic business entities (that is, all other entities besides public business entities). Therefore, the lessee disclosure package is equally applicable to both public and nonpublic business entities.

Lessor

The Boards decided that a lessor should be required to disclose:

1. Information about the nature of its leases, as well as information about significant assumptions and judgments made in applying the leases requirements;
2. A table of lease income during the reporting period; and
3. Information about how a lessor manages its risk associated with the residual value of its leased assets.

The Boards decided that a lessor should treat assets subject to Type B leases as a class of property, plant, and equipment (IFRS) or a major class of depreciable assets (U.S. GAAP), further distinguished by significant class of underlying asset. Accordingly, a lessor should provide the required property, plant, and equipment disclosures for assets subject to Type B leases separately from owned assets held and used by the lessor.

The Boards also decided that a lessor should be required to disclose:

1. For Type A leases, a maturity analysis of the undiscounted cash flows that comprise the lessor's lease receivables for each of the first five years following the reporting date and a total of the amount for the remaining years thereafter. A lessor should reconcile the maturity analysis to the balance of lease receivables presented separately in the balance sheet or disclosed separately in the notes; and
2. For Type B leases, a maturity analysis of the undiscounted future lease payments to be received for each of the first five years following the reporting date and a total of the amount for the remaining years thereafter.

The FASB decided that a lessor should be required to provide an explanation of the significant changes in the components of the net investment in Type A leases other than the lease receivable during the reporting period. The FASB will consider disclosures related to Type A lease receivables when it discusses disclosures in its project on accounting for financial instruments—credit impairment.

The IASB decided that a lessor should be required to provide a qualitative and quantitative explanation of the significant changes in the net investment in Type A leases during the reporting period.

Related Party

The FASB decided that lessees and lessors should be required to apply the disclosure requirements for related party transactions in accordance with Topic 850.

**NEXT STEPS**

The Boards will continue their joint redeliberations of the May 2013 Exposure Draft.

Please see the Current Technical Plan for more information about the project timeline.

***BOARD/OTHER PUBLIC MEETING DATES (AFTER THE ISSUANCE OF THE 2013 EXPOSURE DRAFT)**

*The IASB meeting summaries and FASB meeting minutes are provided for the information and convenience of constituents who want to follow the Boards' deliberations. All of the conclusions reported are tentative and may be changed at future Board meetings. Decisions become final only after a formal written ballot to issue a final Accounting Standards Update.*

(View list of meetings prior to the issuance of the Exposure Draft)

| Topic | IASB Meeting Summaries and Observer Notes | FASB Board Minutes |
|---|---|---|
| **Joint IASB/FASB Board Meeting**<br>The Boards discussed lessee disclosure requirements. | January 2015 | January 21, 2015 |
| **Joint IASB/FASB Board Meeting**<br>The Boards discussed definition of a lease. | December 2014 | December 16, 2014 |
| **Joint IASB/FASB Board Meeting**<br>The Boards discussed definition of a lease. | October 2014 | October 22, 2014 |
| **FASB-only Board Meeting**<br>The FASB discussed nonpublic business entity discount rate considerations, related party leasing transactions, accounting for sale and leaseback transactions, and leveraged leases. | N/A | August 27, 2014 |

| | | |
|---|---|---|
| **Joint IASB/FASB Board Meeting**<br>The Boards discussed sale and leaseback transactions and lessor disclosure requirements. | July 2014 | July 23, 2014 |
| **Joint IASB/FASB Board Meeting**<br>The Boards discussed subleases, lessee balance sheet presentation, and cash flow presentation. | June 2014 | June 18, 2014 |
| **Joint IASB/FASB Board Meeting**<br>The Boards discussed definition of a lease, separating lease and nonlease components, and initial direct costs. | May 2014 | May 22, 2014 |
| **Joint IASB/FASB Board Meeting**<br>The Boards discussed lease modifications and contract combinations, variable lease payments, in-substance fixed payments, and discount rate. | April 2014 | April 23, 2014 |
| **Joint IASB/FASB Board Meeting**<br>The Boards discussed the lessee accounting model, the lessor accounting model, small ticket leases, lease term, and short-term leases. | March 2014 | March 18-19, 2014 |
| **Joint IASB/FASB Board Meeting**<br>The Boards began their redeliberations of the proposals included in the May 2013 Exposure Draft, *Leases*. | January 2014 | January 23, 2014 |
| **Joint IASB/FASB Board Meeting**<br>The Boards discussed a summary of feedback received on the leases project through outreach activities, roundtable meetings, and comment letters. The Boards also discussed the plans for redeliberations. | November 2013 | November 20, 2013 |

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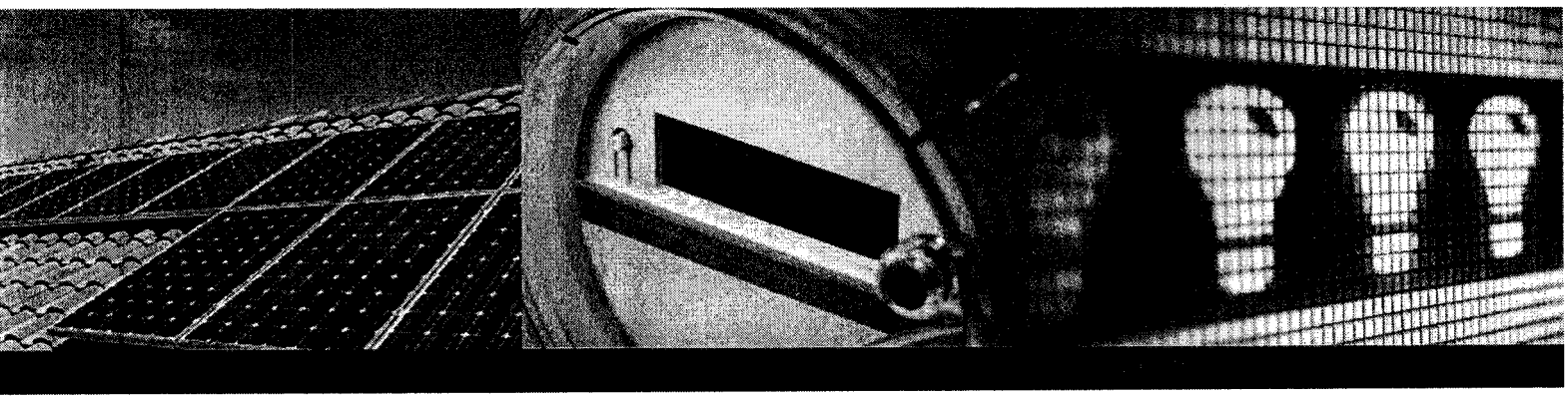
# EXHIBIT
# 117



# Innovations and Opportunities in Energy Efficiency Finance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**MAY 2012**
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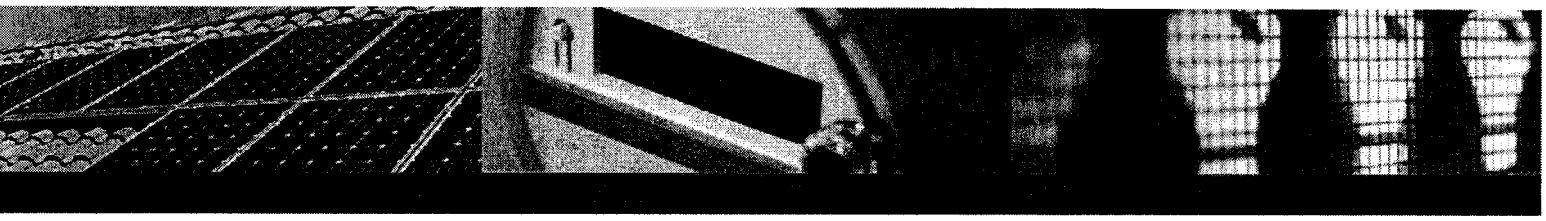

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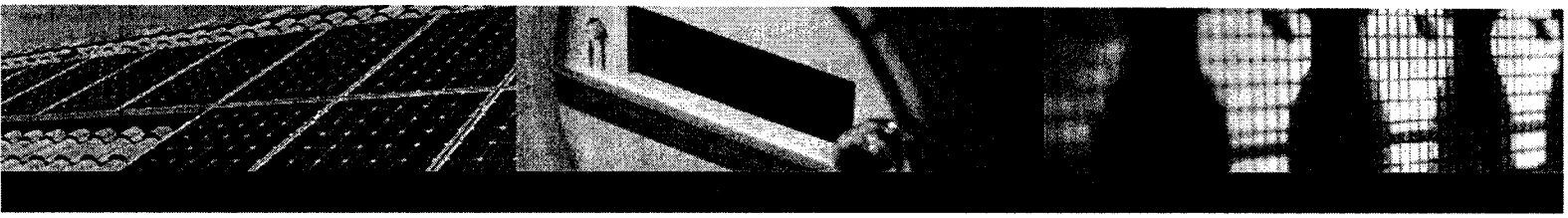
[1]The MESA structure was pioneered by Transcend Equity, which was acquired in 2012 by SCIenergy, and MESA is a trademark of SCIenergy.



# Introduction

The purpose of this white paper is to discuss key concepts in energy efficiency finance, with a focus on emerging solutions to long-standing barriers to financing projects in the United States, as well as the specific challenges posed by energy efficiency projects, and the potentially scalable solutions that have recently gained some market traction. Although this primer is principally written for readers not yet familiar with the details of energy efficiency finance who would like to achieve a working knowledge of the main concepts, issues, and developing solutions, this paper also presents a useful précis for readers already steeped in the details of energy efficiency finance.

Energy efficiency has long been recognized as the "low-hanging fruit" in delivering a clean energy economy, especially when compared to investments in capital-intensive energy generation technologies. According to the U.S. Department of Energy, buildings account for approximately 40 percent of total U.S. energy costs, which amounts to $400 billion each year for residential and commercial buildings alone. Reducing energy use in U.S. buildings by 20 percent would save approximately $80 billion annually on energy bills, and savings from commercial buildings would account for half of this amount, or $40 billion.[i]

Tapping into this enormous potential for energy efficiency projects to cost-effectively lower energy consumption would help create new investment opportunities, drive economic growth, reduce air pollution and greenhouse gas emissions, increase economic efficiency and productivity, create jobs, and advance energy security. Despite these benefits, advanced energy efficiency improvements and technologies have not yet been widely adopted.

This is changing now.

Recent innovations in energy efficiency finance and the development of new business models to address the first-time cost issue and other historical market barriers have begun to accelerate this sector's growth, and billions of dollars in project opportunities are being driven by renewed investor interest and important legislative changes. Federal mandates, state-level regulatory proceedings, and state-level financing support, in concert with innovative financing methods, are mobilizing capital for energy efficiency projects and further mitigating project-level risks.

An expanding menu of energy efficiency finance strategies is also encouraging more rapid adoption of cutting-edge technologies related to energy efficiency, such as smart grid hardware and software, energy information management and sensor controls, demand response, energy storage, super efficient lighting, and other building mechanical and electrical equipment, as well as distributed renewable generation technologies. These technologies, in turn, can facilitate more solutions to existing challenges in implementing energy efficiency projects on a larger scale.

This primer provides an overview of five major energy efficiency finance models prevalent today in the United States:

(1) the energy savings performance contract (ESPC) model implemented by an energy service company (ESCO);

(2) the energy services agreement (ESA) model;
(3) the managed energy services agreement (MESA) model;
(4) the Property Assessed Clean Energy (PACE) model; and
(5) on-bill financing and on-bill repayment (OBF/OBR) approaches.

It also provides an analysis of the main challenges, legal considerations, and opportunities associated with scaling and deploying these models. While many other energy efficiency finance options also exist, these five models are among those attracting significant interest from both private-sector and public-sector stakeholders. This paper outlines an evolving roadmap, which we will update periodically as significant innovations in energy efficiency finance continue to be developed and refined.

# I. An Introduction to Energy Efficiency Finance

## A. What is Energy Efficiency Finance?

The objective of energy efficiency finance is to provide building owners with a cost-effective alternative to using their own cash on hand for the purchase or installation of energy efficiency improvements. Energy efficiency finance structures provide building owners with access to up-front capital and financing for a specific set of facility energy improvements, which are then repaid over time as energy savings are generated. Numerous financing structures propose different arrangements for how and when the cash flows from energy savings are shared among the finance provider, customer, end-user, or other project investors. The suitability of a particular financing model often depends on a combination of factors, from project size and anticipated payback period to utility incentives/rebates and security features, to name but a few.

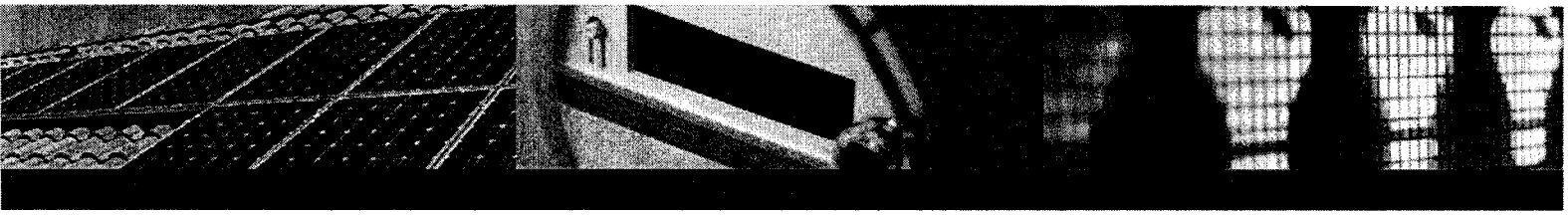
No single "silver bullet" for financing energy efficiency projects has yet emerged. Instead, various energy efficiency finance models have developed to address the particular needs of specific end-user and customer markets, which may be generally categorized as follows:

1. Municipalities, universities, schools, and hospitals (often dubbed the "MUSH" market)
2. Commercial and industrial businesses
3. Residential customers

### *1. The MUSH market*

The MUSH market generally refers to properties that are owned and operated by government entities and by nonprofit institutions, such as municipal buildings, universities, other schools, and nonprofit hospitals. These governmental and institutional properties typically have tight operating budgets, but may be able to more easily access tax-exempt municipal leases or bonds to finance energy efficiency capital improvements.

While this market segment has access to a wide range of energy efficiency finance options, such as general obligation municipal bonds or state or local government loans funded by bonds, and federally subsidized finance tools such as Qualified Energy Conservation Bonds, tax-exempt lease financing is currently the most common tool to finance energy efficiency projects, installed usually by ESCOs. Indeed,



ESCOs derive more than half of their revenues from the MUSH segment.[ii] Recently, more MUSH building segment owners have been examining alternative approaches to the ESPC/ESCO model commonly used to finance energy efficiency projects, such as the ESA and MESA models. Each of the ESPC, ESA, and MESA financing structures is discussed in further detail in Section II.

The MUSH segment is beginning to circle back to a more "energy services"-oriented financing model, which was first introduced in the U.S. in the 1980s but then gradually lost market share in favor of the ESPC structure. Thirty years later, through an energy services contract such as an ESA or MESA, some ESCOs or project developers are once again sharing the amount of energy savings with the property owner. These financing models encourage the ESCO or project developer to minimize the capital investment required and to maximize the energy savings achieved.[iii]

### *2. Commercial and industrial market*

The commercial and industrial market segment includes a range of end-users: industrial users, small and large commercial businesses, other commercial real estate, and market-rate multifamily (defined as five or more) units. While this market segment encompasses several different kinds of properties, from a financing perspective, these end-user groups often have similar economic objectives.

