PROJECT DESCRIPTION

1. If this project is implemented as proposed, how much space will be “mothballed”?

Applicant Response:

Suburban’s response to Standard .04B (16) shell space includes a summary table by floor of shell space in the new building addition and space in the existing facility that will be vacated and is not identified to be renovated for a new purpose. (See p. 68)

In the new building, Suburban proposes to build 35,212 sf on the second floor as shell space for physicians' offices. Suburban also proposes to build 35,288 of shell space on the third floor which could be fitted out as a nursing unit in the future. Because of the Zoning obstacles Suburban’s future opportunities for expansion are limited, this flexible shell space is the only way Suburban can assure an ability to add nursing unit or other clinical capacity if needed.

In the existing building, Suburban will be vacating 8,009 sf on the basement level, 5,391 sf on the first floor, 7,890 sf on the fourth floor, and 38,718 sf on the fifth floor (for a total of 60,008 sf of vacated space in the existing building). While Suburban has provided an explanation of how it may use this space in the future on page 68 of the CON, it has not been determined what the top priorities yet, off campus departments etc.

2. Please resubmit Table B in a form that shows the “before and after” space allotted to each department/functional area. The purpose of this table is to allow analysis of the changes in space allocation.

Applicant Response:

Please refer to Exhibit 39 for revised Table B.

PROJECT BUDGET

3. Is the cost of widening the sewer that was described in the application included in the project budget?

Applicant Response:

The estimated cost of widening the sewer, $5,000,000 is included in the project budget. Please refer to Exhibit 1D, Offsite Costs Utilities.

4. Please describe/define “imputed interest.”

Applicant Response:

Imputed Interest Capitalized As Part of Asset Construction

The objective of capitalizing interest costs as required under FASB ASC 835-20 (“Capitalization of Interest Costs”) is to obtain a measure of acquisition cost that more clearly reflects the enterprise's total investment in the asset and achieves a better matching of costs deferred to future periods with revenue of those future periods. There are two types of interest costs that, if material, are required to be included in the costs of a self-constructed, long-term asset. The first are the actual financing transactions associated with the specific construction project (i.e. interest costs incurred on debt specifically issued to finance the project). The second is an allocation to the construction project of (1) interest costs incurred by the enterprise for debt that was not specifically issued to finance the project but was outstanding during the period of construction and was used to fund project costs or (2) opportunity costs associated with the loss of investment income on the enterprise’s cash that is used to fund project costs. This allocation is referred to as imputed interest costs. The theory behind capitalizing non-specific interest costs or opportunity costs associated with the loss of investment income is that these costs could have been avoided if the asset had not been constructed. The calculation is the weighted average interest rate of the non-specific debt or investment earning rate that could have been earned on the enterprise’s cash applied to the weighted average accumulated expenditures on the project that are funded with the non-specific debt or non-philanthropic cash.

CONSISTENCY WITH GENERAL REVIEW CRITERIA (COMAR 10.24.01.08G(3))

a) The State Health Plan

COMAR 10.24.10 - ACUTE HOSPITAL SERVICES standards

Bed Need and Addition of Beds

5. Please provide the basis of the projected 11.5% increase in discharges for 2015, following on a small decrease in 2014, and in an environment in which population health is being emphasized and disincentives created for volume increases. If based on YTD volumes, can you provide any data or hypothesis as to the reason(s) for this increased volume?

Applicant Response:

The 11.5% noted in the question above reflects projected growth in general medical/ surgical discharges (line 1a of Table F); total SH discharges per Table F are only projected to grow 3.4%. As indicated in the table below, in FY2015, the increase in inpatient discharges was driven by two major service lines – Medicine (11% increase over FY14) and Orthopedic Surgery (33% over FY14). The projected FY15 volumes included in Table F at the time the application was filed were based on 8 months of FY15 actual data. Now with an additional 2 months of data, Suburban Hospital's (SH) FY15 actual discharges are 11,280 which annualize to 13,536 compared to 13,635 included in Table F of the Certificate of Need application. As noted in Exhibits 28 and 29 of the application, the population in Suburban Hospital's service area is an aging population, and the growth in volumes is consistent with this demographic. Growth is also consistent with the HSCRC's assumed 1.02% growth for SH's HSCRC defined market area included in SH's GBR calculation.

