BAKER DONELSON

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HOWARD L. SOLLINS, SHAREHOLDER
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July 11, 2018

VIA EMAIL & HAND DELIVERY
Kevin McDonald, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Adventist Rehabilitation Hospital of Maryland, Inc.
d/b/a Adventist HealthCare Rehabilitation
Adventist HealthCare, Inc. d/b/a Washington Adventist Hospital
Certificate of Need Application

Dear Mr. McDonald:

Enclosed please find six copies of a Certificate of Need Application being filed on behalf of Adventist Rehabilitation Hospital of Maryland, Inc. d/b/a Adventist HealthCare Rehabilitation ("AHR") and Adventist HealthCare, Inc., d/b/a Washington Adventist Hospital ("WAH") regarding relocating 42 rehabilitation beds (comprised of 32 beds currently licensed to AHR and operated within WAH, plus an additional 10 approved waiver beds that AHR plans to add to its WAH location in current space) to two floors to be built by WAH at its new facility presently under construction in White Oak. A full copy of the application will also be emailed to you in searchable PDF, Excel and Word forms. WAH previously submitted one set of full size project drawings on March 2, 2018 with its Request for Project Change After Certification, which is superseded by this submission. If the full size project drawings are not readily accessible by the Commission, another copy will be provided upon request.

I hereby certify that a copy of the CON application has been provided to the affected local health department.

If any further information is needed, please let us know.

Sincerely,

BAKER, DONELSON, BEARMAN,
CALDWELL & BERKOWITZ, PC

Howard L. Sollins

JJE/mla

Enclosures

cc: Dr. Travis A. Gayles, M.D., Ph.D., Health Officer
Montgomery County
Ben Steffen, Executive Director
Ms. Ruby Potter
Health Facilities Coordination Officer
Brent Reitz, President, MSPT, MBA, FACHE
Adventist Rehabilitation Hospital of Maryland, Inc.
Erik D. Wangsness, President
Adventist HealthCare Washington Adventist Hospital
Robert E. Jepson, Vice President/Business Development
Washington Adventist Hospital
John J. Eller, Esquire

STATE OF MARYLAND

Craig P. Tanio, M.D.
CHAIR

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION
4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

INSTRUCTIONS FOR APPLICATION FOR CERTIFICATE OF NEED HOSPITAL PROJECTS

ALL APPLICATIONS MUST FOLLOW THE FORMATTING REQUIREMENTS DESCRIBED IMMEDIATELY BELOW. NOT FOLLOWING THESE FORMATTING INSTRUCTIONS WILL RESULT IN THE APPLICATION BEING RETURNED.

REQUIRED FORMAT:

Table of Contents. The application must include a Table of Contents referencing the location of application materials. Each section in the hard copy submission should be separated with tabbed dividers. Any exhibits, attachments, etc. should be similarly tabbed, and pages within each should be numbered independently and consecutively. **The Table of Contents must include:**

- **Responses to PARTS I, II, and III of this application form**
- **Responses to PART IV**
  COMAR 10.24.10: Acute Care Hospital Services
  Other applicable facility-specific State Health Plan chapters
  Review Criteria listed at 10.24.01.08G(3)(b) through(f)
- **Attachments, Exhibits, or Supplements**
  Identification of each attachment, exhibit, and supplement

Application pages must be consecutively numbered at the bottom of each page. Exhibits attached to subsequent correspondence during the completeness review process shall use a consecutive numbering scheme, continuing the sequencing from the original application. (For example, if the last exhibit in the application is Exhibit 5, any exhibits used in subsequent responses should begin with Exhibit 6. However, a replacement exhibit that merely replaces an exhibit to the application should have the same number as the exhibit it is replacing, noted as a replacement.

SUBMISSION FORMATS:

We require submission of application materials in three forms: hard copy; searchable PDF; and in Microsoft Word.

- **Hard copy:** Applicants must submit six (6) hard copies of the application to:
  Ruby Potter
  Health Facilities Coordinator
  Maryland Health Care Commission
  4160 Patterson Avenue
  Baltimore, Maryland 21215

- **PDF:** Applicants must also submit *searchable* PDF files of the application, supplements, attachments, and exhibits.[1] All subsequent correspondence should also be submitted both by paper copy and as *searchable PDFs*.

- **Microsoft Word:** Responses to the questions in the application and the applicant's responses to completeness questions should also be electronically submitted in Word. Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

PDFs and spreadsheets should be submitted to ruby.potter@maryland.gov and kevin.mcdonald@maryland.gov.

Note that there are certain actions that may be taken regarding either a health care facility or an entity that does not meet the definition of a health care facility where CON review and approval are not required. Most such instances are found in the Commission's procedural regulations at COMAR 10.24.01.03, .04, and .05. Instances listed in those regulations require the submission of specified information to the Commission and may require approval by the full Commission. Contact CON staff at (410) 764-3276 for more information.

[1] PDFs may be created by saving the original document directly to PDF on a computer or by using advanced scanning technology

For internal staff use

MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

HOSPITAL
APPLICATION FOR CERTIFICATE OF NEED

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: **Adventist Rehabilitation Hospital of Maryland, Inc. d/b/a Adventist HealthCare Rehabilitation**

Address:

7600 Carroll Ave	**Takoma Park**	**20912**	**Montgomery**
Street	City	Zip	County

Name of Owner (if differs from applicant):

2. OWNER

Name of owner: **Adventist HealthCare, Inc.**

3. APPLICANT. ***If the application has co-applicants, provide the detail regarding each co-applicant in sections 3, 4, and 5 as an attachment.***

Legal Name of Project Applicant
Adventist Rehabilitation Hospital of Maryland, Inc.

Address:

7600 Carroll Ave	**Takoma Park**	**20912**	**MD**	**Montgomery**
Street	City	Zip	State	County

Telephone: **301-891-5560**

Name of Owner/Chief Executive: **Brent Reitz, President**

3. Co-APPLICANT. ***If the application has co-applicants, provide the detail regarding each co-applicant in sections 3, 4, and 5 as an attachment.***

Legal Name of Project Applicant
Adventist HealthCare, Inc. d/b/a Washington Adventist Hospital

Address:

7600 Carroll Ave	**Takoma Park**	**20912**	**MD**	**Montgomery**
Street	City	Zip	State	County

Telephone: **301-891-7600**

Name of Owner/Chief Executive: **Erik Wangsness, President**

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from applicant:

5. LEGAL STRUCTURE OF APPLICANT (and LICENSEE, if different from applicant).

Check ☑ or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☒	
	(2) For-profit	☐	
	(3) Close	☐	State & date of incorporation Maryland, 2001
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited liability partnership	☐	
	Limited liability limited partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☐	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	☐	

6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Name and Title: **Rob Jepson, VP, Business Development**

Mailing Address:

7600 Carroll Avenue	**Takoma Park**	**20912**	**MD**

Street	City	Zip	State

Telephone: **301-891-6276**
E-mail Address (required): **RJEPSON@adventisthealthcare.com**
Fax:

B. Additional or alternate contact:

Name and Title: **Howard L. Sollins, Counsel, Baker, Donelson, Bearman, Caldwell & Berkowitz**
Mailing Address:

100 Light Street	**Baltimore**	**21202**	**MD**
Street	City	Zip	State

Telephone: **410-685-1120**
E-mail Address (required): **hsollins@bakerdonelson.com**
Fax:

7. TYPE OF PROJECT

The following list includes all project categories that require a CON under Maryland law. Please mark all that apply.

If approved, this CON would result in:

(1)	A new health care facility built, developed, or established	☐
(2)	An existing health care facility moved to another site	X
(3)	A change in the bed capacity of a health care facility	☐
(4)	A change in the type or scope of any health care service offered by a health care facility	☐
(5)	A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf	X

8. PROJECT DESCRIPTION

A. Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is; why you need/want to do it; and what it will cost. A one-page response will suffice. Please include:

(1) Brief description of the project – what the applicant proposes to do;
(2) Rationale for the project – the need and/or business case for the proposed project;
(3) Cost – the total cost of implementing the proposed project; and
(4) Master Facility Plans – how the proposed project fits in long term plans.

Adventist HealthCare Rehabilitation (AHR) seeks Commission authorization to relocate 42 rehabilitation beds (comprised of 32 beds currently licensed to AHR and operated within WAH, plus an additional 10 waiver beds that AHR plans to add to its WAH location in current space) to two floors built by Washington Adventist Hospital (WAH) at its facility presently under

construction in White Oak. The capital cost for construction of the two floors is $19.5 million.

AHR is a separate and distinct facility from WAH, having its own Chief Medical Officer, Board of Directors, President and medical staff. AHR serves patients that need Inpatient Rehabilitation, with the majority of the diagnoses being: Stroke, Traumatic and Non-Traumatic Brain Injuries, Traumatic and Non-Traumatic Spinal Cord Injuries, Amputation, Multi-Trauma and other miscellaneous diagnoses. AHR and WAH function currently as a landlord-tenant relationship, with a lease agreement. This relationship will continue at White Oak. The lease agreement includes market rent and operating costs for the leased square footage. Additionally, AHR contracts with WAH to provide other services: nutrition, EVS, respiratory therapy, radiology services, cardiology consults, and other emergent medical support.

AHR cannot sustain its infrastructure with the carrying costs of an aging building on the Takoma Park campus once WAH moves to its new location in White Oak. With WAH under active construction, now is the most cost-effective time to plan for the AHR relocation to White Oak and the addition of space to be leased for this purpose. Land use approvals do not need to be changed, the additional floors can be added to the existing, planned footprint in a cost-effective manner and support, utilities and parking can accommodate the use without other changes. In sum, this project provides all private rooms on a more accessible campus and will allow AHR to better serve its patients.

B. Comprehensive Project Description: The description must include details, as applicable, regarding:

(1) Construction, renovation, and demolition plans;
(2) Changes in square footage of departments and units;
(3) Physical plant or location changes;
(4) Changes to affected services following completion of the project; and
(5) If the project is a multi-phase project, describe the work that will be done in each phase. <u>If the phases will be constructed under more than one construction contract, describe the phases and work that will be done under each contract.</u>

The plan to construct the additional space to accommodate the 42 rehabilitation beds will be executed as a single phase, single contract project to be completed within 15 months. As the replacement WAH is under active construction, now is the most cost-effective time to construct additional space to accept the AHR program.

In order to accommodate the proposed 42 bed AHR program, two additional floors of 19,432 square feet (SF) each, totaling 38,864 SF, will be constructed on to the south portion of the existing five story building. This section of the building is the best location for the addition as it has been designed to accept two additional floors from a structural and mechanical, electrical, and plumbing

perspective.

The 42 bed rehabilitation program is distributed across the two additional floors with the appropriate amount of support spaces for each floor. All private rooms, 21 on each of the two additional floors, will be provided along with the appropriate support spaces required for acute rehabilitation programs.

As stated, now is the time to initiate construction as the WAH replacement continues to be an active construction site. Construction prior to occupancy and patient activation allows for better site-wide logistics and the avoidance of disruption to hospital patients.

Complete the DEPARTMENTAL GROSS SQUARE FEET WORKSHEET (Table B) in the CON TABLE PACKAGE for the departments and functional areas to be affected.

9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES

Complete the Bed Capacity (Table A) worksheet in the CON Table Package if the proposed project impacts any nursing units.

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: 48.86 acres

B. Have all necessary State and local land use approvals, including zoning, for the project as proposed been obtained? YES_X NO _____ (If NO, describe below the current status and timetable for receiving necessary approvals.)

C. Form of Site Control (Respond to the one that applies. If more than one, explain.):

(1) Owned by: Adventist HealthCare, Inc.
Please provide a copy of the deed. (Exhibits 1, 2)

(2) Options to purchase held by: _____
Please provide a copy of the purchase option as an attachment.

(3) Land Lease held by: _____
Please provide a copy of the land lease as an attachment.

(4) Option to lease held by: _____
Please provide a copy of the option to lease as an attachment.

(5) Other: _____
Explain and provide legal documents as an attachment.

11. PROJECT SCHEDULE

In completing this section, please note applicable performance requirement time frames set forth at COMAR 10.24.01.12B & C. Ensure that the information presented in the following table reflects information presented in Application Item 7 (Project Description).

	Proposed Project Timeline	
Single Phase Project		
Obligation of 51% of capital expenditure from CON approval date	4	Months
Initiation of Construction within 4 months of the effective date of a binding construction contract, if construction project	3	Months
Completion of project from capital obligation or purchase order, as applicable	15	Months
Multi-Phase Project for an existing health care facility (Add rows as needed under this section)		
One Construction Contract		Months
Obligation of not less than 51% of capital expenditure up to 12 months from CON approval, as documented by a binding construction contract.		Months
Initiation of Construction within 4 months of the effective date of the binding construction contract.		months
Completion of 1st Phase of Construction within 24 months of the effective date of the binding construction contract		months
Fill out the following section for each phase. (Add rows as needed)		
Completion of each subsequent phase within 24 months of completion of each previous phase		months
Multiple Construction Contracts for an existing health care facility (Add rows as needed under this section)		
Obligation of not less than 51% of capital expenditure for the 1st Phase within 12 months of the CON approval date		months
Initiation of Construction on Phase 1 within 4 months of the effective date of the binding construction contract for Phase 1		months
Completion of Phase 1 within 24 months of the effective date of the binding construction contract.		months
To Be Completed for each subsequent Phase of Construction		
Obligation of not less than 51% of each subsequent phase of construction within 12 months after completion of immediately preceding phase		months
Initiation of Construction on each phase within 4 months of the effective date of binding construction contract for that phase		months
Completion of each phase within 24 months of the effective date of binding construction contract for that phase		months

12. PROJECT DRAWINGS

A project involving new construction and/or renovations must include scalable schematic drawings of the facility at least a 1/16” scale. Drawings should be completely legible and include dates.

Project drawings must include the following before (existing) and after (proposed) components, as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, room sizes, number of beds, location of bathrooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as “shell space”.

B. For a project involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.

C. For a project involving site work schematic drawings showing entrances, roads, parking, sidewalks and other significant site structures before and after the proposed project.

D. Exterior elevation drawings and stacking diagrams that show the location and relationship of functions for each floor affected.

Project drawings are included as Exhibit 3.

13. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete the Construction Characteristics (Table C) and Onsite and Offsite Costs (Table D) worksheets in the CON Table Package.

B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project, and the steps necessary to obtain utilities. Please either provide documentation that adequate utilities are available or explain the plan(s) and anticipated timeframe(s) to obtain them.

The construction of the additional space is planned as an addition to the replacement hospital currently under construction. The additional space would be located as two new levels atop the existing five level south portion of the main hospital building. As such, all utilities required for the additional space will be provided by the utility infrastructure constructed for the replacement hospital, and already in place.

PART II - PROJECT BUDGET

Complete the Project Budget (Table E) worksheet in the CON Table Package.

Note: Applicant must include a list of all assumptions and specify what is included in all costs, as well the source of cost estimates and the manner in which all cost estimates are derived.

Table E is contained in Exhibit 4

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

1. List names and addresses of all owners and individuals responsible for the proposed project.

   Brent Reitz; Erik Wangsness

2. Is any applicant, owner, or responsible person listed above now involved, or has any such person ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each such facility, including facility name, address, the relationship(s), and dates of involvement.

   Mr. Reitz: Good Shepherd Rehabilitation Network, 850 Fifth St, Allentown PA 18103
   Vice President- Pediatrics 2007-2012
   Children's Specialized Hospital, 150 New Providence Rd, Mountainside, NJ 07092
   Director of Operations
   Mr. Wangsness: Jellico Community Hospital 188 Hospital Ln, Jellico, TN 37762, President/CEO 2011-2014
   Adventist Boiling Brook Hospital 500 Remington Blvd, Bolingbrook, IL 60440
   Director of Business Development/Assistant to CEO 2008-2011

3. In the last 5 years, has the Maryland license or certification of the applicant facility, or the license or certification from any state or the District of Columbia of any of the facilities listed in response to Question 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) ? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant(s), owners, or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

   No

4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) ever received inquiries from a federal or any state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with Maryland, another state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

   No

5. Has any applicant, owner, or responsible individual listed in response to Question 1, above, ever pled guilty to, received any type of diversionary disposition, or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

   No

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

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.

7/5/18
Date

Signature of Owner or Board-designated Official

President
Adventist Rehabilitation Hospital of Maryland, Inc.
Position/Title

Brent Reitz, MSPT, MBA, FACHE
Printed Name

Date

Signature of Owner or Board-designated Official

President
Adventist HealthCare Washington Adventist Hospital
Position/Title

Erik D. Wangsness
Printed Name

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

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.

7/5/18
Date

Signature of Owner or Board-designated Official

President
Adventist Rehabilitation Hospital of Maryland, Inc.
Position/Title

Brent Reitz, MSPT, MBA, FACHE
Printed Name

7/6/18
Date

Signature of Owner or Board-designated Official

President
Adventist HealthCare Washington Adventist Hospital
Position/Title

Erik D. Wangsness
Printed Name

PART IV - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

INSTRUCTION: Each applicant must respond to all criteria included in COMAR 0.24.01.08G(3), listed below.

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards and other review criteria.

If a particular standard or criteria is covered in the response to a previous standard or criteria, the applicant may cite the specific location of those discussions in order to avoid duplication. When doing so, the applicant should ensure that the previous material directly pertains to the requirement and the directions included in this application form. Incomplete responses to any requirement will result in an information request from Commission Staff to ensure adequacy of the response, which will prolong the application's review period.

10.24.01.08G(3)(a). <u>The State Health Plan</u>.

To respond adequately to this criterion, the applicant must address each applicable standard from each chapter of the State Health Plan that governs the services being proposed or affected, and provide a direct, concise response explaining the project's consistency with each standard. <u>In cases where demonstrating compliance with a standard requires the provision of specific documentation, documentation must be included as a part of the application.</u>

Every acute care hospital applicant must address the standards in COMAR 10.24.10: Acute Care Hospital Services. A Microsoft Word version is available for the applicant's convenience on the Commission's website. Use of the *CON Project Review Checklist for Acute Care Hospitals General Standards* is encouraged. This document can be provided by staff.

Other State Health Plan chapters that may apply to a project proposed by an acute care hospital are listed in the table below. A pre-application conference will be scheduled by Commission Staff to cover this and other topics. It is highly advisable to discuss with Staff which State Health Plan chapters and standards will apply to a proposed project before application submission. Applicants are encouraged to contact Staff with any questions regarding an application.

Copies of all applicable State Health Plan chapters are available from the Commission and are available on the Commission's web site here:
http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/hcfs_shp

10.24. 07	**State Health Plan: an overview** o **Psychiatric services** o **EMS**
10.24. 09	**Specialized Health Care Services - Acute Inpatient Rehab Services**
10.24. 11	**General Surgical Services**
10.24. 12	**Inpatient Obstetrical Services**
10.24. 14	**Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services**
10.24. 15	**Organ Transplant Services**
10.24. 17	**Cardiac Surgery and Percutaneous Coronary Artery Intervention Services**
10.24. 18	**Neonatal Intensive Care Services**
Capital Projects Exceeding the CON Threshold for Capital Expenditures	**Hospital Capital Projects Exceeding the CON Threshold for Capital Expenditures** Hospital projects that require CON review because the capital expenditure exceeds the CON threshold for capital expenditures but do not involve changes in bed capacity, the addition of new services, and otherwise have no elements that are categorically regulated should address all applicable standards in **COMAR 10.24.10: Acute Care Hospital Services** in their CON application. Applicants should consult with staff in a pre-application conference about any other SHP chapters containing standards that should be addressed, based on the nature of the project.

Adventist HealthCare Rehabilitation ("AHR"), the applicant, is not an acute care facility, but instead a specialty rehabilitation facility located in Washington Adventist Hospital ("WAH"). The response below will address the Specialized Health Care Services - Acute Inpatient Rehab Services standards. Because this project proposes the relocation of AHR's existing beds from WAH's Takoma Park campus to two newly constructed floors in WAH's replacement hospital in White Oak, and WAH will lease space to AHR, the relevant Acute Care Standards will also be addressed.

10.24.09 Specialized Health Care Services – Acute Inpatient Rehabilitation Services

.4 Standards.

A. General Review Standards.

(1) Charity Care Policy.

(a) Each hospital and freestanding acute inpatient rehabilitation provider shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide acute inpatient rehabilitation services on a charitable basis to qualified persons consistent with this policy. The policy shall have the following provisions:

(i) Determination of Eligibility for Charity Care. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the facility shall make a determination of probable eligibility.

(ii) Notice of Charity Care Policy. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's admission, facilities should address any financial concerns of patients, and individual notice regarding the facility's charity care policy shall be provided.

(iii) Criteria for Eligibility. A hospital shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. A hospital that is not subject to HSCRC regulations regarding financial assistance policies shall at a minimum include the following eligibility criteria in its charity care policies. Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge. At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of hospitals that are not subject to HSCRC regulations regarding financial assistance policies.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent HSCRC Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

(c) A proposal to establish or expand an acute inpatient rehabilitation hospital or subunit, for which third party reimbursement is available, and which is not subject to HSCRC regulations regarding financial assistance policies, shall commit to provide charitable rehabilitation services to eligible

patients, based on its charity care policy, which shall meet the minimum requirements in .04A(1)(a) of this Chapter. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(d) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a CON for a project that involves acute inpatient rehabilitation services, shall commit to provide charitable services to indigent patients. Charitable services may be rehabilitative or non-rehabilitative and may include a charitable program that subsidizes health plan coverage. At a minimum, the amount of charitable services provided as a percentage of total operating expenses for the health maintenance organization will be equivalent to the average amount of charity care provided statewide by acute general hospitals, measured as a percentage of total expenses, in the most recent year reported. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If the health maintenance organization's track record is not consistent with the expected level for the population in the proposed service area, the applicant shall demonstrate that the historic level of charity care was appropriate to the needs of the population in the proposed service area.

APPLICANT RESPONSE:

AHC provides financial assistance to low to mid income patients in need of our services. AHC's Financial Assistance Policy (FAP) provides a systematic and equitable way to ensure that patients who are uninsured, underinsured, and/or lack adequate resources to pay for services can access the medical care they need. In the event that third-party coverage is not available, a determination of potential eligibility for financial assistance will be made within two business days of a request for charity care or an application for medical assistance. AHC's Notice of Financial Assistance and Charity Care Policy is clearly posted in the emergency departments, business offices, and registration areas as well as on the AHC website https://www.adventisthealthcare.com/patients/billing/financial-assistance/ so that patients are aware that they can request financial assistance if they do not have the resources necessary for the total payment of their bill.

The FAP policy applies to AHC Shady Grove Medical Center, AHC Washington Adventist Hospital, AHC Behavioral Health & Wellness Services, and AHC Rehabilitation ("AHR"). It has been adopted by the governing body of AHC in accordance with regulations and requirements of

the State of Maryland and with the regulations under Section 501(r) of the Internal Revenue Code.

Notices of the availability of financial assistance are prominently posted in English and Spanish in the AHR Registration/Admissions Department and business offices. The charity care policy is made available to patients during the preadmission and/or admission process.

Public notice of nondiscrimination policy and access to care regardless of ability to pay is posted annually in The Washington Post. The most recent posting was made on July 6, 2017. The same notice was posted in Spanish in El Tiempo Latino, a daily newspaper in the Washington metropolitan area on July 6, 2017.

In 2017, WAH provided a total community benefit of 16.21% total operating expenses, respectively, as reported in the May 1, 2018 Maryland Hospital Community Benefit Report FY 2017 (`http://www.hscrc.state.md.us/Pages/init_cb.aspx`). The total net community benefit was 12.13% of operating expenses, ranking the hospital as providing the 6th highest amount of net community benefit for all hospitals in Maryland, with an average for all hospitals of 6.81%.

A copy of Financial Assistance Policy of the Adventist Health Care, Inc., Corporate Policy Manual and the public notices are appended to this application as Exhibits 7, 8, 9, 10.

The current proposal is compliant with this Standard.

(2) Quality of Care.
A provider of acute inpatient rehabilitation services shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene.

APPLICANT RESPONSE:

AHR's acute inpatient rehabilitation facility at the Takoma Park campus is licensed in good standing with the Maryland Department of Health and Mental Hygiene's Office of Health Care Quality.

See AHR's license attached as Exhibit 11.

(ii) Accredited by the Commission for Accreditation of Rehabilitation Facilities.

APPLICANT RESPONSE:

AHR is accredited by the Commission for Accreditation of Rehabilitation Facilities ("CARF") at both its Rockville and Takoma Park campuses. In fact, AHR was the first acute rehabilitation

hospital to be CARF certified for all four of its specialty programs (Stroke, Brain Injury, Spinal Cord Injury and Amputee) in a 5-state area that includes West Virginia, Delaware, Virginia, Maryland, and Washington, D.C.

See AHR's CARF certificate attached as Exhibit 12.

(iii) in compliance with the conditions of participation of the Medicare and Medicaid programs.

APPLICANT RESPONSE:

AHR is in compliance with the Centers for Medicare and Medicaid Services program's conditions of participation. AHR maintains deemed status and Joint Commission (TJC) (Exhibit 13)
as well as Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation.

(b) An applicant that currently provides acute inpatient rehabilitation services that is seeking to establish a new location or expand services shall report on all quality measures required by federal regulations or State agencies, including information on how the applicant compares to other Maryland acute inpatient rehabilitation providers. An applicant shall be required to meet quality of care standards or demonstrate progress towards reaching these standards that is acceptable to the Commission, before receiving a CON.

APPLICANT RESPONSE:

AHR seeks to relocate its 42 licensed acute rehabilitation beds at its Takoma Park campus to a new location at White Oak. AHR provides quality care to its patients and compares favorably to other Maryland acute inpatient rehabilitation providers. AHR's all cause readmission rate (30 days) per CMS data collected between 01/01/2014 and 12/31/2015 was 12.79% as compared to the nation at 13.39%.

Rehab Quality Metrics

	2015	2016	2017	2018
Fall with Injury Rate	0.79	0.38	0.27	0.28
HAI-Pressure Ulcer	27	7	2	0
HAI-MRSA Rate	0.15	0.04	0.15	0
HAI-CDIFF Rate	0.57	0.38	0.27	0.08
CAUTI Rate	1.2	2.5	4.2	0

Source: Internal. Rates are per 1,000 patient days and pressure ulcer is a count.

Discharge Home			
Year	AHC	Regional (Weighted)	National (Weighted)
2015	80.37%	75.15%	77.16%
2016	78.53%	75.12%	77.02%
2017	77.31%	74.83%	76.11%
YTD (as of 6/22/18)	77.83%	72.99%	74.54%

FIM Change Per Day			
Year	AHC	Regional (Weighted)	National (Weighted)
2015	2.39	2.27	2.14
2016	2.45	2.21	2.06
2017	2.53	2.24	2.09
YTD (as of 6/22/18)	2.67	2.25	2.13

Source: eRehab Database

FIM: Functional Independence Measure is an assessment of the severity of patient disability and is used to track the changes in the functional ability of a patient during an episode of hospital rehabilitation care.

(c) An applicant that does not currently provide inpatient rehabilitation services that is seeking to establish an inpatient rehabilitation unit within an acute care hospital or an inpatient rehabilitation specialty hospital shall demonstrate through reporting on quality measures that it provides high quality health care compared to other Maryland providers that provide similar services or, if applicable, nationally.

APPLICANT RESPONSE:

Not applicable. AHR is an existing provider of acute inpatient rehabilitation services.

B. Project Review Standards.

In addition to these standards, an acute general hospital applicant shall address all applicable standards in COMAR 10.24.10 that are not duplicated in this Chapter. These standards apply to applicants seeking to provide comprehensive acute

rehabilitation services or both comprehensive acute rehabilitation services and specialized acute rehabilitation services to adult or pediatric patients.

Because WAH, an acute care hospital, is a co-applicant with AHR for this project, the relevant acute care standards in COMAR 10.24.10 that are not duplicated in this Chapter will be addressed below.

(1) Access.

A new or relocated acute rehabilitation hospital or subunit shall be located to optimize accessibility for its likely service area population. An applicant that seeks to justify the need for a project on the basis of barriers to access shall present evidence to demonstrate that barriers to access exist for the population in the service area of the proposed project, based on studies or other validated sources of information. In addition, an applicant must demonstrate that it has developed a credible plan to address those barriers. The credibility of the applicant's plan will be evaluated based on whether research studies or empirical evidence from comparable projects support the proposed plan as a mechanism for addressing the barrier(s) identified, whether the plan is financially feasible and whether members of the communities affected by the project support the plan.

APPLICANT RESPONSE:

According to the Centers for Medicare and Medicaid Services (CMS), inpatient rehabilitation services are designed to provide intensive rehabilitation therapy in a resource intensive hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitative needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary approach to the delivery of rehabilitation care. CMS requires that at least 60% of the patients admitted to a rehabilitation facility or unit have one of 13 diagnoses. These 13 diagnoses are:

- Stroke
- Spinal cord injury
- Congenital deformity
- Amputation
- Major multiple trauma
- Hip fracture
- Brain injury
- Certain neurological disorders
- Arthritic conditions
- Systemic blood vessel disorders with joint inflammation
- Severe or advanced osteoarthritis
- Substantial loss of range of motion and atrophy of muscles surrounding joints
- Knee or hip joint replacement under certain conditions.

Alternatives to inpatient rehabilitation include skilled nursing facilities, home health services, and outpatient therapies. None of these alternatives, however, offer the same intensity of services and degree of functional improvement for patients who meet criteria for admission to an inpatient rehabilitation facility.

Adventist HealthCare Rehabilitation

Adventist HealthCare (AHC), based in Gaithersburg, Maryland, is a faith-based, not-for-profit organization of dedicated professionals who work together each day to provide excellent wellness, disease management, and health-care services to the community. AHR, an affiliate of AHC, offers inpatient and outpatient rehabilitation services that treat the whole person. Its compassionate experts partner with the patient and their family to promote physical, mental, and spiritual recovery after an illness or injury. AHR's goal is to provide expert rehabilitative care for adults while teaching patients and caregivers skills that help achieve a more independent, fulfilling life.

AHR operates a facility in leased space at WAH. This site provides inpatient care, and AHR's outpatient facility for Takoma Park patients is nearby at the corner of Carroll Ave and University Boulevard in Silver Spring. This outpatient service will stay at its current location. AHR's Rockville location is a free-standing 55-bed hospital next to Adventist HealthCare Shady Grove Medical Center and includes an outpatient gym for continued rehabilitation services. AHR offers comprehensive rehabilitation programs for traumatic brain injuries, spinal cord injuries, strokes, amputations, orthopedic injuries and surgeries, sports related injuries, work-related injuries and more.

Among the services offered at AHR are:

- Acute inpatient rehabilitative care
- Outpatient
- Occupational therapy
- Physical therapy
- Recreational therapy
- Speech, language and swallowing therapy
- Condition-specific programs – Includes cardiac and cancer rehabilitation

As part of the AHC system, patients have immediate access to acute care hospital services and a broad network of complementary services, including behavioral health care and home health care.

AHR offers an interdisciplinary team, which includes certified therapists and certified rehabilitation nurses who are qualified to treat complex conditions utilizing evidence-based practices to develop a personalized care plan upon admission that establishes rehabilitation goals which is reassessed throughout the patient's stay.

Barriers to Access

AHR's acute inpatient rehabilitation facility will be relocated from the current WAH facility in Takoma Park to the WAH replacement hospital in White Oak. The WAH replacement facility received Certificate of Need approval in December 2015, and it is anticipated that it will become operational in Summer 2019.