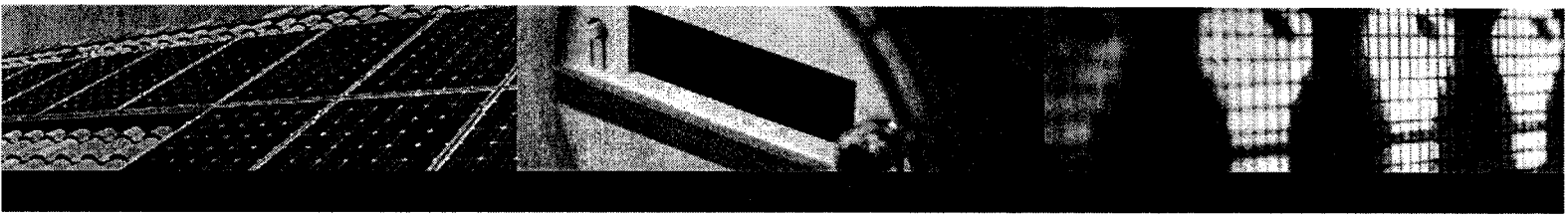
This market segment presents a huge opportunity, accounting for 65 percent of the total end-use efficiency potential in the U.S., according to a recent report by McKinsey & Company.[iv] Possible funding sources in the commercial and industrial market include traditional bank loans, self-funding for large corporations, loans funded by bonds, commercial PACE financing, on-bill utility financing, lease financing options, the ESPC/ESCO model, ESA financing, and MESA models.

### *3. Residential market*

In the single-family residential sector, traditional sources of funding, such as unsecured loans and credit and home equity lines of credit, are the primary means for financing energy retrofits in most parts of the country. In addition, utility or state-administered rebates supplemented by federal and state funds are being used to finance relatively "low tech" projects such as window and door replacements, sealing and insulation, HVAC, and appliance upgrades. New and innovative models for financing energy efficiency are beginning to emerge, including PACE and OBF/OBR. The use of PACE in the residential sector is currently on hold pending the resolution of a rulemaking proceeding at the Federal Housing Finance Agency (FHFA) and related litigation. California is exploring the use of On Bill Repayment in the multi-family residential sector, and New York's On-Bill Repayment program provides loans to retrofit both single-family and multi-family residential buildings. The PACE and OBF/OBR models and the associated legal issues are discussed in greater detail below.

## B. Energy Efficiency Finance – Risks and Returns

Like many renewable energy projects, energy efficiency projects involve many stakeholders, including end-users, technology providers, engineering procurement and construction (EPC) firms, project developers, investors, financiers, and utilities. Given this mix, energy efficiency projects and financing arrangements can quickly become complex due to diverse stakeholder interests and the introduction of

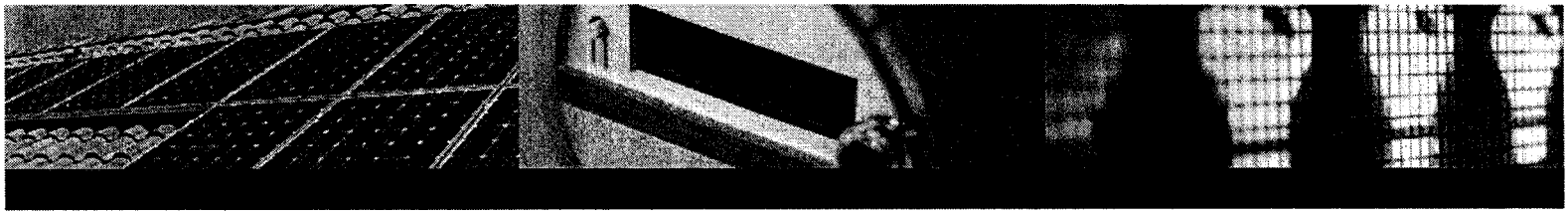


new technologies and regulatory and incentive structures. In addition, up-front capital costs, long payback periods, or performance risk aversion can discourage energy efficiency investments, even when capital for energy efficiency projects is available. Navigating and integrating financing from multiple and often complex sources (e.g., private investors, utilities, governmental sources) to address some of these challenges is further complicated by the fact that applicable regulations and incentives vary drastically from state to state and continue to evolve at the federal level. This complexity often results in high transaction costs, especially in the more fragmented commercial and residential segments. However, new financing and business models have emerged to better address these issues, alleviating some of the pain points associated with payback periods and up-front capital investments borne by the customer.

A successful energy efficiency finance structure incentivizes each of the major stakeholders involved, and balances the relative risks of implementing energy efficiency improvements with the resulting energy savings returns and benefits. Each of the five energy efficiency finance models examined in this paper achieves this balance in a different way, and addresses the following major issues to varying degrees:

| | |
|---|---|
| First-Cost Hurdle | •How to finance the initial capital investment in energy efficiency measures at little or no up-front cost to the end-user<br>•How to enable and incentivize the use of more efficient but potentially more expensive upgrades rather than lower cost, lower efficiency upgrades |
| Timing Mismatch | •How to overcome the mismatch between the longer useful lives and varying payback periods of some energy efficiency improvements (such as HVAC equipment) and the sometimes shorter expected occupancy of the property (whether by a property owner or a tenant) |
| Split Incentives | •Particularly prevalent in the commercial real estate sector, how to balance the different time horizons and incentives of a tenant versus a property owner |
| Scalability | •How to achieve scale by aggregation despite the often fragmented and disparate nature of the targeted market and facilities |
| Existing Property or Financing Restrictions | •Restrictions under existing mortgages on mortgaged property or under existing debt financing to property owners |
| Energy Baseline Measurements | •Where payments to service providers and sponsors are based on performance, how to establish baseline energy usage and normalize for changes in energy consumption that are not related to the energy efficiency project |

A brief assessment of each examined financing model relative to these issues is summarized below.



### 1. *ESPC/ESCO model*

In the traditional ESCO model using an ESPC, the customer owns the energy efficiency improvements and the initial cost of equipment and installation may be self-funded by the host customer, particularly if the host customer is in the MUSH segment and can access university endowment funds, maintenance and reserve accounts, or other cash on hand. MUSH building owners have also often combined some equity contributions with some form of debt or lease financing to fund the up-front costs.

The timing mismatch and split incentive issues arise less frequently in the MUSH context because these are typically facilities that are occupied for many years, either owned by the customer or under a long-term lease.

Lease financing can take many forms, such as capital leases, operating leases, or, where available, tax-exempt lease purchase agreements. For building owners interested in using off-balance sheet structures, operating leases and tax-exempt lease purchase agreements may be suitable to finance certain kinds of energy efficiency improvements, depending on the residual value of the equipment involved. Lease financing also offers a flexible way of addressing the timing mismatch issue noted above, since the timing of lease payments can be structured to coincide with the projected energy cost savings and payback period under the ESPC and to accommodate the customer's cash flow demands.

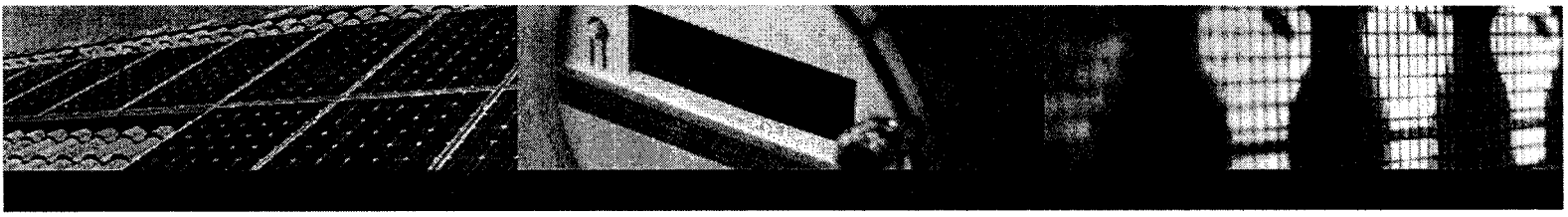
A master lease agreement structure may be used to aggregate a series of energy efficiency projects to be implemented over time. The master lease agreement establishes a framework agreement, with separate leases executed on a project-by-project basis.

In addition, other debt financing such as bonds and loans may be used to finance energy efficiency improvements using the ESPC/ESCO model. Larger projects for creditworthy institutions may be able to access greater amounts of capital through the bond capital markets. Of course, debt financings or lease financings would need to be compatible with any existing mortgage restrictions that may apply to the applicable properties.

### 2. *ESA and MESA models*

In both the ESA and MESA models, the customer does not front the initial cost of the energy efficiency project, but instead enters into an ESA or a MESA with an energy services provider. This energy services provider handles the first-cost hurdle by fronting 100 percent of the capital to finance the energy efficiency improvements. Pursuant to the ESA or MESA, the ESA/MESA service provider owns the energy efficiency improvements and the customer pays the energy services provider over time, based, for example, on a cost-per-avoided-unit-of-energy basis, a floating percentage of the host customer's actual utility rate, or agreed-upon historical energy costs. Building owners can thus avoid expensive initial capital outlays using these PPA-like arrangements. Moreover, ESA and MESA financings may be structured as off-balance sheet for the customer under current accounting rules, and generally do not run afoul of existing mortgage restrictions.

The ESA/MESA structure can also offer an innovative solution to the split-incentive issue in multi-tenant commercial properties. Under most standard multi-tenant commercial property leases, a tenant pays its



own energy bills. The ESA/MESA financing model may allow the building owner to enter into an ESA/MESA to improve the energy efficiency of the building as a whole (thereby reducing the tenant's utility bills) and then pass through to its tenants, per the commercial lease terms, an applicable share of the ESA/MESA energy payments that the landlord pays to the energy service provider.[v] Due to the decrease in the tenant's utility bills, this arrangement should be cash-flow positive for the tenant.

ESA and MESA models are particularly well suited for larger energy efficiency projects rather than smaller-scale improvements in the residential market. Standardized ESA contracts and structures could be used to aggregate projects and achieve greater economies of scale. With their often equity-like returns, energy efficiency projects financed using the ESA and MESA models may also be appealing vehicles for private equity investors interested in investing in this sector.[vi]

### *3. PACE and On-Bill Finance and Repayment models*

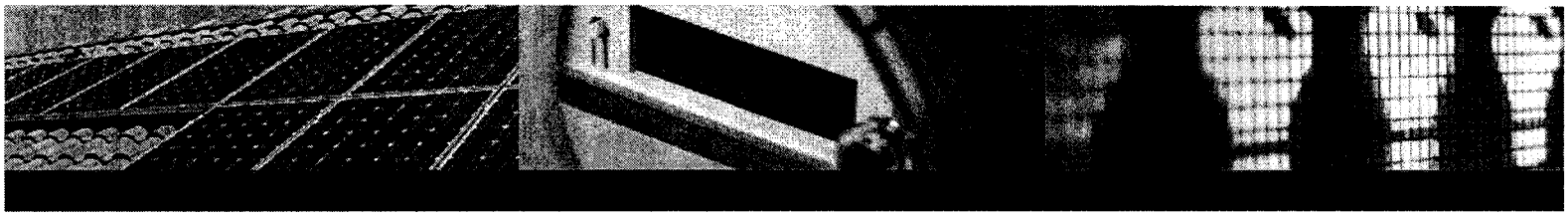
PACE financing models address many of the hurdles described above. PACE financing is a solution to the first-cost hurdle that allows local governments to use their traditional assessment or improvement district authority to provide property owners within their communities with the up-front capital for energy efficiency projects. The capital investment is then repaid through assessments levied on property that benefits from these improvements. The property assessments are secured by a lien that, as with other local government taxes and assessments, ranks senior to a mortgage lien.

Since a PACE lien is tied to the property, the term of the financing can be very long (up to 20 years in some jurisdictions). Even if the owner sells the property or a tenant leaves, the lien remains on the property. PACE has the potential to create the kinds of standardized assets that are more easily securitized and if a large enough volume of PACE loans can be aggregated, larger pools of financing may be accessed through securitization.

Due to actions by the FHFA and mortgage industry concerns, the implementation of PACE in the past two years has centered around the commercial markets. In several current commercial PACE financing programs, mortgage holder consent to the senior PACE lien is required, and in some cases, the total amount of the PACE assessment may be limited to a certain percentage of the property's value. As more jurisdictions develop commercial PACE programs and as FHFA's regulatory proceeding relating to residential PACE moves forward, this energy efficiency finance model may continue to gain ground.

On-bill finance and repayment models provide yet another method to address the first-cost hurdle for the customer in which the utility or a third party provides a zero- or low-interest loan or tariff to the customer to finance up to 100 percent of the energy efficiency improvement cost. The customer repays the loan or tariff in installment charges that are added to the customer's regular utility bill. In some cases, the threat of utility disconnection can reduce the risk of default or delinquency. The customer's monthly repayments are usually less than or equal to the energy savings. On-bill loans may be tied to the customer (i.e., if the customer moves, it must pay off the loan) or structured as tariffs that run with the meter (i.e., if the customer moves, the next occupant continues to pay the tariff).

While tying on-bill finance models to a participating utility can offer many advantages, these may also be offset by several disadvantages, as examined more fully in Section II below. The balance of pros and



cons using an on-bill finance approach depends very much on the particular utility's situation and resources.

## C. Taking Measurements in Energy Efficiency Finance

It has become almost axiomatic that implementing energy efficiency improvements is the most cost-effective, rapid way to achieve energy efficiency goals and reductions mandated by both the federal and state governments, and to achieve voluntary goals adopted by a growing number of forward-thinking businesses.

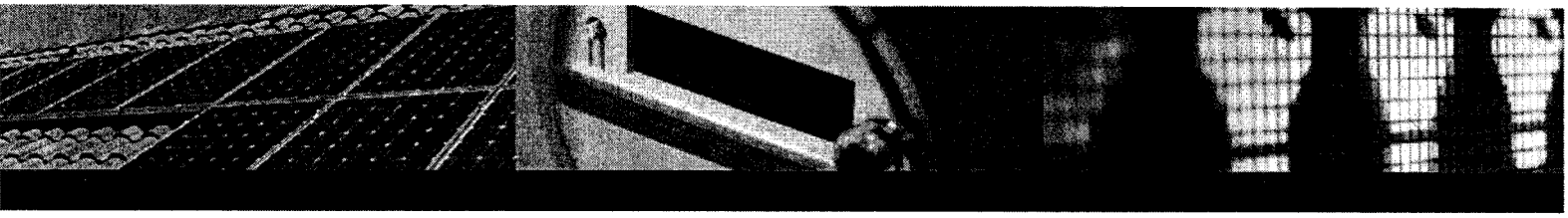
A guiding principle in energy efficiency finance, often called "bill neutrality," is that the total amount of energy savings achieved by an energy efficiency project should equal or exceed the cost of installing and servicing the energy efficiency improvement. How these energy efficiency benefits and costs are measured, however, is not as straightforward as it may first seem. Some corporations, for example, have historically used a simple payback method of calculating their returns on energy efficiency investments. Alternatively, an Environmental Defense Fund program shows how other corporations have begun to use more sophisticated cost-benefit analyses that incorporate net present value (NPV) calculations, "resulting in a more reasoned choice between projects with only modest NPVs but short payback periods and projects with very significant NPVs despite somewhat longer payback periods."[vii]

A related and critical development with a potentially significant impact on energy efficiency finance that has recently received increased attention is the appraisal process for properties. In June 2011, the Appraisal Foundation, a key source of national appraisal standards, and the U.S. Department of Energy's Office of Energy Efficiency and Renewable Energy announced an MOU to cooperate on creating guidelines under the Uniform Standards of Professional Appraisal Practice for green appraisals and energy performance. Because of the fundamental gatekeeper role that appraisals play in property valuations and access to finance, moving toward an industry-wide consensus on how to value greener buildings could significantly impact calculations of returns on investment in energy efficiency finance projects.[viii]

Moreover, property appraisals currently do not incorporate the value of energy efficiency improvements because there is no uniform standard for doing so. Federal legislation has been proposed (but not adopted) that would define more standardized rating codes and require that the value of existing efficiency improvements be incorporated into property value. If adopted, this would directly impact energy efficiency financing.