The Medicine discharges were primarily from flu and influenza related diseases (these accounted for 60% of Medicine discharges based on ICD9 Septicemia related diagnosis). This is consistent with primary market demographic as well as the fact that the flu vaccine missed the strains that became prevalent. In the projections, Suburban accounted for FY15 influenza-related cases t as a one-time exception and adjusted for it by removing 79 discharges in pulmonology and 22 discharges in medicine from the FY15 base when projecting FY16 volumes.

The Orthopedic surgery growth is mainly due to large growth in Orthopedic Joint Replacement surgery (grew in FY15 by 23% over prior year) and other orthopedic surgery (grew in FY15 by 10% over prior year). This is due to a combination of the fact that the population in Suburban's service area is aging, as well as physician alignment

strategies involving Johns Hopkins employed physicians and community based physicians. Additionally, SH has been designated by Kaiser Permanente as a joint replacement hospital for its members, which has also contributed to the growth of orthopedic volumes at Suburban. Both physician alignment strategies and becoming a Kaiser designated joint replacement hospital shift patients from other hospitals, both in state and out of state.

With the emphasis on population health and disincentives for volume increases, SH is actively working with community and other providers to reduce avoidable utilization such as readmissions, ambulatory sensitive condition- related admissions, etc. As SH inpatient discharges grow, potentially avoidable utilization (PAU), like readmission, is not projected to increase. The current FY 2015 (YTD March) readmission rate to the hospital is 9.5% and is lower than the FY 2014 rate of 10.2%. (This represents readmissions on discharges from SH and readmitted to SH.)

		IP Discharges			% Change from Prior Year	
Product Line	Sub Product Line	**2013**	**2014**	**2015P***	**2014**	**2015P***
Medicine	Medicine	1,361	1,518	1,688	12%	11%
Orthopedics	Ortho Joint Replacement	1,306	1,461	1,791	12%	23%
	Orthopedic Medicine	135	147	144	9%	-2%
	Orthopedic Surgery	403	433	476	7%	10%
ALL IP DISCHARGES		**13,277**	**13,169**	**13,628**	**-1%**	**3%**

*2015P: FY 2015 Discharges estimated based on annualized number calculated from FY 2015 YTD April IP discharges .

6. Please provide an updated projection of licensed beds (p.30) using the latest available information.

Applicant Response:

FY16 licensed beds will be determined based on total patient days for the 12 months ended March 31, 2015. Below is an updated calculation:

Total Patient Days April 2014 through March 2015	61,299
Average Daily Census (ADC)	167.9
ADC flexed 140% for licensed beds	235
Less licensed psychiatric beds	(24)
Less licensed pediatric beds	(3)
Projected FY15 MSGA beds	208

Cost-Effectiveness

7. Given the space that will be vacated – without immediate plans for use – was there consideration of using that space for medical office space instead of building it in the proposed new section, and if so, why was that option rejected?

Applicant Response:

Initial consideration was given to the possibility of locating physician office space in the vacated fifth floor of the existing facility, however this alternative was rejected for the design and operational flow reasons explained below:

- The square footage available is spread out on 4 different wings. The geometry of the narrow wings does not provide the depth required for an efficient layout of medical office space.
- Medical Office space generates more patient volume per square foot than a hospital department in the same square footage. Suburban's existing elevators do not have the capacity for the foot traffic that will be generated by the medical office space.
- As noted in the narrative of the application, Suburban has multiple departments that are currently offsite that will be relocated back to the campus in the future. Additionally, there are numerous departments that are not moving to the building addition that are undersized in their current location. Over the next five years Suburban will identify priorities for use and renovation of the vacant space to address the space needs of the organization.

The main entry level location of the physician office space in the building addition was specifically selected as it will not require elevators to support the space and the space is convenient to patient parking, the outpatient pharmacy and other retail services.

8. Please provide excerpts from the AECOM-developed master facility plan that would further the Commission's understanding of the space issues and needs. At minimum, an Executive Summary (assuming one is part of the presentation) and any tables or matrices that summarize the space shortages and issues would prove useful.

Applicant Response:

A written report and executive summary was not prepared by AECOM (Ellerbe Becket) as part of the master planning engagement. Exhibit 40 includes the May 5, 2005 PowerPoint presentation provided by AECOM summarizing the discovery phase of their engagement. Many of the slides have already been incorporated as exhibits in the original application. A full report was prepared by AECOM as part of the zoning submittal. Although this report was written to address specific zoning criteria, this report is included in Exhibit 41 as a reference document.