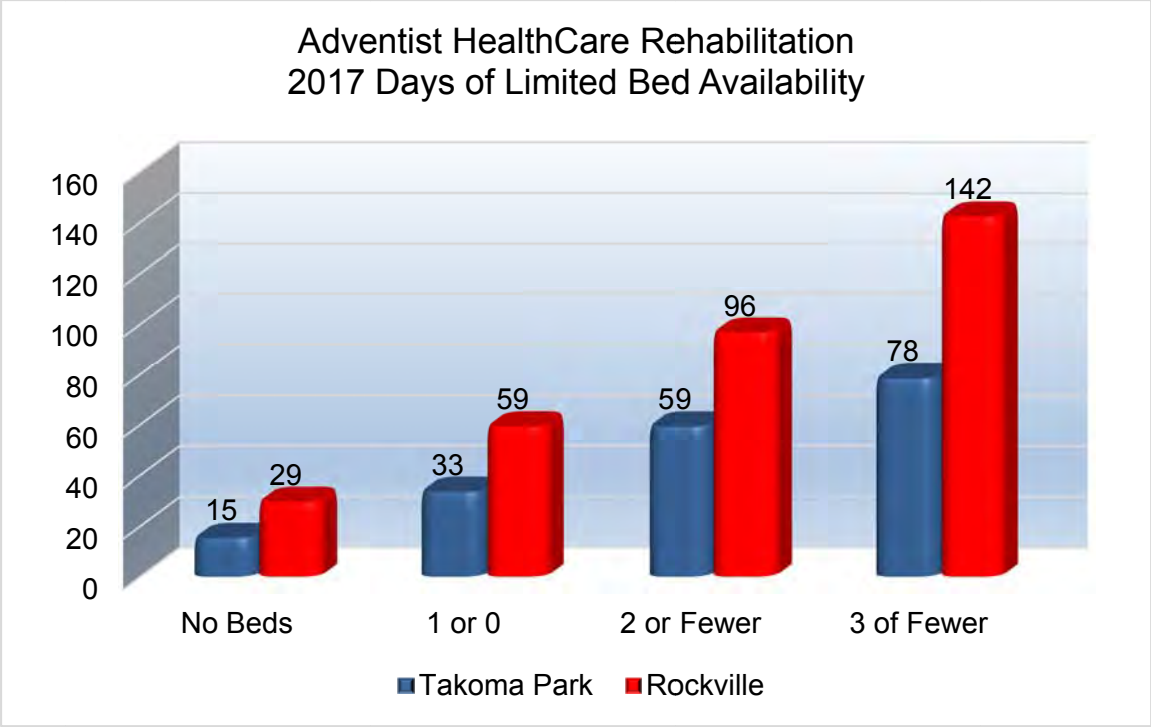
AHR's new location in White Oak will enhance access to the population that AHR currently serves. At its current location at WAH in Takoma Park, AHR is not convenient to access. WAH is located in a residential area and is only accessible by narrow, two-lane residential streets, making it difficult for patients and employees to access. In contrast, the WAH replacement hospital site is located on a 48.8 acre parcel on the west side of Plum Orchard Drive, west of its

intersection with Cherry Hill Road in the White Oak section of Montgomery County. This site is located approximately 6.6 miles from the existing Takoma Park campus of WAH; drive time is approximately 16 minutes according to MAPQUEST©. Additionally, the site is accessible to major interconnecting roadways, such as, Interstate 95, New Hampshire Avenue, Route 29 and Cherry Hill Road. The Inter County Connector (ICC) has a major connecting intersection just 1 mile north of the proposed White Oak campus located along Route 29 and Interstate 95.

Further, the White Oak site is serviced by Metrobus and Montgomery County plans to extend its Ride-On bus #10 to service the new site.

Another access consideration is the current configuration of AHR's existing unit in Takoma Park, which includes primarily semi-private rooms. Of the 32 beds currently in operation, only 4 beds are in private rooms. The 10 acute rehabilitation beds recently approved under waiver beds for Takoma Park will add 6 additional private rooms and 4 beds in semi-private rooms, which will assist in meeting current demands but will still limit AHR's operational flexibility. In many instances, the effective capacity of the Takoma Park facility has been reduced by the inability to use both beds in a semi-private room due to incompatible clinical conditions, infection risk, or gender matching. When a patient bed is 'blocked' in this way, a rehabilitation admission must sometimes be delayed or the patient referred to a more distant facility for care.

AHR closely coordinates services between its facilities in Rockville and Takoma Park. When a patient requiring acute rehabilitation cannot be accommodated on one campus due to capacity issues, the family is referred to the other campus for admission. Often there is limited flexibility to accommodate patients on either campus because of the number of double occupancy rooms. AHR's Rockville facility has a single private room. On a number of days each year, there have been few beds available, as summarized in the following chart for 2017. Even when beds are available at Takoma Park, the barriers presented by the number of beds in semi-private rooms creates an additional problem to fully utilize the available capacity, as well as the aging facilities and lack of contiguous gym space. Expected future growth in the demand for acute rehabilitation, discussed below, will further exacerbate the problems with bed availability.



Source: AHR internal records

The limited number and configuration of acute rehabilitation beds explains why AHR has to sometimes deny admission to patients who otherwise meet admission criteria, as shown in the table below. In some cases, patients referred to Rockville are reluctant to accept admission instead to AHR in Takoma Park because of its aging physical plant and the lack of private rooms. In some cases, patients may accept a referral to another provider outside of Montgomery County. Some patients simply elect to go home rather than leave the area. The recent addition of 10 acute rehabilitation waiver beds to Takoma Park will assist in reducing the number of denials, which in turn will increase the utilization of AHR's acute rehabilitation beds. However, the issues presented by WAH's aging facilities and semi-private beds will remain a barrier.

Adventist HealthCare Rehabilitation
Denials of Admission Due to No Bed Available

	2015	2016	2017	2018*
Rockville	79	63	42	53
Takoma Park	18	32	16	5
Total	97	95	58	58

*Through May 15, 2018

Source: AHR internal records

The relocation of the Takoma Park beds to a replacement acute rehabilitation hospital in the new White Oak facility will address these current barriers. Rehabilitation patients will be able to receive needed care on a timely basis and in their own community. The replacement hospital will feature 42 single bedded rooms, which will offer greater flexibility in admitting patients and offer a more efficient design with appropriately configured therapy, activity, dining spaces, and support spaces.

As a result, the relocation of AHR to White Oak is expected to have a positive impact on its service area. It is essential for AHR to accommodate the rehabilitative needs of its service area residents in modern facilities, using two facilities that serve different parts of the County that offer the most clinically appropriate and efficient treatment setting, which this project will accomplish.

This proposal is supported by the community. Attached as Exhibit 14 are letters of support for the project.

This proposal is compliant with this Standard.

(2) Need.

A project shall be approved only if a net need for adult acute rehabilitation beds is identified by the need methodology in Section .05 in the applicable health planning region (HPR) or if the applicant meets the applicable standards below. The burden of demonstrating need rests with the applicant.

This project does not propose any increase in the number of acute rehabilitation beds in the Montgomery HPR; instead, this proposal is to relocate 42 acute rehabilitation beds from AHR's facility in Takoma Park to a new hospital on WAH's campus in White Oak. There is a demonstrable need for the relocation of services and the retention of all 42 beds.

AHR Historical Utilization

AHR has operated 32 acute rehabilitation beds at WAH since 2014, and prior to that time operated 22 beds. AHR also operates 55 acute rehabilitation beds in Rockville. Recently, AHR received authorization to add 10 more beds under waiver to AHR's Takoma Park facility to address the high utilization of beds on both campuses. The strong historical occupancy rates of both campuses are displayed in the table below and are the result of growth in discharges over the period from 2013 through 2017. The addition of 10 beds to the Takoma Park facility in 2014 permitted this growth to occur, and it is expected that the opening of 10 additional beds in Takoma Park in 2018 will similarly result a greater number of patients requiring inpatient rehabilitative care to be served in the future. As the information presented in the table shows, AHR in Takoma Park is well utilized.

Adventist HealthCare Rehabilitation
Inpatient Utilization for the Years ended December 31

	2013	2014	2015	2016	2017
Takoma Park					
Discharges	501	678	706	635	678
Average Length of Stay	13.16	12.64	13.54	14.12	14.07
Patient Days	6,591	8,569	9,561	8,968	9,538
Average Daily Census	18.1	23.5	26.2	24.5	26.1
Licensed Beds	22	32	32	32	32
Occupancy (%)	82.3%	73.4%	81.9%	76.6%	81.7%
Rockville					
Discharges	1,078	1,128	1,240	1,227	1,257
Average Length of Stay	14.40	14.04	13.67	13.79	13.25
Patient Days	15,518	15,837	16,946	16,919	16,658
Average Daily Census	42.5	43.4	46.4	46.4	45.6
Licensed Beds	55	55	55	55	55
Occupancy (%)	77.3%	78.9%	84.4%	84.3%	83.0%
Total					
Discharges	1,579	1,806	1,946	1,862	1,935
Average Length of Stay	14.00	13.51	13.62	13.90	13.54
Patient Days	22,109	24,406	26,507	25,887	26,196
Average Daily Census	60.6	66.9	72.6	70.9	71.8
Licensed Beds	77	87	87	87	87
Occupancy (%)	78.7%	76.9%	83.5%	81.5%	82.5%

Source: Hospital Records

The actual utilization data does not tell the full story regarding the level of demand for acute rehabilitation services in AHR's service area. WAH, where AHR's Takoma Park beds are located, is an aging facility with access challenges. WAH received a CON to construct a replacement facility in White Oak, less than seven miles from Takoma Park. The initial plan was to leave acute rehabilitation and behavioral health at the Takoma Park campus; however, AHC has determined that its inpatient services should be concentrated at its two acute care hospital campus locations in Rockville and White Oak.

Maintaining Takoma Park as an inpatient campus with limited specialty hospital services is a not viable option from the perspectives of continuity of care and cost. With the planned consolidation of behavioral health beds in Rockville and White Oak, for which separate filings have been submitted, it would be challenging for AHR to maintain its presence in Takoma Park as the only inpatient service on the campus because it depends on a number of clinical and ancillary services provided by WAH that would not be available after WAH moves to White Oak. These include medical consults, pharmacy, laboratory, housekeeping, and dietary, to name a few.

Without other inpatient services on the Takoma Park campus, AHR would have to contract for those services at a higher cost because there would no longer be the sharing of costs that exist between WAH and AHR. By moving AHR's facility to White Oak, as a separate rehabilitation hospital, AHR would be able to contract with WAH for those services more cost effectively. Not only is this relocation to White Oak the best approach from an operational, clinical, and cost-efficiency standpoint, but the continuation of this service in Takoma Park would substantially decrease the options for the future use of the Takoma Park campus.

As a regional service, AHR on the White Oak campus is not expected to experience a material change in the patient population that it has historically served. Placing rehabilitation patients in facilities close to families and caregivers is essential in the treatment process. Because patients are learning adaptive skills to address physical deficits, it is important for principal caregivers to participate in the therapies to learn how to assist patients once discharged to home. If patients are referred to more distant facilities outside of Montgomery County, this caregiver participation becomes more difficult, particularly because many of the patients and caregivers are elderly.

For all of the foregoing reasons, the proposed relocation of AHR's 42 beds in Takoma Park is needed to enhance access to acute inpatient rehabilitation care. As demonstrated below, the 42 beds will be well utilized after relocation to White Oak.

Need for Acute Rehabilitation Beds

AHR is located in the Montgomery Health Planning Region ("HPR") and will continue to be after relocation to White Oak. The acute rehabilitation bed need calculation published by the MHCC, presented below, indicates a 2021 minimum need of -8 beds and a maximum need of 32 additional beds in Montgomery. These calculations do not consider the 10 additional inpatient rehabilitation beds approved under waiver for AHR in Takoma Park, which are expected to be operational in September 2018. Factoring in these 10 new beds would result in a minimum need of -18 beds and a maximum need of 22 new beds in the Montgomery HPR. The relocation will not involve any new inpatient rehabilitation beds.

Gross and Net Bed Need Projections for Acute Rehabilitation Beds: Maryland 2021							
Health Planning Region	**Minimum Occupancy Standard**	**Range**	**Total Days Projected**	**Current Licensed Bed Capacity**	**Available Bed Days**	**Gross Bed Need Range**	**Net Bed Need Range**
Central	**0.77**	**minimum**	62,848	260	94,900	224	-36
		maximum	76,994			274	14
Eastern Shore	**0.79**	**minimum**	14,167	79	28,835	49	-30
		maximum	25,447			89	10
Montgomery	**0.8**	**minimum**	22,947	87	31,755	79	-8
		maximum	34,665			119	32
Southern	**0.75**	**minimum**	3,133	28	10,220	11	-17
		maximum	26,109			95	67
Western	**0.75**	**minimum**	9,385	33	12,045	34	1
		maximum	11,501			42	9

Based on the actual utilization of AHR's acute rehabilitation beds in Takoma Park, it is clear that AHR needs to retain all 42 beds to White Oak. While no new beds are being requested in this application, retaining all 42 AHR beds in White Oak is consistent with the identified need for acute rehabilitation beds.

The map below displays the existing acute rehabilitation providers in Maryland. The closest Maryland provider outside of Montgomery County is UM Laurel Regional Hospital, which has not been highly utilized historically. There are two acute rehabilitation providers located in the District of Columbia ("DC"), and a number of Maryland residents, including Montgomery County residents, requiring acute rehabilitation travel to DC because of the limited available bed capacity in the Southern Maryland and the Montgomery County HPRs.

Maryland Acute Rehabilitation Providers

Service Area of the AHR Facility

The following table summarizes AHR's 2017 acute rehabilitation patient origin for its Takoma Park facility. The primary service area includes ZIP Codes, ranked from highest to lowest number of patients served, that encompass 60 percent of AHR's total inpatients, and the secondary service area includes those ZIP Codes representing the next 25 percent of total patient volume.

The service area for AHR's acute rehabilitation facility in Takoma Park is not expected to change materially with its relocation to White Oak. Given its location near the boundary of Montgomery and Prince George's County, AHR's existing facility serves patients from both counties as well as some patients from DC. The White Oak location is also near the Prince George's boundary and the replacement facility is expected to continue to serve patients from both Montgomery and Prince George's counties. This expectation is also supported by the regional nature of acute rehabilitation services, the relatively short distance that the beds are moving, the locations of other existing acute rehabilitation providers, and the expectation that AHR will draw from the same referral sources in White Oak that is does in Takoma Park.

Adventist HealthCare Rehabilitation at Takoma Park
60/85 Service Area
Based on Discharges, CY 2017

ZIP Code	County of Residence	Patients	% Total	Cumulative %
Primary Service Area				
20783	Prince George's	45	6.60%	6.60%
20904	Montgomery	44	6.50%	13.10%
20912	Montgomery	33	4.90%	18.00%
20901	Montgomery	31	4.60%	22.60%
20910	Montgomery	31	4.60%	27.10%
20902	Montgomery	29	4.30%	31.40%
20782	Montgomery	26	3.80%	35.30%
20906	Montgomery	23	3.40%	38.60%
20903	Montgomery	21	3.10%	41.70%
20705	Prince George's	20	2.90%	44.70%
20706	Prince George's	16	2.40%	47.10%
20740	Prince George's	15	2.20%	49.30%
20770	Prince George's	14	2.10%	51.30%
20743	Prince George's	13	1.90%	53.20%
20781	Prince George's	12	1.80%	55.00%
20785	Prince George's	12	1.80%	56.80%
20012	District of Columbia	11	1.60%	58.40%
20747	Prince George's	10	1.50%	59.90%
20707	Prince George's	8	1.20%	61.10%
Total Primary Service Area		414	61.10%	
Secondary Service Area				
20721	Prince George's	8	1.20%	62.20%
20723	Howard County	8	1.20%	63.40%
20772	Prince George's	8	1.20%	64.60%
20774	Prince George's	8	1.20%	65.80%
20784	Prince George's	8	1.20%	67.00%
20712	Prince George's	7	1.00%	68.00%
20722	Prince George's	7	1.00%	69.00%
20735	Prince George's	7	1.00%	70.10%
20748	Prince George's	7	1.00%	71.10%
20866	Montgomery	7	1.00%	72.10%
20011	District of Columbia	6	0.90%	73.00%
20019	District of Columbia	6	0.90%	73.90%
20746	Prince George's	6	0.90%	74.80%
20853	Montgomery	6	0.90%	75.70%
20653	Saint Mary's	5	0.70%	76.40%

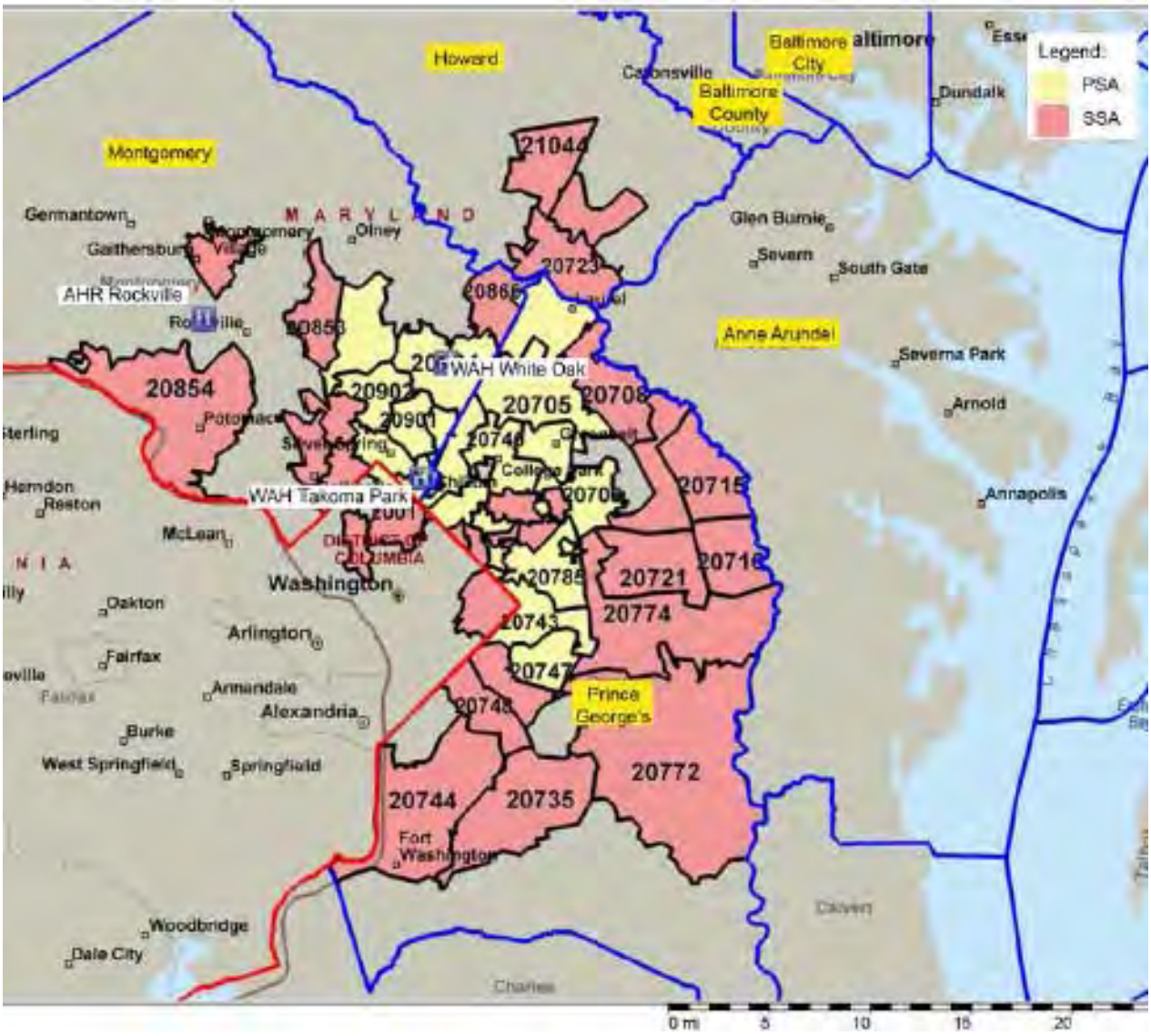
Adventist HealthCare Rehabilitation at Takoma Park
60/85 Service Area
Based on Discharges, CY 2017

ZIP Code	County of Residence	Patients	% Total	Cumulative %
20737	Prince George's	5	0.70%	77.10%
20744	Prince George's	5	0.70%	77.90%
20708	Prince George's	4	0.60%	78.50%
20710	Prince George's	4	0.60%	79.10%
20720	Prince George's	4	0.60%	79.60%
20814	Montgomery	4	0.60%	80.20%
20815	Montgomery	4	0.60%	80.80%
20877	Montgomery	4	0.60%	81.40%
20895	Montgomery	4	0.60%	82.00%
21044	Howard County	4	0.60%	82.60%
20008	District of Columbia	3	0.40%	83.00%
20715	Prince George's	3	0.40%	83.50%
20716	Prince George's	3	0.40%	83.90%
20854	Montgomery	3	0.40%	84.40%
21046	Howard	3	0.40%	84.80%
Total Secondary Service Area		161	23.70%	
Total Service Area		575	84.80%	
Others		103	15.20%	100.00%
Grand Total		678	100.00%	

Source: AHR internal records

The following map displays the AHR service area for its Takoma Park facility.

Adventist HealthCare Rehabilitation at Takoma Park
Primary and Secondary Service Areas



Population

The following table summarizes adult population estimates and projections prepared by the Maryland Department of Planning, Projections and State Data Center for Montgomery and Prince George's counties for 2010 and 2015 (estimates) and 2020 and 2025 (projections).

Population Estimates and Projections

Adult Age Cohorts

					CAGR (a)		
	2010	2015	2020	2025	2010-2015	2015-2020	2020-2025
Montgomery County							
18-44	350,934	369,480	369,446	377,595	1.04%	0.00%	0.44%
45-64	272,462	284,792	279,905	275,097	0.89%	-0.35%	-0.35%
65+	119,769	143,311	166,271	192,066	3.65%	3.02%	2.93%
Total	743,165	797,583	815,622	844,758	1.42%	0.45%	0.70%
Prince George's County							
18-44	347,292	356,765	350,220	349,419	0.54%	-0.37%	-0.05%
45-64	225,183	235,514	233,785	229,600	0.90%	-0.15%	-0.36%
65+	81,513	104,128	126,659	151,738	5.02%	4.00%	3.68%
Total	653,988	696,407	710,664	730,757	1.26%	0.41%	0.56%

(a) CAGR: Compound Annual Growth Rate

Source: Maryland Department of Planning, Projections and State Data Center (January 2018)

The population projections show that it is anticipated that the overall growth in both counties will be positive throughout the 2010 – 2025 projection period. The age 65 and over cohort is expected to increase at a faster rate than younger residents, which will result in the 65 and over age cohort representing a greater proportion of the service area population overall.

This growth in the age cohort 65 and over is significant because seniors exhibit a greater need and demand for acute inpatient rehabilitation services. The following table shows the distribution by age cohort of rehabilitation patients discharged from the AHR facility in Takoma Park.

Adventist HealthCare Rehabilitation at Takoma Park								
Discharges by Age Cohort								
Years Ended December 31								
	2015		2016		2017		Total 2015-2017	
Age Cohort	Discharges	% of Total	Discharges	% of Total	Discharges	% of Total	Discharges	% of Total
18-44	70	10.2%	56	8.8%	60	8.8%	186	9.3%
45-64	237	34.5%	206	32.4%	199	29.4%	642	32.1%
65+	380	55.3%	373	58.7%	419	61.8%	1,172	58.6%
Total	687	100.0%	635	100.0%	678	100.0%	2,000	100.0%
Source: AHR internal records								

As the data presented in the table show, the percentage of patients discharged from the AHR's facility in Takoma Park age 65 and over has been increasing and was nearly 62 percent in 2017. The strong growth in this age cohort will increase the need for acute rehabilitation services in the future.

Projected Utilization

Utilization of acute rehabilitation services in Montgomery County has seen growth over the period from 2012 to 2016, based on data provided by the MHCC. This increase correlates closely with AHR opening 10 additional beds in Takoma Park in 2014. Average length of stay has been stable over the period, and discharges per 1,000 population have remained relatively flat since 2014. With the recent authorization of 10 additional beds to AHR in Takoma Park, there is the potential for additional increases in the future; however, this projection of utilization will assume that discharge rates per 1,000 remain constant at historical levels.

Acute Rehabilitation Utilization and Use Rate by Age Cohort
Montgomery County
2012 – 2016

	2012	2013	2014	2015	2016
Adult Population					
18 - 44	358,238	361,946	365,694	369,480	369,473
45 - 64	277,329	279,794	282,282	284,792	283,808
65 +	128,529	133,226	138,149	143,311	147,632
Total	764,095	774,966	786,125	797,583	800,913
Adult Discharges					
18 - 44	122	119	149	140	138
45 - 64	372	421	480	477	449
65 +	875	809	944	1,052	940

Acute Rehabilitation Utilization and Use Rate by Age Cohort
Montgomery County
2012 – 2016

	2012	2013	2014	2015	2016
Total	1,369	1,349	1,573	1,669	1,527
Adult Days					
18 - 44	2,452	1,790	2,314	2,146	1,923
45 - 64	5,540	6,090	7,031	6,494	6,717
65 +	11,198	10,756	12,662	13,891	12,664
Total	19,190	18,636	22,007	22,531	21,304
ALOS					
18 - 44	20.1	15.0	15.5	15.3	13.9
45 - 64	14.9	14.5	14.6	13.6	15.0
65 +	12.8	13.3	13.4	13.2	13.5
Total	14.0	13.8	14.0	13.5	14.0
ADC					
18 - 44	6.7	4.9	6.3	5.9	5.3
45 - 64	15.2	16.7	19.3	17.8	18.4
65 +	30.7	29.5	34.7	38.1	34.7
Total	52.6	51.1	60.3	61.7	58.4
Use Rate (Discharges per 1,000 Population)					
18 - 44	0.34	0.33	0.41	0.38	0.37
45 - 64	1.34	1.50	1.70	1.67	1.58
65 +	6.81	6.07	6.83	7.34	6.37
Total	1.79	1.74	2.00	2.09	1.91

Source: Maryland Health Care Commission

Utilization projections of acute rehabilitation services to be provided by AHR on the White Oak campuses for the years ending December 31, 2020, through December 31, 2023 are presented in the following table. This projection period consists of the first three full years that the rehabilitation services will be operational in the new White Oak facility.

Adventist HealthCare Rehabilitation at White Oak
Projected Inpatient Utilization
For the Years ending December 31

	2020	2021	2022
Discharges			
Primary Service Area	**531**	**534**	**538**
Secondary Service Area	**180**	**181**	**182**
DC Impact	**50**	**60**	**70**
Total Service Area Discharges	**760**	**775**	**790**
Other Discharges	**125**	**126**	**127**
Total Discharges	886	901	917
Average Length of Stay	**13.5**	**13.5**	**13.5**
Inpatient Days	**11,955**	**12,166**	**12,380**
Average Daily Census	**32.7**	**33.3**	**33.9**
Beds	**42**	**42**	**42**
Occupancy (%)	77.8%	79.4%	80.8%

These utilization projections are based on several assumptions.

- It has been assumed that existing referral relationships and intensity of services provided will remain unchanged.
- Age-specific rates of acute rehabilitation discharges per 1,000 population have been held constant at 2016 levels.
- AHR's historical combined market shares for the Takoma Park and Rockville facilities in Montgomery County and Prince George's County will remain at current levels. There is a small shift in market share from Rockville to White Oak in Montgomery County in recognition of the 10 new beds being added to Takoma Park this year and the move to all private rooms in a modern facility at White Oak.
- Discharges have been assumed to increase at the same rate as the population in each relevant portion of the service area and age cohort.
- Length of stay has been held constant at current levels, with appropriate consideration given to variation among age cohorts.

- The portion of in-migration attributable to areas outside of Montgomery County, Prince George's County, and the District of Columbia has been assumed to remain constant throughout the projection period.

- As noted above, more than 200 residents of Montgomery County received inpatient rehabilitation services at a provider located in DC. It was assumed that the reduction in outmigration to DC will result in 70 Montgomery County residents currently traveling to DC will choose instead to go to AHR in White Oak by 2022. The overall net impact on DC facilities is expected to be small.

Based on the assumptions outlined above, the occupancy rate of AHR at White Oak will be 79.0 percent in 2020, 79.5 percent in 2021, and 80.8 percent in 2022.

(a) An application proposing to establish or expand adult acute inpatient rehabilitation services in a jurisdiction that is directly contiguous to another health planning region may be evaluated based on the need in contiguous regions or states based on patterns of cross-regional or cross-state migration.

APPLICANT RESPONSE:

Not applicable. AHR is not proposing to establish or expand an adult acute inpatient rehabilitation service.

(b) For all proposed projects, an applicant shall explicitly address how its assumptions regarding future in-migration and out-migration patterns among Maryland health planning regions and bordering states affect its need projection.

APPLICANT RESPONSE:

AHR expects with the relocation of its 42 acute rehabilitation beds, out-migration from Montgomery County will be reduced. This reduction in out-migration is expected to result from placing these beds in a more accessible location for Montgomery County residents as well as having a more efficiently configured physical plant that will eliminate the use of semi-private beds as well as an expanded gym and dining area.

AHR does not anticipate that the level of in-migration will change materially with the relocation of the acute rehabilitation service to White Oak. AHR expects to continue to serve some patients from Prince George's County after relocation and other in-migration is expected to remain at historical percentages of total discharges.

(c) If the maximum projected bed need range for an HPR includes an adjustment to account for out-migration of patients that exceeds 50 percent of acute rehabilitation discharges for residents of the HPR, an applicant proposing to meet the need for additional bed capacity above the minimum projected need, shall identify reasons why the existing out-migration pattern is attributable to access barriers and demonstrate a credible plan for addressing the access barriers identified.

APPLICANT RESPONSE:

Not applicable. The bed need projection for Montgomery County does not include an adjustment to account for out-migration exceeding 50 percent of acute rehabilitation discharges for residents of the HPR.

(d) An applicant proposing to establish or expand adult acute rehabilitation beds that is not consistent with the projected net need in .05 in the applicable health planning region shall demonstrate the following:

(i) The project credibly addresses identified barriers to access; and

(ii) The applicant's projection of need for adult acute rehabilitation beds explicitly accounts for patients who are likely to seek specialized acute rehabilitation services at other facilities due to their age or their special rehabilitative and medical needs. At a minimum, an applicant shall specifically account for patients with a spine or brain injury and pediatric patients; and

(iii) The applicant's projection of need for adult acute rehabilitation beds accounts for in-migration and out-migration patterns among Maryland health planning regions and bordering states.

APPLICANT RESPONSE:

Not applicable. This project is not seeking to establish or expand adult acute rehabilitation beds in the HPR.

(e) An applicant that proposes a specialized program for pediatric patients, patients with brain injuries, or patients with spinal cord injuries shall submit explanations of all assumptions used to justify its projection of need.

APPLICANT RESPONSE:

AHR already offers specialized programs for patients with brain and spinal cord injuries. In fact, AHR has specialty CARF accreditation for these two patient populations. AHR does not propose a specialized program for pediatric patients.