Another market challenge has been the cost of performing energy audits. This is one reason that mortgage brokers and financers do not require them. However, new home energy audit technologies are currently being developed to help bring down the cost of up-front appraisals, where both reporting standardization and requirements would make these assessments more economical and desirable for customers, mortgage brokers, and investors.

One difficulty for the energy efficiency finance structures—such as ESPC, ESA, and MESA—that are driven by the amount of energy savings actually realized by the energy efficiency improvements is difficulty in identifying the source of changes in energy consumption by the customer. Fluctuating occupancy rates, equipment usage and changes, behavior, and other factors that are out of the control



of the ESCO or the ESA/MESA project developer can undermine the efficiency project's energy savings performance, and thus the ESCO's or ESA/MESA project developer's payment stream. The customer and the ESCO or ESA/MESA project developer will go to great lengths to establish the baseline energy patterns of the customer and to determine the methodology for calculating what changes to that baseline are attributable to the energy efficiency measures for purposes of payment. One solution to this approach is to define the efficiency project's performance metrics on criteria other than electricity reduction. For example, payments are sometimes based on the average availability of the energy efficiency equipment instead of the energy savings.

Since the measurement and verification of energy efficiency savings and costs is a critical decision point for both the customer considering whether to implement and finance an energy efficiency improvement and the providers of energy efficiency finance, continued innovation in these areas will provide crucial tools to facilitate energy efficiency financings.

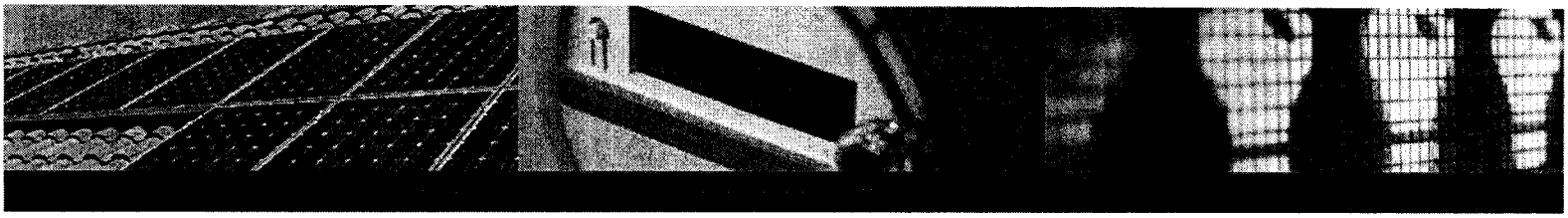
# II. Energy Efficiency Finance Structures and Negotiating Key Agreements

The market has embraced energy efficiency as more than just incremental product upgrades; energy efficiency projects are increasingly integrated, engineered systems comprised of advanced technology products as well as the associated unique and valuable services that demand equally unique financing solutions. Figure 2 below summarizes the five emerging energy efficiency finance models covered by this primer. The ESA and MESA models have diverged from the more traditional ESPC model, while the PACE and on-bill models have developed independently as a response to market demand.

**Figure 2: Energy Efficiency Finance Models**

| Financing Model | Energy Savings Performance Contract (ESPC) | Energy Services Agreement (ESA) | Managed Energy Services Agreement (MESA) | Property Assessed Clean Energy (PACE) | On-Bill Financing/ Repayment (OBF/OBR) |
|---|---|---|---|---|---|
| Market Penetration | High for MUSH; low for Commercial and Industrial | Low | Low | Low | Low |
| Target Market Segment | MUSH, Commercial, and Industrial | MUSH, Commercial, and Industrial | MUSH, Commercial, and Industrial | Residential, Commercial | Residential, Commercial, and Industrial |
| Balance Sheet | On or Off | On or Off | On or Off | Undetermined | On or Off |
| Typical Project Size | Unlimited | $250,000 - $10 million | $250,000 - $10 million | $2,000 - $2.5 million | $5,000 - $350,000 |
| Allows for Extensive Retrofits | Yes | Yes | Yes | Yes | No |
| Repayment Method | Energy savings | Energy savings | Energy savings | Property assessments | Via utility bill |
| Security/ Collateral | Depends on financing (e.g., lease or debt) | Equipment | Equipment | Assessment Lien | Equipment; Service termination |
| Responsibility for Utility Bills | ESCO or Customer | Customer | MESA provider | Customer | Customer |

This section describes each of these emerging models in brief and provides an assessment of the advantages and disadvantages associated with each.



## A. Energy Savings Performance Contracts (ESPCs)

The ESPC model has dominated the ESCO energy efficiency market to date. Sixteen major ESCOs and hundreds of smaller companies complete between $4 to 6 billion in energy efficiency projects annually,[ix] with the majority of these projects in public buildings that form part of the MUSH segment. The advantages of the ESPC model in leveraging experienced, multinational corporations have also yielded several challenges, as described below.

*Description and Key Features*

With an ESPC structure, energy efficiency improvements are owned by the customer and may be installed with little or no up-front cost. Typically, the large ESCO will play multiple roles, from originator and developer to the arranger of the financing, and for very large retrofit projects this level of centralized coordination and project/process management can be extremely useful. After project construction and implementation is complete, the ESCO monitors the savings and may also provide service upgrades for a period of time.

In an ESPC model, the ESCO installs the energy efficiency retrofit and sometimes also guarantees certain energy savings to the customer during the term of the ESPC. ESPCs are typically designed so that the value of the energy savings is split between the customer and the ESCO throughout the contract term, such that the customer's total savings exceed the sum of all of the customer's payments (financing payments and the payments to the ESCO) over the term of the 10- or 20-year contract.

After the ESPC term, payments to the ESCO cease and the customer operates and maintains the energy efficiency improvements and retains all energy savings. In many cases, an ESCO will guarantee a certain level of energy savings to the customer. If the guaranteed level of energy savings is not delivered, the ESCO will have to pay the difference between the guaranteed and the actual level of savings. An energy savings guarantee from a creditworthy ESCO can improve the financeability of the ESPC if the customer is securing financing. This financial commitment by the ESCO serves to create a baseline performance incentive; however, if all savings in excess of the guaranteed level remain with the customer, then the ESCO is not incentivized to significantly exceed the guaranteed level of energy savings. This performance contracting model, in which payments to the ESCO are based in part on the capital acquisition value and capital expenditure size, encourages increasingly bigger project sizes and incentivizes the ESCO to implement more low-risk, high-cost energy efficiency retrofits that do not necessarily result in the greatest energy savings. According to one recent study, one perceived drawback of the ESCO/ESPC model among MUSH segment property owners is that this model encourages energy efficiency installations with short payback periods, resulting in high profit margins for the ESCOs.[x] Figure 3 below provides an illustrative ESPC structure.

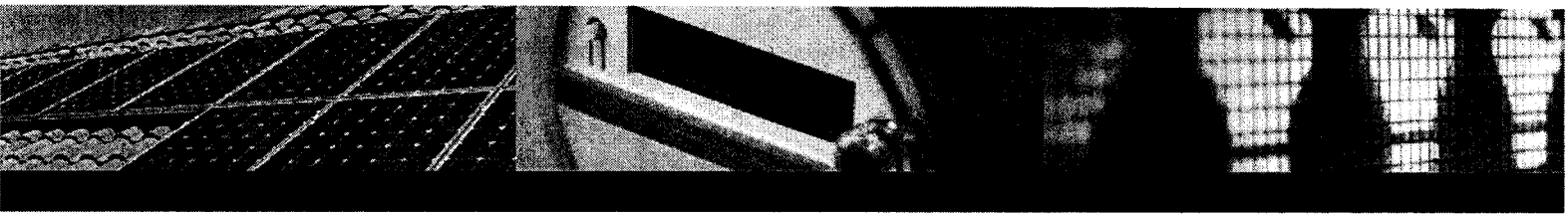
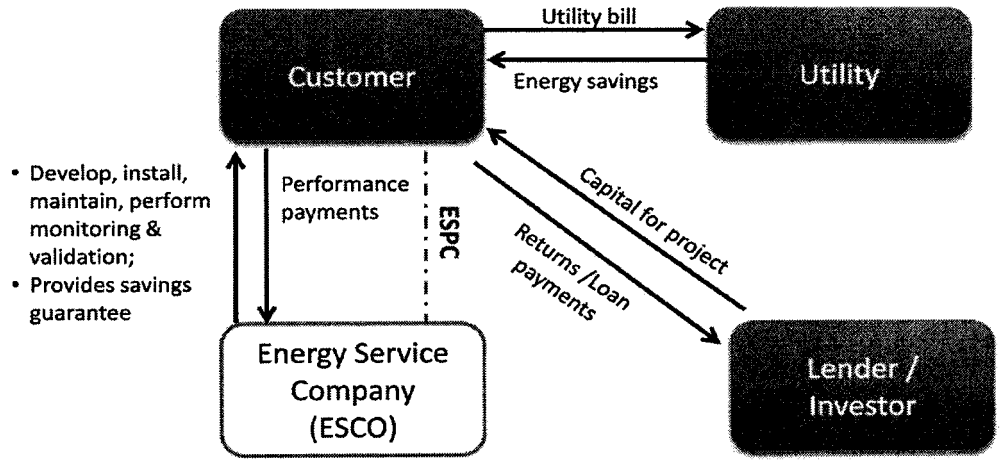


**Figure 3: ESPC Basic Structure**




The baseline energy profile of the facility and predictability of the technology performance are also important inputs in determining the financeability of ESPCs. Introducing innovative technologies that lack extensive performance data increases the overall risk of the project's performance. Because neither the lender nor the ESCO see significant upside for deploying more innovative (and potentially more effective but less reliable) technologies, ESPC arrangements tend to remain on the technologically conservative side. Even for component providers, penetrating the ESCO market can be a long and slow process, but it is not without reward given the multibillion-dollar addressable market.

ESPC contracts can also be used in projects that bundle energy efficiency and renewable energy improvements for the customer. For the customer that wishes to own energy efficiency improvements and on-site renewable energy generation, adding generation, such as a solar photovoltaic system, to the scope of the ESPC can be an efficient way to accomplish (and finance) both. In some cases, an ESPC for energy efficiency owned by the customer, coupled with a PPA for renewable energy generation owned by a third party, is the most capital-efficient way to deliver both projects, especially if the customer is a tax-exempt entity that is not able to effectively use or monetize the renewable energy generation tax benefits such as the investment tax credit (ITC) and accelerated depreciation.

*Sources of Financing*

The customer's ownership of energy efficiency improvements under ESPCs may be financed using a mix of debt, equipment leasing, tax equity, government incentives, rebates, and grants, as described in Section I above. Loans are generally secured via liens on equipment installed and are underwritten based on the creditworthiness of the customer. The availability and cost of capital will largely be tied to the credit of the customer, as opposed to the potential performance of the energy efficiency upgrades, thus making financing available to primarily the most creditworthy customers, not necessarily the most efficient projects. Furthermore, the value of any energy efficiency capital investments that accrue beyond the term of the ESPC cannot readily be captured at the time of financing.

*Accounting Issues*

Although the ESCO is providing services relating to the installation and performance of the energy efficiency upgrades, the upgrades are owned by the customer whether or not they are financed. Thus,

the capital cost of the upgrades will appear on the customer's balance sheet. Investments that appear on a company's balance sheet often face a more challenging internal approval process, even where an internal champion is supportive of the project. The energy efficiency investment is not likely central to the customer's business and, from an accounting point of view, it's better for the customer if treated as an expense kept off its balance sheet. As compared to the ESA and MESA models in which the monthly payments are simply off-balance sheet expenses, similarly sized monthly payments for debt service that are on the balance sheet will likely be treated with greater scrutiny.

*Legal Issues*

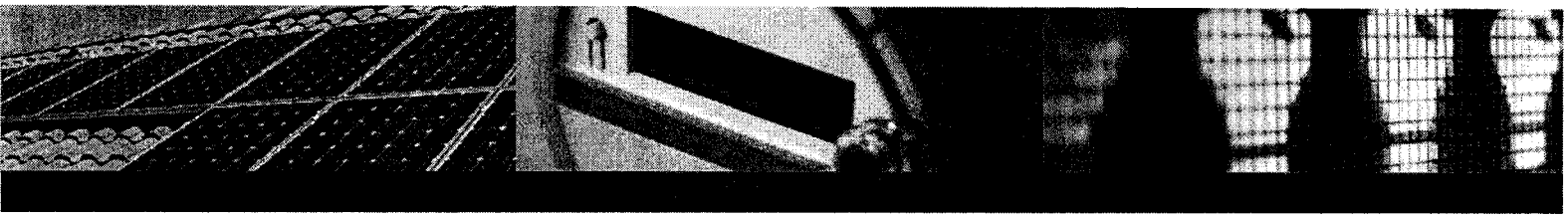
As part of its Dodd-Frank rulemaking process, the U.S. Securities and Exchange Commission (SEC) has proposed that ESCOs be required to register as "municipal financial advisors" and be subject to regulatory oversight as such. The ESCO industry, however, argues that ESCOs, like engineering firms, should be exempted from this new registration requirement. This debate is ongoing and has yet to be resolved.

*Overall Assessment*

| Strengths | Weaknesses |
|---|---|
| - Performance guarantees reduce project risks, which is valuable in large, complex retrofits<br>- ESCOs have a long history of contracting experience and standardized processes<br>- Projects are maintained through rigorous monitoring and verification | - Contractor and financier incentives limit deployment of new technology<br>- High transaction costs<br>- Long negotiation periods<br>- Not a realistic framework for smaller projects<br>- Unclear whether ESCOs will be able to administer programs or originate loans without being registered Municipal Finance Advisors under the Dodd-Frank Wall Street Reform and Consumer Protection Act<br>- On customer's balance sheet |

## B. Energy Services Agreements (ESAs)

As discussed above, under an ESPC the customer owns the energy efficiency improvements on-balance sheet and either self-funds the up-front costs or uses debt or lease financing to cover the up-front costs. As an alternative, the ESA model diverged from the ESPC structure and draws its inspiration from the Power Purchase Agreement (PPA) structure. In a PPA, a utility or a host customer agrees to purchase the electricity generated by a project from the project owner. The PPA structure has been widely adopted for power projects across the U.S. for conventional, renewable, utility-scale, and distributed energy generation projects, including in the residential space. Financing innovations and tax incentives such as the ITC have led to widespread adoption of residential and commercial-scale solar projects using the PPA structure. The ESA model's innovation is to translate the PPA into an ESA as a tool for financing



energy efficiency improvements, while also leveraging the vast resources and experience of the large, established ESPC companies.

*Description and Key Features*

In an ESA financing, a project developer arranges for the installation of energy efficiency measures by an ESCO and coordinates the capital investment in the project. The project developer then owns, operates, and maintains the energy efficiency measures during the term of the ESA, while the host customer pays for the energy saved (sometimes referred to as "negawatts") as a service. The customer's payments are structured as a percentage of the actual energy savings achieved, either as a percentage of the customer's utility rate or as a fixed dollar amount per kilowatt-hour saved. While fixed $/kwh rates can insulate customers from future utility rate increases, they do not provide a hedge in the event of utility rate decreases. Figure 4 depicts a typical ESA structure.