Construction Cost of Hospital Space

9. Explain how the elevator add-on amount was calculated for the basement. (The calculation of the cost per sq. ft. add-on on page 4 of Exhibit 19 does not appear correct.)

Applicant Response:

In Section 15, page 36 of the MVS, the cost of adding one stop of a freight elevator in Good quality construction is listed as $9,800. Suburban inadvertently divided that by the number of square feet in the Penthouse, rather than the Basement. The corrected calculation is presented below:

$9,800	MVS Good Cost/Stop, p. 15-36
64,432	SF
$0.15	Cost/SF

This correction reduces the MVS benchmark from $195.41 to $184.70. It further affects the Consolidated Benchmark as follows:

		MVS Benchmark	Sq. Ft.		Total Cost Based on MVS
Standard					
"Tower" Component		$364.44	235,597	$	85,862,129.23
Basement		$184.70	64,432	$	11,900,450.58
Mechanical Penthouse		$173.68	1,046	$	181,665.23
Consolidated	**$**	**325.32**	301,075	$	97,944,245.03

Hence the comparison of the Project Costs to the Consolidated Benchmark is as follows:

MVS Benchmark	$325.32
The Project	$329.94
Difference	$4.62
	1.42%

10. Regarding the so called “extraordinary costs”, please provide the following additional explanations:

    a. Explain how the adjustment for restricted site was calculated and why the amount of the adjustment is a reasonable estimate for this adjustment.

Applicant Response:

The scope of construction elements used to address the topic of “Restricted Site” focused on the construction of the building structure, building envelope and central mechanical and electrical facilities. While site work is also strongly influenced by a restricted site it was not used in this determination since it has been addressed in and of its own right elsewhere in the application. At the other extreme of performing the construction there has only been minor consideration given to the finish trades involved limited to factors for storage and transportation; the concept being once the materials are inside the building and on the floor the performance of the work will proceed no differently than any other project of similar scale.

Each area of work considered to be affected by the restricted site condition was broken into its approximated percentages for labor and all other costs. To these the estimator judgmentally applied the impact of the restricted site to the individual labor and individual other components. Out of a labor cost of approximately $19.284 million, $1.486 million (7.71%) was determined to be a premium construction cost due to restricted site conditions. The other cost pool is valued at approximately $28.932 million where the premium for restricted site was approximately $1.682 million (5.81%). Of the elements being considered the blended premium is 6.57% and if compared to all costs of building construction ($80.816 million) the premium is 3.62%.

The approach to this adjustment is based on the work of seasoned construction professionals and estimators benefitting from their experience and judgment in the construction industry as well as the local markets. MVS is a proponent of applying experience and judgment in the development of costs. The result of the blended calculation is favorable when compared with the Zayed-Bloomberg project constructed by The Johns Hopkins Hospital also subject to review under the CON process.

10.

b. The explanation of the Sheet and Shore Basement Excavation premium and the Backfill premium seems to suggest that that the sheet and shore excavation will replace the more standard sloped excavation and backfill. If this is a correct reading of the description on page 49, explain why the calculation of MVS comparison includes adjustments removing costs for both from the project cost that is compared with the MVS benchmark. Shouldn't the MVS benchmark be adjusted downward for the fact that the project will not include the backfill that is explicitly included in the MVS base cost per square foot? If the reading of the explanation for these premiums is not correct explain why not.

Applicant Response:

The characterization made in this question is accurate and we have taken this into consideration but have not reflected it properly.

To be clear, the value provided for the item entitled "Sheet and Shore Basement Excavation" is specific to the subcontractor operation of furnishing and installing the structural shoring system which is a process that includes a very minor excavation function complementing the installation. Perhaps the title of this item with its inclusion of the word "Excavation" gives rise to some confusion. The operative words in the title are "Sheet and Shore".

To the root of the question, the value provided for the item entitled "Backfill Premium" is net of the quantities and costs had a normal layback excavation been possible as is the case with the MVS benchmark value. This has not been properly reflected in Table D. Please see a modified version of Table D (Exhibit 42) where you will find the Backfill Premium value of $721,520 has been removed from the Normal Site Preparation line and a new line item entitled "Backfill Premium" has been included with the various "Excluded" items.