(f) An applicant that proposes to add additional acute rehabilitation beds or establish a new health care facility that provides acute inpatient rehabilitation services cannot propose that the beds will be dually licensed for another service, such as chronic care.

APPLICANT RESPONSE:

Not applicable. AHR does not propose to add acute rehabilitation beds or establish a new facility. This application is, based on discussions with Commission staff, put forward as the relocation of the AHR facility in Takoma Park to White Oak, not the establishment of a new facility.

(3) Impact.

A project shall not have an unwarranted adverse impact on the cost of hospital services or the financial viability of an existing provider of acute inpatient rehabilitation services. A project also shall not have an unwarranted adverse impact on the availability of services, access to services, or the quality of services. Each applicant must provide documentation and analysis that supports:

APPLICANT RESPONSE:

The proposed relocation of beds from Takoma Park to White Oak will not have an unwarranted adverse impact on the cost of hospital services or the financial viability of an existing provider of acute inpatient rehabilitation services. To the contrary, the approval of this project will allow AHR's existing acute rehabilitation program to serve patients more effectively through the development of facilities designed to provide cost effective inpatient and outpatient rehabilitative services.

The project will have a positive impact on the availability of services, access to services, and the quality of services. With respect to availability, the new facility on the White Oak campus will include all private rooms. AHR's existing facility at Takoma Park includes semi-private rooms that restricts the availability of the service due to issues of patient matching because of clinical conditions or gender. Geographic access to services will be improved at the White Oak campus because it is a more accessible location given the road systems around that site. Quality of services will be enhanced by providing services in modern, efficiently configured facilities.

(a) Its estimate of the impact of the proposed project on patient volume, average length of stay, and case mix, at other acute inpatient rehabilitation providers;

APPLICANT RESPONSE:

AHR does not anticipate that the project will have a significant impact on other acute inpatient rehabilitation providers. AHR expects the same sources that have historically referred patients for inpatient rehabilitation to AHR to continue these referrals at the new site. The projections of utilization do not assume significant shifts in market share from other existing rehabilitation providers to AHR. Instead, these projections are based on:

- Projected growth in population
- Some reduction in patients out-migrating to Washington, D.C.
- Constant rates of acute inpatient rehabilitation discharges over the projection period.

These projections are described more fully in Section .04B(2) above.

(b) Its estimate of any reduction in the availability or accessibility of a facility or service that will likely result from the project, including access for patients who are indigent or uninsured or who are eligible for charity care, based on the affected acute rehabilitation provider's charity care policies that meet the minimum requirements in 04A(1)(a) of this Chapter;

APPLICANT RESPONSE:

This project will not result in any reduction in the availability or accessibility to AHR's acute rehabilitation services, including access for patients who are indigent or uninsured or who are eligible for charity care. AHR's charity care policy is described above in response to 04A(1)(a) of this Chapter and meet these requirements. To the contrary, this project will enhance the availability and accessibility of services for all patients

(c) Its estimate of any reduction in the quality of care at other providers that will likely be affected by the project; and

APPLICANT RESPONSE:

AHR's project will not have impact on the quality of care of other providers. This project seeks to serve the same patient base that AHR has historically served.

(d) Its estimate of any reduction in the ability of affected providers to maintain the specialized staff necessary to provide acute inpatient rehabilitation services.

APPLICANT RESPONSE:

AHR's project will not result in the reduction in the ability of any other provider to maintain specialized staff. The project seeks only to relocate beds already licensed, and it is anticipated that the existing staff will relocate to the White Oak once the replacement facilities are completed. AHR anticipates some incremental growth in patient volumes due to population growth and aging and the reduction of out-migration, but these additional staff will be recruited through the same mechanisms that AHR has in place today.

Recruitment efforts will include, but are not limited to:

1. Newspaper and magazine advertising;
2. Attendance at job fairs and career days;
3. Open houses;
4. Direct mailings;
5. Sign-on bonuses;
6. Educational affiliations with numerous academic institutions.
7. Transfers from within AHR or other AHC entities;
8. Specific recruitment and retention plans for those personnel believed to be in short supply.

(4) Construction Costs.

(a) The proposed construction costs for the project shall be reasonable and

consistent with current industry and cost experience in Maryland.

(b) For a hospital that is rate-regulated by the Health Services Cost Review Commission, the projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not included the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

APPLICANT RESPONSE:

WAH conducted an MVS analysis for the two new floors to house AHR rehabilitation beds to determine the reasonableness of the construction costs. The MVS analysis for the additional floors was aggregated into the overall hospital calculation as previously revised and submitted in connection with the September 19, 2017 project modification to add a Central Utility Plant ("CUP") to the WAH building. Exhibit 15 shows the MVS calculation for the hospital, inclusive of the two additional floors. Column B of the chart in Exhibit 15 shows the final MVS calculation for the approved hospital CON relocation project as conducted by the Reviewer in her final decision. Column D provides the overall total calculation for the relocation project as previously modified to be inclusive of the CUP. Column H provides the overall total MVS calculation for the project after including construction costs for the two additional floors. WAH's analysis shows the overall project costs to be $392.17 per square-foot, $6.34 lower than the MVS benchmark of $398.51. Exhibit 16 highlights the Extraordinary Above-MVS costs permitted as part of the MVS calculation which have not changed since the prior approved project change to add the Central Utility Plant.

Exhibit 3_ includes the drawings for the new project elements.

(5) Safety.

The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety.

APPLICANT RESPONSE:

Evidence-based architectural methods have been employed in the design of the rehabilitation floors at the WAH replacement hospital to improve patient outcomes, safety, and satisfaction. Additionally, these design methods will also improve staff efficiency, satisfaction, and staff retention.

At the White Oak campus, all of the acute rehabilitation rooms will be private, while the existing Takoma Park facility has 4 beds in private rooms and 32 beds in semi-private rooms. The replacement facility will eliminate infection risks inherent in semi-private rooms occupied by two patients. In addition, hand washing sinks will be located both directly inside the entry door to each patient room as well as along the corridor to further reduce the risk of infection. Patients will enjoy greater privacy as well.

APPLICANT RESPONSE:

(6) Financial Feasibility.

A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.

APPLICANT RESPONSE:

As reflected in the projected financial statements, AHR's project is financially feasible. Additionally, relocating the beds to White Oak will provide long-term financial stability, with the ability to attract patients to a hospital with single-bed rooms and expanded gym and dining space, allowing ARH to better serve patients in the community who would benefit for years to come from acute rehabilitative services. As seen in Exhibit 4 and Tables J and K, the AHR Takoma Park relocation generates a positive margin consistent with historical performance at the Takoma Park facility and projection years 2020 - 2022. The volume assumptions are built on the market demand analysis outlined previously in this document for acute rehabilitative services. The Average Daily Census (ADC) targets for 2020 – 2022 are 32.7 – 33.9, respectively, representing a 77.8% - 80.8% occupancy rate. The Average Length of Stay (ALOS) averages 13.5 and is consistent with historical performance. The revenue assumptions included in the financial feasibility analysis considers annual updates and payor escalators, mirroring historical performance at Takoma Park. Expense assumptions are held at historical levels, with the exception of inflation, which can be seen by comparing Table J and Table K as well as variable staffing growth commensurate with the volume increases ARH is expected to experience through 2022 and beyond. There is additional expense built into 2019 as AHR will absorb the Takoma Park campus costs when Washington Adventist Hospital relocates to White Oak in the Summer of 2019 and before the proposed AHR relocation to White Oak in the beginning 2020.

A financial feasibility study was conducted for the option of remaining at the Takoma Park location. AHC has recently submitted two separate filings to the Commission for the relocation and merger of acute psychiatric beds. This move would result in AHR remaining in Takoma Park; as such, AHR would have to absorb the significant cost to maintain the otherwise vacant Washington Adventist Hospital, and the surrounding campus, which totals to an annual amount of $6.7 million. This option is not viable as evidenced in Exhibit 4, which contains Table G and Table H, representing current performance projected for in the scenario of remaining at Takoma Park once WAH relocates to White Oak. As shown in these financial tables, remaining at Takoma Park results in a multiple-million dollar annual loss for AHR. The largest expenses include current interest on the campus, the campus depreciation expense, and building and maintenance for routine upkeep for the aging facility. On top of these overhead expenses, AHR would also have to contract with outside service providers for routine services such as medical consults, pharmacy, laboratory, housekeeping and dietary, to name a few, which negatively impacts the continuity of care. The significant financial loss to remain at Takoma Park is not

sustainable and therefore it is not a viable option.

(a) Financial projections filed as part of a hospital CON application must be accompanied by a statement containing each assumption used to develop the projections.

APPLICANT RESPONSE:

The assumptions underlying the financial projections are included in Exhibit 17.

(b) Each applicant must document that:

(i) Utilization projections are consistent with observed historic trends in the use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;

APPLICANT RESPONSE:

The projected utilization for the project is consistent with observed historical trends in acute inpatient rehabilitation in AHR's service area as well as utilization at the Takoma Park facility.

As discussed above, these projections are based primarily on growth in population by age cohort. The projected hospital census reflects the market demand for AHR's services consistent with the analyses shown above. The utilization assumes that:

- Existing referral relationships and intensity of services provided will remain unchanged
- AHR's market share in Montgomery County and Prince George's County will remain at current levels
- Discharges will increase at the same rate as the population in each relevant portion of the service area and age cohort
- Length of stay is a minimal decrease from current levels, with appropriate consideration given to variation among age cohorts
- The portion of in-migration attributable to areas outside of Montgomery County, Prince George's County, and the District of Columbia will remain constant throughout the projection period
- As noted above, more than 200 residents of Montgomery County received inpatient rehabilitation services at a provider located in DC. It was assumed that the reduction in outmigration to DC will result in 70 Montgomery County residents currently traveling to DC will choose instead to go to AHR in White Oak by 2022. The net impact on DC facilities is not expected to be material.

The volume assumptions are built on the market demand analysis outlined previously in this document for acute rehabilitative services and on the above assumptions. The Average Daily Census (ADC) targets for 2020 – 2022 are 32.7 – 33.9, respectively, representing a 77.8% - 80.8% occupancy rate. The Average Length of Stay (ALOS) averages 13.5 and is a minimal decrease when compared with historical performance of 13.9 days.

(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;

APPLICANT RESPONSE:

AHR's projected revenues are consistent with the utilization projections discussed in the prior response, and are based on actual performance experiences by AHR at Takoma Park. It is assumed that this current performance will be replicated at AHR at WOMC. For the projection years 2020 – 2022, revenue is assumed to increase an average of 0.4% annually due to annual updates and payor escalators.

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or if a new hospital, the recent experience of other similar hospitals; and

APPLICANT RESPONSE:

The staffing and overall expense projections are based on the utilization projections as well as AHR's historical operating experience at Takoma Park and reasonably estimated future need. Expense assumptions are held at historical levels, with the exception of inflation, which can be seen by comparing Table J and Table K as well as variable staffing growth commensurate with the volume increases AHR is expected to experience through 2022 and beyond. There is additional salary expense built into 2019 as AHR will absorb the Takoma Park campus costs when Washington Adventist Hospital relocates to White Oak in the Summer of 2019 and before the proposed AHR relocation to White Oak in the beginning of 2020. FTEs per bed averages 3.4, which is consistent with historical experience at the Takoma Park location. This ratio is scheduled to continue upon relocation to White Oak. The details of the FTE changes are included in Exhibit 4, Table L. Note that this ties to the total salary expense from Table G, which is the alternative scenario of remaining at Takoma Park, which results in a multiple millions dollar loss for AHR. Included is almost $800,000 of facilities support staff in order to maintain the hospital building and the surrounding campus. This expense would not be needed upon AHR's relocation to White Oak

(iv) The hospital will generate excess revenues over total expense (including debt service expenses and plant and equipment depreciation), if the applicant's utilization forecast is achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital proposing an acute inpatient rehabilitation unit that does not generate excess revenues over total expenses, even if utilization forecasts are achieved for the services affected by the project, may demonstrate that the hospital's overall financial performance will be positive.

APPLICANT RESPONSE:

As reflected in Exhibit 4, AHR at White Oak will generate an excess of revenues over expenses,

consistent with its historical experience. As seen in Exhibit 4 Tables J and K, the AHR Takoma Park relocation generates a positive margin consistent with historical performance at the Takoma Park facility and projection years 2020 - 2022. The volume assumptions are built on the market demand analysis outlined previously in this document for acute rehabilitative services. The Average Daily Census (ADC) targets for 2020 – 2022 are 32.7 – 33.9, respectively, representing a 77.8% - 80.8% occupancy rate. The Average Length of Stay (ALOS) averages 13.5 and is a minimal decrease when compared with historical performance of 13.9 days. The revenue assumptions included in the financial feasibility analysis considers annual updates and payor escalators, mirroring historical performance at Takoma Park. Expense assumptions are held at historical levels, with the exception of inflation, which can be seen by comparing Table J and Table K as well as variable staffing growth commensurate with the volume increases AHR is expected to experience through 2022 and beyond. There is additional expense built into 2019 as AHR will absorb the Takoma Park campus costs when Washington Adventist Hospital relocates to White Oak in the Summer of 2019 and before the proposed AHR relocation to White Oak in the beginning of 2020.

(7) Minimum Size Requirements.

(a) A proposed acute inpatient rehabilitation unit in a hospital shall contain a minimum of 10 beds and shall be projected to maintain an average daily census consistent with the minimal occupancy standard in this Chapter within three years.

APPLICANT RESPONSE:

This proposal does not involve creating an inpatient unit in a hospital. Instead, AHR will occupy space in WAH but be separately licensed as an acute inpatient rehabilitation facility.

(b) A proposed acute inpatient rehabilitation specialty hospital shall contain a minimum of 30 beds and shall be projected to maintain within three years an average daily census consistent with the minimum occupancy standard in this Chapter.

APPLICANT RESPONSE:

AHR proposes to relocate 42 acute inpatient rehabilitation beds to WAH's White Oak campus and operate as a separately licensed rehabilitation specialty hospital. This bed complement exceeds the minimum size requirement under this standard.

The current proposal is compliant with this Standard.

(8) Transfer and Referral Agreements.

Each applicant shall provide documentation prior to licensure that the facility will have written transfer and referral agreements with facilities, agencies, and organizations that:

(a) Are capable of managing cases that exceed its own capabilities; and

APPLICANT RESPONSE:

Not applicable.

(b) Provide alternative treatment programs appropriate to the needs of the persons it serves.

APPLICANT RESPONSE:

AHR carefully evaluates patients before admission to the acute rehabilitation service to be certain the patient meets clinical criteria and has the ability to tolerate the intensive rehabilitation services provided. AHR can accommodate most patients with the exception of those with ventilator dependency. In the event that a patient's condition changes during the course of a stay, AHR has relationships with skilled nursing facilities, long-term acute care hospitals, home health agencies, and other providers to allow the patient to transition to the most appropriate level of care.

(9) Preference in Comparative Reviews.

In the case of a comparative review of applications in which all standards have been met by all applicants, the Commission will give preference to the applicant that offers the best balance between program effectiveness and costs to the health care system as a whole.

APPLICANT RESPONSE:

Not applicable.

.5 Methodology for Projecting Adult Acute Rehabilitation Bed Need.

Adult acute rehabilitation bed need is projected using the following methodology. There is no need projection for pediatric acute inpatient rehabilitation beds. The need for pediatric acute rehabilitation beds will be evaluated on a case-by-case basis, considering the needs assessment provided by the applicant.

A. Period of Time Covered.

(1) The base year from which projections are calculated is the most recent calendar year for which discharge abstract data is available from Maryland and District of Columbia acute general hospitals and special hospitals that provide acute inpatient rehabilitation services.

(2) The target year for which projections are calculated is five years after the base year.

B. Services and Age Groups.

Use rates (discharges per thousand population) for the following age groups will be calculated: under 18; 18 to 44; 45 to 64; 65 to 74; and 75 and over. The rate for the under 18 age group will be calculated based only on discharges from Maryland hospitals that are not providers of specialized

pediatric acute inpatient rehabilitation services. For patient discharges from District of Columbia hospitals, only patients age 18 and older are counted in use rate calculations.

C. Geographic Areas.

The need for acute rehabilitation hospital bed capacity will be calculated for each of the five health planning regions defined in this Chapter.

(1) The Eastern Shore is comprised of Caroline, Dorchester, Kent, Queen Anne's, Talbot, Somerset, Wicomico, and Worcester Counties.

(2) Southern Maryland is comprised of Charles, Calvert, Prince George's, and St. Mary's Counties.

(3) Montgomery County is comprised of Montgomery County.

(4) Central Maryland is comprised of Baltimore City and Anne Arundel, Baltimore, Carroll, Cecil, Harford, and Howard Counties.

(5) Western Maryland is comprised of Allegany, Frederick, Garrett, and Washington Counties.

D. Assumptions.

(1) Interstate patterns of migration from states bordering Maryland (Delaware, District of Columbia, Pennsylvania, Virginia, and West Virginia), by age group, will be accounted for in the baseline projection at the health planning region level, using the most recent population projections developed for official state government use in the applicable states. Discharges and days for patients from non-bordering states, foreign countries, or unidentified locations will be held constant as a proportion of total days from the base year to the target year for each health planning region.

(2) Health planning region target year discharge rates are calculated as follows:

(a) Calculate the average annual rates of discharges per thousand population by age group for Maryland residents by HPR for the most recent five-year period available. For residents of border states (Delaware, District of Columbia, Pennsylvania, Virginia, West Virginia), calculate a discharge rate per thousand population based on discharges from Maryland hospitals, for the most recent five-year period available.

(b) Calculate the statewide average annual rates of discharges per

thousand population by age group for all Maryland residents, excluding Maryland residents from unidentified counties, for the most recent five-year period available.

(c) Determine the minimum target year projected discharge rate for each age group in each HPR by choosing the lower of either the five-year average annual discharge rate per 1,000 population calculated for the HPR or the five-year statewide average discharge rate per 1,000 population.

(d) Determine the maximum target year projected discharge rate for each age group in each HPR by choosing the higher of either the five-year average annual discharge rate per 1,000 population by the projected population for the HPR or the five-year statewide average discharge rate per 1,000 population.

(e) Both the minimum and maximum target year projected discharge rate for residents in each age group from bordering states will be the five-year average annual discharge rate per 1,000 population.

(3) Health planning region target year average lengths of stay (ALOS) are calculated as follows:

(a) Calculate the average length of stay for each of the most recent five years of data by dividing the total number of days by the total number of discharges by geographic location and age group. Then add the calculated ALOS for each group for all five years and divide by five.

(4) Health planning region bed capacity is calculated as follows:

(a) Sum the total number of beds licensed for acute rehabilitation services, by HPR;

and

(b) For beds dually licensed for chronic care and acute rehabilitation, the number of acute rehabilitation beds will be based on the average daily census for chronic and acute rehabilitation patients and the proportion of beds available for acute rehabilitation patients.

(5) Minimum Occupancy Standard.

(a) The minimum occupancy standards used in calculating gross bed need are based on the average daily census projected for the HPR, applied at the hospital level, and are as follows:

Average Daily	*Minimum Percent Occupancy*
0-49	**75%**
50-99	**80%**
100+	**85%**

APPLICANT RESPONSE:

As discussed previously, the following summarizes the bed need calculation for all HPRs in Maryland. The Montgomery HPR, where this project will be located, reflects a need for a minimum of -8 beds and a maximum of 32 beds. When adjusting for the 10 additional acute rehabilitation beds that AHR recently received through exemption, the range changes to a minimum of -18 to a maximum of 22 beds. This project does not propose to add new acute rehabilitation beds. The high levels of historical and projected utilization of the AHR beds documents the need to retain all existing beds in the relocation to the White Oak campus.

Gross and Net Bed Need Projections for Acute Rehabilitation Beds: Maryland 2021							
Health Planning Region	**Minimum Occupancy Standard**	**Range**	**Total Days Projected**	**Current Licensed Bed Capacity**	**Available Bed Days**	**Gross Bed Need Range**	**Net Bed Need Range**
Central	**0.77**	**minimum**	62,848	260	94,900	224	-36
		maximum	76,994			274	14
Eastern Shore	**0.79**	**minimum**	14,167	79	28,835	49	-30
		maximum	25,447			89	10
Montgomery	**0.8**	**minimum**	22,947	87	31,755	79	-8
		maximum	34,665			119	32
Southern	**0.75**	**minimum**	3,133	28	10,220	11	-17
		maximum	26,109			95	67
Western	**0.75**	**minimum**	9,385	33	12,045	34	1
		maximum	11,501			42	9

COMAR 10.21.10: Acute Care Hospital Services

AHR does not offer acute care hospital services. WAH is a co-applicant for the project, but WAH will only serve as a landlord and provide some support services to AHR in the space to be constructed at White Oak. WAH itself will not be a provider of any new rehabilitation services. There will not be any change in the WAH services to be provided as an acute care hospital pursuant to the prior CON approval for construction of the new WAH facility that is currently underway.

There are three possible areas where the Acute Care Hospital Services standards are implicated. First, the proposed new construction to accommodate the relocation of AHR's acute rehabilitation beds from Takoma Park to White Oak will occur within an acute general hospital building. The proposed construction will create an acute hospital facility environment for acute rehabilitation beds and services. In addition, the proposed construction will occur in a facility that is presently under construction pursuant to an earlier CON approval. Though WAH will not be providing rehabilitation services, WAH is a co-applicant for the project.

WAH will address each of the Acute Care Hospital Services standards that are relevant to the proposed relocation of AHR's beds to the White Oak campus.

.04 Standards.

A. General Standards.

The following general standards encompass Commission expectations for the delivery of acute care services by all hospitals in Maryland. Each hospital that seeks a Certificate of Need for a project covered by this Chapter of the State Health Plan must address and document its compliance with each of the following general standards as part of its Certificate of Need application. Each hospital that seeks a Certificate of Need exemption for a project covered by this Chapter of the State Health Plan must address and demonstrate consistency with each of the following general standards as part of its exemption request.

(1) Information Regarding Charges.

Information regarding hospital charges shall be available to the public. After July 1, 2010, each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;

APPLICANT RESPONSE:

This is not applicable to WAH for this filing.

(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and

APPLICANT RESPONSE:

This is not applicable to WAH for this filing.

(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

APPLICANT RESPONSE:

This is not applicable to WAH for this filing.

(2) Charity Care Policy.

Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay.

(a) The policy shall provide:

(i) Determination of Probable Eligibility. Within two business days following a

patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.

(ii) Minimum Required Notice of Charity Care Policy.

1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;

2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital; and

3. Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

APPLICANT RESPONSE:

This is not applicable to WAH in this filing.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

APPLICANT RESPONSE:

This is not applicable to WAH in this filing.

(3) Quality of Care.

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;

APPLICANT RESPONSE:

WAH is licensed and in good standing with the Maryland Department of Health and Mental Hygiene.

WAH's license is attached as Exhibit 18.

(ii) Accredited by the Joint Commission; and

APPLICANT RESPONSE:

WAH is accredited by the Joint Commission.

WAH's accreditation certificate is attached as Exhibit 19.

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

APPLICANT RESPONSE:

WAH is in compliance with the conditions of participation of the Medicare and Medicaid programs.

(b) A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90% level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

APPLICANT RESPONSE:

Not applicable to WAH for this filing.

B. Project Review Standards.

The standards in this section are intended to guide reviews of Certificate of Need applications and exemption requests involving acute care general hospital facilities and services.

An applicant for a Certificate of Need must address, and its proposed project will be evaluated for compliance with, all applicable review standards. An applicant for a Certificate of Need exemption must address, and its proposed project will be evaluated for consistency with, all applicable review standards.

(4) Adverse Impact.

A capital project undertaken by a hospital shall not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. The Commission will grant a Certificate of Need only if the hospital documents the following:

(a) If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted average Charge Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group. In addition, if the project involves replacement of physical plant assets, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise demonstrate why the physical plant assets require replacement in order to achieve the primary objectives of the project; and

(b) If the project reduces the potential availability or accessibility of a facility or service by eliminating, downsizing, or otherwise modifying a facility or service, the applicant shall document that each proposed change will not inappropriately diminish, for the

population in the primary service area, the availability or accessibility to care, including access for the indigent and/or uninsured.

APPLICANT RESPONSE:

WAH's capital project to build two additional floors will not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. The project will increase the availability and accessibility of acute inpatient rehabilitation services with the relocation of AHR's 42 beds to the White Oak campus. Continuity of care will be enhanced for patients requiring acute rehabilitation following an acute care stay at WAH. The White Oak campus is geographically more accessible than Takoma Park given its proximity to major roadways and access to public transportation.

(5) Cost-Effectiveness.

A proposed hospital capital project should represent the most cost effective approach to meeting the needs that the project seeks to address.

(a) To demonstrate cost effectiveness, an applicant shall identify each primary objective of its proposed project and shall identify at least two alternative approaches that it considered for achieving these primary objectives. For each approach, the hospital must:

(i) To the extent possible, quantify the level of effectiveness of each alternative in achieving each primary objective;

(ii) Detail the capital and operational cost estimates and projections developed by the hospital for each alternative; and

(iii) Explain the basis for choosing the proposed project and rejecting alternative approaches to achieving the project's objectives.

APPLICANT RESPONSE:

The primary objectives of this project are to provide the most effective treatment setting for AHR to provide acute rehabilitation services and maximizing the sharing of resources between WAH and AHR. There were two alternatives considered: maintaining AHR's services on the Takoma Park campus or relocating and consolidating all of AHR's beds on the Rockville campus, where it operates a 55-bed acute rehabilitation hospital. No services are being eliminated, downsized, or modified.

Maintaining AHR's operations on the Takoma Park campus would be challenging for AHR because it would be the only inpatient service remaining on that campus. AHR depends on a number of clinical and ancillary services provided by WAH that would not be available after WAH moves to White Oak. These services include medical consults, pharmacy, laboratory, housekeeping, and dietary, among others. Absent this project, AHR would need to contract for those services at a higher cost, since there would no longer be the sharing of costs that exist between WAH and AHR. By moving AHR to White Oak, it would be able to contract with WAH for those services more cost effectively. Not only is this the best approach from an operational, clinical, and cost-efficiency standpoint, but the continuation of this service in Takoma Park would substantially decrease the options for the future use or disposition of the Takoma Park

campus.

AHR also considered the alternative of consolidating all of its acute rehabilitation beds on the Rockville campus. It conducted an in-depth feasibility study of various options for expanding the Rockville facilities, but these options were significantly more expensive than developing the replacement facility at White Oak. The most cost efficient option for building on the Rockville campus was $40 million. The consolidation of all beds on the Rockville campus would reduce geographic access to care. By placing the 42 beds in White Oak, travel will be reduced for many residents.

The relocation of AHR's Takoma Park acute rehabilitation beds to a new location and establishing a freestanding rehabilitation hospital outside of leased space within WAH is similarly problematic. As a starting point, constructing a freestanding facility would necessarily involve higher capital costs because there would be the need to acquire land, undertake site preparation, and construct administrative and support spaces not required if AHR is integrated into an acute care hospital like WAH. As with the alternative of maintaining services on the White Oak campus, if AHR were to move its beds to a new location it would need to contract for those services at a higher cost, rather than the sharing of costs that relocating to the White Oak campus provides.

For these reasons, the most appropriate alternative is to relocate AHR's operations to White Oak for a licensed hospital in leased space. Capital expenditures will be minimized, cost sharing will be maximized, and patients requiring acute rehabilitation will have improved access to care.

(b) An applicant proposing a project involving limited objectives, including, but not limited to, the introduction of a new single service, the expansion of capacity for a single service, or a project limited to renovation of an existing facility for purposes of modernization, may address the cost-effectiveness of the project without undertaking the analysis outlined in (a) above, by demonstrating that there is only one practical approach to achieving the project's objectives.

APPLICANT RESPONSE:

WAH's portion of this project does have limited objectives, namely to construct two additional floors on its replacement facility to accommodate AHR's existing beds currently located in Takoma Park. As discussed in the prior response, the only practical alternative is to place the beds in White Oak to ensure access and operational efficiency.

(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital to a new site that is not within a Priority Funding Area as defined under Title 5, Subtitle 7B of the State Finance and Procurement Article of the Annotated Code of Maryland shall demonstrate:

(i) That it has considered, at a minimum, an alternative project site located within a Priority Funding Area that provides the most optimal geographic accessibility to the population in its likely service area, as defined in Project Review Standard (1);

APPLICANT RESPONSE:

The WAH site in White Oak, which will provide the space for AHR's 42 acute rehabilitation beds,

is located in a Priority Funding Area.

(ii) That it has quantified, to the extent possible, the level of effectiveness, in terms of achieving primary project objectives, of implementing the proposed project at each alternative project site and at the proposed project site;

APPLICANT RESPONSE:

Not applicable.

(iii) That it has detailed the capital and operational costs associated with implementing the project at each alternative project site and at the proposed project site, with a full accounting of the cost associated with transportation system and other public utility infrastructure costs; and

APPLICANT RESPONSE:

Not applicable.

(iv) That the proposed project site is superior, in terms of cost-effectiveness, to the alternative project site or sites located within a Priority Funding Area.

APPLICANT RESPONSE:

Not applicable.

(7) Construction Cost of Hospital Space.

The proposed cost of a hospital construction project shall be reasonable and consistent with current industry cost experience in Maryland. The projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

APPLICANT RESPONSE:

WAH conducted an MVS analysis for the two new floors to house AHR rehabilitation beds to determine the reasonableness of the construction costs. The MVS analysis for the additional floors was aggregated into the overall hospital calculation as previously revised and submitted in connection with the September 19, 2017 project modification to add a Central Utility Plant ("CUP") to the WAH building. Exhibit 15 shows the MVS calculation for the hospital, inclusive of the two additional floors. Column B of the chart

in Exhibit 15 shows the final MVS calculation for the approved hospital CON relocation project as conducted by the Reviewer in her final decision. Column D provides the overall total calculation for the relocation project as previously modified to be inclusive of the CUP. Column H provides the overall total MVS calculation for the project after including construction costs for the two additional floors. WAH's analysis shows the overall project costs to be $392.17 per square-foot, $6.34 lower than the MVS benchmark of $398.51. Exhibit 16 highlights the Extraordinary Above-MVS costs permitted as part of the MVS calculation which have not changed since the prior approved project change to add the Central Utility Plant.

(9) Inpatient Nursing Unit Space.

Space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type of unit being developed shall not be recognized in a rate adjustment. If the Inpatient Unit Program Space per bed of a new or modified inpatient nursing unit exceeds 500 square feet per bed, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost for the space that exceeds the per bed square footage limitation in this standard or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

APPLICANT RESPONSE:

The proposed design (both floors combined) provides 42 beds in 35,109 DGSF or 836 sf/bed. The standard appears to refer to inpatient medical/surgical acute care nursing units, however, this is a rehabilitation hospital which must meet additional requirements.

(11) Efficiency.

A hospital shall be designed to operate efficiently. Hospitals proposing to replace or expand diagnostic or treatment facilities and services shall:

(a) Provide an analysis of each change in operational efficiency projected for each diagnostic or treatment facility and service being replaced or expanded, and document the manner in which the planning and design of the project took efficiency improvements into account; and

(b) Demonstrate that the proposed project will improve operational efficiency when the proposed replacement or expanded diagnostic or treatment facilities and services are projected to experience increases in the volume of services delivered; or

(c) Demonstrate why improvements in operational efficiency cannot be achieved.