Similar to the ESPC model, in an ESA, the project developer may provide a performance guarantee to the customer, or the ESCO may provide a performance guarantee to the project developer. However, because the customer pays the developer based on the actual amount of realized energy savings, there is incremental upside to the developer for savings that exceed the baseline or guaranteed level. As a result, this model may serve to encourage the implementation of newer technology that has been successfully piloted or demonstrated. Typically, the ESA customer has an option to purchase the energy efficiency improvements at the end of the ESA contract term for their then current fair market value.

*Sources of Financing*

As in most energy project finance structures, a special purpose entity (SPE) is typically established by the developer for each energy efficiency project that is financed using an ESA structure. Both equity and debt investors may be involved in providing capital for the energy efficiency project through investments in the SPE. The SPE then owns the energy efficiency equipment and all rebates, tax incentives, or other government incentives. Third-party ownership of the energy efficiency equipment enables structuring approaches in which those incentives, particularly the tax incentives, belong to an entity that can make the most use out of them. The tax benefits for energy efficiency equipment, however, are significantly less than for renewable energy generation, since energy efficiency improvements do not qualify for the investment tax credit (ITC) or production tax credit (PTC). As a result, tax equity investors, who are important financiers of solar and wind projects, are typically not a source of capital for energy efficiency projects.

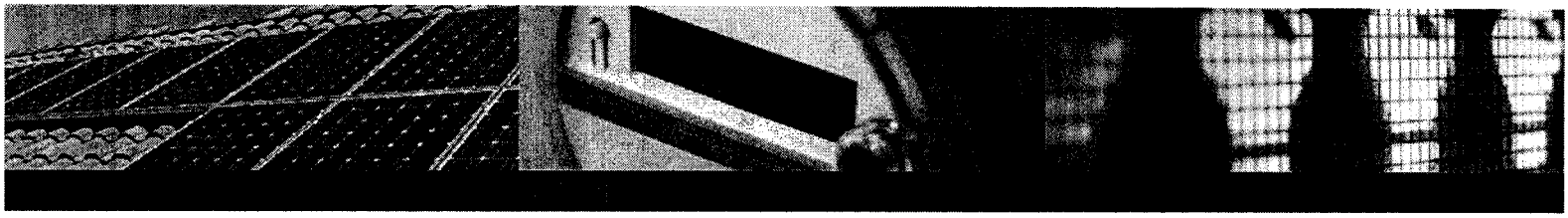
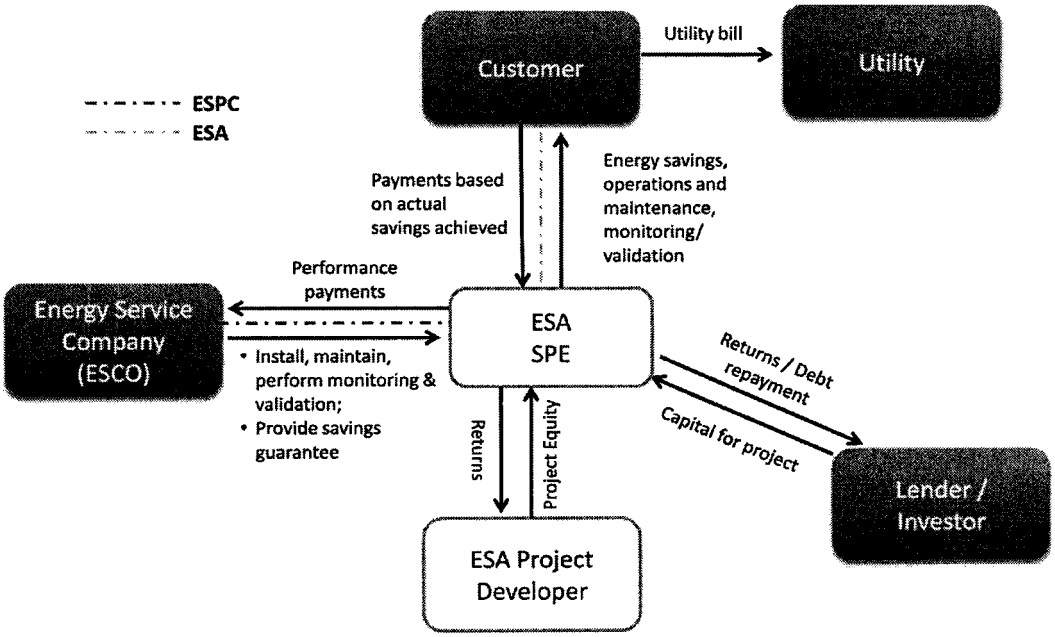


**Figure 4: Basic ESA Structure**



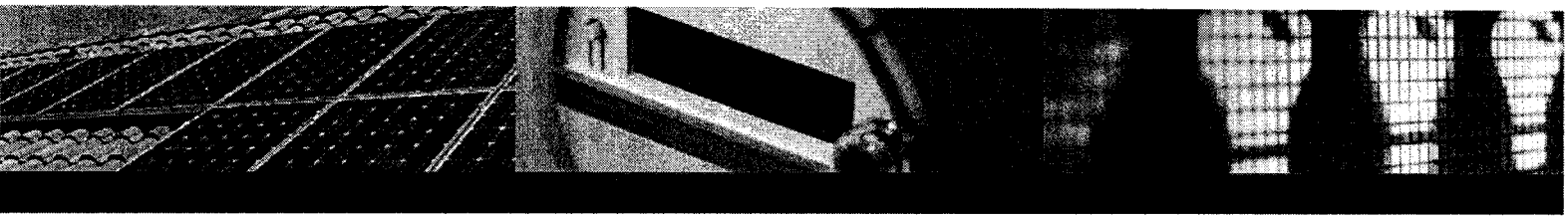

Investors are repaid through the stream of customer payments for energy savings, tax incentives, rebates, and environmental attributes. The creditworthiness of the customer and the ESCO will impact the ability of the project developer to secure financing for an ESA-based project and the pricing of such financing. In some cases, parent guarantees may be needed in innovative financing models until investors in this area become comfortable with their risk exposure. In an attempt to reduce transaction costs and expand investment into this segment, the market may increasingly see transactions in which a single investor funds groups of projects that meet certain criteria.

*Accounting Issues*

ESAs may be treated as operating leases or capital leases. Under current Federal Accounting Standards Board (FASB) standards, ESAs that are treated as operating leases remain off the customer's balance sheet (while capital leases are on-balance sheet). However, FASB has proposed new rules that would impact the accounting treatment of operating leases. If FASB adopts this new lease treatment, ESA projects treated as operating leases would not remain off-balance sheet and instead would be placed on the customer or obligor's balance sheet. Under the proposed FASB revisions, however, an ESA can be structured to meet the service agreement criteria (which would remain off-balance sheet), avoiding treatment as an on-balance sheet operating lease. ESA providers and providers of emerging energy efficiency financing structures such as Managed ESAs are avoiding this potential accounting issue by offering service-based agreements that are not treated as leases under current or proposed FASB standards. Managed ESAs are described in further detail below.

*Overall Assessment*

ESAs build on the successful PPA model of project finance, where third-party project developers and investors provide the up-front capital for energy efficiency improvements, which is repaid over time by a



customer through energy savings. This model may face barriers to implementation if revised FASB standards result in on-balance sheet treatment and ESAs cannot be structured to meet revised FASB standards for off-balance sheet treatment.

| Strengths | Weaknesses |
|---|---|
| - Currently, customers may finance energy efficiency improvements off-balance sheet<br>- Customers pay only for actual savings realized<br>- Customers do not bear operation and maintenance responsibilities or performance risk during the ESA contract term<br>- Project developers are incentivized to maximize energy savings or other performance metrics<br>- ESA provider may be able to monetize tax benefits that customer could not<br>- The ESA provider may be able to obtain financing for groups of similar energy efficiency projects that meet certain criteria from a single investor, thereby lowering transaction costs | - Proposed FASB rule modification could subject ESAs to new accounting rules<br>- Project developer has to secure debt and/or equity financing from providers that understand the ESA model; familiarity with the well-established PPA model, however, may help mitigate this weakness |

## C. Managed Energy Service Agreement (MESA)

*Description and Key Features*

The MESA is a slightly different version of an ESA, wherein a project developer owns the energy efficiency equipment and in addition serves as a middle person between the customer and the utility. With a MESA structure, the customer has the project developer as a single point of contact and makes a single payment for all of its utility expenses. In contrast, under an ESA structure, the customer pays the ESA provider for the realized savings and then pays each of its utilities individually for the water, gas, and/or electricity that may be consumed. As with an ESA, MESAs involve the sale of energy savings as a service and are considered to be off-balance sheet arrangements at this time. Companies with a fully integrated business model (e.g., technology provider, developer, and financier) that want to enter the energy efficiency market may find it most attractive to utilize the MESA structure for energy efficiency projects.

New companies in this space have established varying arrangements for how energy savings accrue to the customer. Under one structure, the customer pays the MESA project developer its baseline energy bill for the duration of the contract, and all savings accrue to the MESA project developer. In other models, the project developer guarantees a percentage reduction in energy bills to the customer, thereby sharing in the energy savings throughout the contract period.

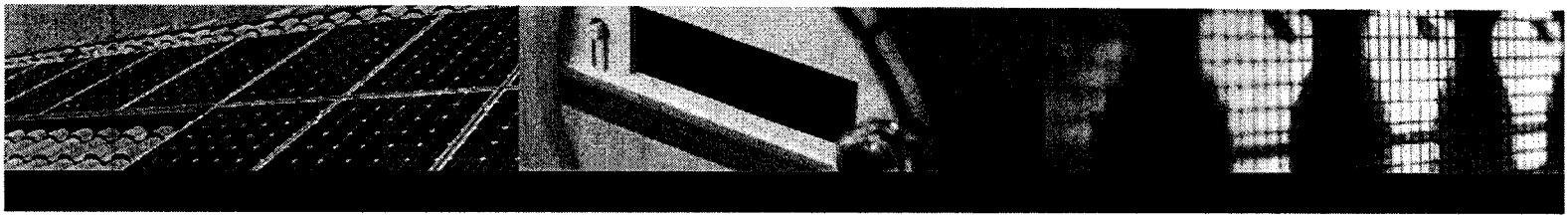
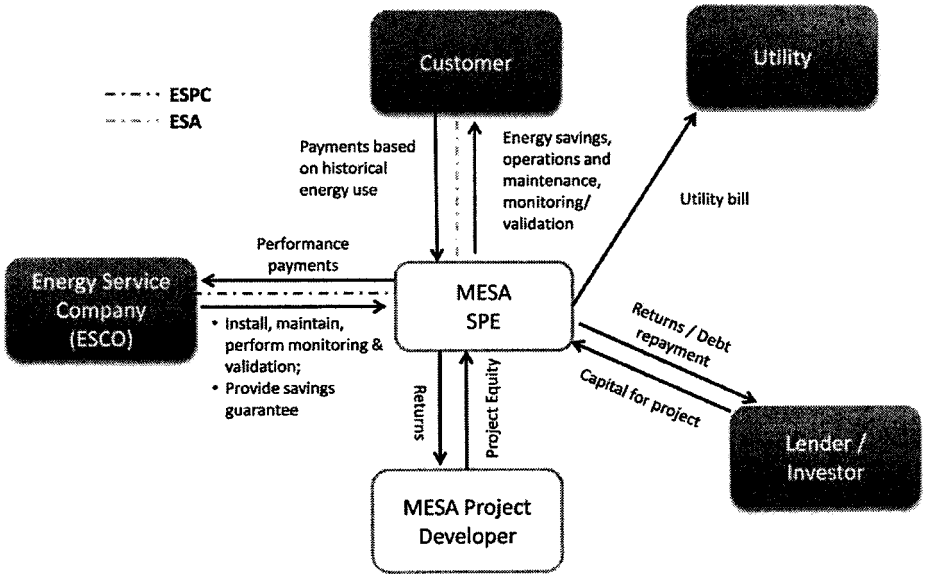


Figure 5 below provides an illustrative MESA structure.

**Figure 5: Basic MESA Structure**

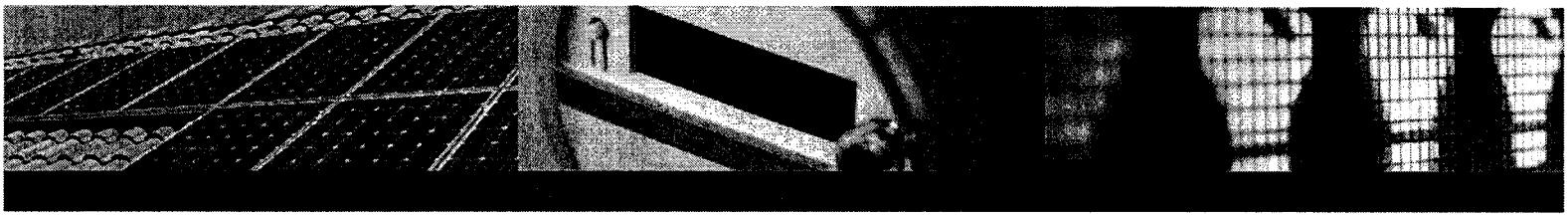



*Sources of Financing*

The MESA project developer may finance a MESA project using the same strategies as the ESA developer described above, including the establishment of an SPE for each MESA project. MESA projects will attract lenders, however, who are generally willing and able to tolerate the risk on utility rates. Since the MESA project developer is responsible for utility payments, it carries the risk of utility rates increasing faster than predicted. As with the ESA structure, since energy efficiency improvements do not qualify for the ITC or PTC, unlike solar and wind-generation projects, tax equity investors are not a primary source of capital for energy efficiency projects.

*Overall Assessment*

| Strengths | Weaknesses |
|---|---|
| - Currently, customers may finance energy efficiency improvements off-balance sheet<br>- Customers do not bear operations and maintenance responsibilities or performance risk during the MESA contract term<br>- Project developers are incentivized to maximize energy savings<br>- Customer has a single point of contact and a single payment for all utility expenses | - Same as the ESA structure<br>- MESA project developer typically carries utility rate escalation risk |



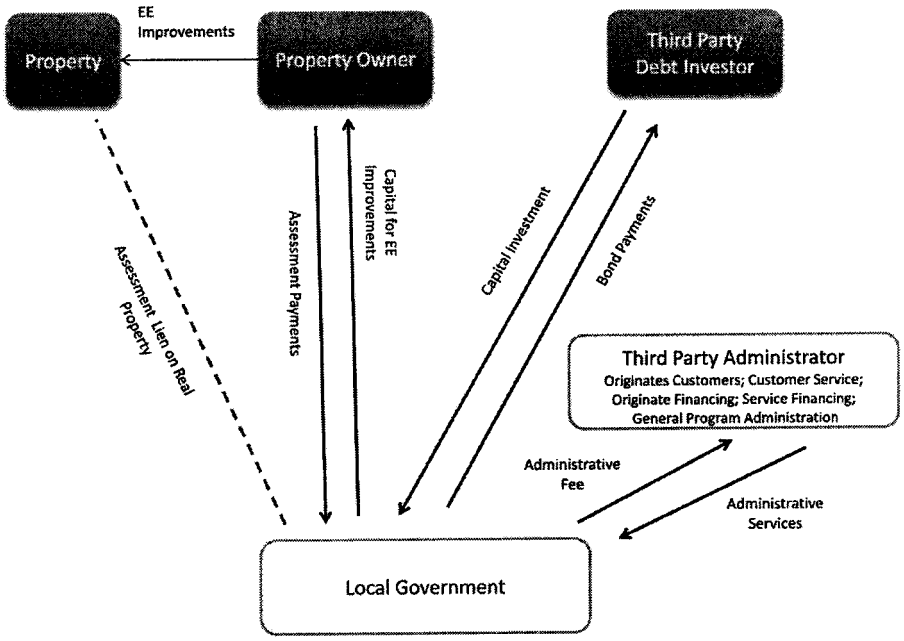
## D. Property Assessed Clean Energy (PACE)

PACE was developed in 2007 and enables local governments to finance energy efficiency improvements using land-secured special assessment or improvement district structures. The authority to create land-secured municipal finance districts already exists in most states around the country and has been used as far back as the 17th century to finance local improvements such as sewer lines, sidewalks, seismic retrofits, fire safety improvements, parks, and sports arenas. Under such authority, local governments issue bonds to finance local improvements that have a public purpose and levy assessments against property benefitted by such improvements. The assessments are collected along with property taxes and are secured by a lien on the property.