10.

c. Regarding the adjustment for concrete frame construction, please describe concrete frame construction compared to steel frame (MVS Class A) and reinforced concrete columns and beams (MVS Class B). Explain why this is necessary or preferable to steel frame construction or reinforced concrete columns and beam construction.

Applicant Response:

In a healthcare facility, a concrete frame structure offers several benefits to steel frame construction, when viewed in the context of a facility's lifecycle operations. The benefits a concrete frame structure can provide include:

- Ability to eliminate the need for braced frames, which increases future flexibility
- Fireproofing is not required
- Improved infection and dust control performance
- Ability to more readily meet vibration and live load requirements associated with medical equipment

10.

d. Submit the calculation of the architectural and engineering fees related to extraordinary costs and explain how they are accounted for in the calculation of the total cost adjustment of $24,986,258.

Applicant Response:

The adjustment for architectural and engineering fees was calculated by first determining the percentage that the Extraordinary Costs comprised of the Building, Site Preparation, and Permits. This percentage was then applied to the A&E Fees. The calculations are shown below.

Building	$89,816,065
Site Preparation	$13,372,894
Permits	$1,049,400
Total	$104,238,359
Extraordinary Costs	$24,986,258
Percent	23.97%
A&E Fees	$5,537,540
Adjustment	$1,327,366
Adjusted A&E Fees	$4,210,174

Inpatient Nursing Unit Space

11. Reconcile the space reported for Inpatient Nursing Unit Space in the response to Standard 04.B(9) in the table on page 54 (424.7 SF/Bed) with that reported in Table B., Departmental Gross Square Feet Affected by Proposed Project, which shows considerably more space, and appears in excess of this standard.

Applicant Response:

In the response to Standard 04.B (9) the square footages were calculated per the "Inpatient Unit Program Space per bed" definition in the COMAR standard. The COMAR standard square footage calculation results in a departmental **net** square footage for the proposed Inpatient Nursing Unit which does not exceed the standard. Table B requests the **gross** departmental square footage for the hospital departments. The gross square footage of the Inpatient Nursing Unit is calculated to the outside of the exterior walls on the patient floor. The difference between the square footages is simply the difference between the net and gross square footage on the Inpatient Nursing Unit.

Financial Feasibility

10. Please provide the following additional information and clarifications:

    a. Reconcile the FY 2014 and 2015 patient revenues set forth in Tables G and H with the Global Budget Revenue agreement that covers Suburban Hospital.

Applicant Response:

Suburban Hospital entered into a Global Budget Revenue (GBR) agreement with the Health Services Cost Review Commission (HSCRC) effective July 1, 2013. This agreement covered all in-state revenue leaving out-of-state revenue subject to HSCRC rate center regulations only. In FY 2014 (FYE June 30, 2014) Suburban's GBR was set at $257,153,000. This amount was not provided to Suburban until late in the fiscal year resulting in an overcharge of $2.8 million. The HSCRC agreed to waive penalties and adjust this amount from the FY 2015 GBR so that for the 2-year period we would be neutral. The attached schedule demonstrates that overcharge and adjustment in FY 2015. The schedule also shows that we are in compliance with the FY 2015 agreement.

FY 2014 out-of-state revenue and unregulated revenue are at actual charges for the period. FY 2015 out-of-state revenue and unregulated revenue is an estimate based on actual experience July 2014 – February 2015.

10.

b. Project the GBR for FY 2016 through FY 2022 detailing year to year adjustments including annual update, population, market share and capital-related rate increase. Reconcile the projections with Tables G and H.

Applicant Response:

For FY 2016 our GBR update includes an update factor of 2.21% adjusted by (0.95%) for a reduction in uncompensated care funding along with a population adjustment of 0.97%. For Market Share, we used the estimate provided by the HSCRC in February to account for the amount we would expect in revenue in FY 2016. The other adjustment that is on the schedule refers to the one-time infrastructure adjustment. For out-of-state, we assumed a 1.71% update factor adjusted by (0.95%) for the uncompensated care funding. The out-of-state volume growth is based on 100% of actual volume growth assumptions, it does not include any assumption on increasing the overall percentage of out-of-state volumes. The unregulated revenue carries the same assumptions as out-of-state with the exception that it does not include the adjustment for uncompensated care.