APPLICANT RESPONSE:

The new rehab hospital bed units are designed with a central nurse station that can serve both corridors, allowing physicians, nutritionists, pharmacists and others to support both sides of the all-private room unit with relatively short walking distances.

The all-private room facility will allow private consultations to occur between patients and clinicians (including caseworkers, social workers, etc.) to occur in the patient bedroom. Eliminating the need for transfers will increase efficiency.

The design of the unit supports electronic health records (EHR) systems implementation throughout the unit, and allows clinicians easy access to computers.

Overhead patient lift tracks will be installed in patient bedrooms which will significantly reduce the need for staff to go to an equipment storage room to retrieve a mobile patient lift when such needs arise.

(12) Patient Safety.

The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety. A hospital proposing to replace or expand its physical plant shall provide an analysis of patient safety features included for each facility or service being replaced or expanded, and document the manner in which the planning and design of the project took patient safety into account.

APPLICANT RESPONSE:

The new rehab hospital beds will be designed to current codes and standards. All bedrooms will be private, which will help patients rest.

All the new bedrooms will be barrier-free per the ADA, which should help prevent patient falls.

All bathrooms will have curbless showers. Elimination of the curb will help reduce falls by patients and staff while bathing patients. The doors to the patient bathrooms are proposed to be 42” wide; the extra width allows staff members to walk alongside patients to help them navigate between rooms. Furthermore, the rooms are designed so that the bathroom door can remain open without obstructing activities by the staff or the patient, a design feature that has been related to reduced patient falls in safety studies.

The gym and other patient treatment areas are significantly larger than the current facility at Takoma Park, which provides more maneuvering space around equipment.

Location of rehab beds in new construction allows for overhead patient lifts to be included in the construction of the new facility, assisting both patients and staff.

Increased space for storage of durable medical equipment will allow staff easier access to medical equipment.

Key support spaces (clean supply room, equipment room, soiled rooms, main nurse station)

along with the day/dining room are accessed directly from both major corridors on the unit. Reducing the travel distance will allow staff to spend more time with patients which will increase both patient and staff safety.

Evidence-based architectural methods have been employed in the design of the rehabilitation floors at the WAH replacement hospital to improve patient outcomes, safety, and satisfaction. Additionally, these design methods will also benefit staff as they care for patients.

At the White Oak campus, all of the acute rehabilitation rooms will be private. Hand washing sinks will be located both directly inside the entry door to each patient room as well as along the corridor to reduce the risk of infection. Patients will enjoy greater privacy as well.

(13) Financial Feasibility.

A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.

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

APPLICANT RESPONSE:

As discussed in response to .04B(6), AHR's financial projections are accompanied by a detailed specification of assumptions.

(b) Each applicant must document that:

(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;

APPLICANT RESPONSE:

As discussed in response to .04B(1) the utilization projections for the project are based on observed historical trends by the service area population.

(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;

APPLICANT RESPONSE:

As discussed in response to .04B(6), revenue projections for this project are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by AHR.

(iv) Staffing and overall expense projections are consistent with utilization projections

and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or, if a new hospital, the recent experience of other similar hospitals; and

APPLICANT RESPONSE:

As discussed in response to .04B(6), staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by AHR.

(iv) The hospital will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital may receive a Certificate of Need for a project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project when the hospital can demonstrate that overall hospital financial performance will be positive and that the services will benefit the hospital's primary service area population.

APPLICANT RESPONSE:

As discussed in 04B(6), AHR projects to generate an excess of revenues over total expenses within the first year of operations of the replacement facility and throughout the projection period.

10.24.01.08G(3)(b). Need.

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

INSTRUCTIONS: Please identify the need that will be addressed by the proposed project, quantifying the need, to the extent possible, for each facility and service capacity proposed for development, relocation, or renovation in the project. The analysis of need for the project should be population-based, applying utilization rates based on historic trends and expected future changes to those trends. This need analysis should be aimed at demonstrating needs of the population served or to be served by the hospital. The existing and/or intended service area population of the applicant should be clearly defined.

Fully address the way in which the proposed project is consistent with each applicable need standard or need projection methodology in the State Health Plan.

If the project involves modernization of an existing facility through renovation and/or expansion, provide a detailed explanation of why such modernization is needed by the service area population of the hospital. Identify and discuss relevant building or life safety code issues, age of physical plant issues, or standard of care issues that support the need for the proposed modernization.

Please assure that all sources of information used in the need analysis are identified. Fully explain all assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), the relevant population considered in the analysis, and the service capacity of buildings and equipment included in the project, with information that supports the validity of these assumptions.

Explain how the applicant considered the unmet needs of the population to be served in arriving at a determination that the proposed project is needed. Detail the applicant's consideration of the provision of services in non-hospital settings and/or through population-based health activities in determining the need for the project.

Complete the Statistical Projections (Tables F and I, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package.

APPLICANT RESPONSE:

The need for the project was discussed in detail in response to acute rehabilitation service specific standards in Section .04B(2).

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the proposed project. The applicant should identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including:

a) the alternative of the services being provided through existing facilities;

APPLICANT RESPONSE:

This was discussed earlier in the cost effectiveness section.

Describe the hospital's population health initiatives and explain how the projections and proposed capacities take these initiatives into account.

APPLICANT RESPONSE:

AHR is fully integrated into the population health initiatives that AHC has implemented. These population health initiatives will not, however, eliminate or significantly reduce the need for acute inpatient rehabilitation. For many patients with serious injuries or disabling conditions, acute rehabilitation is the most appropriate setting in which to restore the patient to his or her

functionality to the maximum level possible.

AHR is working to reduce hospital readmissions by using a readmission risk analytics tool embedded within our Electronic Medical Record (EMR). This tool cross references clinical indicators with social and behavioral determinants to predict a patients' risk of readmission. Once a patient has been determined to be at risk for readmission, an algorithm in the tool creates a plan of care that can be tracked and documented. Case managers and a care transition team follow high risk patients into the community and connect them with community resources to help keep discharged patients from being readmitted.

In addition, AHR is working to reduce Prevention Quality Indicators (PQI). Approximately 60% of PQI patients have either: Congestive Heart Failure, COPD, or Diabetes. AHR is working with the AHC network of providers to create Integrated Care Pathways that span acute care, Rehabilitation, Home Health, and Ambulatory services to ensure that these patients receive research based clinically indicated care at any point that they come in contact with AHC. This will include AHR and will help to improve patients' Quality of Life, improve the application of preventative medicine, and reduce Total Cost of Care (TCC).

Finally, through improvements in care processes, AHR continues to raise its outcomes on the Functional Independence Measure (FIM). The FIM is the CMS mandated patient outcome measure that tracks the patients "Burden of Care" on society. This measure approximates how much each patient "costs" the community with an inverse relationship of FIM score to Cost. The hospital has improved patient FIM outcome from the 41st percentile in 2013 to the 82nd percentile in 2018, thus reducing TCC and improving patient health.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development costs to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective method to reach stated goal(s) and objective(s) or the most effective solution to the identified problem(s) for the level of costs required to implement the project, when compared to the effectiveness and costs of alternatives, including the alternative of providing the service through existing facilities, including outpatient facilities or population-based planning activities or resources that may lessen hospital admissions, or through an alternative facility that has submitted a competitive application as part of a comparative review.

APPLICANT RESPONSE:

This was discussed earlier in Section .04B(5).

10.24.01.08G(3)(d). Viability of the Proposal.

The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames

set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

- **Complete applicable Revenues & Expenses (Tables G, H, J and K as applicable), and the Work Force information (Table L) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable.**

- **Describe and document relevant community support for the proposed project.**

- **Identify the performance requirements applicable to the proposed project and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, contracting and obtaining and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame.**

- **Audited financial statements for the past two years should be provided by all applicant entities and parent companies.**

APPLICANT RESPONSE:

The capital cost for adding two additional floors to the White Oak hospital project is $19,547,323. AHC is not requesting an increase to the overall project budget for this initiative. This project will be sourced through cash, as a result of excess equity generated by savings realized from the WAH replacement hospital project. AHC was able to identify areas within the existing project budget where savings is available to cover the added cost for the two additional floors for AHR. The savings of approximately $14 million come mainly from efficiencies achieved from the development of the parking garage and the CUP. The additional dollars needed to fund the project will come from AHC routine capital allocations, which average approximately $50M per year. As noted in the table below, AHC continues a trend of strong financial performance, which has resulted in improved cash balances, which will easily cover the additional dollars needed to complete the two additional floors.

AHC Consolidated (in thousands)	2012	2013	2014	2015	2016	2017	YTD 3/31/2018
Net Income	$ 5,369	$ 4,046	$ 14,675	$ 24,018	$ 21,615	$ 26,502	$ 5,240
Cash	$ 175,383	$ 187,334	$ 195,677	$ 184,057	$ 218,792	$ 238,518	$ 235,351

10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.

An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

INSTRUCTIONS: List all of the Certificates of Need that have been issued to the applicant or related entities, affiliates, or subsidiaries since 2000, including their terms and conditions, and any changes to approved CONs that were approved. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

APPLICANT RESPONSE:

Adventist HealthCare, Inc. was issued a CON by the Commission to build a rehabilitation hospital on April 14, 1995.

Adventist Health Care, Inc. was issued a CON by the Commission on September 10, 1996 to create the Shady Grove Adventist Hospital Neonatal Intensive Care Unit (NICU).

Adventist HealthCare, Inc. was issued a CON by the Commission on November 12, 1996 to establish a 20-bed hospital-based subacute care unit. This unit operated as Care-Link at Washington Adventist Hospital.

Adventist HealthCare, Inc. was issued a CON by the Commission on February 20, 2003 for 15 of the 20 comprehensive care beds operated at Care-Link at Washington Adventist Hospital to be consolidated and relocated with the existing 82 bed complement at Fairland Nursing and Rehabilitation Center, expanding its bed capacity to 97 beds. The remaining five beds were relinquished.

Adventist HealthCare, Inc. was issued a CON by the Commission on June 19, 2003 for 22 rehabilitation beds.

Adventist HealthCare, Inc. was issued a CON on February 16, 2005 to expand the patient tower at Shady Grove Adventist Hospital.

Washington Adventist Hospital was issued a CON on November 18, 2005 to

establish the Washington Adventist Surgery Center. The CON was relinquished on August 18, 2006.

The MHCC has found that Adventist HealthCare, Inc. has complied with all conditions applicable to these Certificates of Need as part of its First Use Reviews.

Adventist HealthCare, Inc. was issued a CON on December 17, 2015 to relocate Washington Adventist Hospital from Takoma Park to Silver Spring (Docket No.: 13-15-2349). Progress on the construction is on schedule and on budget. Compliance with the conditions of this CON will be timely for the project under development.

10.24.01.08G(3)(f). Impact on Existing Providers and the Health Care Delivery System.

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

INSTRUCTIONS: **Please provide an analysis of the impact of the proposed project:**

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project[2];

APPLICANT RESPONSE:

As discussed in response to Section .04(3)(a), the project will not have a material impact on other providers. AHR expects the same sources that have historically referred patients for inpatient rehabilitation to continue these referrals at the new site. The projections of utilization do not assume reduction in market shares of existing acute rehabilitation providers in Maryland. These projections of future growth, instead, rely on:

- Projected growth in population.
- Some reduction in Montgomery County patients out-migrating to acute rehabilitation providers in Washington, D.C.
- Constant rates of acute inpatient rehabilitation discharges over the projection period.

In addition, the evidence based design features of the AHR replacement hospital will clearly demonstrate a positive impact on the health care system. The plan to construct all private rooms will positively impact patient care by: 1) promoting efficiency by allowing the hospital to operate at a higher occupancy; 2) promoting clinical effectiveness by permitting safer environment for patients and staff alike; and 3) promoting an environment that will foster more patient- and family-centered care.

[2] **Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, the relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions.**

b) On access to health care services for the service area population that will be served by the project. (state and support the assumptions used in this analysis of the impact on access);

APPLICANT RESPONSE:

As discussed in response to Section .04(1), AHR's replacement location in White Oak will enhance access to the population that AHR currently serves. At its current location in Takoma Park, AHR is difficult to access. The hospital is located in a residential area and is only accessible by narrow, two-lane residential streets, making it difficult for patients and employees to access. In contrast, the WAH replacement hospital site is located on a 48.8 acre parcel on the west side of Plum Orchard Drive, west of its intersection with Cherry Hill Road in the White Oak section of Montgomery County. This site is located approximately 6.6 miles from the existing Takoma Park campus of WAH; drive time is approximately 16 minutes according to MAPQUEST©. Additionally, the site is accessible to major interconnecting roadways, such as, Interstate 95, New Hampshire Avenue, Route 29 and Cherry Hill Road. The Inter County Connector (ICC) has a major connecting intersection just 1 mile north of the proposed White Oak campus located along Route 29 and Interstate 95.

Further, the White Oak site is serviced by Metrobus and Montgomery County plans to extend its Ride-On bus #10 to service the new site. Hospital representatives are working with Metrobus to enhance service connections to existing routes originating in Prince George's County.

c) On costs to the health care delivery system.

If the applicant is an existing hospital, provide a summary description of the impact of the proposed project on costs and charges of the applicant hospital, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

APPLICANT RESPONSE:

The project will not have an impact on the proposed cost and charges of AHR. As shown in the financial projections, relocating to White Oak decreases potential future costs compared to the alternative of remaining in Takoma Park, therefore reducing the total cost of care and allowing AHR to better serve patients within the community.

List of Exhibits

1. Purchase Agreement
2. Assignment and Assumption of Membership Interest
3. Project Drawings
4. Financial Tables
5. Adventist Rehabilitation Hospital of Maryland, Inc. Corporate Bylaws
6. Rules and Regulations of the Governing Board of Washington Adventist Hospital
7. Adventist HealthCare, Inc. Financial Assistance Policy #AHC 3.19
8. Adventist HealthCare, Inc. Financial Assistance Policy #AHC 3.19B (Spanish language version)
9. Proof of Publication, The Washington Post
10. Proof of Publication, El Tiempo Latino
11. Adventist Rehabilitation Hospital of Maryland, Inc. Hospital Licenses
12. Adventist Rehabilitation Hospital of Maryland, Inc. CARF Certification
13. Adventist Rehabilitation Hospital of Maryland, Inc. The Joint Commission Accreditation
14. Community Letters of Support
15. MVS Calculation
16. MVS Extraordinary Costs
17. Financial Assumptions
18. Washington Adventist Hospital License
19. Washington Adventist Hospital The Joint Commission Accreditation
20. Audited Financials
21 Affirmations

EXHIBIT 1

PURCHASE AGREEMENT

THIS PURCHASE AGREEMENT (the "**Agreement**") is dated as of the Effective Date (as hereinafter defined) by and among PS BUSINESS PARKS, L.P. (the "**Seller**"), PSB/K LLC, a Delaware limited liability company (the "**Kaiser LLC**"), and ADVENTIST HEALTHCARE, INC., a Maryland non-profit corporation ("Purchaser").

RECITALS

R-1. Seller is the contract purchaser of or has the option to purchase the membership interests in GB Three, LLC (the "**Grosvenor LLC**"), which owns certain real property containing approximately 35 acres of land located in Montgomery County, Maryland known as Parcels RR, SS and MMM in Westfarm Technology Park (the "**Grosvenor Property**") as more particularly described in and pursuant to the terms of an Agreement of Purchase and Sale and Joint Escrow Instructions, as amended, by and between Seller, as buyer, and GB Two, LLC, as Seller (the "**Grosvenor Purchase Agreement**"), a copy of which is attached hereto as **Exhibit A** and incorporated herein by reference.

R-2. Seller is also the contract purchaser of certain real property containing approximately 13.54 acres of land located in Montgomery County, Maryland known as Parcels B-B and C-C, in Westfarm Technology Park (the "**Kaiser Property**") as more particularly described in and pursuant to the terms of a Sale-Purchase Agreement by and between Seller, as buyer, and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., as Seller (the "**Kaiser Purchase Agreement**"), a copy of which is attached hereto as **Exhibit B** and incorporated herein by reference.

R-3. Seller will acquire one hundred percent (100%) of the membership interests of Grosvenor LLC which was formed for the sole purpose of acquiring the Grosvenor Property pursuant to the terms of the Grosvenor Purchase Agreement.

R-4. Seller owns one hundred percent (100%) of the membership interests of Kaiser LLC which was formed for the sole purpose of acquiring the Kaiser Property pursuant to the terms of the Kaiser Purchase Agreement.

R-5. Purchaser desires to purchase from Seller and Seller desires to sell to Purchaser one hundred percent (100%) of the membership interests in Grosvenor LLC and one hundred percent (100%) of the membership interests in Kaiser LLC, upon the terms and subject to the conditions set forth in this Agreement.

NOW, THEREFORE, in consideration of the premises, the mutual representations, warranties, covenants and agreements hereinafter contained, and other good and valuable consideration the receipt and sufficiency of which are hereby acknowledged and intending to be legally bound, the parties hereby agree as follows:

1. **Recitals; Definitions.** The Recitals are incorporated herein by reference. As used in this Agreement, the following additional terms have the following respective meanings:

(a) *Actual Knowledge of Purchaser (or Purchaser's Actual Knowledge).* The knowledge of William G. Robertson, which individual Purchaser represents to Seller is the actual President and Chief Executive Officer of Purchaser charged with primary responsibility for Purchaser, without duty of inquiry; provided that so qualifying Purchaser's knowledge shall in no event give rise to any personal liability on the part of the William G. Robertson, on account of any breach of any representation and warranty of Purchaser herein. Actual Knowledge shall not include constructive knowledge, imputed knowledge, or knowledge Purchaser or William G. Robertson does not have but could have obtained through further investigation or inquiry.

(b) *Actual Knowledge of Kaiser LLC (or Kaiser LLC's Actual Knowledge).* The knowledge of Brett Franklin, which individual Kaiser LLC represents to Purchaser is the actual Senior Vice-President of Kaiser LLC charged with primary responsibility for Kaiser LLC without duty of inquiry; provided that so qualifying Seller's knowledge shall in no event give rise to any personal liability on the part of Brett Franklin, on account of any breach of any representation and warranty of Kaiser LLC herein. Actual Knowledge shall not include constructive knowledge, imputed knowledge, or knowledge Kaiser LLC or Brett Franklin does not have but could have obtained through further investigation or inquiry.

(c) *Actual Knowledge of Seller (or Seller's Actual Knowledge).* The knowledge of Brett Franklin, which individual Seller represents to Purchaser is the actual Senior Vice President of Seller charged with primary responsibility for Seller without duty of inquiry; provided that so qualifying Seller's knowledge shall in no event give rise to any personal liability on the part of Brett Franklin, on account of any breach of any representation and warranty of Seller herein. Actual Knowledge shall not include constructive knowledge, imputed knowledge, or knowledge Seller or Brett Franklin does not have but could have obtained through further investigation or inquiry.

(d) *Affiliate of Purchaser.* An entity which controls, is controlled by, or is under common control with Purchaser.

(e) *Affiliate of Seller.* An entity which controls, is controlled by, or is under common control with Seller.

(f) *Agreement.* This Agreement among Seller, Kaiser LLC and Purchaser, including all addenda, schedules and exhibits attached hereto and incorporated herein by reference.

(g) *Closings.* The Grosvenor Closing and the Kaiser Closing.

(h) *Closing Agent.* Chicago Title Insurance Company.

(i) *Company.* Individually or collectively, Grosvenor LLC and Kaiser LLC.

(j) *Costs and Expenses.* Costs and Expenses shall include expenses attributable to the Property, but shall not be limited to, legal fees and expenses of Seller, Kaiser LLC and Purchaser, consulting fees and expenses, due diligence costs, closing costs, escrow charges, tax certificates, State and County transfer and recordation, documentary and any other taxes and stamps recording fees, recording costs, title costs including cost of the title policies, Survey costs, inspections, brokerage fees and commissions, costs and expenses incurred in connection with zoning matters, and all prorations and adjustments attributable to the Seller and/or Kaiser LLC under the Grosvenor Purchase Agreement and Kaiser Purchase Agreement, as applicable, if not already reflected in the purchase price payable by Seller to the seller of the Property or the seller of the Grosvenor Membership Interests.

(k) *Developer Entity.* The entity formed to develop the MOB's, as provided in Section 16.

(l) *Effective Date.* The date of the last signature to this Agreement by Seller and Purchaser.

(m) *Fair Market Land Value.* The fair market value of the Property, or the applicable portion of the Property, as determined in accordance with Section 19.

(n) *Grosvenor Closing.* The closing on the sale of the Grosvenor Membership Interests from Seller to Purchaser.

(o) *Grosvenor Membership Interests.* Seller's one hundred percent (100%) membership interests in Grosvenor LLC.

(p) *Grosvenor Purchase Price.* The purchase price payable by Seller to GB Two, LLC pursuant to the Grosvenor Purchase Agreement, plus the Grosvenor Reimbursable Expenses.

(q) *Grosvenor Reimbursable Expenses.* All actual Costs and Expenses incurred by Seller in connection with the acquisition and closing of the Grosvenor Membership Interests and the sale of the Grosvenor Membership Interests to Purchaser as evidenced by invoices provided by Seller to Purchaser; provided the aggregate of such expenses accruing prior to May 23, 2006 shall not exceed $450,000.

(r) *Grosvenor Title Commitment.* Commitment for Title Insurance Number 2950-60141 , issued by the Title Company to Grosvenor LLC in connection with the acquisition of the Grosvenor Membership Interests by Seller.

(s) *Kaiser Closing.* The closing on the sale of the Kaiser Membership Interests from Seller to Purchaser.

(t) *Kaiser Membership Interests*. Seller's one hundred percent (100%) membership interests in Kaiser LLC.

(u) *Kaiser Purchase Price*. The purchase price payable by Kaiser LLC to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. pursuant to the Kaiser Purchase Agreement, plus the Kaiser Reimbursable Expenses.

(v) *Kaiser Reimbursable Expenses*. All actual costs and expenses incurred by Seller and/or Kaiser LLC in connection with the acquisition and closing of the Kaiser Property as evidenced by invoices provide by Seller to Purchaser; provided the aggregate of such expenses accruing prior to May 23, 2006 shall not exceed $50,000.

(w) *Kaiser Survey*. Survey prepared by VIKA dated _____ with respect to the Kaiser Property.

(x) *Kaiser Title Commitment*. Commitment for title insurance Number 4506-44411, issued by the Title Company to Kaiser LLC in connection with the acquisition of the Kaiser Property by Kaiser LLC.

(y) *Membership Interests*. The Grosvenor Membership Interests and the Kaiser Membership Interests.

(z) *MOB's*. The medical office buildings described in Section 16 which may be developed on the Property.

(aa) *Permitted Exceptions*. The Property shall be conveyed subject to the following:

(i) those exceptions to title to the Property reflected in the Title Commitments;

(ii) the lien of all ad valorem real estate taxes and assessments not yet due and payable as of the date of the Grosvenor Closing;

(iii) local, state and federal laws, ordinances or governmental regulations, including, but not limited to, building and zoning laws, ordinances and regulations, now or hereafter in effect relating to the Property;

(iv) all items shown on the Title Commitments and Survey (or if Purchaser elects not to conduct a survey which would have been disclosed by a survey) and all items which a visual inspection of the Property would reveal;

(v) the standard or printed exclusions and standard or printed exceptions in the form of title policy;

(vi) any liens, encumbrances, easements or other exceptions or matters voluntarily imposed or consented to by Purchaser prior to or as of the closing hereunder and all matters created by or resulting from the acts of Purchaser or parties claiming by, through or under Purchaser, including those matters arising as a result of Purchaser's or its agent's or representative's actions or inactions.

(bb) *Property.* Individually and collectively, the Grosvenor Property and the Kaiser Property.

(cc) *Purchase Agreements.* The Grosvenor Purchase Agreement and the Kaiser Purchase Agreement.

(dd) *Purchase Price.* The Grosvenor Purchase Price plus the Kaiser Purchase Price.

(ee) *Qualified Appraiser.* an appraiser who (i) is a member of the Master Appraiser Institute (or its successor or equivalent) and is licensed in the State of Maryland, (ii) has not less than ten (10) years' experience in appraising commercial real estate, (iii) is practicing in the State of Maryland, and (iv) is not, and during the preceding five (5) years has not been, an employee of Purchaser, Seller or any of their affiliates.

(ff) *Survey.* The Grosvenor Survey and the Kaiser Survey.

(gg) *Title Commitments.* The Grosvenor Title Commitment and the Kaiser Title Commitment.

(hh) *Title Company.* Chicago Title Insurance Company

2. **Agreement to Purchase and Sell.** Subject to and upon the terms and conditions herein set forth, Seller agrees to sell the Membership Interests to Purchaser, and Purchaser agrees to purchase the Membership Interests from Seller.

3. **Consideration.**

(a) Seller and Purchaser agree that the total consideration for the Membership Interests shall be the Purchase Price.

(b) Within two (2) business days of the execution of this Agreement, Purchaser shall pay to Seller by wire transfer the amount of all deposits and other sums previously paid or deposited by Seller under the Grosvenor Purchase Agreement and under the Kaiser Purchase Agreement as more particularly set forth on **Exhibits A and B**. Purchaser covenants and agrees to promptly pay to Seller, from time to time, upon request, any additional deposits that may be required under the Purchase Agreements.

(c) By the close of business on July 6, 2006, Purchaser shall pay by wire transfer to the Closing Agent that portion of the Grosvenor Purchase Price equal to the purchase

price payable by Seller to GB Two, LLC pursuant to the Grosvenor Purchase Agreement. Such funds shall be delivered to the Closing Agent pursuant to escrow instructions which shall provide that the Closing Agent shall be entitled to release such funds to GB Two, LLC provided GB Two LLC tenders performance under the Grosvenor Purchase Agreement.

4. **Approval of Title.** Purchaser acknowledges that Seller has provided Purchaser with copies of the Title Commitments. Purchaser hereby agrees that all of the exceptions noted in the Title Policy shall be Permitted Exceptions, other than those matters relating to the Kaiser Property as set forth in **Exhibit E** attached hereto or to be attached hereto within five (5) business days and incorporated herein by reference ("Title Objections"). Seller agrees to cooperate with Purchaser in connection with such Title Objections by notifying Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., and proceeding under the Kaiser Purchase Agreement, as the case may be, in connection with any such Title Objections. Purchaser acknowledges and agrees that (i) Purchaser shall be subject to the terms and conditions set forth in the Purchase Agreements, (ii) Seller or Kaiser LLC shall not be obligated or liable to cure any Title Objections except to provide notice of such objections in accordance with the Purchase Agreements provided that if any time period for objections to a title matter has passed, Purchaser shall be deemed to have waived such Title Objection, and (iii) Purchaser shall not be entitled to terminate this Agreement in the event of a Title Objection unless it is entitled to do so under the terms of the applicable Purchase Agreement.

5. **Closing under Purchase Agreements.** Provided GB Two, LLC satisfies all conditions to closing under the Grosvenor Purchase Agreement and is not otherwise in default thereunder, Seller shall timely consummate closing under the Grosvenor Purchase Agreement. Provided Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. satisfies all conditions to closing under the Kaiser Purchase Agreement and is not otherwise in default thereunder, Kaiser LLC shall timely consummate closing under the Kaiser Purchase Agreement. Purchaser shall be obligated to acquire both the Grosvenor Membership Interests and the Kaiser Membership Interests and shall not be entitled to close on one and not the other. Failure to acquire all Membership Interests shall be a default and breach under this Agreement.

6. **Seller's and Kaiser LLC's Representations and Warranties.** Seller and Kaiser LLC hereby represent and warrant as follows, all of which shall be true as of the date of execution of this Agreement and shall be true and correct in all material respects as of date of the Grosvenor Closing and the date of the Kaiser Closing Date, as applicable.

(a) Seller is a limited partnership duly formed and validly existing under the laws of the State of California.

(b) Grosvenor LLC is a limited liability company duly organized on or about January 30, 2006, validly existing and in good standing under the laws of the State of Maryland.

(c) Grosvenor LLC was formed for the sole purpose of acquiring the Grosvenor Property and Grosvenor LLC has conducted no business or activities unrelated to the acquisition, ownership, development and sale of the Grosvenor Property.

(d) Grosvenor LLC has no outstanding liabilities other than liability for property taxes or assessments which shall either be paid or adjusted at closing under the Grosvenor Purchase Agreement.

(e) Kaiser LLC is a limited liability company duly organized on or about June 29, 2006, validly existing and in good standing under the laws of the State of Delaware.

(f) Kaiser LLC was formed for the sole purpose of acquiring the Kaiser Property and Kaiser LLC has conducted no business or activities unrelated to the acquisition, development and sale of the Kaiser Property.

(g) Seller has full power and authority to execute and deliver this Agreement and to perform all of the terms and conditions hereof to be performed by Seller and to consummate the transactions contemplated hereby. This Agreement and each of the documents to be executed by Seller which is to be delivered to Purchaser at the Grosvenor Closing or the Kaiser Closing, as applicable, has been or will be duly executed and delivered by Seller and is, or at the time of Grosvenor Closing or the Kaiser Closing, as the case may be, will be the legal, valid and binding obligation of Seller, enforceable against Seller in accordance with its terms, except as the enforceability thereof may be limited by bankruptcy, insolvency, reorganization or moratorium or other similar laws relating to the enforcement of creditors' rights generally and by general equitable principles. Seller is not presently subject to any bankruptcy, insolvency, reorganization, moratorium, or similar proceeding.

(h) Kaiser LLC has full power and authority to execute and deliver this Agreement and to perform all of the terms and conditions hereof to be performed by Kaiser LLC and to consummate the transactions contemplated hereby. This Agreement and each of the documents executed by Kaiser LLC which is to be delivered to Purchaser at the Grosvenor Closing or the Kaiser Closing has been or will be duly executed and delivered by Kaiser LLC and is, or at the time of Grosvenor Closing or the Kaiser Closing, as the case may be, will be the legal, valid and binding obligation of Kaiser LLC, enforceable against Kaiser LLC in accordance with its terms, except as the enforceability thereof may be limited by bankruptcy, insolvency, reorganization or moratorium or other similar laws relating to the enforcement of creditors' rights generally and by general equitable principles. Kaiser LLC is not presently subject to any bankruptcy, insolvency, reorganization, moratorium, or similar proceeding.

(i) The individuals executing this Agreement and the instruments referenced herein on behalf of Seller have the legal power, right and actual authority to bind Seller to the terms and conditions hereof and thereof.

(j) The individuals executing this Agreement and the instruments referenced herein on behalf of Kaiser LLC have the legal power, right and actual authority to bind Kaiser LLC to the terms and conditions hereof and thereof.

(k) The copies of the Purchase Agreements attached hereto as **Exhibits A and B** are true and correct copies of the Purchase Agreements, which have not been modified and remain in full force and effect. To Seller's Actual Knowledge, no defaults exist under either of the Purchase Agreements.

(l) The copies of the governing documents of the Company attached hereto or to be attached hereto prior to the Grosvenor Closing as **Exhibit F, Exhibit G, Exhibit H**, and **Exhibit J** (articles of organization of Grosvenor LLC, operating agreement of Grosvenor LLC, articles of organization of Kaiser LLC, and operating agreement of Kaiser LLC, respectively) are true and correct copies. Seller owns, or will own at each of the Closings, one hundred percent (100%) of the Membership Interests in the applicable Company, free and clear of all liens and encumbrances. Seller has not heretofore entered into any agreement, contract, commitment or other obligation to sell, donate, pledge, convey, mortgage, hypothecate, assign or otherwise transfer all or any portion of the Membership Interests, which will not be satisfied or released at Closing.