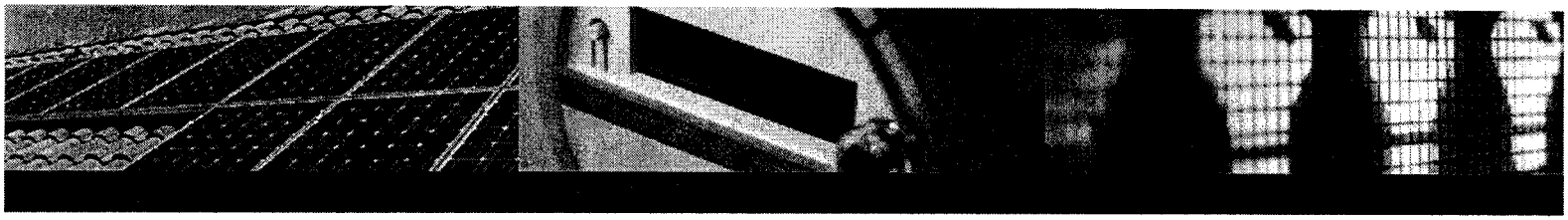
*Description and Key Features*

In a PACE program, existing municipal improvement district authority typically is expanded to include energy efficiency or renewable energy improvements on private property. These districts generally are established as a result of petition or vote of constituents or property owners in a local jurisdiction and then approved by the governing body of that jurisdiction. Property owners voluntarily agree to have assessments levied against their property in exchange for receiving the up-front capital for the energy efficiency improvements.

**Figure 6: Basic PACE Structure**




In the event of a sale or transfer, the lien securing the assessments remains on the property, becoming an obligation of the next property owner. Thus, the repayment obligation is tied to the entity benefiting from the energy savings achieved at the property. As with other tax and government assessment liens, liens used to secure PACE assessments are senior to privately held liens such as mortgages. This security feature reduces risk to bond investors and lenders, thereby enabling local governments to offer this financing at relatively low interest rates. It is important to note, however, that as with property taxes, in



the event of foreclosure, only the past due assessments are paid out of the proceeds of a sale ahead of the first mortgage (i.e., rather than the full amount of the capital provided by the local government). This feature is often referred to as "non-acceleration."

The term of PACE assessments is generally tied to the payback period for the energy savings measure, in some cases as long as 20 years. Property assessments are generally treated as an expense, not capitalized on the balance sheet as a long-term liability. However, PACE assessments are not the typical property assessment and there is no clear consensus yet from the accounting community as to whether PACE assessments should be treated as on-balance sheet or off-balance sheet.

*Legal Issues*

PACE gained a great deal of popularity and momentum between 2008 and 2010, with 27 states[xi] around the country passing legislation to expand existing land-secured municipal improvement district authority to enable local governments to establish PACE programs in both the residential and commercial sectors.

In 2010, Fannie Mae and Freddie Mac (GSEs) issued advisory statements to lenders and servicers of mortgages owned or guaranteed by the GSEs stating that PACE programs were inconsistent with the GSE's uniform security instruments because of the seniority of PACE liens. The FHFA, the agency authorized to regulate the GSEs, then issued statements upholding the GSEs' advisories, concluding that PACE programs present "safety and soundness concerns," and directing the GSEs to refrain from purchasing mortgages on properties with outstanding PACE liens. These actions had the effect of halting the implementation of PACE programs in the U.S. residential sector, with the exception of pilot programs in Sonoma County, Palm Desert, Boulder, and the Town of Babylon, New York. The State of California, Sonoma County, and others brought suit in federal court and obtained an order requiring the FHFA to conduct a formal rulemaking proceeding on PACE under the Administrative Procedures Act. The uptake of PACE in the residential sector is currently on hold pending the outcome of the FHFA's rulemaking proceeding (which was in progress at the time of this writing).

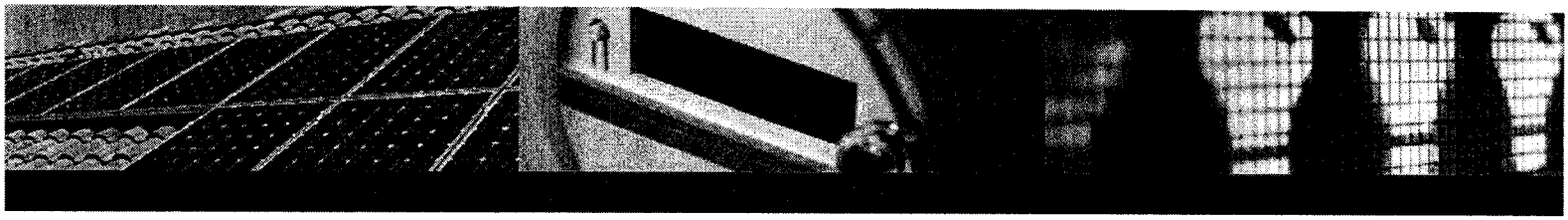
In the meantime, several jurisdictions have advanced commercial PACE programs, including Ann Arbor, San Francisco, Los Angeles, Sacramento, and Lantana, Florida. Currently, several commercial PACE programs require consent or acknowledgment by the existing mortgage holder.

*Sources of Financing*

PACE improvements are financed via the issuance of bonds by local governments under existing land-secured municipal improvement district authority. Third-party entities typically work with the local government to arrange for lines of credit, capital warehouse facilities, project origination, and administrative processing. As discussed above, assessment liens are attractive security instruments to the capital markets and lower the effective cost of capital to property owners. Several jurisdictions are permitting commercial property owners to arrange financing directly with lenders. In fact, some existing mortgage holders are expressing an interest in providing PACE financing to properties in their portfolios. PACE has the potential to evolve into standardized instruments that can be securitized and sold in the secondary markets.

*Overall Assessment*

PACE is a promising energy efficiency financing structure with enormous potential to scale energy retrofits. Currently, the implementation of PACE in the residential sector is on hold pending the outcome



of the FHFA's rulemaking proceeding and federal litigation. PACE is advancing and holds promise as a model for financing energy efficiency improvements in the commercial sector.

| Strengths | Weaknesses |
|---|---|
| - Assessment lien is attractive to investors; security feature enables competitive interest rates<br>- Repayment obligation remains with property in the event of sale or transfer by owner<br>- Term tied to payback period | - Legal challenges to lien priority in the residential sector<br>- Local government approval process required to implement program<br>- While PACE provides a model for raising financing for capital investments, it does not provide a model for financing the servicing aspects of energy efficiency<br>- No consensus yet regarding accounting treatment as on-balance sheet or off-balance sheet |

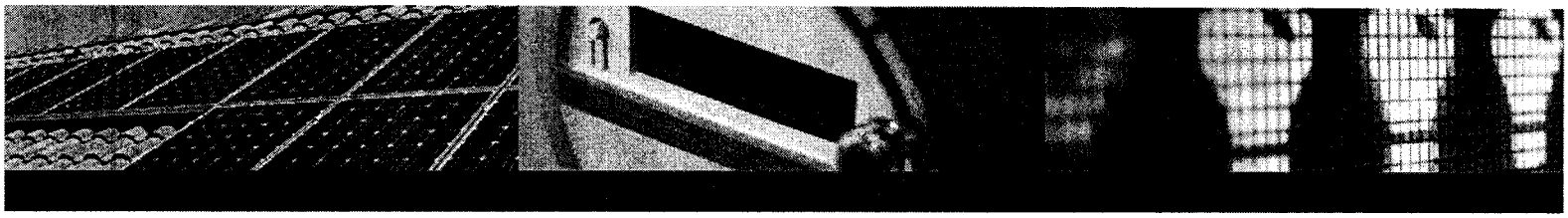
## E. On-Bill Financing/Repayment

On-Bill Financing/On-Bill Repayment (OBF/OBR) uses utility or third-party capital to pay for energy efficiency or renewable energy retrofits in a building, the cost of which is repaid by the customer on the customer's utility bill. OBF refers to programs that use utility capital, whereas OBR programs leverage third-party capital. To date, various forms of on-bill programs have been implemented in over 20 states, serving residential, commercial, and industrial customers. While OBF/OBR programs are currently in pilot stages and market penetration is still low, these programs are generally seen as successful, with low default rates and borrowing costs.

*Description and Key Features*

Although OBF/OBR programs vary significantly, key elements include (1) repayment of the costs of building energy efficiency retrofits through the customer's utility bill; (2) very low up-front costs to the customer and very low interest rates (often zero percent); (3) threat of utility disconnection in the event of default; and (4) use of utility or third-party capital for the initial cost of energy efficiency retrofits (see "Sources of Financing" below).

The central feature of OBF/OBR programs is that repayment for energy efficiency improvements is bundled into the customer's monthly utility bill. This feature allows customers to immediately see the effect of energy efficiency improvements on their overall energy expenditures, which often decrease immediately—even with the bundled repayments—due to low interest rates and minimal up-front costs for the customer. Because customers are able to quickly realize the economic benefits of energy savings, OBR/OBF addresses the "first-cost" hurdle to energy efficiency retrofits and expands customer demand. The utility bill repayment mechanism also lowers administrative costs by leveraging the existing infrastructure and resources of the utility (which typically administers the program or partners with the administrator), including customer relationships and billing systems.



Another key element of most OBF/OBR programs is the threat of utility disconnection: customers tend to place a high priority on utility bill payments due to the threat of shutdown, and because OBF/OBR payments are bundled into the utility bill, default rates for OBR/OBF programs have been exceedingly low to date (mostly 0-2 percent). This feature of OBF/OBR is credited with lowering borrowing costs and extending energy efficiency retrofits to parties that might not otherwise have been creditworthy. As discussed below, the availability of service disconnection, particularly in the residential sector, is subject to legal uncertainty.

Within this basic framework, OBF/OBR programs vary significantly. In addition to variation in sources of financing (discussed below), programs are administered by various types of entities (e.g., utilities, government agencies, or other third parties) and target different types of customers and buildings. For example, New York's Green Jobs Green New York (GJGNY) program, which is administered by the New York State Energy Research and Development Authority (NYSERDA), targets residential buildings, multi-family residential buildings, and nonprofits and small businesses, with different eligibility requirements, loan sizes, and payback periods for each. In comparison, California's on-bill programs, which are administered by investor-owned utilities, only extend loans to business customers. The types of retrofits and technologies covered by OBF/OBR programs vary as well: a number of programs specifically exclude lighting and non-permanent fixtures, while others also cover renewable energy installation.

One key difference between programs is whether the customer's payment is characterized as payment on a loan or payment for a service. In on-bill loan programs, the program administrator extends financing to an individual or company. The obligation to repay is typically non-transferrable, even if the customer sells or ceases to occupy the building, unless there are provisions in the program or its enabling legislation that allow for such transfer. In contrast, under on-bill tariff programs, the payment is structured as a tariff that the customer pays in return for energy efficiency services. The obligation to pay is tied to the property or utility meter and transfers to subsequent owners or occupants, usually subject to certain notice requirements. For example, the Oregon MPower program is set up such that the utility pays all of the up-front costs for retrofitting a multi-family residential building. The building owner agrees to a 10-year tariff, which is pro-rated across all of the meters in the building, and addresses the division of energy savings in rental agreements with tenants. An advantage of the tariff structure is that it removes the disincentive for renters to apply for OBF/OBR in programs that allow renters to initiate the application process, and reduces the emphasis on the building occupant's creditworthiness as a determining factor in the application. Tariff programs also avoid certain legal issues related to lending laws, as discussed below.

*Sources of Financing*

Existing OBF/OBR programs rely on a mix of public, private, and ratepayer funds. Many programs currently rely on public capital, such as revolving loan or public benefits funds, some of which are capitalized with American Recovery and Reinvestment Act (ARRA) funds and continue to draw from federal loans, bonds, or grants. These funds typically cover the up-front costs of retrofits and energy audits and may provide credit enhancements, such as loan-loss reserves or payment guarantees, to manage default risk and reduce borrowing costs.

Community Development Financial Institutions (CDFI), which serve a community development purpose and often lend at lower interest rates and expected returns, have also played a role in administering

OBF/OBR. Clean Energy Works Portland, for example, is an OBF/OBR program in Oregon that is administered by a CDFI using $3 million in federal stimulus dollars, and provides loans to parties that could not have obtained financing for energy efficiency from traditional lenders. To a lesser extent, some utilities use ratepayer capital for OBF/OBR, though concern has been expressed that this practice could expose utilities to lending laws, and it has not been widely adopted. Finally, though capital markets and larger banks could be tapped in the future, they have not been a significant source of financing to date due to the relatively small volume and lack of standardization of OBF/OBR agreements.

New York provides an interesting example of OBF/OBR financing because of the combination of financing sources on which it relies. GJGNY was started with seed funding from proceeds from the Regional Greenhouse Gas Initiative (RGGI), a cap-and-trade program in the Northeast that has allocated $112 million to GJGNY's revolving loan fund. In addition to energy audits and retrofits, GJGNY also provides credit enhancements through a separate loan-loss reserve that draws from ARRA funding. The objective is for these credit enhancements to eventually make the GJGNY revolving loan fund attractive to the capital markets. The loans provided to customers are secured with a mortgage on the property that is subordinate to existing and future mortgages, and that attaches to the property, rather than the owner or occupant.

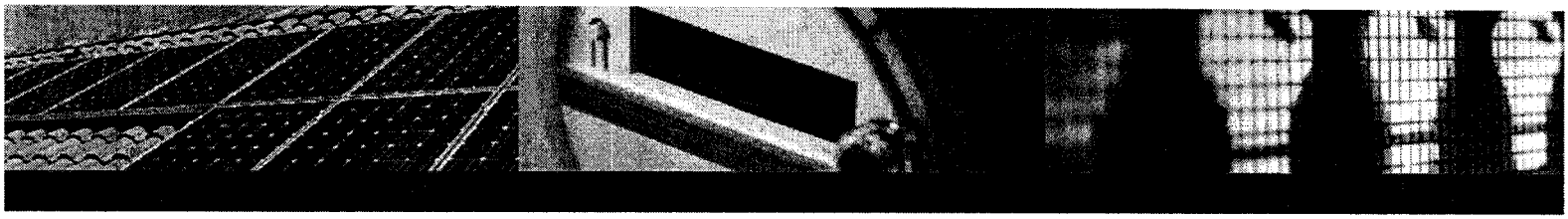
*Legal Issues*

Although utility service disconnection reduces default rates in OBF/OBR programs, this practice is subject to legal uncertainty as well as political controversy. For example, the California Public Utilities Commission (CPUC) proposed the establishment of an OBR program for investor-owned utilities (IOUs) in California. In response, the state's IOUs and ratepayer advocacy groups expressed concern that state law prohibits termination of residential service for non-payment to a third party. The CPUC subsequently narrowed its OBR proposal to the commercial sectors, and proposed a possible OBR program in the multi-family residential sector, indicating that legislative changes may be required to extend OBR to the single-family residential sector. OBF remains an energy efficiency financing option for commercial buildings in California. Capital providers do not view the threat of service termination as a security instrument, however, and in some cases data on default rates for existing OBF/OBR programs is not yet widely available. In the interim, projected interest rates on OBR financing are likely to be tied to customer creditworthiness in the absence of ratepayer-funded credit enhancements.