For FY 2017 – FY 2022, the GBR rate includes the following:

- Update Factor – 2.40% annually

- Population Adjustment – 1.07% annually (based on HSCRC population assessment FY 2014)

- Market Share – Looks at volume growth percent annually, subtracts out the 1.07% population adjustment and applies a 50% adjustment for fixed expenses to come up with the percent market share. For example, in FY 2021 we anticipate a 1.7% growth in volumes, we subtracted the 1.07% with the assumption that this was population growth, we then took 50% of the difference to come up with the 0.3% market share.

- For out-of-state and unregulated revenue, we assumed a 1.71% annual update factor and have volume at the annual assumed growth rate.

10.

c. For any revenues not covered by the GBR, please specify all assumptions on a year to year basis.

Applicant Response:

Other Operating Revenue assumes an annual growth rate of 2% in FY 2016 and 3% in FY 2017 – 2022. With the exception of Meaningful Use Incentive dollars (expected to reduce ($700) thousand per year in FY 2016, FY 2017 and FY 2018 when the incentive payments come to an end.

10.

d. For each expense line in Tables G and H submit a table specifying all assumptions on a year to year basis.

Applicant Response:

Please find attached the Expense inflation assumptions for the financials:

EXPENSES	FY 2016	FY 2017 – FY 2022
Salaries & Wages	2.0% Inflation plus staffing related to volume change	2.5% Inflation plus staffing related to volume change plus staffing for new construction operations (Schedule L)
Contractual Services	2.0% Inflation plus 4% for ongoing expenses related to Information Systems plus 5% for one-time Information System related expenses around system transitions	3.0% inflation less 5% for one-time Information Systems related expenses around system transitions
Interest of Current Debt	Based on Amortization Schedule	Based on Amortization Schedule
Interest on Project Debt	N/A	Based on planned Debt Level Assumed Amortization Schedule
Current Depreciation	Based on life of planned capital expenditures	Based on life of planned capital expenditures
Project Depreciation	N/A	Based on planned project with each component spread over depreciable life
Project Amortization	Based on planned Debt Level Assumed Amortization Schedule	Based on planned Debt Level Assumed Amortization Schedule
Supplies	2.0% inflation plus variable costs related to volume change – less 1% programmed operational efficiency improvements	3.0% inflation annually– less programmed operational efficiency improvements based on benchmarking consistent with historical improvements of approximately 2-3% per year
Other Expenses	2.0% inflation - less programmed operational efficiency	3.0% inflation - less programmed operational efficiency improvements based on benchmarking consistent with historical improvements of approximately 2-3% per year plus incremental costs associated with project

Table G. Uninflated excludes all items related to inflation and removes any planned annual operational efficiency improvements.

10.

e. A statement on page 64 says that the hospital will generate excess revenues over expenses in the 2nd year following opening of the new building as indicated by Table G. Which year is the second year[1]?

Applicant Response:

The second year is FY2022

[1] Note that Table G reports project related interest and depreciation beginning in FY 2020 and negative income from operations in both 2020 and 2021.

Shelled Space

11. What is meant by the statement “The physician office space is classified as shell for the purposes of the application and is not part of the performance requirements of the proposed project”?

Applicant Response:

The physician space included in the proposed project was classified as shell as it will be leased to Johns Hopkins affiliated and community based physicians. The project budget includes only the cost of the shell and an allowance for tenant improvement funds. The full cost of the fit out will be the responsibility of the physician practices leasing the space. The physician space fit-out will not be completed as part of the building addition construction contract. Design and construction services will be contracted by individual suites based on the preferences of the practice and lease negotiations. Accordingly, physician office space fitout will not be part of the performance requirements of the proposed project.

COMAR 10.24.11 GENERAL SURGICAL SERVICES standards

12. Please define the meaning and use of the variable “Suburban cases/1000” (Table 2, p. 77).

Applicant Response:

Suburban cases/ 1000 is a calculation of Suburban surgical cases per 1,000 people of the total service area population. It was simply used to provide a comparison between years of Suburban utilization.

(d) Viability of the Proposal

13. Regarding the philanthropic funding of the Suburban's Campus Enhancement effort address the reasonableness of the $75 million goal sources of funds for this project and specify the plans for the $37 million that is not expected to be designated to the proposed project.