(m) Neither the execution and delivery of this Agreement, the consummation of the transactions contemplated by this Agreement, nor the compliance with the terms and conditions hereof will (a) violate or conflict, in any material respect, with any provision of Seller's organizational documents or, to Seller's Actual Knowledge, any injunction, judgment, order, decree, ruling, charge or other restrictions of any government, governmental agency or court to which Seller is subject, and which violation or conflict would have a material adverse effect on Seller.

(n) Neither the execution and delivery of this Agreement, the consummation of the transactions contemplated by this Agreement, nor the compliance with the terms and conditions hereof will (a) violate or conflict, in any material respect, with any provision of the Company's organizational or, to the Seller's Actual Knowledge or Kaiser LLC's Actual Knowledge, any injunction, judgment, order, decree, ruling, charge or other restrictions of any government, governmental agency or court to which the Company is subject, and which violation or conflict would have a material adverse effect on the Company.

(o) Seller and Kaiser LLC shall, and shall cause their attorneys, members, partners, shareholders, consultants, directors, officers, employees, agents, contractors and representatives (collectively, the "**Seller Parties**") to, hold in strict confidence, and not disclose to any other person or entity without the prior written consent of Purchaser any information with respect to the Purchaser and this Agreement, except for information concerning the Purchaser which was available to Seller or Kaiser LLC other than in connection with the Property and the negotiation of this Agreement (collectively, the "**Purchaser Confidential Information**"). In the event of a breach or threatened breach by Seller or Kaiser LLC or its agents or representatives of this Section 6(p), Purchaser shall be entitled to an injunction restraining Seller or Kaiser LLC or

any of the Seller Parties from disclosing, in whole or in part, such Purchaser Confidential Information. Nothing herein shall be construed as prohibiting Purchaser from pursuing any other available remedy at law or in equity for such breach or threatened breach. Notwithstanding anything to the contrary hereinabove set forth, Seller or Kaiser LLC may disclose such Purchaser Confidential Information (i) on a need-to-know basis to its employees, its title insurer and members of professional firms serving it in connection with this transaction, including, without limitation, its attorneys, architects, environmental consultants and engineers, and its clients provided such employees, title insurer and members of professional firms agree to hold such information in strict confidence; (ii) as any governmental agency or authority may require in order to comply with applicable laws or regulations; and (iii) if required by an order of any court of competent jurisdiction.

No constituent partner, member, shareholder or other person or entity in or agent of Seller or Kaiser LLC, nor any advisor, trustee, director, employee, beneficiary, shareholder, member, partner, participant, representative or agent of any partnership, limited liability company, corporation, trust or other entity that has or acquires a direct or indirect interest in Seller or Kaiser LLC shall have any personal liability, directly or indirectly, under or in connection with this Agreement, or any amendment or amendments to this Agreement made at any time or times, heretofore or hereafter, and Purchaser, on behalf of itself and its successors and assigns, hereby waives any and all such personal liability. This provision shall survive the Closings.

7. **Purchaser's Representations and Warranties.** Purchaser hereby represents and warrants as follows, all of which shall be true as of the date of execution of this Agreement and as of the date of the Grosvenor Closing and date of the Kaiser Closing, as applicable:

(a) Purchaser is a corporation duly organized, validly existing and in good standing under the laws of the State of Maryland.

(b) Purchaser has full power and authority to execute and deliver this Agreement and to perform all of the terms and conditions hereof to be performed by Purchaser and to consummate the transactions contemplated hereby. This Agreement and each of the documents to be executed by Purchaser which is to be delivered to Seller and/or the Company at the Grosvenor Closing or the Kaiser Closing, as applicable, has been or will be duly executed and delivered by Purchaser and is, or at the time of the Grosvenor Closing or the Kaiser Closing, as the case may be, will be the legal, valid and binding obligation of Purchaser, enforceable against Purchaser in accordance with its terms, except as the enforceability thereof may be limited by bankruptcy, insolvency, reorganization or moratorium or other similar laws relating to the enforcement of creditors' rights generally and by general equitable principles. Purchaser is not presently subject to any bankruptcy, insolvency, reorganization, moratorium, or similar proceeding and no such action is contemplated or has been threatened.

(c) The individuals executing this Agreement and the instruments referenced herein on behalf of Purchaser have the legal power, right and actual authority to bind Purchaser to the terms and conditions hereof and thereof.

(d) Neither the execution and delivery of this Agreement, the consummation of the transactions contemplated by this Agreement, nor the compliance with the terms and conditions hereof will (a) violate or conflict, in any material respect, with any provision of Purchaser's organizational documents to Purchaser's Actual Knowledge, any injunction, judgment, order, decree, ruling, charge or other restrictions of any government, governmental agency or court to which Purchaser is subject, and which violation or conflict would have a material adverse effect on Purchaser.

(e) Purchaser shall furnish all of the funds for the purchase of the Membership Interests and such funds will not be from sources of funds or properties derived from any unlawful activity.

(f) Purchaser acknowledges that all information with respect to the Property and the Company obtained by Purchaser or furnished to Purchaser, including, without limitation, due diligence materials (collectively, the "**Seller Confidential Information**"), is and has been so furnished on the condition that Purchaser maintains the confidentiality thereof. Accordingly, Purchaser shall, and shall cause its attorneys, members, partners, shareholders, consultants, directors, officers, employees, agents, contractors and representatives (collectively, the "**Purchaser Parties**") to, hold in strict confidence, and not disclose to any other person or entity without the prior written consent of Seller until the later to occur of the Grosvenor Closing or the Kaiser Closing shall have been consummated, any of the Seller Confidential Information in respect of the Property and the Company delivered to Purchaser by Seller or any of its agents, representatives, directors, officers or employees. If the Closings do not occur and this Agreement is terminated, Purchaser shall promptly return, or cause to be returned, to Seller all copies of such Seller Confidential Information without retaining, or permitting retention of, any copy thereof. In the event of a breach or threatened breach by Purchaser or its agents or representatives of this Section 7(g), Seller shall be entitled to an injunction restraining Purchaser or any of the Purchaser Parties from disclosing, in whole or in part, such Seller Confidential Information. Nothing herein shall be construed as prohibiting Seller from pursuing any other available remedy at law or in equity for such breach or threatened breach. Notwithstanding anything to the contrary hereinabove set forth, Purchaser may disclose such Seller Confidential Information (i) on a need-to-know basis to its employees, its title insurer and members of professional firms serving it in connection with this transaction, including, without limitation, its attorneys, architects, environmental consultants and engineers, and its clients provided such employees, title insurer and members of professional firms agree to hold such information in strict confidence; (ii) as any governmental agency or authority may require in order to comply with applicable laws or regulations; and (iii) if required by an order of any court of competent jurisdiction.

(g) As of the Closing, (1) Purchaser will not be an employee benefit plan as defined in Section 3(3) of the Employee Retirement Income Security Act of 1974, as amended ("**ERISA**"), which is subject to Title I of ERISA, nor a plan as defined in Section 4975(e)(1) of the Internal Revenue Code of 1986, as amended (each of the foregoing hereinafter referred to collectively as "Plan"), and (2) the assets of the Purchaser will not constitute "plan assets" of one

or more such Plans within the meaning of Department of Labor Regulation Section 2510.3-101. As of the Closing, if Purchaser is a "governmental plan" as defined in Section 3(32) of ERISA, the closing of the sale of the Property will not constitute or result in a violation of state or local statutes regulating investments of and fiduciary obligations with respect to governmental plans. As of the Closing, Purchaser will be acting on its own behalf and not on account of or for the benefit of any Plan. Purchaser is not, and will not be as of the Closing, a party in interest as defined in Section 3(14) of ERISA to a Plan, other than a plan maintained by Purchaser for the benefit of its employees. Purchaser has no present intent to transfer the Property to any entity, person or Plan which will cause a violation of ERISA.

(h) Purchaser is experienced in and knowledgeable about the ownership and management of commercial real estate properties, and has relied and shall rely exclusively on its own consultants, advisors, counsel, employees, agents, principals and/or studies, investigations and/or inspections with respect to the Property, its condition, value and potential. Notwithstanding the fact the Purchaser has received certain information from Seller or its agents or consultants, Purchaser has relied solely upon an shall continue to rely solely upon its own analysis and shall not rely on any information provided by Seller or its agents or consultants, except as expressly set forth in Section 6.

No constituent partner, member, shareholder or other person or entity in or agent of Purchaser, nor any advisor, trustee, director, employee, beneficiary, shareholder, member, partner, participant, representative or agent of any partnership, limited liability company, corporation, trust or other entity that has or acquires a direct or indirect interest in Purchaser shall have any personal liability, directly or indirectly, under or in connection with this Agreement, or any amendment or amendments to this Agreement made at any time or times, heretofore or hereafter, and Seller and Company, on behalf of themselves and their successors and assigns, hereby waive any and all such personal liability. This provision shall survive the Closings.

8. **Indemnification**. Seller and Kaiser LLC hereby agree to indemnify and hold harmless Purchaser from and against any and all claims, demands, liabilities, costs, expenses, penalties, damages and losses, including, without limitation, reasonable attorneys' fees, resulting from any misrepresentations or breach of warranty or breach of covenant made by Seller or Kaiser LLC in this Agreement. Purchaser hereby agree to indemnify and hold harmless Seller and Kaiser LLC from and against any and all claims, demands, liabilities, costs, expenses, penalties, damages and losses, including, without limitation, reasonable attorneys' fees, resulting from any misrepresentations or breach of warranty or breach of covenant made by Purchaser in this Agreement.

9. **Grosvenor Closing.**

(a) The Grosvenor Closing shall be held contemporaneously with the date that Seller closes on its acquisition of the Grosvenor Membership Interests or such other date as the parties may mutually agree in writing (the "**Grosvenor Closing Date**"), it being expressly understood and agreed that in no event shall Seller have any obligation or duty to advance any money at Seller's closing on its acquisition of the Grosvenor Membership Interests; all such

(i) Unless otherwise directed by Seller, the balance of the Grosvenor Purchase Price not previously delivered to Closing Agent in accordance with Section 3(c), in an amount agreed to by Seller and Purchaser;

(ii) a duly executed and acknowledged assignment of the Grosvenor Membership Interests in the form to be agreed upon by Seller and Purchaser which shall contain reciprocal indemnification provisions and be subject to the representations and warranties set forth in this Agreement;

(iii) which shall contain reciprocal indemnification provisions and be subject to the representations and warranties set forth in this Agreement;

(iv) a resolution of Purchaser authorizing the execution of this Agreement, the assignment and all other documents to be executed by Purchaser and the performance by Purchaser hereunder;

(v) a duly executed Memorandum of Rights as described in Section 18; and

(vi) any documents reasonably requested by Closing Agent, Seller or the Title Company to evidence Purchaser's capacity and authority to execute this Agreement, all documents to be executed by Purchaser hereunder, and to consummate Closing; and

(vii) such other instruments customarily required by closing agents for similar transactions in Montgomery County, Maryland.

(d) Except as provided for in the Grosvenor Purchase Agreement, there shall be no adjustment or pro-rations on the date of the Grosvenor Closing of any expenses related to the Grosvenor Property.

10. **Kaiser Closing.**

(a) The Kaiser Closing shall be held contemporaneously with the date that Kaiser LLC closes on its acquisition of the Kaiser Property or such other date as the parties may mutually agree in writing (the "**Kaiser Closing Date**"). Prior to the Kaiser Closing Date, Purchaser shall transfer to the Closing Agent, on or before the due date, any additional deposits required to be posted pursuant to the Kaiser Contract, it being expressly understood and agreed that in no event shall Seller have any obligation or duty to advance any money at Kaiser LLC's closing on its acquisition of the Kaiser Property; all such money and funds shall be put up by Purchaser. The Kaiser Closing will take place at the offices of the Closing Agent, 388 Market Street, Suite 1300, San Francisco, California 94111. All title insurance company charges and premiums, survey costs, costs of preparation of the assignment of the Kaiser Membership Interests and all other closing costs shall be paid by Purchaser. In the event the Kaiser Closing does not occur on or before the Kaiser Closing Date, the Closing Agent shall, unless it is notified

by both parties to the contrary, within five (5) days after the Kaiser Closing Date, return to the depositor thereof items which may have been deposited pursuant to this Agreement. Any such return shall not, however, relieve either party hereto of any liability it may have for its wrongful failure to close. Closing Agent shall be obligated (i) to wire transfer the Kaiser Purchase Price to the Title Company on the Kaiser Closing Date pursuant to wire transfer instructions to be given to Closing Agent by Seller, (ii) to deliver to Seller by courier, if within the Washington, DC metropolitan area, or by overnight delivery, originals of each of the closing documents to be delivered by Purchaser, and (iii) to deliver to Purchaser by courier, if within the Washington, DC metropolitan area, or by overnight delivery, originals of each of the closing documents to be delivered by Seller or Kaiser LLC.

(b) At least one day before the Kaiser Closing Date, Seller shall deliver or cause to be delivered the following to the Closing Agent to be held in escrow by Closing Agent in accordance with the terms hereof:

(i) a duly executed and acknowledged assignment of the Kaiser Membership Interests in the form to be agreed upon by Seller and Purchaser, which shall contain reciprocal indemnification provisions and be subject to the representations and warranties set forth in this Agreement;

(ii) any and all title affidavits, in forms reasonably requested by the Title Company and such other documents and instruments in forms acceptable to Seller as may be otherwise necessary to permit the issuance of the non-imputation endorsement to the title policy issued by the Title Company in connection with Kaiser LLC's acquisition of the Kaiser Property;

(iii) a duly executed certificate to the effect that all representations and warranties made by Seller and Kaiser LLC to Purchaser are true and correct in all material respects on and as of the date of the Kaiser Closing with the same effect as if such representations and warranties had been made on and as of the date of the Kaiser Closing, which certificate and the certifications therein shall survive Closing for the period set forth in Section 35 and not merge into the assignment of the Kaiser Membership Interests or other closing documents;

(iv) a resolution of Seller authorizing the execution of this Agreement, the assignment and all other documents to be executed by Seller and the performance by Seller hereunder;

(v) a duly executed Memorandum of Rights as described in Section 18;

(vi) such other customarily required by closing agents for similar transactions in Montgomery County, Maryland.

(c) At least one day before the Kaiser Closing Date, Purchaser shall deliver or cause to be delivered to the Closing Agent the following:

(i) Unless otherwise directed by the Seller, the Kaiser Purchase Price in an amount agreed to by Seller and Purchaser;

(ii) a duly executed and acknowledged assignment of the Kaiser Membership Interests in the form to be agreed upon by Seller and Purchaser, which shall contain reciprocal indemnification provisions and be subject to the representations and warranties set forth in this Agreement;

(iii) a duly executed certificate to the effect that all representations and warranties made by Purchaser to Seller and Kaiser LLC are true and correct in all material respects on and as of the date of the Kaiser Closing with the same effect as if such representations and warranties had been made on and as of the date of the Kaiser Closing, which certificate and the certifications therein shall survive the Kaiser Closing for the period set forth in Section 35 and not merge into the assignment of the Kaiser Membership Interests or other closing documents;

(iv) a resolution of Purchaser authorizing the execution of this Agreement, the assignment and all other documents to be executed by Purchaser and the performance by Purchaser hereunder;

(v) a duly executed Memorandum of Rights as described in Section 18; and

(vi) any documents reasonably requested by Closing Agent, Seller or the Title Company to evidence Purchaser's capacity and authority to execute this Agreement, all documents to be executed by Purchaser hereunder, and to consummate Closing; and

(vii) such other instruments customarily required by closing agents for similar transactions in Montgomery County, Maryland.

(d) Except as provided for in the Kaiser Closing Agreement, there shall be no adjustment or pro-rations on the date of the Kaiser Closing of any expenses related to the Kaiser Property.

11. **Conditions Precedent to Obligation of Purchaser**. The obligation of Purchaser to consummate the transaction hereunder shall be subject to the fulfillment on or before the date of the applicable Closing of all of the following conditions, any or all of which may be waived by Purchaser in its sole discretion:

(a) Seller shall have delivered to Closing Agent or Purchaser (as applicable) all of the items required to be delivered to Purchaser pursuant to the terms of this Agreement, including but not limited to those provided for in Section 9 or 10 hereof, as applicable.

(b) All of the representations and warranties of Seller contained in this Agreement shall be true and correct in all material respects as of the date of Closing.

(c) Seller shall have performed and observed, in all material respects, all covenants and agreements of this Agreement to be performed and observed by Seller as of the date of the applicable Closing.

12. **Conditions Precedent to Obligation of Seller**. The obligation of Seller to consummate the transaction hereunder shall be subject to the fulfillment on or before the date of Closing of all of the following conditions, any or all of which may be waived by Seller in its sole discretion:

(a) Seller shall have received the applicable Purchase Price pursuant to and payable in the manner provided for in this Agreement.

(b) Purchaser shall have delivered to Seller or as applicable to the Closing Agent, all of the items required to be delivered to Seller or the Closing Agent pursuant to the terms of this Agreement, including but not limited to, those provided for in Section 9 or 10 hereof, as applicable.

(c) All of the representations and warranties of Purchaser contained in this Agreement shall be true and correct in all material respects as of the date of the applicable Closing.

(d) Purchaser shall have performed and observed, in all material respects, all covenants and agreements of this Agreement to be performed and observed by Purchaser as of the date of Closing.

13. **Property Condition**. Purchaser and Seller agree that the Property is in "AS IS" condition, WITH ALL FAULTS, IF ANY, AND WITHOUT ANY WARRANTY, EXPRESS OR IMPLIED. Except as otherwise expressly set forth in Section 6 herein, neither Seller, Kaiser LLC nor any agents, representatives, or employees of Seller or Kaiser LLC have made any representations or warranties, direct or indirect, oral or written, express or implied, to Purchaser or any agents, representatives, or employees of Purchaser with respect to the condition of the Property, its fitness for any particular purpose, or its compliance with any laws, and Purchaser is not aware of and does not rely upon any such representation from any other party. Purchaser acknowledges that there is no value assigned to any improvements on the Property. In the event of a casualty or condemnation loss to any improvements on the Property, there will be no reduction in the Purchase Price.

14. **Disclaimers.**

(a) **EXCEPT AS SET FORTH IN SECTION 6 HEREOF, SELLER AND COMPANY EACH DISCLAIMS THE MAKING OF ANY REPRESENTATIONS OR WARRANTIES, EXPRESS OR IMPLIED, REGARDING THE PROPERTY OR**

MATTERS AFFECTING THE PROPERTY, INCLUDING, WITHOUT LIMITATION, THE PHYSICAL CONDITION OF THE PROPERTY, THE EXISTENCE OF WETLANDS ON THE PROPERTY, THE QUALITY OF ANY WORK OR MATERIALS USED IN CONNECTION WITH THE IMPROVEMENTS ON THE PROPERTY, TITLE TO OR THE BOUNDARIES OF THE PROPERTY, PEST CONTROL MATTERS, SOIL CONDITION, HAZARDOUS WASTE, TOXIC SUBSTANCE OR OTHER ENVIRONMENTAL MATTERS, COMPLIANCE WITH BUILDING, HEALTH, SAFETY, LAND USE AND ZONING LAWS, REGULATIONS AND ORDERS, STRUCTURAL AND OTHER ENGINEERING CHARACTERISTICS, TRAFFIC PATTERNS, THE DEVELOPMENT POTENTIAL OF AND/OR REQUIREMENTS TO DEVELOP THE PROPERTY AND THE PROPERTY'S USE, FITNESS, VALUE OR ADEQUACY FOR ANY PARTICULAR PURPOSE, AND ALL OTHER INFORMATION PERTAINING TO THE PROPERTY. PURCHASER, MOREOVER, ACKNOWLEDGES (I) THAT PURCHASER HAS ENTERED INTO THIS AGREEMENT WITH THE INTENTION OF MAKING AND RELYING UPON ITS OWN INDEPENDENT INVESTIGATION, INSPECTION, ANALYSIS, EXAMINATION AND EVALUATION OF THE PHYSICAL, ENVIRONMENTAL, ECONOMIC AND LEGAL CONDITION OF THE PROPERTY AND ALL OTHER RELEVANT FACTS AND CIRCUMSTANCES AND (II) THAT, EXCEPT AS SET FORTH IN SECTION 6 HEREOF, PURCHASER IS NOT RELYING UPON ANY REPRESENTATIONS AND WARRANTIES MADE BY COMPANY, SELLER, SELLER'S AGENTS, BROKERS, MANAGEMENT AGENT OR ANYONE ELSE ACTING OR CLAIMING TO ACT ON COMPANY'S BEHALF OR SELLER'S BEHALF CONCERNING THE PROPERTY (INCLUDING SPECIFICALLY, WITHOUT LIMITATION, OFFERING PACKAGES DISTRIBUTED WITH RESPECT TO THE PROPERTY). PURCHASER FURTHER ACKNOWLEDGES THAT IT HAS NOT RECEIVED FROM SELLER ANY INVESTMENT, ACCOUNTING, TAX, LEGAL, ENVIRONMENTAL, ARCHITECTURAL, ENGINEERING, PROPERTY MANAGEMENT OR OTHER ADVICE WITH RESPECT TO THIS TRANSACTION AND IS RELYING SOLELY UPON THE ADVICE OF ITS OWN INVESTMENT, ACCOUNTING, TAX, LEGAL ENVIRONMENTAL, ARCHITECTURAL, ENGINEERING, PROPERTY MANAGEMENT AND OTHER ADVISORS. SUBJECT TO THE PROVISIONS OF SECTION 6 OF THIS AGREEMENT, PURCHASER SHALL ACCEPT THE PROPERTY IN ITS "AS-IS, WHERE-IS" CONDITION, WITH ALL FAULTS, ON THE CLOSING, AND THAT NO PATENT OR LATENT DEFECT IN THE PHYSICAL OR ENVIRONMENTAL CONDITION OF THE PROPERTY, WHETHER OR NOT KNOWN OR DISCOVERED, SHALL AFFECT THE RIGHTS OF EITHER PARTY HERETO, AND ASSUMES THE RISK THAT ADVERSE PHYSICAL, ENVIRONMENTAL, ECONOMIC OR LEGAL CONDITIONS MAY NOT HAVE BEEN REVEALED BY ITS INVESTIGATION. PURCHASER ALSO ACKNOWLEDGES THAT THE PURCHASE PRICE REFLECTS AND TAKES INTO ACCOUNT THAT THE PROPERTY IS BEING SOLD "AS-IS."

(b) **EXCEPT FOR THE REPRESENTATIONS AND WARRANTIES PROVIDED BY SELLER IN SECTION 6, PURCHASER, ON BEHALF OF ITSELF AND**

THE PURCHASER'S PARTIES AND THEIR SUCCESSORS AND ASSIGNS, AND EACH OF THEM, HEREBY RELEASES SELLER AND COMPANY AND EACH OF THE SELLER PARTIES AND COMPANY PARTIES AND THEIR RESPECTIVE SUCCESSORS AND ASSIGNS FROM AND AGAINST ANY AND ALL CLAIMS, DEMANDS, CAUSES OF ACTION, OBLIGATIONS, DAMAGES AND LIABILITIES OF ANY NATURE WHATSOEVER, DIRECTLY OR INDIRECTLY, KNOWN OR UNKNOWN, ARISING OUT OF OR RELATED TO THE CONDITION OF THE PROPERTY. WITHOUT IN ANY WAY LIMITING ANY PROVISION OF THIS SECTION 14, PURCHASER SPECIFICALLY ACKNOWLEDGES AND AGREES THAT IT HEREBY WAIVES, RELEASES AND DISCHARGES ANY CLAIM IT HAS, MIGHT HAVE HAD OR MAY HAVE AGAINST SELLER OR ANY OF THE SELLER PARTIES OR COMPANY OR ANY OF THE COMPANY PARTIES WITH RESPECT TO (i) THE DISCLAIMED MATTERS DESCRIBED IN SECTION 14(a) ABOVE, (ii) THE CONDITION OF THE PROPERTY, EITHER PATENT OR LATENT, (iii) THE PAST, PRESENT OR FUTURE CONDITION OR COMPLIANCE OF THE PROPERTY WITH REGARD TO ANY RULES, REGULATIONS, ORDERS OR REQUIREMENTS, INCLUDING, WITHOUT LIMITATION, THE COMPREHENSIVE ENVIRONMENTAL RESPONSE, COMPENSATION AND LIABILITY ACT OF 1980, AND (iv) ANY OTHER STATE OF FACTS THAT EXISTS WITH RESPECT TO THE PROPERTY.

PURCHASER HEREBY SPECIFICALLY ACKNOWLEDGES THAT PURCHASER HAS CAREFULLY REVIEWED THIS SECTION 14 AND DISCUSSED ITS IMPORT WITH LEGAL COUNSEL AND THAT THE PROVISIONS OF THIS SECTION 14 ARE A MATERIAL PART OF THIS AGREEMENT. THE DISCLAIMER CONTAINED IN THIS SECTION 14 SHALL NOT MERGE WITH THE TRANSFER OF THE PROPERTY AND SHALL SURVIVE CLOSING OR ANY TERMINATION OF THIS AGREEMENT, WITHOUT ANY LIMITATION AS TO A SURVIVAL PERIOD.

By signing in the space provided below in this Section 14, Purchaser acknowledges that it has read and understood the provisions of this Section 14.

PURCHASER:

ADVENTIST HEALTHCARE, INC.

By: _____
Name: WILLIAM G. ROBERTSON
Title: PRESIDENT & CEO

15. **Risk of Loss.** The risk of loss by reason of fire or other casualty between the date hereof and the date of Settlement shall be borne by the Purchaser. The parties agree that the Property is unimproved.

16. **Development of the Property.**

(a) The parties acknowledge that the Purchaser intends to develop all or a portion of the Property as an acute care hospital with not less than 120 beds, which shall include all typical hospital related services such as emergency rooms, operating rooms, psychiatric care, and outpatient services (the "**Hospital**"). In the event Purchaser has constructed or is in the process of constructing a Hospital on a portion of the Property, Purchaser shall also be entitled as of right to develop the following related facilities on the Property: Medical office buildings (subject to Seller's development rights as set forth below), structured and surface parking, ambulatory surgery centers, diagnostic services centers, therapeutic services centers, long-term care facilities, rehabilitation facilities, emergency medical and ambulance base facilities, urgent care facilities, retail medical facilities, educational facilities, child care facilities and fitness centers (the "**Hospital Related Facilities**"). The Purchaser shall be deemed to have constructed or be constructing a Hospital on the Property if the majority of the Hospital building will be located on the Property, even if a portion of the Hospital will be located on adjacent Property. For a period of ten (10) years following the date that the Hospital opens for services, the Purchaser shall not construct any facilities on the Property, other than Hospital Related Facilities, nor shall Purchaser construct any facilities on the Property if Purchaser has not or is not then in the process of constructing the Hospital, without the prior written consent of Seller, which Seller may grant or deny in its sole discretion. In the event the Purchaser determines to develop medical office buildings (the "**MOB**" or "**MOB's**") on all or a portion of the Property, it shall notify Seller who shall have the right, but not the obligation, to develop any or all of the MOB's, either itself or through an Affiliate of Seller or permitted assignee (the "**Developer Entity**"). Seller shall notify Purchaser within sixty (60) days of its receipt from Purchaser of conceptual plans for the location, size and design of the MOB's whether or not it desires to exercise its right to develop the MOB's. In the event Seller fails to notify Purchaser within such time period, Seller shall be deemed to have elected not to develop the MOB's. In the event Seller elects to develop some or all of the MOB's, the Purchaser shall sell to the Developer Entity, for Fair Market Land Value, that portion of the Property on which the MOB's will be located (with the parties paying equally all applicable transfer and recordation taxes); provided, in the event such a conveyance would violate local laws or ordinances, Seller will enter into a ground lease with the Developer Entity for that portion of the Property on which the MOB's will be located. The ground lease shall be for a term of 99 years and shall provide for a fair market rent. Payment by Seller of the Fair Market Land Value shall not be due and payable, or ground rent shall not commence under the ground lease, as applicable, until an MOB is substantially completed and rent commences under the applicable Master Lease (as defined in subsection (b) below) for such MOB.

(b) If the Seller elects to develop the MOB's, Purchaser shall enter into a master lease for each MOB (the "**Master Lease**"), in a form mutually agreeable to Developer Entity and Purchaser, which Master Lease shall provide for an initial triple net rental rate based on a return of Developer Entity's costs at a rate equal to the greater of 10.5% or 450 basis points above LIBOR, with annual rental increases of 3%. The Master Lease shall provide for partial termination for any space in the MOB leased by Developer Entity to physicians on terms to be

determined by Developer Entity in its sole discretion; provided, after the Master Lease has been terminated as to 50% of the rentable area in an MOB, Purchaser shall be required to guarantee the rental payments on any future leases entered into in such MOB.

(c) The initial size, location and general design of the MOB's shall be determined by Purchaser and the final design specifications for the MOB's shall be subject to Purchaser's reasonable prior written approval.

(d) Following Seller's exercise of its right to develop the MOB's, the Purchaser, itself or through an Affiliate of Purchaser, shall have a right of first offer to purchase should the Developer Entity elect to sell any of MOB's, which right of first offer shall be further described in the development agreement provided for in subsection (g) below.

(e) In the event Seller elects not to develop any of the MOB's, the Purchaser shall be free to construct the MOB's itself or through an unrelated third party; provided Seller shall still retain the right to approve any facilities other than Hospital Related Facilities to be constructed on the Property.

(f) Unless Purchaser sells the Property prior to the time frame set forth below, whether or not Seller elects to purchase the Property pursuant to Section 17 below, in the event Purchaser has not notified Seller of its intent to develop an MOB on the Property by the earlier to occur of (a) completion of construction of the Hospital on the Property, or (b) seven (7) years from the Kaiser Closing Date, or if the master plans developed by Purchaser do not include MOB's on the Property or it is earlier determined that an MOB cannot be constructed on the Property, then Purchaser shall pay to Seller, as liquidated damages to compensate Seller for its lost MOB development opportunity, the sum of Three Million and No/100 Dollars ($3,000,000.00). Purchaser agrees to use commercially reasonable efforts to procure applicable governmental approvals for the development of MOB's on the Property.

(g) The development rights described in this Section 16 and the right of first offer described in Section 17 below shall be more fully set forth in a development agreement to be agreed upon by Seller and Purchaser. Seller and Purchaser shall use commercially reasonable efforts to agree upon the development agreement before Kaiser Closing Date, but in all events such development agreement shall be finalized within six (6) months following the Kaiser Closing Date. The parties shall negotiate in good faith to agree upon the terms of a development agreement within such time frame. In the event the parties are unable to agree upon all terms and conditions of the development agreement within six (6) months following the Kaiser Closing Date, either party shall have the right to submit any outstanding issues to binding arbitration as provided in Section 20 below.