Another legal issue at play with OBF/OBR is the application of state and federal consumer lending laws when the financing is structured as a "loan." Utilities and other entities for which lending is not the core business are wary of being regulated as financial institutions, particularly as the regulatory scheme evolves in the shadow of the banking crisis. On-bill tariff programs can avoid lending laws, but tariffs still require regulatory approval from the relevant entities. In addition, the structure of the OBF/OBR program as a loan or a payment will impact its accounting treatment for the customer as on-balance sheet or off-balance sheet.

*Overall Assessment*

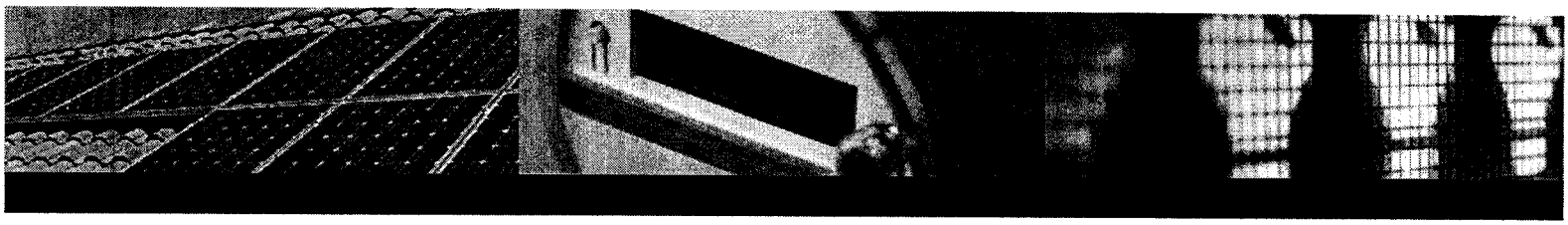
OBF/OBR is a relatively new structure, with most programs still in pilot or early phases of deployment, and has low market penetration overall. However, it has been widely adopted across the country, and most pilots have been successful at achieving very low rates of default, having positive cash flow (i.e., energy savings in excess of loan or tariff payments), and reaching underserved customers. Some keys to



this financing model's success seem to be the ability to combine multiple funding sources within one program and the ability to target multiple building sectors, which increases project volume.

To scale up, however, OBF/OBR programs would need to overcome a number of barriers. Administrative costs remain high, particularly for programs that serve residential customers, due to the need for individual energy audits and new billing structures, and the lack of standardized agreements. Many programs still rely on government funding, which reduces sustainability. And while pilot programs have had low default rates, there are a number of matters that would need to be dealt with more thoroughly to make OBF/OBR viable on a larger scale, including financial and consumer protection regulations, allocation of risk in the event of default, priority of OBF/OBR-related payments as compared to customers' regular energy bills, transferability of obligations in the event of property sale, and ways to ensure positive cash flows.

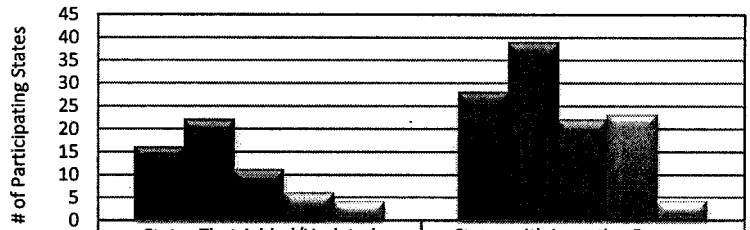
| Strengths | Weaknesses |
|---|---|
| - Addresses "first-cost" hurdle to customer adoption by requiring little capital up front<br>- Shows strong record of repayment by customers to date<br>- Leverages existing utility resources and customer practices to collect payments<br>- Bundled utility bill clearly shows impact of energy efficiency on overall energy expenditures<br>- Payment obligation may follow the customer or the meter<br>- Can be structured to address diverse customers and market segments<br>- Can be structured to address split energy incentives of tenants and owners<br>- Accounting treatment may be on-balance sheet or off-balance sheet | - In some cases, requires a third party to bear the "first costs" that are avoided by the customer<br>- Threat of utility disconnection is subject to legal uncertainty<br>- May require high up-front investment by utility to reform billing structures and other systems<br>- Assuring that energy savings will exceed loan/tariff payments is difficult<br>- Potential consumer lending regulations increase legal costs and uncertainty<br>- Obtaining landlord buy-in may be difficult if the tenant reaps all of the energy efficiency benefits<br>- Transaction and implementation costs can be relatively high<br>- Existing programs rely heavily on government funding and support |



# III. The Role of Public-Private Partnerships: Integrating Public and Private Financing

Innovation in the energy efficiency sector is occuring at both the state and federal levels. States have been increasingly aggressive in their adoption of energy efficiency programs and many offer a range of incentives that can finance projects. According to the National Governor's Association,[xii] 48 states expanded their energy efficiency measures in 2011, with 40 states adopting or updating their energy efficiency funding and financing mechanisms. As depicted in Figure 7 to the right, a number of states created or updated their loan and rebate programs in 2011, making these the most prevalent tools for supporting energy efficiency retrofits and other measures. According to information collected by the National Association of State Energy Officials (NASEO), there are at least 66 different state loan funds in the U.S. and its Territories. Some loan funds have been operating for years, while others were created and capitalized through the American Recovery and Reinvestment Act (ARRA) of 2009.

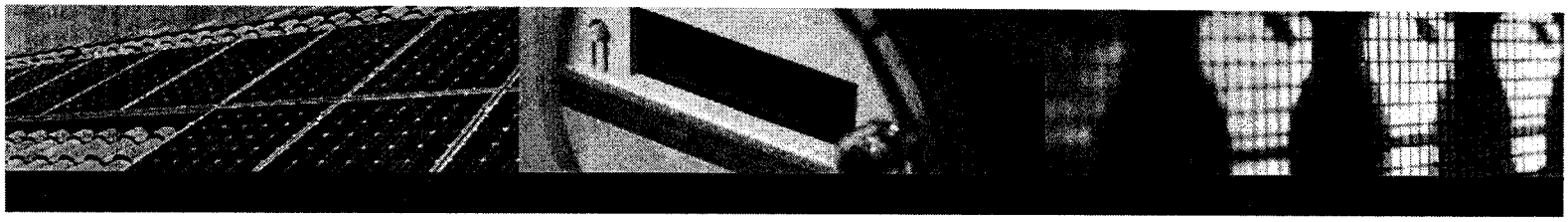
**Figure 7:**
**Activity in State-Level Energy Efficiency Financing Programs**




| | States That Added/Updated Programs in 2011 | States with Incentive Programs (by type) |
|---|---|---|
| Rebates | 16 | 28 |
| Loans | 22 | 39 |
| Grants | 11 | 22 |
| Tax Benefits | 6 | 23 |
| Non-Financial | 4 | 4 |

The federal government provides accelerated depreciation for certain energy efficiency property under Section 179D of the Internal Revenue Code. The Section 179D tax deduction is available for the installation of lighting systems, HVAC systems, hot water systems, and certain other building efficiency improvements that meet specified energy efficiency standards and that are installed prior to January 1, 2014, with the total amount available based on the square footage of building space. The accelerated depreciation benefit is modest in comparison to the energy credit available to renewable energy systems, but for certain building owners and/or tax equity investors who value accelerated depreciation, it does provide an additional financial incentive to justify energy efficiency projects.

State-level financing can also serve as a critical foothold in attracting private capital. Many companies are reaping significant benefits in leveraging the very low interest rates of state-level debt and, in some cases, the ability to subordinate public capital to private debt. Over the next year, emerging state-level authorities such as Connecticut's Clean Energy Finance and Investment Authority[xiii] and new public private partnerships such as Tennessee's INCITE Initiative[xiv] are expected to bring momentum to the energy efficiency financing sector. These and other state-level efforts to pair public investment capital with access to strategic networks are an increasingly common trend because of the economic development potential in energy retrofits and efficiency improvements. Moreover, states are actively



working to attract and augment the success of innovative entrepreneurs, where in some cases prospective investment deal flow is more limited than the funding available.

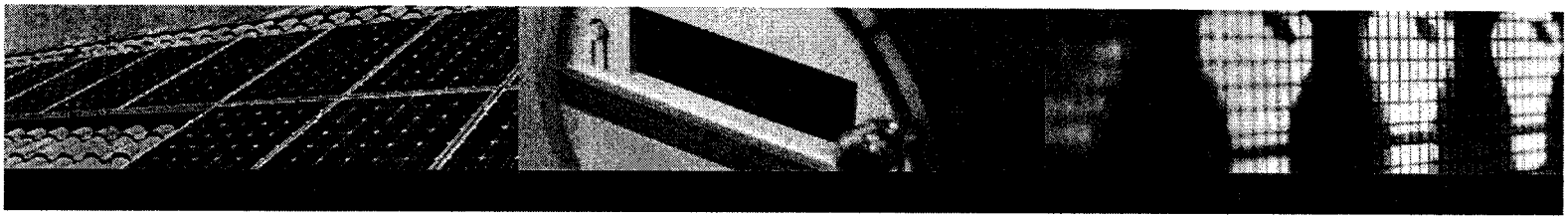
There are also certain benefits to working at the state level because loan and grant programs are typically processed more quickly than federal-level funding, creating new project pipelines or potentially filling a funding gap in an existing project. In addition, the funding landscape tends to evolve quickly. For example, some state revolving loan funds solicit new projects or investments as soon as funds become available, with less formally announced or scheduled requests for proposals. Opportunities are often channeled through economic development offices versus state energy offices, and in some cases through the state governor's office. Regardless of program origination, successfully weaving public capital into a private project requires a strategic dialogue with the state to understand its preferences and available investment tools. Delving into the local landscape and getting to know the state-level landscape can be tremendously valuable in capitalizing on what are sometimes fleeting windows of opportunity.

In addition to evaluating sources of state-level financing for energy efficiency, various federal-level policies and initiatives are spurring both public projects and private markets. For example, the Better Buildings Initiative, announced by President Obama on February 3, 2011, sets a national target for improving energy efficiency in commercial buildings by 20 percent by 2020.

One way the Better Buildings Initiative is mobilizing private capital is by applying public tools such as ESPC contracting authority. In 2009, a new Super ESPC vehicle was established and qualified 16 ESCOs to exercise their contracting authority and bid on government project opportunities. Each of the 16 indefinite quantity contracts with the ESCOs has a ceiling authority of $5 billion. However, this authority has not been fully exercised due to a number of factors, including challenges associated with streamlining the bidding process for government projects under the new Super ESPC contract vehicle.

Within the Better Buildings Initiative, the President signed an MOU directing all federal agencies to maximize their existing authorities to use performance-based contracting, setting a minimum of $2 billion dollars in contracts to be implemented over the next two years. Because of the nature of performance contracting and ESPCs, this $2 billion commitment is not in the form of up-front capital to be expended by the federal government; rather, it provides a market opportunity for ESCOs, as well as companies that partner with ESCOs through ESAs and other innovative structures. Another significant component of the Better Buildings Initiative is the Better Buildings Challenge, designed as a public-private partnership to mobilize $2 billion in private financing for building energy upgrades.

A second federal mechanism that is spurring energy efficiency opportunities within the federal government is the implementation of two Presidential Executive Orders. Executive Order (EO) 13423,[xv] Strengthening Federal Environmental, Energy, and Transportation Management, and EO 13514, Federal Leadership in Environmental, Energy, and Economic Performance,[xvi] collectively contain mandates that federal agencies measure, establish, and implement energy efficiency and renewable energy goals. EO 13423 requires federal facilities to reduce facility energy use per square foot by 3 percent annually, stemming back from 2006 through 2015, or 30 percent by the end of 2015. Under EO 13514, energy efficiency and renewable energy goals were expanded and, as was required, each agency has developed a Strategic Sustainability Performance Plan (SSPP) that defines specific targets and milestones for achieving its various energy objectives.

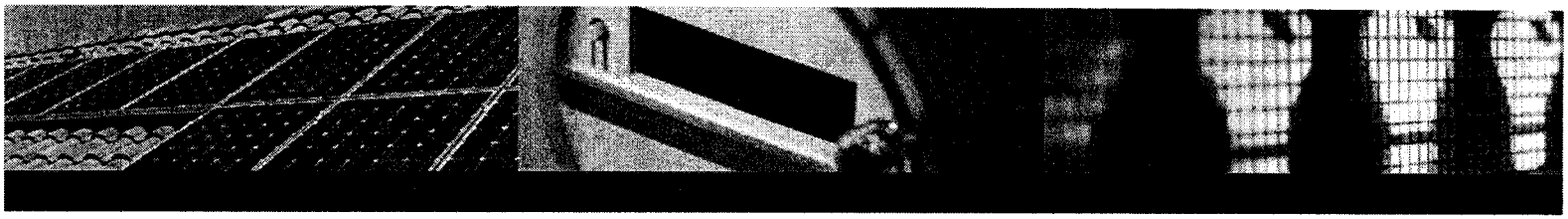


The scale of energy efficiency opportunities under the Better Buildings Initiative, EO 13424, and EO 13514 becomes more evident when combined with the fact that the federal government accounts for approximately 1 percent of total U.S. energy consumption. Moreover, the Department of Defense (DOD) is one of the largest single government consumers of energy. As a result of these and other federal mandates, project opportunities are evolving most rapidly within DOD, where pursuit of these projects can be a useful strategy for companies seeking a creditworthy customer with aggressive goals for reducing energy consumption as well as adopting new technologies. The current ESPC structure has been most widely adopted by government customers for energy efficiency improvements, but as discussed previously, this structure often does not encourage the adoption of new technologies. And, as a significant potential customer for energy efficiency improvements, DOD is in need of innovative financing solutions that can spur the adoption of new technology. In particular, methods that bring third-party financing to the table and offer unique risk-mitigation strategies will be attractive to DOD.

The Army, given its vast number of domestic installations, is aggressively pursuing energy efficiency. In 2011, the Army launched its Net Zero initiative with 17 bases designated Net Zero Energy, Net Zero Water, and/or Net Zero Waste. Each designated base will be implementing projects to achieve Net Zero status, and the Army has an overall goal to have 25 Net Zero installations by 2030. Figure 8 below provides a list of the designated installations, although all military installations are expected to implement projects.

**Figure 8: Army Net Zero Installations**

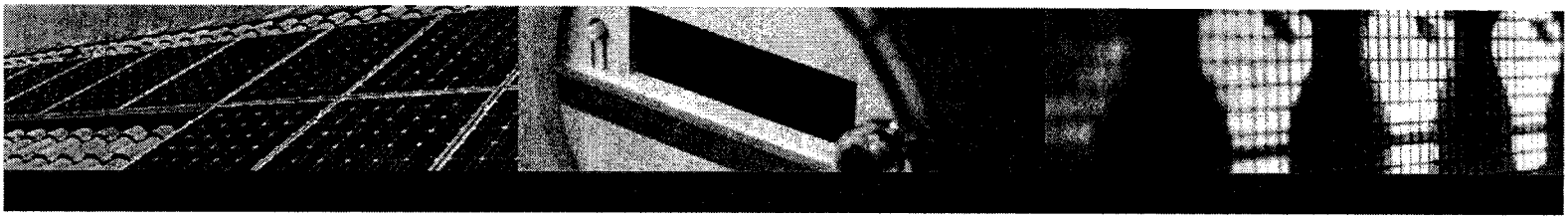
| NET ZERO ENERGY PILOT SITES | NET ZERO WATER PILOT SITES | NET ZERO WASTE PILOT SITES |
|---|---|---|
| Fort Detrick, MD | Aberdeen Proving Ground, MD | Fort Detrick, MD |
| Fort Hunter Liggett, CA | Camp Rilea, OR | Fort Hood, TX |
| Kwajalein Atoll, Republic of the Marshall Islands | Fort Buchanan, PR | Fort Hunter Liggett, CA |
| Parks Reserve Forces Training Area, CA | Fort Riley, KS | Fort Polk, LA |
| Sierra Army Depot, CA | Joint Base Lewis-McChord, WA | Joint Base Lewis-McChord, WA |
| West Point, NY | Tobyhanna Army Depot, PA | U.S. Army Garrison, Grafenwoehr, Germany |
| Fort Bliss, TX | | |
| Fort Carson, CO | | |



Due to the geographic diversity of the installation locations as well as various other factors, many Army bases will adopt energy efficiency initiatives in combination with renewable energy improvements. Given the significant amount of investment required at military bases to achieve DOD's energy objectives, leveraging untapped resources at the state level and/or navigating local regulatory issues may be crucial elements in bringing these projects to fruition. While the current model of choice for DOD may be the ESPC, new energy efficiency financing models offer an element of scalability that DOD desires.