Applicant Response:

The Suburban Hospital Foundation (the Foundation) is a not-for-profit, tax exempt organization created in 1996 to serve as the philanthropic arm of Suburban Hospital *(see below)*. The Foundation is governed by a volunteer Board of Trustees and supported annually by more than 2,500 generous donors, including grateful patients, community members, corporations and foundations, employees, and medical staff. The Foundation fulfills its mission by encouraging annual fund gifts, actively seeking major and planned gifts, and by managing a variety of special events. By allowing significant investment in advanced technology, program expansion, and clinical initiatives, charitable funding helps to assure the best possible healthcare for all members of the community.

Suburban Hospital Foundation believes a $75M campaign is realistic and achievable given the $39M raised to date and the fact that Suburban Hospital has a consistent history of meeting or exceeding fundraising goals. Currently, the Foundation is in the silent phase of the campaign for the Campus Enhancement Effort; future plans include:

- Developing a strategic plan to create a messaging platform
- Initiating and managing a campaign committee of grateful patients and current donors
- Coordinating fundraising efforts with our colleagues at Johns Hopkins.
- Engaging support from former trustees and board members
- Cultivating and soliciting major community leaders and philanthropists
- Creating sponsor opportunities for the corporate community
- Conducting a series of events to build awareness and raise funds
- Initiate and manage a staff and physician campaign"

The $37M that is not designated for the proposed building addition will be used for the portion of the Campus Enhancement Effort that is not include in the Certificate of Need application (sitework and garage).

14. Regarding the source of the cash contribution, please reconcile the $262 million in Suburban Hospital and Suburban Hospital Healthcare System assets whose use is limited by the Board of Trustees with the balance sheet in Exhibit 33 (specify the amounts included in this number by line and column).

Applicant Response:

The $262 million in Suburban Hospital and Suburban Hospital Health System is a combination of the assets whose use is limited by Board of Trustees from Suburban Hospital ($139 million Column 4, Row 16) and Suburban Hospital Health System ($123 million Column 10, Row 16).

15. Identify any commitments or plans for the use of these assets in addition to the proposed project and the schedule for implementation of such commitments and plans.

Applicant Response:

The only other commitments or plans for use of assets, is for ongoing operations and routine capital needs of the organization. As part of Suburban's long range financial planning, Suburban included routine capital needs in addition to the commitment needed for the total Campus Enhancement effort. At this time there are no plans for new operational programs that will negatively impact financial performance and require a working capital commitment. The projected anticipated routine capital needs are very similar to historical experience. Below is a summary of the anticipated commitment for routine capital needs through FY2022.

	Suburban Hospital						
	Dollars in Thousands ($000s)						
	Projected Capital Spending						
	FY16	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**	**FY22**
Routine							
Construction	2,655	2,341	2,388	2,435	2,484	2,534	2,585
Physical Plant	1,100	936	955	974	994	1,014	1,034
Information Technology	2,200	2,081	2,122	2,165	2,208	2,252	2,297
Medical Equipment	7,342	6,675	6,808	6,945	7,083	7,225	7,370
Non Medical Equipment	255	260	265	271	276	282	287
Strategic Priorities	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Contingency	0	2,000	2,000	2,000	2,000	2,000	2,000
Total Routine Capital	14,552	15,293	15,539	15,790	16,045	16,306	16,573

16. Specify where the $36 million in cash that has already been raised is reported on the balance sheet.

Applicant Response:

The $36 million of funds that have already been received are split with $33 million in located in Suburban Hospital Unrestricted Net Assets and $3 million located in Temporarily Restricted Net Assets.

17. Specify the source of funds for Projects 1 and 2 as described in Anne Langley's letters of February 13, 2013 and September 17, 2013 and where these funds are reported on the balance sheet.

Applicant Response:

Projects 1 and 2 are part of the larger Campus Enhancement Effort discussed throughout the application. Similar to the proposed building addition, source of funds for Projects 1 and 2 is a combination of debt, cash reserves and philanthropic support.

18. Given that the debt financing for this project will be part of a larger debt offering by Johns Hopkins Healthcare System ("JHHS"), please provide the following:

    a. The most recent audited financial statement for JHHS;

Applicant Response:

Please see Exhibit 43 for most recent audited financial statements for JHHS

18.

b. A summary of JHHS experience with similar sized debt offerings; and

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Applicant Response:

The Johns Hopkins Health System (JHHS) has completed eleven separate financing transactions in the last three years totaling more than $1.1 billion. These transactions ranged in size from $48 million to $238 million and consisted of both fixed and floating rate instruments. Currently, all parity debt of the JHHS Obligated Group has ratings of AA-/Aa3/AA- from S&P, Moody's, and Fitch (collectively the national bond rating agencies), respectively. JHHS is currently the only AA rated Healthcare institution in Maryland.