17. **Right of First Offer**. In the event Purchaser desires to sell all of the Property, the Grosvenor Property or the Kaiser Property at any time for a period of ten (10) years following the Kaiser Closing Date, Purchaser shall notify Seller in writing, which notice shall identify that portion of the Property which Purchaser desires to sell; provided Purchaser acknowledges that it shall not be entitled to sell a portion of the Property other than the Grosvenor Property or the

Kaiser Property without Seller's prior consent, which Seller may grant or deny in its sole discretion.. Seller shall have sixty (60) days to notify Purchaser that Seller, itself or through an Affiliate of Seller, desires to purchase the entire portion of the Property which Purchaser identified in its notice, at a purchase price equal to the lesser of (a) Fair Market Land Value, or (b) the Purchase Price, or the pro-rated portion of the Purchase Price based on that portion of the Property which Purchaser has elected to sell, plus interest from the date of the Kaiser Closing until the date of closing on the resale at the rate of five percent (5%), compounded annually, plus all transactional and development costs incurred by Purchaser prior to the date of such resale. In the event the parties cannot agree upon the computation of the purchase price, either party shall have the right to submit any outstanding issues to binding arbitration as provided in Section 20 below. In the event Seller notifies Purchaser that it desires to purchase the Property, Seller shall have one hundred twenty (120) days from the date of such notification ("**Seller Due Diligence Period**") to conduct due diligence test and investigations regarding such purchase. Seller shall notify Seller prior to the expiration of the Seller Due Diligence Period whether it intends to proceed with closing on the acquisition of the Property. If Seller elects to proceed, Seller shall close on the acquisition of the applicable portion of the Property within ten (10) days following the expiration of the Seller Due Diligence Period. Seller may not assign its right of first offer, other than to an Affiliate of Seller. Further, if Seller exercises its rights hereunder and purchases the Property or a portion thereof from Purchaser, then if Seller shall (i) resell the applicable portion of the Property, or (ii) convey more than 75% of the membership interests in the acquiring entity other than to an Affiliate of Seller, for a period of two (2) years from the date of closing on Seller's acquisition of the applicable portion of the Property, then Seller shall pay to Purchaser fifty percent (50%) of the net proceeds from such sale in excess of the purchase price paid by Seller to Purchaser. After two (2) years from the date of closing on Seller's acquisition of the applicable portion of the Property, Seller shall be free to convey such portion of the Property or membership interest in the acquiring entity without liability for payments of any of the excess proceeds to Purchaser. In the event Seller notifies Purchaser that it elects not to purchase specified portion of the Property, or fails to notify Purchaser of its intent to purchase within the sixty (60) day period, or fails to notify Purchaser that it intends to proceed to closing prior to the expiration of the Seller Due Diligence Period, Purchaser shall be free, for a period of nine (9) months from the date of Seller's notice or the date of the expiration of the sixty (60) day period, to enter into a contract to sell the specified portion of the Property to a third party on substantially similar terms and for a purchase price equal to or greater than that offered to Seller, except as otherwise provided in the development agreement described in Section 16 (g). Following any sale to such third party, Seller shall have no further purchase rights in that portion of the Property sold. In the event Purchaser fails to enter into a contract for sale with a third party within such nine (9) month period, Purchaser shall again be required to provide Seller with a right of first offer before selling any or all of the Property. Seller's right of first offer shall automatically terminate ten (10) years following the Kaiser Closing Date.

18. **Recordation of Memoranda**. The development rights and restrictions and the rights of first offer contained in Sections 16 and 17 shall be included in two Memoranda to be executed by Seller and Purchaser and Company at each of the Closings and to be recorded

among the Land Records of Montgomery County, Maryland immediately following the Grosvenor Closing and the Kaiser Closing.

19. **Fair Market Land Value**. The "Fair Market Land Value" shall be the fair market value of the Property, or the applicable portion of the Property, for its highest and best use. The Fair Market Land Value shall be determined by appraisal as set forth below:

(a) During the sixty (60) day period following the date it is determined that an appraisal is necessary, the Purchaser Appraiser and the Seller Appraiser shall independently determine the Fair Market Land Value. On or before the date that is sixty (60) days after the date it is determined that an appraisal is necessary, the Purchaser Appraiser and the Seller Appraiser shall each deliver to the other a written report of its determination of the Fair Market Land Value. Each of the Seller Appraiser and the Purchaser Appraiser shall be a Qualified Appraiser approved by Purchaser or Seller, as the case may be.

(b) If the greater of the Fair Market Land Value as determined by either the Purchaser Appraiser or the Seller Appraiser is equal to or less than 105% of the lesser of the Fair Market Land Value as determined by the Purchaser Appraiser or the Seller Appraiser, then the Fair Market Land Value shall be the average of such Fair Market Land Values. If the greater of the Fair Market Land Value as determined by either the Purchaser Appraiser or the Seller Appraiser is greater than 105% of the lesser of the Fair Market Land Value as determined by the Purchaser Appraiser or the Seller Appraiser, then the Purchaser Appraiser and the Seller Appraiser shall appoint two additional Appraisers pursuant to Section 19(c).

(c) Within ten (10) business days after delivery of the reports of both the Purchaser Appraiser and the Seller Appraiser pursuant to Section 19(a), the Purchaser Appraiser and the Seller Appraiser shall meet to appoint two additional Appraisers. Purchaser Appraiser and Seller Appraiser shall each bring to such meeting a list of three qualified appraisers that it proposes. At such meeting, such lists shall be exchanged and any two Qualified Appraisers that are on both lists shall be the Additional Appraisers. If no qualified Appraiser is on both lists, then Purchaser appraiser and Seller Appraiser may each select a qualified Appraiser from the other's list, and if either Purchaser Appraiser or Seller Appraiser does so, the Qualified Appraiser(s) so selected shall be the Additional Appraiser(s). If both Additional Appraisers are not so selected, Purchaser Appraiser and Seller Appraiser shall each provide a supplemental list of three Qualified Appraisers (which may include Qualified Appraisers on the other's prior list). Any Qualified Appraiser that is on any list provided by the Purchaser Appraiser and any list provided by the Seller Appraiser shall be an additional Appraiser. If no Qualified Appraiser is on both lists, then Purchaser Appraiser and Seller Appraiser may each select a qualified appraiser from the other's lists, and if either Purchaser Appraiser or Seller Appraiser does so the Qualified Appraiser so selected shall be the additional Appraisers(s). Such process shall continue until both additional Appraisers are identified. If more than one Qualified Appraiser is identified purchase to this process, the additional Appraisers shall be determined by coin toss among such Qualified Appraisers. If for any reason the additional Appraisers have not been selected, or if selected have not agreed to serve, by the date that is ten (10) business days after delivery of the reports of both the Purchaser Appraiser and Seller Appraiser pursuant to Section 19(a), then

either Purchaser or Seller may request the President of the State Bar of Maryland to appoint two Qualified Appraisers from any list(s) provided by the Purchaser Appraiser or the Seller Appraiser as the additional Appraisers.

(d) During the sixty (60) day period following their appointment, the additional Appraisers shall independently determine the Fair Market Land Value. On or before the date that is sixty (60) days after their appointment, the additional Appraisers shall deliver to Purchaser and Seller written reports of their respective determinations of the Fair market Land Value. The Fair Market Land Value shall e the average of the three Fair Market Land Values determined by the Purchaser Appraiser, the Seller Appraiser and the two additional Appraisers that are closest (in terms of absolute dollars) in amount.

(e) Any documents or other written information provided by Purchaser or Seller to its Qualified Appraiser shall also concurrently be provided to the other Qualified appraiser.

(f) Purchaser shall pay all costs and expenses of the Purchaser Appraiser, Seller shall pay all costs and expenses of the Seller Appraiser, and Purchaser and Seller shall each pay one-half of the costs and expenses of the additional Appraisers.

20. **Arbitration**. Either party shall be entitled to submit any dispute arising under Section 16 or Section 17 of this Agreement to binding arbitration in accordance with the rules of the American Arbitration Association by notifying the other party in writing. The arbitration shall be conducted in Montgomery County Maryland before three (3) arbitrators. Within fifteen (15) days after receipt of notice of arbitration, Purchaser and Seller shall each select one arbitrator. Within fifteen (15) days of their selection, the two arbitrators shall select a third arbitrator. Each party shall bear equally the costs of arbitration and the fees and expenses of the arbitrators. Any award in arbitration may be enrolled in a court of competent jurisdiction and enforced in accordance with Maryland's Uniform Arbitration Act.

21. **Seller Cooperation; Costs**.

(a) Prior and subsequent to the Closings, Seller, at no cost to Seller, shall cooperate in a timely manner with Purchaser in efforts to obtain zoning approval ("Zoning Approval") for a hospital and related medical offices (the "Proposed Use"). Notwithstanding any provision hereof to the contrary, in the event that, as a direct or indirect result of Purchaser's efforts to secure Zoning approvals for the Proposed Use of the Property or any portion thereof, Seller is made a party to or required to participate in, defined or appeal any administrative, judicial or quasi-judicial action or proceeding or is otherwise required to take affirmative legal action directly or indirectly resulting therefrom, Purchaser hereby agrees to indemnify Seller and hold Seller harmless from any and all liabilities, judgments, demands and expenses, including reasonable attorney's fees, in connection therewith. Purchaser shall pay (or cause to be paid) all application fees or costs to governmental authorities, utility companies and third parties in connection with the actions described in this Section 21 and shall indemnify Seller in connection with any out-of-pocket cost, expense or liability (including reasonable attorney's fees) incurred

in connection with Seller's joinder in such applications or other matters as they relate to the Zoning Approval. All costs and expenses incurred by Seller in connection with such cooperation shall be reimbursed [upon demand] by Purchaser and added to the Grosvenor Reimbursable Expenses or the Kaiser Reimbursable Expenses, as applicable.

(b) After the Closings on the Property, subject to the rights of any tenants under the leases and subject to Seller's use thereof, Seller, at no cost or expense to Seller and subject to prompt reimbursement by Purchaser of Seller's costs and expenses incurred in connection therewith, shall cooperate in connection with the granting of easements over portions of the Property pursuant to which Seller has exercised its option under Section 16 and acquired a portion thereof for utility, construction staging and other purposes as may be required by the governmental authorities in connection with the Permitted Use or as otherwise required hereunder.

(c) To the extent Seller exercises its rights under Section 17 and acquires a portion of the Property, Seller may, in its sole and absolute discretion, provide a portion of such Property for use by Purchaser as a staging area for Purchaser's construction on the property without payment to Seller (other than prompt reimbursement of Seller's costs and expenses incurred in connection with providing such staging areas) and without entering into a lease agreement with respect thereto. In the event Seller elects to provide such a staging area, Seller and Purchaser shall enter into an easement acceptable to Seller and Purchaser regarding use of the staging area. Any such easement shall be subject to the rights of tenants under any leases and shall provide an indemnification of Seller by Purchaser and Company against any and all liabilities, costs, demands, judgments or expenses (including reasonable attorney's fees) in any manner arising therefrom or related thereto.

22. **Default.**

(a) If Purchaser shall fail to proceed to the Grosvenor Closing under the provisions of this Agreement, Seller shall be entitled, as its sole remedies at law or in equity (a) to pursue an action for specific performance, together with collection of costs and expenses incurred in connection with enforcing specific performance, or (b) to payment of agreed upon liquidated damages, since actual damages are difficult to ascertain, in an amount equal to the Grosvenor Purchase Price plus (i) the Kaiser Purchaser Price in the event Seller is no longer entitled to terminate the Kaiser Contract, or (ii) the Kaiser Reimbursable Expenses in the event Seller is still entitled to terminate the Kaiser Contract as of the date of Purchaser's default; whereupon this Agreement shall terminate and the parties hereto shall be released from any further liability or obligation to each other, other than liabilities or obligations that survive a termination of this Agreement. Notwithstanding the foregoing, in no event does Seller waive any right to indemnification by Purchaser pursuant to the provisions of Sections 8 and 24.

(b) If Purchaser shall fail to proceed to the Kaiser Closing under the provisions of this Agreement, Seller shall be entitled, as its sole remedies at law or in equity (a) to pursue an action for specific performance, together with collection of costs and expenses incurred in connection with enforcing specific performance, or (b) to payment of agreed upon

liquidated damages, since actual damages are difficult to ascertain, in the amount of the Kaiser Purchaser Price; whereupon this Agreement shall terminate and the parties hereto shall be released from any further liability or obligation to each other, other than obligations which survive a termination of this Agreement. Notwithstanding the foregoing, in no event does Seller waive any right to indemnification by Purchaser pursuant to the provisions of Sections 8 and 24.

(c) If Seller shall be obligated to proceed to closing under the Grosvenor Purchase Agreement and shall default under the terms of the Grosvenor Purchase Agreement by failing to close thereunder and Purchaser is not otherwise in default hereunder, or if Seller is obligated to proceed to the Grosvenor Closing under the provisions of this Agreement and shall fail to do so without justification, Purchaser shall be entitled, as its sole remedies at law or in equity (a) to terminate this Agreement and receive agreed upon liquidated damages, since actual damages are difficult to ascertain, in an amount equal to all funds actually paid by Purchaser to Seller or Company in connection with the Grosvenor Purchase Agreement, plus reimbursement for transactional and development expenses actually incurred by Purchaser and documented to third parties in an amount not to exceed $250,000, or (b) only in the event of Seller's failure to proceed to the Grosvenor Closing, to pursue and action for specific performance. Notwithstanding the foregoing, in no event does Purchaser waive any right to indemnification by Seller and Company pursuant to the provisions of Sections 8 and 24.

(d) If, following the Grosvenor Closing, Kaiser LLC shall be obligated to proceed to closing under the Kaiser Purchase Agreement and shall default under the terms of the Kaiser Purchase Agreement by failing to close thereunder and Purchaser is not otherwise in default hereunder, or if Seller is obligated to proceed to the Kaiser Closing under the provisions of this Agreement and shall fail to do so without justification, Purchaser shall be entitled, as its sole remedies at law or in equity (a) to terminate this Agreement and receive agreed upon liquidated damages, since actual damages are difficult to ascertain, in an amount equal to all funds actually paid by Purchaser to Seller or Company in connection with the Kaiser Purchaser Agreement, plus reimbursement for transactional and development expenses actually incurred by Purchaser and documented to third parties in an amount not to exceed $250,000, plus, at Purchaser's option to be exercised within twenty (20) days of Seller's default in failing to close, require Seller to repurchase the Grosvenor Membership Interests from Purchaser at a purchase price equal to the Grosvenor Purchase Price, plus all other funds actually paid by Purchaser to Seller or Company, plus reimbursement for transactional and development expenses actually incurred by Purchaser and documented to third parties in an amount not to exceed $250,000, or (b) only in the event of Seller's failure to proceed to the Kaiser Closing, to pursue and action for specific performance. Notwithstanding the foregoing, in no event does Purchaser waive any right to indemnification by Seller and Company pursuant to the provisions of Sections 8 and 24.

(e) In the event GB Two, LLC defaults under the Grosvenor Purchase Agreement, Seller shall notify Purchaser promptly and Purchaser shall have the right to require Seller to pursue any and all remedies under the Grosvenor Purchaser Agreement, including pursuing an action for specific performance against GB Two, LLC, and Purchaser shall have the

right to direct and control such action for specific performance. Purchaser shall reimburse Seller for all costs and expenses incurred in connection with such specific performance action. Seller shall cooperate with Purchaser in connection with seeking any reimbursement for costs and expenses by GB Two, LLC under the Grosvenor Purchase Agreement.

(f) In the event Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. defaults under the Kaiser Purchase Agreement, Seller or Company shall notify Purchaser promptly and Purchaser shall have the right to require Seller or Company, as appropriate, to pursue any and all remedies under the Kaiser Purchaser Agreement, including pursuing an action for specific performance against Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., and Purchaser shall have the right to direct and control such action for specific performance. Promptly upon request, or from time to time, Purchaser shall reimburse Seller and Company for all costs and expenses incurred in connection with such specific performance action. Seller shall cooperate with Purchaser in connection with seeking any reimbursement for costs and expenses from Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., under the Kaiser Purchase Agreement.

(g) Notwithstanding any term or provision contained herein to the contrary, liquidated damages under this Section 22 shall not apply to any duty, obligation, liability or responsibility which Purchaser, Seller or Company may have under the indemnity provisions attributable to Purchaser, Seller or Company, as applicable, under this Agreement, as to which Purchaser, Seller and Company shall have all rights and remedies provided for or allowed by law or in equity including without limitation, specific performance.

(h) It is expressly understood and agreed that the remedy of specific performance shall not be available to enforce any other obligation of Seller or Purchaser hereunder or other than as expressly set forth herein. Purchaser and Seller shall be deemed to have elected to terminate this Agreement and receive the liquidated damages if Purchaser or Seller fails to file suit for specific performance against Seller in a court having jurisdiction in the county and state in which the property is located, on or before thirty (30) days following the date upon which closing was to have occurred. Purchaser and Seller hereby waive and release all other claims for damages and other remedies against the other and Company for non-performance and expressly acknowledges and agrees that in no event shall any officer, director, member, partner or shareholder of Purchaser, Seller or Company ever have any liability hereunder.

23. **Possession**. Possession of the Grosvenor Property shall remain with Grosvenor LLC upon the Grosvenor Closing and possession of the Kaiser Property shall remain with Kaiser LLC upon the Kaiser Closing.

24. **Brokers**. Seller, Kaiser LLC and Purchaser each represent and warrant that no agent, broker or finder other than Vanguard has acted for it in connection with this transaction and each hereby agrees to indemnify and hold the other harmless from any loss, liability or damage (including attorney's fees and court costs) that may result from any brokerage claims or

other similar claims made in contradiction of this representation and warranty. This provision shall survive the Closing or any termination of this Agreement.

25. **Notices**. Any notice pursuant to this Agreement shall be given in writing by (a) personal delivery, (b) reputable overnight delivery service with proof of delivery, (c) United States Mail, postage prepaid, registered or certified mail, return receipt requested, or (d) legible facsimile transmission, sent to the intended addressee at the address set forth below, or to such other address or to the attention of such other person as the addressee shall have designated by written notice sent in accordance herewith, and shall be deemed to have been given upon receipt or refusal to accept delivery, or, in the case of facsimile transmission, as of the date of the facsimile transmission provided that an original of such facsimile is also sent to the intended addressee by means described in clauses (a), (b), or (c) above. Unless changed in accordance with the preceding sentence, the addresses for notices given pursuant to this agreement shall be as follows:

To Seller:	PS Business Parks, Inc. 701 Western Parkway Glendale, California 91201 Attn: Brett Franklin, Senior Vice President Acquisitions & Dispositions Phone: 818-244-8080 Fax: 818:-244-9267
with a copy to:	WilmerHale 1875 Pennsylvania Avenue, NW Washington, D.C. 20006 Attn: Steven S. Snider, Esq. Phone: 202-663-6405 Fax: 202-663-6363
To Purchaser:	Adventist HealthCare, Inc. 1801 Research Boulevard, Suite 400 Rockville, Maryland 20850 Attn: William G. Robertson, President & CEO
with a copy to:	Lerch, Early & Brewer, Chartered 3 Bethesda Metro Center, Suite 460 Bethesda, Maryland 20814 Attn: Robert G. Brewer, Jr. Esq.

or to any other address or addressee as ay party entitled to receive notice under this Agreement shall designate, from time to time, to others in the manner provided for in this section for the service of

notices. All courtesy copies of notices sent to the parties listed above as receiving copies shall be given in the same manner as the original notice that was sent but shall not be a prerequisite to the effectiveness of any notice.

Unless otherwise specified herein, such notices or other communications shall be deemed to be effective: (i) one (1) business day after deposit with the courier if sent by Federal Express or other recognized delivery service; or (ii) upon actual receipt (or refusal to accept receipt) I accomplished by hand deliver or by confirmed telecopy delivery, provided if by telecopy a hard copy of such notice is sent by overnight delivery service on the day of telecopy transmittal, or (iii) three (3) business days after deposit in the United States mail in accordance with this Section 25.

26. **Successors and Assigns.** Subject to the following, this Agreement shall be binding upon, and inure to the benefit of, the parties and their respective successors, heirs, administrators and assigns. Purchaser shall have the right, with advance written notice to Seller, to assign its right, title and interest in and to this Agreement, to any Affiliate of Purchaser; provided, however that such assignee(s) shall assume all obligations of Purchaser, and such assignment and assumption shall not release Purchaser from any liability or obligation hereunder. Seller shall have the right to assign its right, title and interest in and to this Agreement, including, without limitation, the development rights and options described herein, in whole or in part, to an Affiliate of Seller, without restriction. Otherwise, Seller shall not assign its right, title and interest in and to this Agreement, including, without limitation, the development rights and options described herein, in whole or in part, without the prior written consent of Purchaser, which consent Purchaser shall not unreasonably withhold, condition or delay. The provisions of this Section 26 shall survive the closing or any termination of this Agreement. In the event of an assignment by Purchaser, Purchaser shall send written notice which shall include the legal name and structure of the proposed assignee, as well as any other information that Seller may reasonably request, and Purchaser and the proposed assignee shall execute an assignment and assumption of this Agreement in form and substance reasonably satisfactory to Seller.

27. **Amendments.** Except as otherwise provided herein, this Agreement may be amended or modified only by a written instrument executed by Seller, Kaiser LLC and Purchaser.

28. **Governing Law**. This Agreement has been negotiated and executed in the State of Maryland and the substantive laws of the State of Maryland, without reference to its conflict of laws provisions, will govern the validity, construction, and enforcement of this Agreement.

29. **Merger of Prior Agreements.** This Agreement and any addenda, exhibits and schedules hereto and the letter agreement dated May 23, 2006 constitute the entire agreement between the parties and supersede all prior agreements and understandings between the parties relating to the subject matter hereof; provided in the event there is an inconsistency between the terms of this Agreement and the terms of the letter agreement, the terms of this Agreement shall control.

30. **Time for Performance.** Any time deadlines contained herein shall be calculated by reference to calendar days unless otherwise specifically notes. For notice purposes hereunder, days shall be deemed to end at 5:00 P.M. eastern standard time. In the event that any time periods for performance hereunder fall on a weekend or legal holiday (either a national holiday or official holiday in the state where the Property is located), the date for performance shall be the next following business day. Time is of the essence with respect to each and every provision of this Agreement.

31. **Enforcement**. If any party fails to perform any of its obligations under this Agreement or if a dispute arises between the parties concerning the meaning or interpretation of any provision of this Agreement, then the defaulting party or the party not prevailing in such dispute shall pay any and all reasonable costs and expenses incurred by the other party on account of such default and/or in enforcing or establishing its rights hereunder, including, without limitation, arbitration or court costs and attorneys' fees and disbursements. Any such reasonable attorneys' fees and other expenses incurred by either party in enforcing a judgment in its favor under this Agreement shall be recoverable separately from and in addition to any other amount included in such judgment, and such attorneys' fees obligation is intended to be severable from the other provisions of this Agreement and to survive and not be merged into any such judgment.

32. **Severability**. If any provision of this Agreement or the application thereof to any person, place, or circumstance, shall be held by a court of competent jurisdiction to be invalid, unenforceable or void, the remainder of this Agreement and such provisions as applied to other persons, places and circumstances shall remain in full force and effect.

33. **Counterparts**. This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which taken together shall constitute one and the same instrument.

34. **Construction**. Headings at the beginning of each section and subsection are solely for the convenience of the parties and are not a part of the Agreement. Whenever required by the context of this Agreement, the singular shall include the plural and the masculine shall include the feminine and vice versa. This Agreement shall not be construed as if it had been prepared by one of the parties, but rather as if both parties had prepared the same.

35. **Survival Of Provisions**. Except as otherwise provided in this Agreement, the provisions of this Agreement and the representations and warranties of the Seller, Kaiser LLC and Purchaser herein shall survive the Grosvenor Closing and the Kaiser Closing for a period of two (2) years following the Kaiser Closing Date.

36. **No Third-Party Beneficiary**. The provisions of this Agreement and of the documents to be executed and delivered at Closing are and will be for the benefit of Seller and Purchaser only and are not for the benefit any third party, and accordingly, no third party shall have the right to enforce the provisions of this Agreement or of the documents to be executed and delivered at Closing.

37. **Waiver of Jury Trial.** Seller and buyer each hereby waive any right to jury trial in connection with the enforcement by Purchaser, or Seller, of any of their respective rights and remedies hereunder.

38. **Closing.**

(a) The Closing Agent agrees to hold the Purchase Price in accordance with the terms hereof.

(b) Acceptance by the Closing Agent of its duties under this Agreement is subject to the following terms and conditions:

(i) The duties and obligations of the Closing Agent shall be determined solely by the provisions of this Agreement, and the Closing Agent shall not be liable except for the performance of such duties and obligations as are specifically set out in this Agreement.

(ii) The Seller and the Purchaser will jointly and severally reimburse and indemnify the Closing Agent for, and hold it harmless against any loss, liability or expense, including but not limited to reasonably attorneys' fees, incurred without bad faith, negligence or willful misconduct on the part of the Closing Agent, arising out of or in connection with any dispute or conflicting claim by the Seller or the Purchaser under this Agreement, as well as the costs and expenses of defending against any claim or liability arising out of or relating to this Agreement except where such claim or liability arises from the bad faith, negligence or willful misconduct on the part of the Closing Agent, as between the Seller (on the one hand) and the Purchaser (on the other hand) their obligations under this subsection 38(b)(ii) shall be shared equally.

(iii) The Closing Agent shall be fully protected in acting on and relying upon any written notice, instruction, direction or other document which the Closing Agent in good faith believes to be genuine and to have been signed or presented by the proper party or parties.

(iv) The Closing Agent shall not be liable for any error of judgment, or for any act done or step taken or omitted by it in good faith or for any mistake or fact I law, or for anything which it may do or refrain from doing in connection herewith except for its own bad faith, negligence or willful misconduct.

(v) The Closing Agent may seek the advice of legal counsel in the event of any dispute or question as to the construction of any of the provisions of this Agreement or its duties hereunder, and it shall incur no liability and shall be fully protected in respect of any action taken or suffered by it in good faith in accordance with the opinion of such counsel.

(vi) The Closing Agent may resign and be discharged from its duties hereunder at any time by giving written notice of such resignation to each of the Purchaser and

the Seller specifying a date, not less than thirty (30) days after the date of such notice, when such resignation will take effect. Upon the effective date of such resignation, the Closing Agent shall deliver the funds held in escrow to such person or persons as the Purchaser and the Seller shall in writing jointly direct and upon such deliver the Closing Agent shall be relieved of all duties and liabilities thereafter accruing under this Agreement. The Purchaser and the Seller shall have the right at any time upon joint action to substitute a new closing agent by giving notice thereof to the Closing Agent then acting.

(vii) All disbursements by Closing Agent shall be made by bank wire transfer to the account of the receiving party, as such party may direct;

(viii) Closing Agent shall, at the Closing, hold for personal pickup or arrange for wire transfer at the discretion of Seller, to Seller, or order, as instructed by Seller, all sums to which Seller is entitled; and

[SIGNATURES APPEAR ON FOLLOWING PAGE]

IN WITNESS WHEREOF, the parties have executed this Agreement as of last date listed below next to the signatures of the Seller and Purchaser.

WITNESS/ATTEST

SELLER:

PS BUSINESS PARKS, L.P.

By: PS Business Parks, Inc., General Partner

_____

By:_____
Name:_____
Title:_____
Date:_____

COMPANY:

PSB/K LLC

By: PS Business Parks, Inc., Manager

_____

By:_____
Name:_____
Title:_____
Date:_____

PURCHASER:

ADVENTIST HEALTHCARE, INC.

Mary Christina Hill

By: William G. Robertson
Name: William G. Robertson
Title: President & CEO
Date: July 6, 2006

IN WITNESS WHEREOF, the parties have executed this Agreement as of last date liste below next to the signatures of the Seller and Purchaser.

WITNESS/ATTEST

SELLER:

PS BUSINESS PARKS, L.P.

By: PS Business Parks, Inc., General Partner

By: _____
Name: _____
Title: _____
Date: 7/6/06

COMPANY:

PSB/K LLC

By: PS Business Parks, Inc., Manager

By: _____
Name: _____
Title: _____
Date: 7/06/06

PURCHASER:

ADVENTIST HEALTHCARE, INC.

By: _____
Name: _____
Title: _____
Date: _____

EXHIBIT 2

ASSIGNMENT AND ASSUMPTION OF MEMBERSHIP INTEREST

PSB/K LLC

THIS ASSIGNMENT AND ASSUMPTION OF MEMBERSHIP INTEREST IN PSB/K LLC, a Delaware limited liability company (the "Assignment") is made as of August 31st, 2006, by and between PS BUSINESS PARKS, L.P., a California limited partnership ("Assignor"), the sole member of PSB/K LLC (the "Company"), and ADVENTIST HEALTHCARE, INC., a Maryland non-profit corporation (the "Assignee")

RECITALS

1. Assignor and Assignee are parties to that certain Purchase Agreement dated as of July 6, 2006 (the "Sale Agreement").

2. The Assignor is the owner of all the membership interests in the Company (the "Membership Interest"), pursuant to that certain Certificate of Formation of the Company dated July 6, 2006 and filed with the Secretary of State of the State of Delaware on July 6, 2006 (the "Certificate").

3. By this Assignment, the Assignor desires to assign to the Assignee all of the Assignor's right, title and interest in and to the Membership Interest, and the Assignee desires to accept the same.

NOW, THEREFORE, IN CONSIDERATION of these premises and for other good and valuable consideration, including, without limitation, the consideration set forth in the Sale Agreement, the receipt and adequacy of which are acknowledged by each party, the parties agree as follows:

Section 1. Recitals. The Recitals hereof are hereby incorporated within this Agreement by reference.

Section 2. Assignment and Assumption. The Assignor, hereby assigns, transfers and conveys to the Assignee and the Assignee hereby accepts and assumes from the Assignor, all of the Membership Interest, together with the applicable right, title and interest which the Assignor has under the Operating Agreement and the Certificate, any other documents related to the Membership Interest or applicable law in or to any and all of (a) the Company's assets, and (b) any and all of the Assignor's other rights and obligations under the Operating Agreement and the Certificate.

Section 3. Representations and Warranties, Indemnity. This Assignment is made in connection with the closing of the transactions contemplated in the Sale Agreement, and all the representations, covenants and indemnities of Assignor and Assignee set forth in the Sale Agreement (subject to the limitations on such representations, covenants and indemnities contained therein) are hereby incorporated by reference with the same force and effect as though

the same were set forth in their entirety herein; provided, however, that Assignee shall not be entitled to duplicative remedies as a result of such incorporation by reference.

Section 4. General.

4.1 Effectiveness. This Assignment shall become effective on its execution and delivery by each party.

4.2 Applicable Law; Venue. This Assignment shall be given effect and construed in accordance with the internal laws (as opposed to the conflicts of law provisions) of the State of Maryland.

4.3 Construction. As used in this Agreement, the term "person" means a natural person, a trustee, and any form of legal entity. All references made in the neuter, masculine or feminine gender shall be deemed to have been made in all such genders. All references in the singular or plural number shall be deemed to have been made, respectively, in the plural or singular number as well. All references to any Section shall, unless expressly indicated to the contrary, be deemed to have been made to the Section of this Assignment.

4.4 Assignment. This Assignment shall be binding upon and shall inure to the benefit of the parties hereto and their respective heirs, personal representatives, successors and assigns hereunder.

4.5 Severability. No determination by any court or otherwise that any provision of this Assignment is invalid or unenforceable in any instance shall affect the validity or enforceability of any other provision of this Agreement, or such provision in any circumstance not controlled by the determination. Each provision shall be valid and enforceable to the fullest extent allowed by, and shall be construed wherever possible as being consistent with, applicable law.