In considering the potential role of public-private partnerships for developing and financing energy efficiency projects, it is also important to note that since energy efficiency and energy efficiency finance are less politically charged topics, they typically garner bipartisan support. Six major bipartisan policies have been presented in Congress in the past year that promote energy efficiency. These bills include a national energy efficiency strategy and a new way to finance energy-saving home upgrades:

| Bill Name | Summary and Status[xvii] |
|---|---|
| Electric Consumer Right to Know Act, or e-KNOW (S. 1029) | • Introduced by Senators Mark Udall (D-CO) and Scott Brown (R-MA) in May 2011; the bill is under consideration in the Committee on Energy and Natural Resources.<br>• If enacted, e-KNOW would require utilities to provide customers and other third parties with their energy-usage information, including data from smart meters. E-KNOW also would assist energy auditors, demand response aggregators, and energy service providers in helping consumers reduce energy use. |
| Energy Savings & Industrial Competitiveness Act (S. 1000) | • Introduced by Senators Jeanne Shaheen (D-NH) and Rob Portman (R-OH) in May 2011. The Senate Energy Committee reported it in July 2011 with strong bipartisan support (18–3 vote); the bill is awaiting consideration in the House.<br>• If enacted, it would greatly improve energy efficiency in residential and commercial buildings, as well as in industry and manufacturing. |
| PACE Assessment Protection Act (H.R. 2599) | • Introduced by Representatives Nan Hayworth (R-NY), Mike Thompson (D-CA), and Dan Lungren (R-CA) in July 2011; the bill is under consideration in the Financial Services Committee.<br>• The measure is a budget-neutral, no-mandate policy that would enable local governments to finance home energy efficiency projects with repayment through property taxes.<br>• At the local level, 27 states and the District of Columbia already approved PACE-enabling initiatives. |
| Roofing Efficiency Jobs Act (H.R. 2962, S. 1575) | • Introduced by Representatives Tom Reed (R-N.Y.) and Bill Pascrell (D-N.J.) in the House in September 2011, and Senators Ben Cardin (D-MD) and Mike Crapo (R-ID) in the Senate. The bill has been referred to the House Ways and Means and Senate Finance Committees for further consideration. |



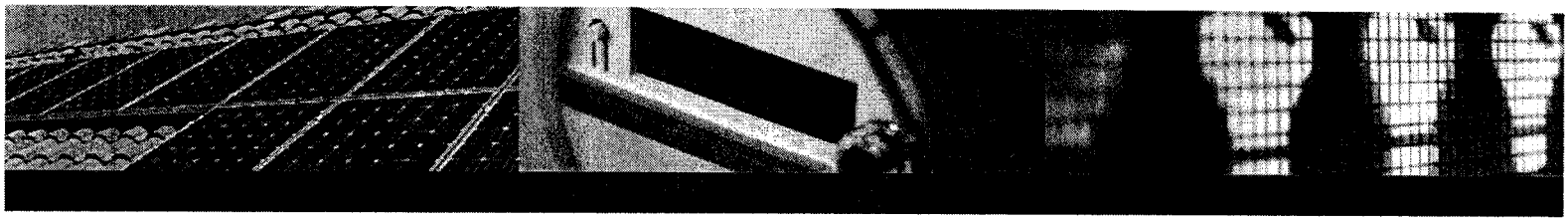
| | |
|---|---|
| | • The measure would incentivize energy efficient commercial roof replacements by accelerating depreciation for new roofs with cool roof coatings and good insulation. |
| Sensible Accounting to Value Energy Act (S. 1737) | • Introduced by Senators Michael Bennet (D-CO) and Johnny Isakson (R-GA) in October 2011; the bill is under consideration in the Committee on Banking, Housing, and Urban Affairs.<br>• The measure is a no-cost, no-mandate policy that would require residential energy efficiency to be considered in determining mortgage eligibility. |
| Cut Energy Bills at Home Act (S. 1914) | • Introduced by Senators Olympia Snowe (R-ME), Jeff Bingaman (D-N.M.), and Dianne Feinstein (D-CA) in November 2011. It has since been referred to the Finance Committee.<br>• If enacted, the bill would provide a performance-based tax credit for deep home retrofits. The size of the credit would depend on predicted cost savings from energy efficient improvements to a home's heating, cooling, lighting, and water systems |

Although a majority of these bills originated in the Democrat-controlled Senate, all of them have received bipartisan support. With the upcoming November elections comes an expected lull in the advancement of any significant energy policies, as leadership positions for these issues are established and the pulse of the new Congress is taken, including their views on the costs and benefits of energy policy. Regardless of the momentum of energy legislation, energy efficiency and innovations in energy efficiency finance are uniquely positioned to continue to gain traction and market adoption, because many of the necessary tools are available today and because of the economic development potential of this industry.

# IV. Conclusion

Improving the energy efficiency of our built environment represents a $279 billion investment opportunity in the U.S. alone.[xviii] Investment of private capital in this market has the potential to drive deeper energy savings, grow the clean energy economy, and lead to reduced greenhouse gas emissions, as well as produce significant returns for the market leaders that emerge.

According to some surveys, lack of capital is one of the main barriers to wider implementation of energy efficiency projects. Providers of capital, however, point to a lack of energy efficiency finance projects to finance as a key barrier. In practice, these two aspects affect and inform each other—as more capital and energy efficiency finance options become available, more energy efficiency finance projects become practical. As more energy efficiency finance projects become financeable and are aggregated, additional energy efficiency financing options develop. With their vast footprints and infrastructure, utilities have the potential to be important aggregators and facilitators in this ongoing process.

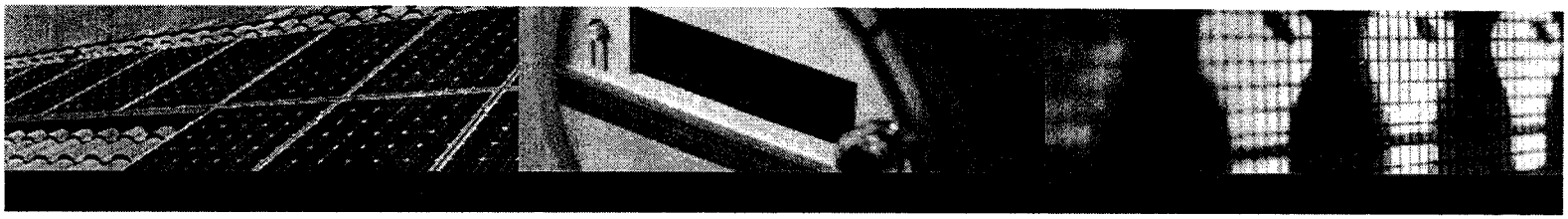


As the energy efficiency finance market continues to grow and evolve, we see a positive dynamic beginning to develop in some market segments, with greater investor interest centered around the ESA, MESA, and commercial PACE financing models in particular. The essential building blocks for a broader energy efficiency finance framework are forming as disparate threads are beginning to come together, such as innovations in how up-front costs and subsequent energy savings are measured; increasing understanding in the appraisal community about green appraisals and valuing energy efficiency improvements; innovations in technologies to conduct more cost-effective and standardized energy audits; reinvigorated interest among investors and local governments in commercial PACE; more advances in state legislation to encourage some forms of energy efficiency finance; growth of the ESA and MESA financing structures; and rare bipartisan political support for increased energy efficiency. Even the U.S. military is getting involved with its multibillion-dollar Net Zero program. In short, momentum is building.

Of course, there are still barriers to overcome and complex problems to solve. But emerging energy efficiency finance structures and ongoing legislative changes are enabling investors to enter this market at an increasing rate, providing more customers and energy efficiency project developers with capital necessary to perform retrofits and install energy efficiency technologies and improvements. Tax, accounting, regulatory, and legal issues surrounding energy efficiency finance structures are in flux, shifting the relative merits of these models. Key stakeholders at the forefront of energy efficiency finance are actively exploring further innovations in energy efficiency finance structures. Increasingly, parties are beginning to work out solutions to the challenges and realize the opportunities that energy efficiency finance presents to promote more sustainable economic development, increase energy security, and improve economic competitiveness. To paraphrase a timeless classic:

*"The situation gives rise to measurements; measurements give rise to balancing; and balancing gives rise to triumph."*

*– Sun Tzu, The Art of War*



[i] http://www1.eere.energy.gov/buildings/about.html
[ii] "Exploring Innovation in Energy Efficiency Financing," Cleantech Group presentation, January 24, 2012.
[iii] "Energy Efficiency Financing in California, Needs and Gaps," Harcourt Brown & Carey, Inc., July 8, 2011.
[iv] "Unlocking Energy Efficiency in the U.S. Economy," McKinsey & Company, July 2009.
[v] "Energy Efficiency Paying the Way: New Financing Strategies Remove First-Cost Hurdles," by Bob Hinkle and David Kenny, CalCEF Innovations White Paper, February 2010.
[vi] "Energy Efficiency Financing – Models and Strategies," prepared by Capital E for the Energy Foundation, by Greg Kats (Principal Author), Aaron Menkin, Jeremy Dommu, and Matthew DeBold, March 2012.
[vii] "Show Me the Money; Energy Efficiency Financing Barriers and Opportunities," by Namrita Kapur (EDF), Jake Hiller (EDF), Robin Langdon (US EPA), and Alan Abramson (Nicholas Institute for Environmental Policy Solutions), July 2011.
[viii] "Financing for Green Building and Energy Efficiency Makes Incremental Gains," by Dan Sheridan, July 29, 2011.
[ix] "U.S. Building Energy Efficiency Retrofits," Rockefeller Foundation and DB Climate Change Advisors, March 2012.
[x] "Energy Efficiency Financing in California, Needs and Gaps," Harcourt Brown & Carey, Inc., July 8, 2011.
[xi] The Database of State Incentives for Renewable Energy (DSIRE) website maintains a map showing states with PACE authority, available here: http://www.dsireusa.org/documents/summarymaps/PACE_Financing_Map.pdf.
[xii] *2011 Clean Energy Update – State Energy Actions*, January 31, 2012, at http://www.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-eet-publications/col2-content/main-content-list/clean-and-secure-energy-2011.html.
[xiii] For more information, visit: http://www.ctcleanenergy.com/default.aspx.
[xiv] For more information, visit: www.tntechnology.org/incite.
[xv] EO 13423 was issued in January 2007 and can be found at: http://www.gpo.gov/fdsys/pkg/FR-2007-01-26/pdf/07-374.pdf.
[xvi] EO 13514 was established by President Obama in October 2009, with the directive that: "Federal agencies shall increase energy efficiency; measure, report, and reduce their greenhouse gas emissions from direct and indirect activities; conserve and protect water resources through efficiency, reuse, and storm water management; eliminate waste, recycle, and prevent pollution; leverage agency acquisitions to foster markets for sustainable technologies and environmentally preferable materials, products, and services; design, construct, maintain, and operate high performance sustainable buildings in sustainable locations; strengthen the vitality and livability of the communities in which Federal facilities are located; and inform Federal employees about and involve them in the achievement of these goals."
[xvii] Alliance to Save Energy website: www.ase.org.
[xviii] "U.S. Building Energy Efficiency Retrofits," Rockefeller Foundation and DB Climate Change Advisors, March 2012.

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(rev. 6/12)

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# EXHIBIT
# 118

# 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
# 119

# 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;<br>2012 – 1,700 vaccines at 65 clinics;<br>2013 – 1,400 vaccines at 32 clinics;<br>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
# 120

www.AdventistHealthCare.com

# Center for Health Equity & Wellness

Population Health
Care Coordination Meeting
January 23, 2015

# Center for Health Equity & Wellness

## Identifying patient and community needs…

Health Equity Report

Community Health Needs Assessment (CHNA)

Community Partnerships

Health Outreach & Program Evaluation Data

Organizational Assessments

## …addressing identified needs…

Health Programs Delivery

Community Health Outreach

Linguistic Services

Cultural Competence Training

Community Partnership Fund

Implementation Strategy Initiatives

## …working toward population health.

Health Equity

Access to Care

Culturally Competent Care

Social Determinants of Health

# 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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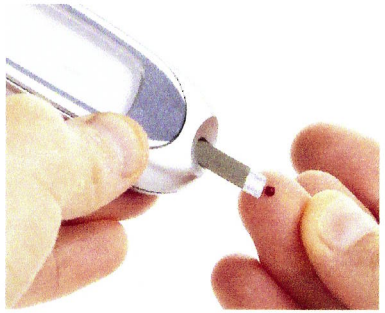
# Cardiac & Diabetes Outreach

- 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

# EXHIBIT
# 121

**Zip Codes with the Lowest Income Metrics in the WAH TP TSA**

| Below 25th Percentile | Median household income | Median earnings for workers | Income per capita | WAH relocation adjustment | Adjusted discharges |
|---|---|---|---|---|---|
| 20020 - Washington | 34,685 | 31,167 | 20,445 | -10.1% | (63) |
| 20019 - Washington | 34,832 | 30,947 | 20,504 | -6.5% | (65) |
| 20710 - Bladensburg | 42,962 | 28,990 | 23,151 | -1.0% | (5) |
| 20712 - Mount Rainier | 44,104 | 30,017 | 25,696 | -20.0% | (55) |
| 20722 - Brentwood | 56,133 | 26,812 | 22,339 | -15.0% | (46) |
| 20784 - Hyattsville | 56,678 | 32,920 | 24,472 | -1.0% | (16) |
| 20903 - Silver Spring | 56,903 | 21,454 | 24,071 | 3.0% | 31 |
| 20783 - Hyattsville | 57,787 | 23,749 | 21,269 | -15.0% | (314) |
| 20737 - Riverdale | 59,427 | 29,443 | 23,375 | -15.0% | (149) |
| 20740 - College Park | 61,952 | 20,820 | 25,854 | -1.0% | (11) |

**Zip Codes with the Highest Income Metrics in the WAH TP TSA**

| Above 75th Percentile | Median household income | Median earnings for workers | Per capita income | WAH MS Adjustment | WAH Adjusted Discharges |
|---|---|---|---|---|---|
| 20910 - Silver Spring | 78,738 | 50,356 | 48,649 | -15.0% | (265) |
| 20774 - Upper Marlboro | 91,855 | 51,305 | 40,263 | -1.0% | (22) |
| 20866 - Burtonsville | 93,828 | 45,308 | 39,412 | 15.0% | 92 |
| 20772 - Upper Marlboro | 99,183 | 54,291 | 41,455 | 0.0% | - |
| 20853 - Rockville | 100,435 | 40,479 | 41,023 | 0.0% | - |
| 20850 - Rockville | 107,459 | 60,078 | 54,267 | 0.0% | - |
| 20723 - Laurel | 108,318 | 53,640 | 43,735 | 5.0% | 66 |
| 20905 - Silver Spring | 116,806 | 46,624 | 42,974 | 15.0% | 139 |
| 20721 - Bowie | 119,851 | 63,383 | 49,989 | 0.0% | - |