Historically JHHS has received superior pricing in the market compared to other national, similarly-rated entities. The most recent fixed-rate Series 2015A bond issue of $135 million had an overall cost of capital of 3.80%. The pricing achieved by JHHS was better than the nine other "AA" rated healthcare institutions recently in the market thereby realizing the tightest credit spreads to the "AAA" benchmark.

JHHS has a treasury staff experienced in and dedicated to coordinating the financing process with the Organization, bond underwriters, tax and bond counsel, and the **Maryland Health and Higher Educational Facilities Authority**. JHHS is the largest issuer of tax-exempt bonds through MHHEFA. The JHHS treasury staff also issues quarterly SEC-level disclosure to the market related to the outstanding debt in addition to routine updates and correspondence with the national bond rating agencies. The senior director of the JHHS Treasury has 30 years of industry experience.

18.

c. Documentation of JHHS likely performance as measured by the financial ratios likely to be required by the bond covenants.

Applicant Response:

Johns Hopkins Health System Obligated Group

Tax-exempt bonds issued by The Johns Hopkins Health System Corporation (to finance a portion of Suburban Hospital's Campus Redevelopment Plan) will constitute Parity Obligations under the Indenture of Trust between the Maryland Health and Higher Educational Facilities Authority(1) and The Bank of New York Mellon (the "Master Trustee"), as amended and supplemented (the "Master Indenture"), and the Master Loan Agreement between the Authority and the Johns Hopkins Health System Obligated Group Members, as amended and supplemented (the "Master Loan Agreement"), secured equally and ratably with other outstanding Parity Debt to the extent provided in the Master Indenture.

Currently, the Johns Hopkins Health System Obligated Group consists of the Johns Hopkins Health System Corporation, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Inc., Suburban Hospital, Inc., Suburban Hospital HealthCare System, Inc., Howard County General Hospital, Inc., Lucy Webb Hayes National Training School for Deaconesses and Missionaries, d/b/a Sibley Memorial Hospital, and All Children's Hospital, Inc.

Each Obligated Group Member, as co-obligor and not as guarantor, jointly and severally covenants to pay the principal of, and premium, if any, and interest on, and the Purchase Price of, all Outstanding Parity Debt and to perform any and all other agreements and obligations of the Obligated Group Members under the Master Loan Agreement.

As of May 31, 2015 there is $1.65 billion of parity debt outstanding under the Master Loan Agreement.

Financial Covenants under the Loan Agreement

1) Rate Covenant – this is the only financial covenant under the Loan Agreement

The JHHS Obligated Group Members covenant in the Master Loan Agreement to fix, charge and collect such fees, rentals, rates and other charges in connection with the operation of the Group Facilities and the products and services provided by the JHHS Obligated Group Members as shall be sufficient to produce in each Fiscal Year a Coverage Ratio (2) as of the last day of such Fiscal Year that is not less than 1.10.

As of June 30, 2014, the most recently audited fiscal year end, the JHHS Coverage Ratio (2) was 5.1, well in excess of the 1.1 minimum required.

Projected Coverage Ratio

FY 2015	5.0
FY 2016	5.1
FY 2017	5.5
FY 2018	5.6
FY 2019	5.4
FY 2020	5.5

NOTES:

(1) The Maryland Health and Higher Educational Facilities Authority (the "Authority").

The Authority is a body politic and corporate of the State of Maryland, constituting an instrumentality organized and existing under and by virtue of the Act, Sections 10-301 through 10-356 of the Economic Development Article of the Annotated Code of Maryland. The purpose of the Authority, as stated in the Act, is to assist certain educational institutions, including institutions of higher education and non-collegiate educational institutions, and health care institutions, including hospitals and life care and continuing-care retirement communities, in the construction, financing and refinancing of certain projects approved by the Authority.

(2) Projected figures are based on Maximum Annual Debt Service and are for JHHS and Affiliates.

For Affirmations, please see Exhibit 44.