4.6 Signature in Counterparts. This Assignment may be executed in separate counterparts, none of which need contain the signatures of all parties, each of which shall be deemed to be an original, and all of which taken together constitute one and the same instrument. It shall not be necessary in making proof of this Assignment to produce or account for more than the number of counterparts containing the respective signatures of, or on behalf of, all of the parties hereto.

[EXECUTION PAGE FOLLOWS]

IN WITNESS WHEREOF, each party has executed and ensealed this Assignment or caused it to be executed and ensealed on its behalf of its duly authorized representatives, the day and year first above written.

ASSIGNOR:

PS BUSINESS PARKS, L.P.

By: PS Business Parks, Inc., General Partner

By: _____
Brett Franklin
Senior Vice President - Acquisitions and Dispositions

Date: _____

ASSIGNEE:

ADVENTIST HEALTHCARE, INC.

By: _____
Name: _____
Title: _____
Date: _____

IN WITNESS WHEREOF, each party has executed and ensealed this Assignment or caused it to be executed and ensealed on its behalf of its duly authorized representatives, the day and year first above written.

ASSIGNOR:

PS BUSINESS PARKS, L.P.

By: PS Business Parks, Inc., General Partner

By: _____
Brett Franklin
Senior Vice President - Acquisitions and Dispositions

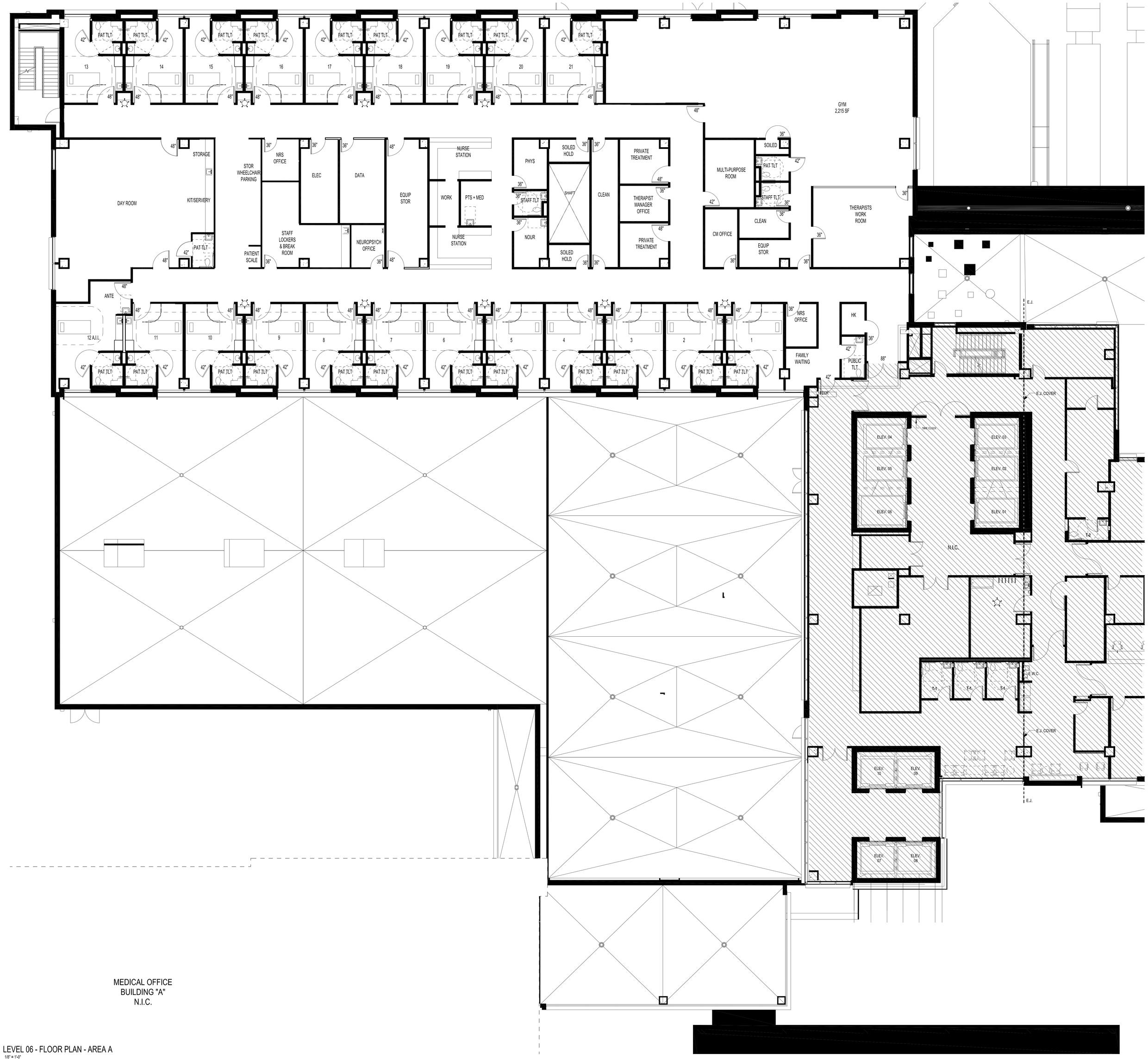
Date: _____

ASSIGNEE:

ADVENTIST HEALTHCARE, INC.

By: _____
Name: _____
Title: _____
Date: _____

EXHIBIT 3



1 LEVEL 06 - FLOOR PLAN - AREA A
1/8" = 1'-0"

RTKL SM

AN ARCADIS COMPANY

RTKL ASSOCIATES INC.
2101 L Street NW, Suite 200
Washington DC 20037
202-833-4400

WWW.RTKL.COM
PROJECT NUMBER 20-15017.00

CONSULTANTS

CIVIL
SOLTESZ
Rockville MD

LANDSCAPE
PARKER-RODRIQUEZ
Alexandria VA

STRUCTURAL
CAGLEY & ASSOCIATES
Rockville MD

MEP
TLC ENGINEERING FOR ARCHITECTURE
Orlando FL

LIFE SAFETY
LASALLE ENGINEERING
Willow Grove PA

TECHNOLOGY
RTKL ASSOCIATES INC.

VERTICAL TRANSPORTATION
LERCH BATES
Bowie MD

FOOD SERVICES
CINI LITTLE INTERNATIONAL, INC.
Germantown, MD

PROJECT

Adventist HealthCare
Washington Adventist Hospital

Replacement Project

CLIENT

Washington Adventist Hospital

PLUM ORCHARD DRIVE
SILVER SPRING, MARYLAND 20904

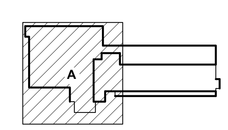
ISSUED DRAWING LOG

	Issued for review and comment 02/08/2018

DRAWING REVISION LOG

SEAL

KEY PLAN



Professional Certification. "I hereby certify that these documents were prepared or approved by me, and that I am a duly licensed architect under the laws of the State of Maryland, License No. 7290 Expiration Date: 10/3/2018

SHEET IDENTIFICATION

BUILDING

MAIN HOSPITAL

TITLE

LEVEL 06 FLOOR PLAN - AREA A

NUMBER

AE.106.A

FILE NAME: C:\Users\Public\Documents\ACCN_MH_Interior_Central_Autopper.rvt
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RTKL℠

AN ARCADIS COMPANY

RTKL ASSOCIATES INC.
2101 L Street NW, Suite 200
Washington DC 20037
202-833-4400

WWW.RTKL.COM
PROJECT NUMBER 20-15017.00

CONSULTANTS

CIVIL
SOLTESZ
Rockville MD

LANDSCAPE
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Alexandria VA

STRUCTURAL
CAGLEY & ASSOCIATES
Rockville MD

MEP
TLC ENGINEERING FOR ARCHITECTURE
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CLIENT

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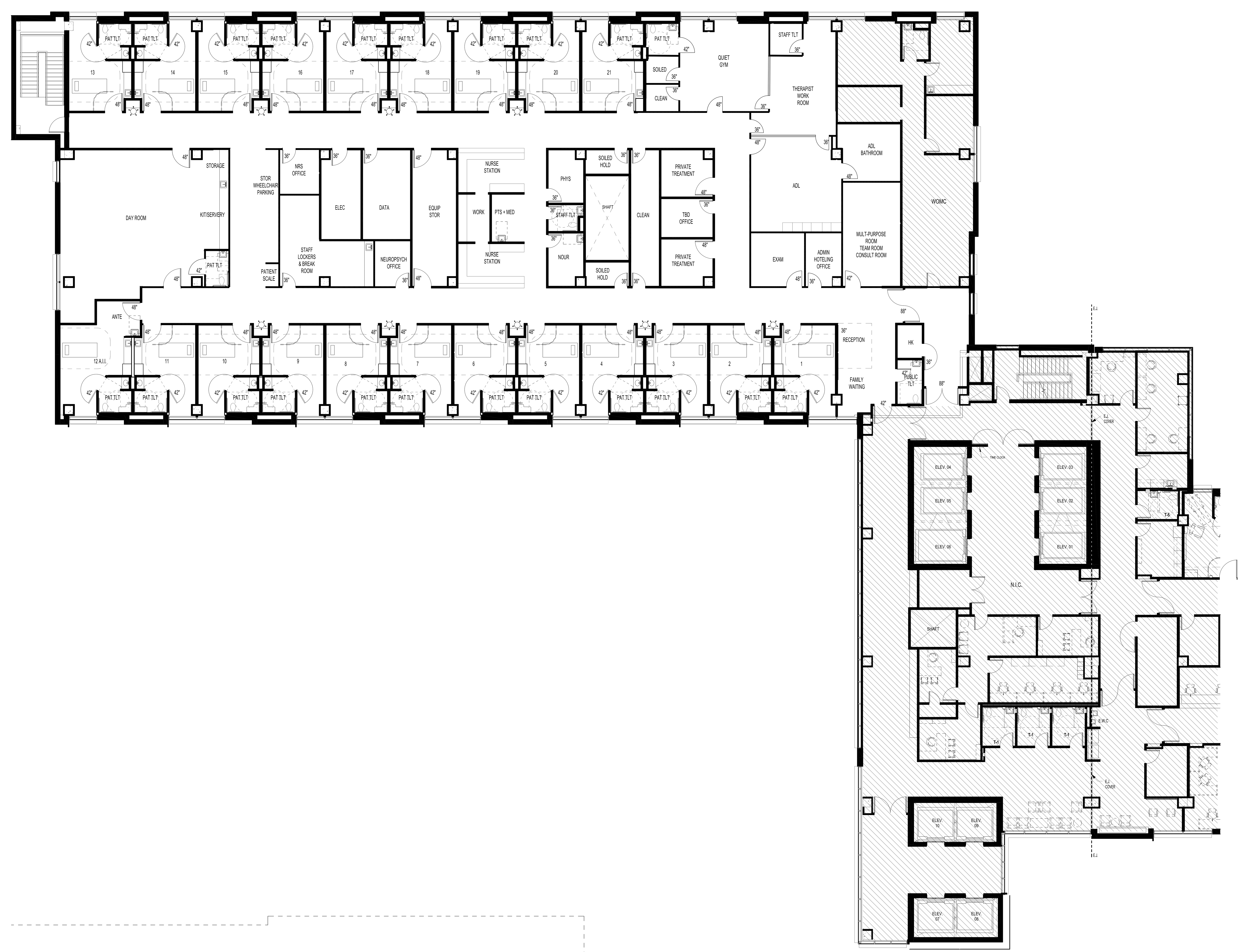
PLUM ORCHARD DRIVE
SILVER SPRING, MARYLAND 20904

ISSUED DRAWING LOG

	Issued for review and comment 02/08/2018

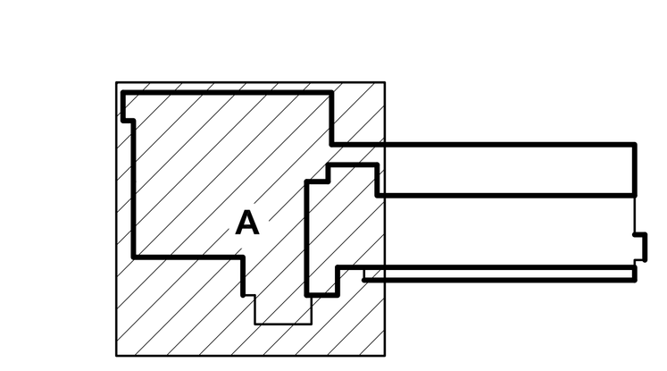
DRAWING REVISION LOG

SEAL



1 LEVEL 07 - FLOOR PLAN - AREA A

KEY PLAN



Professional Certification. "I hereby certify that these documents were prepared or approved by me, and that I am a duly licensed architect under the laws of the State of Maryland, License No. 7290 Expiration Date: 10/3/2018

SHEET IDENTIFICATION

BUILDING

MAIN HOSPITAL

TITLE

LEVEL 07 FLOOR PLAN - AREA A

NUMBER

AE.107.A

EXHIBIT 4

Table Number	Table Title	Instructions
Table A	**Physical Bed Capacity Before and After Project**	All applicants whose project impacts any nursing unit, regardless of project type or scope, must complete Table A.
Table B	**Departmental Gross Square Feet**	All applicants, regardless of project type or scope, must complete Table B for all departments and functional areas affected by the proposed project.
Table C	**Construction Characteristics**	All applicants proposing new construction or renovation must complete Table C.
Table D	**Site and Offsite Costs Included and Excluded in Marshall Valuation Costs**	All applicants proposing new construction or renovation must complete Table D.
Table E	**Project Budget**	All applicants, regardless of project type or scope, must complete Table E.
Table F	**Statistical Projections - Entire Facility**	Existing facility applicants must complete Table F. All applicants who complete this table must also complete Tables G and H.
Table G	**Revenues & Expenses, Uninflated - Entire Facility**	Existing facility applicants must complete Table G. The projected revenues and expenses in Table G should be consistent with the volume projections in Table F.
Table H	**Revenues & Expenses, Inflated - Entire Facility**	Existing facility applicants must complete Table H. The projected revenues and expenses in H should be consistent with the projections in Tables F and G.
Table I	**Statistical Projections - New Facility or Service**	Applicants who propose to establish a new facility, existing facility applicants who propose a new service, and applicants who are directed by MHCC staff must complete Table I. All applicants who complete this table must also complete Tables J and K.
Table J	**Revenues & Expenses, Uninflated - New Facility or Service**	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant who completes a Table I must complete Table J. The projected revenues and expenses in Table J should be consistent with the volume projections in Table I.
Table K	**Revenues & Expenses, Inflated - New Facility or Service**	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant that completes a Table I must complete Table K. The projected revenues and expenses in Table K should be consistent with the projections in Tables I and J.
Table L	**Work Force Information**	All applicants, regardless of project type or scope, must complete Table L.

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

***INSTRUCTIONS:** Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project in accordance with the definition of physical capacity noted below. Applicants should add columns and recalculate formulas to address rooms with 3 and 4 bed capacity. NOTE: Physical capacity is the total number of beds that could be physically set up in space without significant renovations. This should be the maximum operating capacity under normal, non-emergency circumstances and is a physical count of bed capacity, rather than a measure of staffing capacity. A room with two headwalls and two sets of gasses should be counted as having capacity for two beds, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough from a square footage perspective to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain no headwalls or a single headwall, but are normally used to accommodate one or more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms should be counted as they are currently used.*

Before the Project							After Project Completion						
Hospital Service	Location (Floor/ Wing)*	Licensed Beds: 7/1/201_	Based on Physical Capacity				Hospital Service	Location (Floor/ Wing)*	Based on Physical Capacity			
			Room Count			Bed Count			Room Count			Bed Count
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity
ACUTE CARE							**ACUTE CARE**					
General Medical/ Surgical*	Level 3		32		32	32	**General Medical/ Surgical***	Level 3	32		32	32
	Level 4		4		4	4		Level 4	4		4	4
	Level 5		32		32	32		Level 5	32		32	32
	Level 6		32		32	32		Level 6	32		32	32
	Level 7		24		24	24		Level 7	24		24	24
SUBTOTAL Gen. Med/Surg*			**124**		**124**	**124**	**SUBTOTAL Gen. Med/Surg***		**124**		**124**	**124**
ICU/CCU	Level 2 ICU		28		28	28	**ICU/CCU**	Level 2 ICU	28		28	28
Other *(Specify/add rows as needed)*					0	0					0	0
TOTAL MSGA			**152**		**152**	**152**	**TOTAL MSGA**		**152**		**152**	**152**
Obstetrics	Level 4		18		18	18	**Obstetrics**	Level 4	18		18	18
Pediatrics					0	0	**Pediatrics**				0	0
Psychiatric					0	0	**Psychiatric**				0	0
TOTAL ACUTE			**170**	**0**	**170**	**170**	**TOTAL ACUTE**		**170**	**0**	**170**	**170**
NON-ACUTE CARE							**NON-ACUTE CARE**					
Dedicated Observation**	Level 7		8		8	8	**Dedicated Observation****	Level 7	8		8	8
Dedicated Observation**	1st/ED		12		12	12	**Dedicated Observation****	1st/ED	12		12	12
Rehabilitation					0	0	**Rehabilitation**	Level 6 & 7	42		42	42
Comprehensive Care					0	0	**Comprehensive Care**				0	0
Other *(Specify/add rows as needed)*					0	0	**Other** *(Specify/add rows as needed)*				0	0
TOTAL NON-ACUTE			**20**		**20**	**20**	**TOTAL NON-ACUTE**		**62**		**62**	**62**
HOSPITAL TOTAL			**190**	**0**	**190**	**190**	**HOSPITAL TOTAL**		**232**	**0**	**232**	**232**

* Include beds dedicated to gynecology and addictions, if unit(s) is separate for acute psychiatric unit

** Include services included in the reporting of the “Observation Center”. Service furnished by the hospital on the hospital's promise, including use of a bed and periodic monitoring by the hospital's nursing or other staff, which are reasonable and necessary to determine the need for a possible admission to the hospital as an inpatient; Must be ordered and documented in writing, given by a medical practitioner.

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

INSTRUCTION: Add or delete rows if necessary. See additional instruction in the column to the right of the table.

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
Rehabilitation Hospital	0	35,109	0	0	35,109
WAH Nursing Administration Offices	0	1,314	0	0	1,314
Total					36,423

TABLE C. CONSTRUCTION CHARACTERISTICS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table C for each structure.

	NEW CONSTRUCTION	RENOVATION
BASE BUILDING CHARACTERISTICS	**Check if applicable**	
Class of Construction (for renovations the class of the building being renovated)*		
Class A	☐	☑
Class B	☐	☐
Class C	☐	☐
Class D	☐	☐
Type of Construction/Renovation*		
Low	☐	☐
Average	☐	☐
Good	☐	☑
Excellent	☐	☐
Number of Stories		

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Basement		
First Floor		
Second Floor		
Third Floor		
Fourth Floor		
Fifth Floor		
Sixth Floor	19,432	0
Seventh Floor	19,432	0
Average Square Feet		
Perimeter in Linear Feet	**Linear Feet**	
Basement	existing-no change	
First Floor	existing-no change	
Second Floor	existing-no change	
Third Floor	existing-no change	
Fourth Floor	existing-no change	
Fifth Floor	existing-no change	
Sixth Floor	581	
Seventh Floor	581	
Total Linear Feet		
Average Linear Feet		
Wall Height (floor to eaves)	**Feet**	
Basement	existing-no change	
First Floor	existing-no change	
Second Floor	existing-no change	
Third Floor	existing-no change	
Fourth Floor	existing-no change	
Fifth Floor	existing-no change	
Sixth Floor	14'-0"	
Seventh Floor	14'-0"	
Average Wall Height		
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger	existing-no change	existing-no change
Freight	existing-no change	existing-no change

Sprinklers	Square Feet Covered	
Wet System		
Dry System	0	0
Other	**Describe Type**	
Type of HVAC System for proposed project		
Type of Exterior Walls for proposed project		

TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table D for each structure.

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
SITE PREPARATION COSTS		
Normal Site Preparation	$0	$0
Utilities from Structure to Lot Line	$0	$0
Subtotal included in Marshall Valuation Costs	**existing - no change**	**existing - no change**
Site Demolition Costs	**$0**	**$0**
Storm Drains	**$0**	**$0**
Rough Grading	**$0**	**$0**
Hillside Foundation	**$0**	**$0**
Paving	**$0**	**$0**
Exterior Signs	**$0**	**$0**
Landscaping	$0	$0
Walls	$0	$0
Yard Lighting	$0	$0
Other *(Specify/add rows if needed)*		
Subtotal On-Site excluded from Marshall Valuation Costs	**existing - no change**	**existing - no change**
OFFSITE COSTS		
Roads	$0	$0
Utilities	$0	$0
Jurisdictional Hook-up Fees	$0	$0
Other *(Specify/add rows if needed)*		
Subtotal Off-Site excluded from Marshall Valuation Costs	**existing - no change**	**existing - no change**
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$0**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$0**	**$0**

*The combined total site and offsite cost included and excluded from Marshall Valuation Service should typically equal the estimated site preparation cost reported in Application Part II, Project Budget (see Table E. Project Budget). If these numbers are not equal, please reconcile the numbers in an explanation in an attachment to the application.

TABLE E. PROJECT BUDGET

INSTRUCTION: Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application.

NOTE: Inflation should only be included in the Inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.d as a use of funds and on line B.8 as a source of funds

	Hospital Building	Other Structure	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building	$13,448,000		$13,448,000
(2) Fixed Equipment			$0
(3) Site and Infrastructure			$0
(4) Architect/Engineering Fees	$1,626,480		$1,626,480
(5) Permits (Building, Utilities, Etc.)	$289,152		$289,152
SUBTOTAL	**$15,363,632**	**$0**	**$15,363,632**
b. Renovations			
(1) Building			$0
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees			$0
(4) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	**$0**	**$0**	**$0**
c. Other Capital Costs			
(1) Movable Equipment			$0
(2) Contingency Allowance	$984,641		$984,641
(3) Gross interest during construction period			$0
(4) Other *(Specify/add rows if needed)*			$0
Inspections & Certifications	$250,000		$250,000
Security / IT / Comm / Signage, etc	$2,197,050		$2,197,050
SUBTOTAL	***$3,431,691***	***$0***	**$3,431,691**
TOTAL CURRENT CAPITAL COSTS	**$18,795,323**	**$0**	**$18,795,323**
d. *Land Purchase*			
e. Inflation Allowance	$752,000		$752,000
TOTAL CAPITAL COSTS	**$19,547,323**	**$0**	**$19,547,323**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			$0
b. Bond Discount			$0
c CON Application Assistance			
c1. Legal Fees			$0
c2. Other (Specify/add rows if needed)			
d. Non-CON Consulting Fees			
d1. Legal Fees			$0
d2. Other (Specify/add rows if needed)			$0
e. Debt Service Reserve Fund			$0
f Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$0***	***$0***	**$0**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$19,547,323***	***$0***	***$19,547,323***
B. Sources of Funds			
1. Cash			$0
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds			$0
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS			**$0**
	Hospital Building	***Other Structure***	***Total***
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

* Describe the terms of the lease(s) below, including information on the fair market value of the item(s), and the number of years, annual cost, and the interest rate for the lease.

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

CY	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.			
Indicate CY ~~or FY~~	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
1. DISCHARGES							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	635	678	690	849	886	901	917
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL DISCHARGES	***635***	***678***	***690***	***849***	***886***	***901***	***917***
2. PATIENT DAYS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	8,968	9,538	9,344	11,498	11,955	12,165	12,379
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL PATIENT DAYS	***8,968***	***9,538***	***9,344***	***11,498***	***11,955***	***12,165***	***12,379***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

CY	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.			
Indicate CY ~~or FY~~	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)							
a. General Medical/Surgical*	0.0	0.0	0.0	0.0	0.0	0.0	0.0
b. ICU/CCU	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total MSGA	0.0	0.0	0.0	0.0	0.0	0.0	0.0
c. Pediatric	0.0	0.0	0.0	0.0	0.0	0.0	0.0
d. Obstetric	0.0	0.0	0.0	0.0	0.0	0.0	0.0
e. Acute Psychiatric	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Acute	0.0	0.0	0.0	0.0	0.0	0.0	0.0
f. Rehabilitation	14.1	14.1	13.5	13.5	13.5	13.5	13.5
g. Comprehensive Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0
h. Other (Specify/add rows of needed)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL AVERAGE LENGTH OF STAY	14.1	14.1	13.5	13.5	13.5	13.5	13.5
4. NUMBER OF LICENSED BEDS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	32	32	35	42	42	42	42
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL LICENSED BEDS	***32***	***32***	***35***	***42***	***42***	***42***	***42***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

CY	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.			
Indicate CY ~~or FY~~	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. General Medical/Surgical*	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
b. ICU/CCU	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total MSGA	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
c. Pediatric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
d. Obstetric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
e. Acute Psychiatric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total Acute	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
f. Rehabilitation	76.6%	81.7%	72.5%	75.0%	77.8%	79.4%	80.8%
g. Comprehensive Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
h. Other (Specify/add rows of needed)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL OCCUPANCY %	**76.8%**	**81.7%**	**72.5%**	**75.0%**	**78.0%**	**79.4%**	**80.8%**
6. OUTPATIENT VISITS							
a. Emergency Department							
b. Same-day Surgery							
c. Laboratory							
d. Imaging							
e. Other (Outpt Therapy)							
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***
7. OBSERVATIONS**							
a. Number of Patients							
b. Hours							

* Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a medical practitioner; may or may not be provided in a distinct area of the hospital.

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
1. REVENUE							
a. Inpatient Services	$ 21,285,048	$ 21,168,093	$ 20,737,540	$ 25,516,895	$ 26,532,245	$ 26,998,307	$ 27,473,246
b. Outpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Gross Patient Service Revenues	***$ 21,285,048***	***$ 21,168,093***	***$ 20,737,540***	***$ 25,516,895***	***$ 26,532,245***	***$ 26,998,307***	***$ 27,473,246***
c. Allowance For Bad Debt	$ 276,705	$ 141,668	$ 138,787	$ 170,772	$ 177,568	$ 180,687	$ 183,865
d. Contractual Allowance	$ 7,044,897	$ 6,687,431	$ 6,551,411	$ 8,061,306	$ 8,382,076	$ 8,529,314	$ 8,679,357
e. Charity Care	$ 148,995	$ 71,891	$ 70,429	$ 86,660	$ 90,109	$ 91,692	$ 93,305
Net Patient Services Revenue	***$ 13,814,451***	***$ 14,267,103***	***$ 13,976,914***	***$ 17,198,157***	***$ 17,882,493***	***$ 18,196,614***	***$ 18,516,719***
f. Other Operating Revenues (Specify)	$ 78,800	$ 112,324	$ 112,324	$ 112,324	$ 112,324	$ 112,324	$ 112,324
NET OPERATING REVENUE	***$ 13,893,251***	***$ 14,379,427***	***$ 14,089,238***	***$ 17,310,481***	***$ 17,994,817***	***$ 18,308,938***	***$ 18,629,043***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 7,511,506	$ 8,015,695	$ 7,933,420	$ 10,223,162	$ 11,140,904	$ 11,344,838	$ 11,524,682
b. Contractual Services	$ 261,535	$ 62,023	$ 60,761	$ 74,765	$ 77,740	$ 79,106	$ 80,497
c. Interest on Current Debt	$ 57,765	$ 45,475	$ 45,475	$ 654,160	$ 1,262,845	$ 1,262,845	$ 1,262,845
d. Interest on Project Debt							
e. Current Depreciation	$ 403,838	$ 417,526	$ 417,526	$ 1,214,794	$ 2,012,514	$ 2,012,514	$ 2,012,514
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 328,478	$ 313,685	$ 307,305	$ 378,129	$ 393,175	$ 400,082	$ 407,120
j. IT Services	$ 460,605	$ 624,287	$ 624,287	$ 624,287	$ 624,287	$ 624,287	$ 624,287
k. Professional Fees	$ 52,308	$ 59,583	$ 58,371	$ 71,824	$ 74,682	$ 75,994	$ 77,330
l. Building & Maintenance	$ 456,976	$ 435,016	$ 435,016	$ 1,246,580	$ 2,493,160	$ 2,493,160	$ 2,493,160
m. Insurance	$ 27,003	$ 27,360	$ 27,360	$ 27,360	$ 27,360	$ 27,360	$ 27,360
m. G&A	$ 1,434,777	$ 1,750,269	$ 1,750,269	$ 2,969,732	$ 3,122,577	$ 3,122,577	$ 3,122,577
TOTAL OPERATING EXPENSES	**$ 10,994,791**	**$ 11,750,919**	**$ 11,659,790**	**$ 17,484,792**	**$ 21,229,244**	**$ 21,442,761**	**$ 21,632,372**
3. INCOME							
a. Income From Operation	**$ 2,898,460**	**$ 2,628,508**	**$ 2,429,448**	**$ (174,312)**	**$ (3,234,427)**	**$ (3,133,823)**	**$ (3,003,329)**
b. Non-Operating Income							
SUBTOTAL	***$ 2,898,460***	***$ 2,628,508***	***$ 2,429,448***	***$ (174,312)***	***$ (3,234,427)***	***$ (3,133,823)***	***$ (3,003,329)***
c. Income Taxes							
NET INCOME (LOSS)	***$ 2,898,460***	***$ 2,628,508***	***$ 2,429,448***	***$ (174,312)***	***$ (3,234,427)***	***$ (3,133,823)***	***$ (3,003,329)***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	59.2%	60.7%	62.2%	62.2%	62.2%	62.2%	62.2%
2) Medicaid	7.8%	8.3%	6.7%	6.7%	6.7%	6.7%	6.7%
3) Blue Cross	15.8%	13.0%	13.8%	13.8%	13.8%	13.8%	13.8%
4) Commercial Insurance	5.8%	7.6%	7.0%	7.0%	7.0%	7.0%	7.0%
5) HMO	9.1%	8.7%	8.6%	8.6%	8.6%	8.6%	8.6%
6) Self-pay	0.1%	0.0%	0.8%	0.8%	0.8%	0.8%	0.8%
7) Other	2.2%	1.7%	0.9%	0.9%	0.9%	0.9%	0.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	59.9%	60.7%	62.1%	62.1%	62.1%	62.1%	62.1%
2) Medicaid	7.8%	8.3%	6.8%	6.8%	6.8%	6.8%	6.8%
3) Blue Cross	15.4%	13.0%	13.9%	13.9%	13.9%	13.9%	13.9%
4) Commercial Insurance	5.7%	7.7%	6.9%	6.9%	6.9%	6.9%	6.9%
5) HMO	9.0%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
6) Self-pay	0.1%	0.0%	0.8%	0.8%	0.8%	0.8%	0.8%
7) Other	2.2%	1.7%	1.0%	1.0%	1.0%	1.0%	1.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
1. REVENUE							
a. Inpatient Services	$ 21,285,048	$ 21,168,093	$ 21,401,142	$ 26,570,437	$ 27,669,150	$ 28,295,958	$ 28,937,694
b. Outpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Gross Patient Service Revenues	***$ 21,285,048***	***$ 21,168,093***	***$ 21,401,142***	***$ 26,570,437***	***$ 27,669,150***	***$ 28,295,958***	***$ 28,937,694***
c. Allowance For Bad Debt	$ 276,705	$ 141,668	$ 143,228	$ 177,823	$ 185,176	$ 189,371	$ 193,666
d. Contractual Allowance	$ 7,044,897	$ 6,687,431	$ 6,761,056	$ 8,394,141	$ 8,741,247	$ 8,939,269	$ 9,142,006
e. Charity Care	$ 148,995	$ 71,891	$ 72,682	$ 90,238	$ 93,970	$ 96,099	$ 98,278
Net Patient Services Revenue	***$ 13,814,451***	***$ 14,267,103***	***$ 14,424,176***	***$ 17,908,234***	***$ 18,648,756***	***$ 19,071,220***	***$ 19,503,744***
f. Other Operating Revenues (Specify/add rows of needed)	$ 78,800	$ 112,324	$ 114,009	$ 115,719	$ 117,455	$ 117,455	$ 119,217
NET OPERATING REVENUE	***$ 13,893,251***	***$ 14,379,427***	***$ 14,538,185***	***$ 18,023,953***	***$ 18,766,211***	***$ 19,188,675***	***$ 19,622,960***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 7,511,506	$ 8,015,695	$ 8,084,155	$ 10,593,823	$ 11,722,934	$ 12,144,243	$ 12,551,268
b. Contractual Services	$ 261,535	$ 62,023	$ 62,281	$ 78,550	$ 83,718	$ 87,318	$ 91,075
c. Interest on Current Debt	$ 57,765	$ 45,475	$ 45,475	$ 654,160	$ 1,262,845	$ 1,262,845	$ 1,262,845
d. Interest on Project Debt							
e. Current Depreciation	$ 403,838	$ 417,526	$ 417,526	$ 1,214,794	$ 2,012,514	$ 2,012,514	$ 2,012,514
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 328,478	$ 313,685	$ 314,987	$ 397,272	$ 423,407	$ 441,615	$ 460,618
j. IT Services	$ 460,605	$ 624,287	$ 639,894	$ 649,493	$ 659,235	$ 669,124	$ 679,160
k. Professional Fees	$ 52,308	$ 59,583	$ 59,830	$ 75,460	$ 80,424	$ 83,883	$ 87,492
l. Building & Maintenance	$ 456,976	$ 435,016	$ 445,891	$ 1,246,580	$ 2,493,160	$ 2,555,489	$ 2,619,376
m. Insurance	$ 27,003	$ 27,360	$ 28,044	$ 28,745	$ 29,464	$ 30,200	$ 30,955
m. G&A	$ 1,434,777	$ 1,750,269	$ 1,794,026	$ 3,033,709	$ 3,253,609	$ 3,326,030	$ 3,400,127
TOTAL OPERATING EXPENSES	**$ 10,994,791**	**$ 11,750,919**	**$ 11,892,109**	**$ 17,972,586**	**$ 22,021,309**	**$ 22,613,260**	**$ 23,195,432**
3. INCOME							
a. Income From Operation	**$ 2,898,460**	**$ 2,628,508**	**$ 2,646,075**	**$ 51,367**	**$ (3,255,098)**	**$ (3,424,586)**	**$ (3,572,472)**
b. Non-Operating Income							
SUBTOTAL	***$ 2,898,460***	***$ 2,628,508***	***$ 2,646,075***	***$ 51,367***	***$ (3,255,098)***	***$ (3,424,586)***	***$ (3,572,472)***
c. Income Taxes							
NET INCOME (LOSS)	***$ 2,898,460***	***$ 2,628,508***	***$ 2,646,075***	***$ 51,367***	***$ (3,255,098)***	***$ (3,424,586)***	***$ (3,572,472)***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	59.2%	60.7%	62.2%	62.2%	62.2%	62.2%	62.2%
2) Medicaid	7.8%	8.3%	6.7%	6.7%	6.7%	6.7%	6.7%
3) Blue Cross	15.8%	13.0%	13.8%	13.8%	13.8%	13.8%	13.8%
4) Commercial Insurance	5.8%	7.6%	7.0%	7.0%	7.0%	7.0%	7.0%
5) HMO	9.1%	8.7%	8.6%	8.6%	8.6%	8.6%	8.6%
6) Self-pay	0.1%	0.0%	0.8%	0.8%	0.8%	0.8%	0.8%
7) Other	2.2%	1.7%	0.9%	0.9%	0.9%	0.9%	0.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	59.9%	60.7%	62.1%	62.1%	62.1%	62.1%	62.1%
2) Medicaid	7.8%	8.3%	6.8%	6.8%	6.8%	6.8%	6.8%
3) Blue Cross	15.4%	13.0%	13.9%	13.9%	13.9%	13.9%	13.9%
4) Commercial Insurance	5.7%	7.7%	6.9%	6.9%	6.9%	6.9%	6.9%
5) HMO	9.0%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
6) Self-pay	0.1%	0.0%	0.8%	0.8%	0.8%	0.8%	0.8%
7) Other	2.2%	1.7%	1.0%	1.0%	1.0%	1.0%	1.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