# EXHIBIT
# 122

**Payor Mix in Zip Codes with the Lowest Income Metrics**

| | Medicaid & Self-Pay | | | Commercial | | |
|---|---|---|---|---|---|---|
| **Below 25th Percentile** | **WAH** | **HCH** | **Overal l** | **WAH** | **HCH** | **Overal l** |
| 20020 - Washington | 22.2% | 8.2% | 30.6% | 14.3% | 51.8% | 30.5% |
| 20019 - Washington | 15.4% | 10.0% | 36.6% | 20.0% | 45.8% | 21.3% |
| 20710 - Bladensburg | 33.9% | 14.7% | 30.5% | 21.4% | 41.2% | 22.4% |
| 20712 - Mount Rainier | 29.1% | 25.0% | 32.9% | 13.7% | 53.6% | 23.8% |
| 20722 - Brentwood | 22.1% | 17.6% | 23.8% | 11.7% | 47.1% | 21.5% |
| 20784 - Hyattsville | 29.4% | 18.8% | 30.0% | 23.8% | 43.0% | 28.0% |
| 20903 - Silver Spring | 34.8% | 31.4% | 32.4% | 21.7% | 21.6% | 23.5% |
| 20783 - Hyattsville | 36.4% | 33.7% | 35.3% | 15.4% | 22.2% | 18.1% |
| 20737 - Riverdale | 30.2% | 21.0% | 32.8% | 26.4% | 34.3% | 26.5% |
| 20740 - College Park | 19.8% | 12.0% | 16.9% | 22.5% | 32.6% | 27.4% |

**CY2013 Payor Mix within WAH TP TSA**

| | WAH | HCH | Overall |
|---|---|---|---|
| **Commercial** | 21.1% | 29.5% | 28.7% |
| **Medicaid** | 11.5% | 9.4% | 12.0% |
| **Medicare** | 50.7% | 50.9% | 49.1% |
| **Self-Pay** | 15.3% | 8.6% | 8.7% |
| **Other** | 1.4% | 1.6% | 1.5% |

# EXHIBIT
# 123

Martin O'Malley
Governor

Anthony G. Brown
Lt. Governor

Alvin C. Collins
Secretary

MARYLAND DEPARTMENT OF GENERAL SERVICES

FACILITIES OPERATIONS & MAINTENANCE • FACILITIES PLANNING, DESIGN & CONSTRUCTION
PROCUREMENT & LOGISTICS • REAL ESTATE

June 20, 2014

Ms. Joyce Newmyer
President
Governing Board of Adventist HealthCare, Inc. d.b.a., Washington Adventist Hospital
7600 Carroll Avenue
Takoma Park, Maryland 20912

Re: Washington Adventist Hospital
Montgomery County
DGS Item G027, Chapter 463, Acts of 2014 - $480,000

Dear Ms. Newmyer:

Congratulations on receiving your State grant. Funds for your grant are authorized in a "bond bill" enacted by the General Assembly and signed by Governor Martin O'Malley.

The Department of General Services will administer your grant on behalf of the State Board of Public Works (BPW). This application package contains the necessary forms for you to complete and return to us in order to access your grant funds. We will request the Board of Public Works to approve your grant agreement and, when applicable, to certify that you have met your matching fund requirement based on the application information you provide us.

The legislation authorizing your grant requires certain deadlines are met by grant recipients as follows:

(a) The deadline for obtaining BPW certification of matching funds is two (2) years from the date the grant is authorized, or **June 1, 2016.**

(b) The deadline for grant recipients to encumber (enter into project contracts) or expend the State funds is seven (7) years from the date of authorization, or **June 1, 2021.**

Please pay close attention to the important State policies that are outlined in the Capital Grants Program booklet found on the Capital Grants Program web page (www.dgs.maryland.gov/grants). The Board of Public Works is especially concerned that grant recipients utilize a competitive process to select their contractors.

If you have any questions, please contact me at 410-767-4107 or Ms. Kimberly Langkam, Grant Administrator at 410-767-4478.

Sincerely,

Catherine Ensor

Catherine Ensor
Program Manager
Capital Grants Program

cc: Ms. Denise Matricciani

Enclosures

State Office Building, Room 1405, 301 West Preston Street, Baltimore, Maryland 21201
Tel: 410-767-4107 Fax: 410-333-7558

14-G027 - Washington Adventist Hospital

Exhibit 1

# SENATE BILL 171

B5 (4lr0142)

*ENROLLED BILL*

*— Budget and Taxation/Appropriations —*

Introduced by **The President (By Request – Administration)**

Read and Examined by Proofreaders:

_____ Proofreader.

_____ Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this

_____ day of _____ at _____ o'clock, _____M.

_____ President.

CHAPTER 0463 MAY 15 2014

**APPROVED** *BY THE GOVERNOR*

AN ACT concerning

**Creation of a State Debt – Maryland Consolidated Capital Bond Loan of 2014, and the Maryland Consolidated Capital Bond Loans of 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, and 2013**

FOR the purpose of authorizing the creation of a State Debt in the amount of ~~One Billion, One Hundred Sixty Six Million, Sixty Five Thousand Dollars ($1,166,065,000), One Billion, One Hundred Seventy Nine Million, Six Hundred Fifteen Thousand, Three Hundred Seventy Seven Dollars ($1,179,615,377),~~ *One Billion, One Hundred Eighty Million, Five Hundred Fifteen Thousand, Three Hundred Seventy–Seven Dollars ($1,180,515,377),* the proceeds to be used for certain necessary building, construction, demolition, planning, renovation, conversion, replacement, and capital equipment purchases of the State, for acquiring certain real estate in connection therewith, and for grants to certain subdivisions and other organizations for certain development and improvement purposes, subject to certain requirements that certain matching funds be

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.
[Brackets] indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.
*Italics indicate opposite chamber/conference committee amendments.*

*Directors of the Historical Society of Harford County, Inc. for the acquisition, design, construction, repair, renovation, reconstruction, and capital equipping of the Historical Society of Harford County Facility (Harford County)* ..... *50,000*

ZA01 MARYLAND HOSPITAL ASSOCIATION

(A) Anne Arundel Medical Center. Provide a grant to the Board of Trustees of the Anne Arundel Medical Center to assist in the renovation of the Cardiac Catheterization Labs at the Anne Arundel Medical Center, subject to the requirement that the grantee provide an equal and matching fund for this purpose. Notwithstanding the provisions of Section 1(5) of this Act, the matching fund may consist of funds expended prior to the effective date of this Act (Anne Arundel County) ..... 500,000

G024

(B) Holy Cross Hospital. Provide a grant to the Board of Trustees of Holy Cross Hospital of Silver Spring, Inc. to assist in the renovation and expansion of the pre– and post–operative unit at Holy Cross Hospital, subject to the requirement that the grantee provide an equal and matching fund for this purpose. Notwithstanding the provisions of Section 1(5) of this Act, the matching fund may consist of funds expended prior to the effective date of this Act (Montgomery County) ..... 500,000

G025

(C) MedStar Good Samaritan Hospital. Provide a grant to the Board of Directors of The Good Samaritan Hospital of Maryland, Inc. to assist in the expansion of the Geriatrics Program at MedStar Good Samaritan Hospital in Baltimore City, subject to the requirement that the grantee provide an equal and matching fund for this purpose. Notwithstanding the provisions of Section 1(5) of this Act, the matching fund may consist of funds expended prior to the effective date of this Act (Baltimore City) ..... 375,000

G026

(D) Washington Adventist Hospital. Provide a grant to the governing board of Adventist HealthCare, Inc., d.b.a., Washington Adventist Hospital to assist in the renovation of the third floor of the hospital to accommodate the Community Clinic, Inc., subject to the requirement that the grantee provide an equal and matching fund for this purpose. Notwithstanding the provisions of Section 1(5) of this Act, the matching fund may consist of funds expended prior to the effective date of this Act (Montgomery County) ..... 480,000

G027

(E) Meritus Medical Center. Provide a grant to the governing board of the Meritus Medical Center, Inc. to construct a new

G028

| | | |
|---|---|---|
| | *effective date of this Act (Talbot County)* | *50,000* |
| *(BT)* G188 | *Doey's House Initiative. Provide a grant equal to the lesser of (i) $125,000 or (ii) the amount of the matching fund provided, to the Board of Directors of the Hospice of Washington County, Inc. for the acquisition, planning, design, construction, repair, renovation, reconstruction, and capital equipping of a hospice facility called Doey's House. Notwithstanding Section 1(5) of this Act, the matching fund may consist of in kind contributions (Washington County)* | *125,000* |
| *(BU)* G189 | *The Maryland Theatre. Provide a grant equal to the lesser of (i) $125,000 or (ii) the amount of the matching fund provided, to the Board of Directors of The Maryland Theatre Association, Inc. for the acquisition, planning, design, construction, repair, renovation, reconstruction, and capital equipping of The Maryland Theatre (Washington County)* | *125,000* |
| *(BV)* G190 | *YMCA of the Chesapeake. Provide a grant equal to the lesser of (i) $200,000 or (ii) the amount of the matching fund provided, to the Board of Directors of the YMCA of the Chesapeake, Inc. for the acquisition, planning, design, construction, repair, renovation, reconstruction, and capital equipping of the YMCA of the Chesapeake (Wicomico County)* | *200,000* |

(4) An annual tax is imposed on all assessable property in the State in rate and amount sufficient to pay the principal of and interest on the bonds, as and when due and until paid in full. The principal shall be discharged within 15 years after the date of issue of the bonds.

(5) (a) Prior to the payment of any matching grant funds under the provisions of Section 1(3), Items ZA00 through ZA03 above, grantees shall provide and expend matching funds as specified. No part of a grantee's matching fund may be provided, either directly or indirectly, from funds of the State, whether appropriated or unappropriated. Except as otherwise provided, no part of the fund may consist of real property, in kind contributions, or funds expended prior to the effective date of this Act. In case of any dispute as to what money or assets may qualify as matching funds, the Board of Public Works shall determine the matter, and the Board's decision is final. Grantees have until June 1, 2016, to present evidence satisfactory to the Board of Public Works that the matching fund will be provided. If satisfactory evidence is presented, the Board shall certify this fact to the State Treasurer and the proceeds of the loan shall be expended for the purposes provided in this Act. If this evidence is not presented by June 1, 2016, the proceeds of the loan shall be applied to the purposes authorized in § 8–129 of the State Finance and Procurement Article.

(b) It is further provided that when an equal and matching fund is specified in Section 1(3), Items ZA00 through ZA03 above, grantees shall provide a

matching fund equal to the lesser of (i) the authorized amount of the State grant or (ii) the amount of the matching fund certified by the Board of Public Works. If satisfactory evidence is presented, the Board shall certify this fact and the amount of the matching fund to the State Treasurer and the proceeds of the loan equal to the amount of the matching fund shall be expended for the purposes provided in this Act. If this evidence is not presented by June 1, 2016, the proceeds of the loan shall be applied to the purposes authorized in § 8–129 of the State Finance and Procurement Article. The proceeds of any amount of the loan in excess of the matching fund certified by the Board of Public Works shall also be applied to the purposes authorized in § 8–129 of the State Finance and Procurement Article.

(6) (a) Prior to the issuance of the bonds, unless the Maryland Historical Trust determines that the property to be assisted by a grant under Section 1(3) Items ZA00 through ZA03 of this Act is not significant, is significant only as a contributing property to a historic district listed in the Maryland register of historic properties, is a type that is already adequately represented among the Trust's existing easement properties, ~~or~~ is already subject to a perpetual historic preservation easement acceptable to the Trust, <u>or conditions peculiar to the property make an easement impractical,</u> the grantee shall grant and convey to the Maryland Historical Trust a perpetual preservation easement to the extent of its interest:

(i) On the ~~land or such~~ portion of the land ~~acceptable to the Trust~~ <u>necessary to preserve the historic setting of the capital project assisted by the grant</u>; and

(ii) On the exterior and interior, where appropriate, of the historic structures <u>affected by the construction or renovation project assisted by the grant</u>.

(b) If the grantee or beneficiary of the grant holds a lease on the land and structures, the Trust may accept an easement on the leasehold interest.

(c) The easement must be in form and substance acceptable to the Trust, and the extent of the interest to be encumbered must be acceptable to the Trust, and any liens or encumbrances against the land or the structures must be acceptable to the Trust.

<u>(d) (i) A grantee may appeal a perpetual preservation easement determination made by the Maryland Historical Trust or the Director under subparagraph (a) of this paragraph to the Maryland Historical Trust Board of Trustees.</u>

<u>(ii) The decision by the Maryland Historical Trust Board of Trustees is final and is not subject to further administrative appeal or judicial review.</u>

(7) The proceeds of the loan must be expended or encumbered by the Board of Public Works for the purposes provided in this Act no later than June 1, 2021. If any

funds authorized by this Act remain unexpended or unencumbered after June 1, 2021, the amount of the unexpended or unencumbered authorization shall be canceled and be of no further force and effect. If bonds have been issued for the loan, the amount of unexpended or unencumbered bond proceeds shall be disposed of as provided in § 8–129 of the State Finance and Procurement Article.

(8) Multiple grants provided to the same organization in this Section are in addition to one another. Unless otherwise provided, any matching fund requirements apply to each individual grant.

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

**Chapter 445 of the Acts of 2005, as amended by Chapter 483 of the Acts of 2010, Chapter 444 of the Acts of 2012, and Chapter 424 of the Acts of 2013**

Section 1(3)

UB00 MARYLAND ENVIRONMENTAL SERVICE

(A) Infrastructure Improvement Fund. Provide funds to design, construct and equip capital improvements for State institutions. Expenditures for any of the following projects may not exceed the amount listed below by more than 7.5% without notification to the General Assembly. Funds may only be spent on the projects listed below or on previously authorized projects. Expenditure of any part of this appropriation for a previously authorized project shall also require notification to the General Assembly ..... 2,547,000

(5) Eastern Correctional Institution. Construct improvements to the water tower (Somerset County) ..... [276,000] **231,000**

**Chapter 445 of the Acts of 2005, as amended by Chapter 639 of the Acts of 2012 and Chapter 430 of the Acts of 2013**

Section 1(3)

ZA00 MISCELLANEOUS GRANT PROGRAMS

(C) Babe Ruth Birthplace and Museum. Provide a grant to the Board of Directors of the Babe Ruth Birthplace Foundation, Inc. to assist in the design, construction, renovation, and equipping of improvements to the Babe Ruth Birthplace and Museum. Notwithstanding Section 1(7) of this Act, this grant

# EXHIBIT
# 124

| | MSGA and OB (Move to White Oak) | | |
|---|---|---|---|
| | 2018 | 2019 | Variance |
| Inpatient Revenue | $ 167,608,699 | $ 184,624,799 | 10.15% |
| Admissions and Births | 11,006 | 11,116 | 1.00% |
| Revenue per Admission | $ 15,229 | $ 16,609 | 9.06% |

| | All IP Services (White Oak and Takoma Park) | | |
|---|---|---|---|
| | 2018 | 2019 | Variance |
| Inpatient Revenue | $ 180,388,426 | $ 198,187,151 | 9.87% |
| Admissions and Births | 12,613 | 12,731 | 0.94% |
| Revenue per Admission | $ 14,302 | $ 15,567 | 8.85% |