CY	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY ~~or FY~~	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
1. DISCHARGES							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	635	678	690	849	886	901	917
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL DISCHARGES	***635***	***678***	***690***	***849***	***886***	***901***	***917***
2. PATIENT DAYS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	8,968	9,538	9,344	11,498	11,955	12,165	12,379
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL PATIENT DAYS	***8,968***	***9,538***	***9,344***	***11,498***	***11,955***	***12,165***	***12,379***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)							
a. General Medical/Surgical*	0.0	0.0	0.0	0.0	0.0	0.0	0.0
b. ICU/CCU	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total MSGA	0.0	0.0	0.0	0.0	0.0	0.0	0.0
c. Pediatric	0.0	0.0	0.0	0.0	0.0	0.0	0.0
d. Obstetric	0.0	0.0	0.0	0.0	0.0	0.0	0.0
e. Acute Psychiatric	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Acute	0.0	0.0	0.0	0.0	0.0	0.0	0.0
f. Rehabilitation	14.1	14.1	13.5	13.5	13.5	13.5	13.5
g. Comprehensive Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0
h. Other (Specify/add rows of needed)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL AVERAGE LENGTH OF STAY	14.1	14.1	13.5	13.5	13.5	13.5	13.5

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

CY	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY ~~or FY~~	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
4. NUMBER OF LICENSED BEDS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation	32	32	35	42	42	42	42
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL LICENSED BEDS	***32***	***32***	***35***	***42***	***42***	***42***	***42***
5. OCCUPANCY PERCENTAGE *IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. General Medical/Surgical*	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
b. ICU/CCU	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total MSGA	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
c. Pediatric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
d. Obstetric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
e. Acute Psychiatric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total Acute	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
f. Rehabilitation	76.6%	81.7%	72.5%	75.0%	77.8%	79.4%	80.8%
g. Comprehensive Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
h. Other (Specify/add rows of needed)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL OCCUPANCY %	**76.8%**	**81.7%**	**72.5%**	**75.0%**	**78.0%**	**79.4%**	**80.8%**
6. OUTPATIENT VISITS							
a. Emergency Department							
b. Same-day Surgery							
c. Laboratory							
d. Imaging							
e. Other (Specify/add rows of needed)							
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***
7. OBSERVATIONS**							
a. Number of Patients							
b. Hours							

*Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a medical practitioner; may or may not be provided in a distinct area of the hospital.

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
1. REVENUE							
a. Inpatient Services	$ 21,285,048	$ 21,168,093	$ 20,737,540	$ 25,516,895	$ 26,532,245	$ 26,998,307	$ 27,473,246
b. Outpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Gross Patient Service Revenues	***$ 21,285,048***	***$ 21,168,093***	***$ 20,737,540***	***$ 25,516,895***	***$ 26,532,245***	***$ 26,998,307***	***$ 27,473,246***
c. Allowance For Bad Debt	$ 276,705	$ 141,668	$ 138,787	$ 170,772	$ 177,568	$ 180,687	$ 183,865
d. Contractual Allowance	$ 7,044,897	$ 6,687,431	$ 6,551,411	$ 8,061,306	$ 8,382,076	$ 8,529,314	$ 8,679,357
e. Charity Care	$ 148,995	$ 71,891	$ 70,429	$ 86,660	$ 90,109	$ 91,692	$ 93,305
Net Patient Services Revenue	***$ 13,814,451***	***$ 14,267,103***	***$ 13,976,914***	***$ 17,198,157***	***$ 17,882,493***	***$ 18,196,614***	***$ 18,516,719***
f. Other Operating Revenues (Specify)	$ 78,800	$ 112,324	$ 112,324	$ 112,324	$ 112,324	$ 112,324	$ 112,324
NET OPERATING REVENUE	***$ 13,893,251***	***$ 14,379,427***	***$ 14,089,238***	***$ 17,310,481***	***$ 17,994,817***	***$ 18,308,938***	***$ 18,629,043***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 7,511,506	$ 8,015,695	$ 7,933,420	$ 10,223,162	$ 10,019,481	$ 10,223,415	$ 10,403,259
b. Contractual Services	$ 261,535	$ 62,023	$ 60,761	$ 74,765	$ 77,740	$ 79,106	$ 80,497
c. Interest on Current Debt	$ 57,765	$ 45,475	$ 45,475	$ 654,160	$ 45,475	$ 45,475	$ 45,475
d. Interest on Project Debt							
e. Current Depreciation	$ 403,838	$ 417,526	$ 417,526	$ 1,214,794	$ 832,526	$ 832,526	$ 832,526
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 328,478	$ 313,685	$ 307,305	$ 378,129	$ 393,175	$ 400,082	$ 407,120
j. IT Services	$ 460,605	$ 624,287	$ 624,287	$ 624,287	$ 624,287	$ 624,287	$ 624,287
k. Professional Fees	$ 52,308	$ 59,583	$ 58,371	$ 71,824	$ 74,682	$ 75,994	$ 77,330
l. Building & Maintenance	$ 456,976	$ 435,016	$ 435,016	$ 1,246,580	$ 1,850,000	$ 1,850,000	$ 1,850,000
m. Insurance	$ 27,003	$ 27,360	$ 27,360	$ 27,360	$ 27,360	$ 27,360	$ 27,360
m. G&A	$ 1,434,777	$ 1,750,269	$ 1,750,269	$ 2,436,423	$ 2,120,433	$ 2,120,433	$ 2,120,433
TOTAL OPERATING EXPENSES	***$ 10,994,791***	***$ 11,750,919***	***$ 11,659,790***	***$ 16,951,484***	***$ 16,065,159***	***$ 16,278,677***	***$ 16,468,288***
3. INCOME							
a. Income From Operation	**$ 2,898,460**	**$ 2,628,508**	**$ 2,429,448**	**$ 358,997**	**$ 1,929,658**	**$ 2,030,262**	**$ 2,160,756**
b. Non-Operating Income							
SUBTOTAL	***$ 2,898,460***	***$ 2,628,508***	***$ 2,429,448***	***$ 358,997***	***$ 1,929,658***	***$ 2,030,262***	***$ 2,160,756***
c. Income Taxes							
NET INCOME (LOSS)	***$ 2,898,460***	***$ 2,628,508***	***$ 2,429,448***	***$ 358,997***	***$ 1,929,658***	***$ 2,030,262***	***$ 2,160,756***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	59.2%	60.7%	62.2%	62.2%	62.2%	62.2%	62.2%
2) Medicaid	7.8%	8.3%	6.7%	6.7%	6.7%	6.7%	6.7%
3) Blue Cross	15.8%	13.0%	13.8%	13.8%	13.8%	13.8%	13.8%
4) Commercial Insurance	5.8%	7.6%	7.0%	7.0%	7.0%	7.0%	7.0%
5) HMO	9.1%	8.7%	8.6%	8.6%	8.6%	8.6%	8.6%
6) Self-pay	0.1%	0.0%	0.8%	0.8%	0.8%	0.8%	0.8%
7) Other	2.2%	1.7%	0.9%	0.9%	0.9%	0.9%	0.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	59.9%	60.7%	62.1%	62.1%	62.1%	62.1%	62.1%
2) Medicaid	7.8%	8.3%	6.8%	6.8%	6.8%	6.8%	6.8%
3) Blue Cross	15.4%	13.0%	13.9%	13.9%	13.9%	13.9%	13.9%
4) Commercial Insurance	5.7%	7.7%	6.9%	6.9%	6.9%	6.9%	6.9%
5) HMO	9.0%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
6) Self-pay	0.1%	0.0%	0.8%	0.8%	0.8%	0.8%	0.8%
7) Other	2.2%	1.7%	1.0%	1.0%	1.0%	1.0%	1.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
1. REVENUE							
a. Inpatient Services	$ 21,285,048	$ 21,168,093	$ 21,401,142	$ 26,570,437	$ 27,669,150	$ 28,295,958	$ 28,937,694
b. Outpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Gross Patient Service Revenues	***$ 21,285,048***	***$ 21,168,093***	***$ 21,401,142***	***$ 26,570,437***	***$ 27,669,150***	***$ 28,295,958***	***$ 28,937,694***
c. Allowance For Bad Debt	$ 276,705	$ 141,668	$ 143,228	$ 177,823	$ 185,176	$ 189,371	$ 193,666
d. Contractual Allowance	$ 7,044,897	$ 6,687,431	$ 6,761,056	$ 8,394,141	$ 8,741,247	$ 8,939,269	$ 9,142,006
e. Charity Care	$ 148,995	$ 71,891	$ 72,682	$ 90,238	$ 93,970	$ 96,099	$ 98,278
Net Patient Services Revenue	***$ 13,814,451***	***$ 14,267,103***	***$ 14,424,176***	***$ 17,908,234***	***$ 18,648,756***	***$ 19,071,220***	***$ 19,503,744***
f. Other Operating Revenues (Specify/add rows of needed)	$ 78,800	$ 112,324	$ 114,009	$ 115,719	$ 117,455	$ 117,455	$ 119,217
NET OPERATING REVENUE	***$ 13,893,251***	***$ 14,379,427***	***$ 14,538,185***	***$ 18,023,953***	***$ 18,766,211***	***$ 19,188,675***	***$ 19,622,960***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 7,511,506	$ 8,015,695	$ 8,084,155	$ 10,593,823	$ 10,601,511	$ 11,022,820	$ 11,429,845
b. Contractual Services	$ 261,535	$ 62,023	$ 62,281	$ 78,550	$ 83,718	$ 87,318	$ 91,075
c. Interest on Current Debt	$ 57,765	$ 45,475	$ 45,475	$ 654,160	$ 45,475	$ 45,475	$ 45,475
d. Interest on Project Debt							
e. Current Depreciation	$ 403,838	$ 417,526	$ 417,526	$ 1,214,794	$ 832,526	$ 832,526	$ 832,526
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 328,478	$ 313,685	$ 314,987	$ 397,272	$ 423,407	$ 441,615	$ 460,618
j. IT Services	$ 460,605	$ 624,287	$ 639,894	$ 649,493	$ 659,235	$ 669,124	$ 679,160
k. Professional Fees	$ 52,308	$ 59,583	$ 59,830	$ 75,460	$ 80,424	$ 83,883	$ 87,492
l. Building & Maintenance	$ 456,976	$ 435,016	$ 445,891	$ 1,246,580	$ 1,850,000	$ 1,896,250	$ 1,943,656
m. Insurance	$ 27,003	$ 27,360	$ 28,044	$ 28,745	$ 29,464	$ 30,200	$ 30,955
m. G&A	$ 1,434,777	$ 1,750,269	$ 1,794,026	$ 2,516,372	$ 2,182,009	$ 2,227,640	$ 2,274,278
TOTAL OPERATING EXPENSES	**$ 10,994,791**	**$ 11,750,919**	**$ 11,892,109**	**$ 17,455,249**	**$ 16,787,769**	**$ 17,336,851**	**$ 17,875,082**
3. INCOME							
a. Income From Operation	**$ 2,898,460**	**$ 2,628,508**	**$ 2,646,075**	**$ 568,704**	**$ 1,978,443**	**$ 1,851,824**	**$ 1,747,878**
b. Non-Operating Income							
SUBTOTAL	***$ 2,898,460***	***$ 2,628,508***	***$ 2,646,075***	***$ 568,704***	***$ 1,978,443***	***$ 1,851,824***	***$ 1,747,878***
c. Income Taxes							

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	CY 2016	CY 2017	CY 2018 Proj	CY 2019 Proj	CY 2020 Proj	CY 2021 Proj	CY 2022 Proj
NET INCOME (LOSS)	*$ 2,898,460*	*$ 2,628,508*	*$ 2,646,075*	*$ 568,704*	*$ 1,978,443*	*$ 1,851,824*	*$ 1,747,878*

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

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

CY	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**CY 2016**	**CY 2017**	**CY 2018 Proj**	**CY 2019 Proj**	**CY 2020 Proj**	**CY 2021 Proj**	**CY 2022 Proj**
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	59.2%	60.7%	62.2%	62.2%	62.2%	62.2%	62.2%
2) Medicaid	7.8%	8.3%	6.7%	6.7%	6.7%	6.7%	6.7%
3) Blue Cross	15.8%	13.0%	13.8%	13.8%	13.8%	13.8%	13.8%
4) Commercial Insurance	5.8%	7.6%	7.0%	7.0%	7.0%	7.0%	7.0%
5) HMO	9.1%	8.7%	8.6%	8.6%	8.6%	8.6%	8.6%
6) Self-pay	0.1%	0.0%	0.8%	0.8%	0.8%	0.8%	0.8%
7) Other	2.2%	1.7%	0.9%	0.9%	0.9%	0.9%	0.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	59.9%	60.7%	62.1%	62.1%	62.1%	62.1%	62.1%
2) Medicaid	7.8%	8.3%	6.8%	6.8%	6.8%	6.8%	6.8%
3) Blue Cross	15.4%	13.0%	13.9%	13.9%	13.9%	13.9%	13.9%
4) Commercial Insurance	5.7%	7.7%	6.9%	6.9%	6.9%	6.9%	6.9%
5) HMO	9.0%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
6) Self-pay	0.1%	0.0%	0.8%	0.8%	0.8%	0.8%	0.8%
7) Other	2.2%	1.7%	1.0%	1.0%	1.0%	1.0%	1.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE H. WORKFORCE INFORMATION

INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables F and G.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Facility Mgmt	3.1	$128,056	$390,571			$0	0.9	$116,336	$116,336	4.0	$506,908
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration	3.1	$128,056	$390,571			$0	0.9	$116,336	$116,336	4.0	$506,908
Direct Care Staff *(List general categories, add rows if needed)*											
Nursing	28.5	$91,484	$2,603,623			$0	8.5	$775,518	$775,518	36.9	$3,379,141
Therapy	26.7	$91,356	$2,434,629			$0	7.9	$725,181	$725,181	34.6	$3,159,810
Patient Care Tech	25.1	$46,991	$1,179,950			$0	7.5	$351,461	$351,461	32.6	$1,531,411
						$0	0.0	$0	$0	0.0	$0
						$0	0.0	$0	$0	0.0	$0
						$0	0.0	$0	$0	0.0	$0
Total Direct Care	80.2	$229,830	$6,218,201	0.0	0.0	0.0	23.9	$1,852,161	$1,852,161	104.1	$8,070,362
Support Staff *(List general categories, add rows if needed)*											
Case Mgmt	4.3	$93,593	$398,704			$0	1.3	$118,759	$118,759	5.5	$517,463
Unit Secretary	4.1	$41,800	$169,290			$0	1.2	$50,425	$50,425	5.3	$219,715
Overhead and Corporate Allocation	0.0	$0	$1,248,725			$0				0.0	$1,248,725
TP Facilities	0.0	$0	$961,510			$0				0.0	$961,510

TABLE H. WORKFORCE INFORMATION

						$0				0.0	$0
						$0				0.0	$0
						$0				0.0	$0
						$0			$0	0.0	$0
						$0			$0	0.0	$0
						$0			$0	0.0	$0
Total Support	8.3	$135,393	$2,778,229	0.0	0.0	0.0	2.5	$169,183	$169,183	10.8	$2,947,413
REGULAR EMPLOYEES TOTAL	91.6	***$102,501***	$9,387,002	0.0		$0	27.3		$2,137,680	118.9	$11,524,682
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff			$0			$0			$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL			$0			$0			$0	0.0	$0
Benefits *(State method of calculating benefits below)* **:**											
TOTAL COST	***91.6***		***$9,387,002***	***0.0***		***$0***	***27.3***		***$2,137,680***		***$11,524,682***

EXHIBIT 5

BYLAWS
OF
ADVENTIST REHABILITATION HOSPITAL OF MARYLAND, INC.

ARTICLE I
OFFICES AND PURPOSE

Section 1: Purpose. Adventist Rehabilitation Hospital of Maryland, Inc. (the "Corporation") is a non-profit corporation organized pursuant to the laws of the State of Maryland and is an important and inseparable part of the Seventh-day Adventist Church ("Church"). The primary purpose of the Corporation is to further the goals and objectives of the Church's health ministry by providing general supervision to the health care organizations and programs owned or operated by the Church and to promote the wholeness of man physically, mentally, and spiritually. The Corporation shall additionally have the following specific purposes:

(a) To support the goals and objectives of the Church's health ministry;

(b) To establish, own, operate and maintain a Seventh-day Adventist hospital delivering inpatient and outpatient medical rehabilitation services and engaging in other supporting activities within the health care field;

(c) To further by all proper and legal agencies and means in harmony with the goals, objectives and teachings of the Church, a better knowledge of the laws of life and true hygiene, the relief of suffering and the prevention and cure of disease;

(d) To do all acts necessary to the furtherance and the attainment of the purposes of the Corporation.

Section 2: Principal Office and Resident Agent. The Corporation shall have and continuously maintain a principal office and resident agent in the State of Maryland. The location of such principal office and the name of such resident agent shall be such as are designated in the Articles of Incorporation, and they may be changed and determined by the Board of Directors pursuant to the applicable provisions of law.

ARTICLE II
MEMBER

Section 1: Member. The sole member of the Corporation ("Member") shall be Adventist HealthCare, Inc., a not-for-profit Maryland corporation exempt from federal income tax under Internal Revenue Code ("IRC") Section 501(c)(3).

Section 2: Reserved Authority and Responsibility. The following actions shall be reserved to the Member:

(a) The adoption, altering, amending or replacing of the Articles of Incorporation or the Bylaws of the Corporation;

(b) The liquidation, dissolution, winding up, or abandonment of the Corporation;

(c) Appointment of members of the Board of Directors from nominees submitted by the Nominating Committee (as defined hereunder);

(d) Removal of members of the Board of Directors;

(e) Appointment and removal of the President of the Corporation, in consultation with the Board of Directors.

Section 3: Voting. The Member shall have voting rights and shall be entitled to one vote at all meetings of the Member, where all questions shall be determined by a majority vote.

Section 4: Annual Meetings. The annual meeting of the Member shall be held at a time and place as determined by the Board. At such meeting, directors shall be elected, reports of the affairs of the Corporation shall be considered, and any other business may be transacted which is within the power of the Member.

Section 5: Special Meetings. Special meetings of the Member, for any purpose or purposes whatsoever, may be called at any time by the Chair of the Board, by the Vice Chair (in the absence of the Chair), by petition of a majority of the Board of Directors, or as otherwise permitted by applicable state law. Except in special cases where other express provision is made by statute, notice of such special meeting shall be given in the same manner as for annual meetings of the Member. Notices of any special meetings shall specify the place, day and hour of such meeting, and the general nature of the business to be transacted.

Section 6: Place of Meetings. All annual meetings of the Member, and all other meetings of the Member, shall be held at such place within or without the State of Maryland as designated either by the Board of Directors pursuant to authority hereinafter granted to said Board, or by the written consent of all Members entitled to vote thereat, given either before or after the meeting and filed with the Secretary of the Corporation.

Section 7: Notice. Written notice of each annual or special meeting shall be given to each Member entitled to vote, either personally or by mail or by other means of written communication, charges prepaid, addressed to such member at such address appearing on the books of the Corporation or given by the member to the Corporation for the purpose of notice. All such notices shall be sent to each Member entitled thereto not less than ten (10) days nor more than fifty (50) days before each annual or special meeting, and shall specify the place, the day and the hour of such meeting, and, for each special meeting, shall state the general nature of the business to be transacted thereat. Notice under this Section 7 shall be waived if the person who is entitled to notice: 1) before or after the meeting, signs a waiver of notice which is filed with the records of the meeting; or 2) is present at the meeting.

Section 8: Quorum. A quorum for any meeting of the Member shall be fifty percent of the Members. The Members present at a duly called or held meeting at which a quorum is present may continue to do business until adjournment, notwithstanding the withdrawal of enough Members to leave less than a quorum.

Section 9: Action Without A Meeting. Any action required to be taken by the Member, or any action which may be taken by the Member, may be taken without a meeting, without notice, and without a vote if a consent in writing, setting forth the action so taken, is signed by all of the Members. Such written consent or consents shall be filed with the corporate records as the minutes of the proceedings of the Member.

Section 10: Telephone Conference. The Members may participate in a meeting by means of conference telephone or similar communications equipment if all persons participating in the meeting can hear and speak to each other at the same time. Participation in a meeting by these means constitutes presence in person at the meeting.

ARTICLE III
BOARD OF DIRECTORS

Section 1: Composition. The governing body of the Corporation shall be a Board of Directors. The number of directors shall be not less than three (3) nor more than nine (9). The composition of the Board of Directors shall be as follows:

(a) Company Director. At least one of the directors shall serve as a director of the Corporation by virtue of and concurrently with being an officer of Adventist HealthCare, Inc.

(b) Physician Director. At least one of the directors shall be a physician on the Medical Staff of the Corporation.

(c) Director Qualifications. Directors shall consist of persons who have an interest in the community, and:

(1) are at least eighteen years of age;

(2) possess knowledge, skill and experience relevant to the activities of the Corporation, including business, finance, medicine, and/or community affairs;

(3) have respect and/or high visibility in the community;

(4) demonstrate an interest in health care generally; and

(5) be committed to the mission, philosophy, values, and purposes of the Corporation.

(d) Seventh-day Adventist Church Member. At all times, a majority of the directors shall be members of the Seventh-day Adventist Church.

Section 2: Election.

(a) Directors shall be elected by the Member of the Corporation at the annual meeting.

(b) The directors (except for the Company director(s)) shall be divided into three classes as follows:

(1) The initial term of office of the Class I directors shall be until the 2005 annual meeting of the Member and until their successors shall be elected and have qualified and thereafter shall be for three year terms or until their successors shall be elected and have qualified;

(2) The initial term of office of the Class II directors shall be until the 2006 annual meeting of the Member and until their successors shall be elected and have qualified and thereafter shall be for three year terms or until their successors shall be elected and have qualified; and

(3) The initial term of office of the Class III directors shall be until the 2007 annual meeting of the Member and until their successors shall be elected and have qualified and thereafter shall be for three years and until their successors shall be elected and have qualified.

If the number of directors is changed, any increase or decrease shall be apportioned among the classes so as to maintain or attain, if possible, the equality of the number of directors in each class. If such equality is not possible, the increase or decrease shall be apportioned among the classes in such a way that the difference in the number of directors in any two classes shall not exceed one.

Section 3: Nominations. Nominations of individuals to serve as directors of the Corporation shall be made by a Nominating Committee as established in these Bylaws.

Section 4: Absence from Meetings. Any director absent from more than one-third of the meetings during the preceding year may be removed as director by vote of the Member at any annual meeting.

Section 5: Vacancies. At any time, the Member shall have the power to fill all vacancies among directors due to death, resignation or other cause.

Section 6: Removal. Directors of the Corporation may be removed with or without cause by a majority vote of the Member.

Section 7: Regular Meetings. Unless otherwise ordered by the Chair of the Board, regular meetings of the Board of Directors shall be held at least four (4) times a year, approximately quarterly. There shall be ten (10) days written notice by mail of all regular meetings of the Board.

Section 8: Special Meetings. Special meetings of the Board of Directors may be called by the Chair of the Board of Directors and shall be called by the Chair at the request of any two (2) officers of the Board or at the written request of three (3) directors. Written notice by mail of any special meeting shall be given to each director ten (10) days prior to the date of the meeting. Such notice shall set forth the business to be transacted at the special meeting and any actions taken at such meetings shall be limited to the business set forth in the notice.

Section 9: Waiver of Notice. Notice under this Article III shall be waived if the person who is entitled to notice: 1) before or after the meeting, signs a waiver of notice which is filed with the records of the meeting; or 2) is present at the meeting.

Section 10: Quorum. Fifty percent (50%) of the directors qualified to vote shall constitute a quorum for the transaction of business at all meetings of the Board of Directors, but if less than such number is present at a meeting, a majority of the directors present may adjourn the meeting without further notice.

Section 11: Majority Vote. An affirmative vote of a majority of those present shall be necessary for the passage of any resolution.

Section 12: Action Without Meeting. Any action that may be taken at any annual or special meeting of the Board of Directors may be taken without a meeting if a consent in writing, setting forth the action so taken, shall be signed by all the directors.

Section 13: Telephone Conference. Members of the Board of Directors may participate in a meeting by means of a conference telephone or similar communications equipment if all persons participating in the meeting can hear and speak to each other at the same time. Participation in a meeting by these means constitutes presence in person at the meeting.

Section 14: Compensation of directors. Nothing herein contained shall be construed to preclude any director from serving the Corporation, one of its affiliated corporations, or the sponsoring Church in any other capacity as an officer, agent, employee, or otherwise, and receiving compensation therefore.

Section 15: Officers of the Board of Directors. The officers of the Board of Directors shall be a Chair, a Vice Chair, and a Secretary.

(a) Chair. The Chair shall preside at all meetings of the Board of Directors and shall be an ex officio member of all standing and special committees. The Chair shall be selected by the Member.

(b) Vice Chair. The Vice Chair shall, during the absence or disability of the Chair, or during a vacancy in the office of Chair, have all the powers to perform the duties of Chair as set forth in these Bylaws. The Vice Chair shall be appointed by the Chair.

(c) Secretary. The Secretary shall take or cause to be taken the minutes of the meetings of the Board of Directors and issue the notices required by these Bylaws. The Secretary shall be appointed by the Chair.

All officers of the Board of Directors shall hold office for one year or until his/her successor is appointed.

ARTICLE IV
OFFICERS OF THE CORPORATION

Section 1: Officers of Corporation. The officers of the Corporation shall be: a President; a Treasurer; a Secretary; and, if the Board so determines, one or more Vice Presidents, Assistant Secretaries, Assistant Treasurers, and other officers. The officers of the Corporation need not be members of the Board of Directors. One person may be elected to serve in more than one capacity, except that the same individual may not serve as President and Secretary. The President shall be appointed by the Member, after the review and consultation of the Board of Directors. The other officers shall be appointed by the President. All officers shall hold office for one year and/or until their successors are elected and qualified.

Section 2: President. The President shall exercise general supervision over the Corporation's affairs and be, by virtue of his/her office, a member of all standing, working, and special committees. The President's authority shall include power to sign instruments and documents, bank signature cards and similar papers, and to act as attorney-in-fact when authorized on behalf of the Corporation. The President shall perform such other duties as may be required by these Bylaws or by the Board of Directors.

Section 3. Treasurer. The Treasurer of the Corporation shall examine the monthly financial reports and the books of account and see that they are kept in a manner which shall disclose properly assets and liabilities, income and expense of the Corporation. The Treasurer shall make regular reports to the Board of Directors, showing the financial condition of the Corporation. The Treasurer shall submit to the annual meeting of the Member a full financial report for the preceding annual fiscal period. The Treasurer shall perform such other duties as may be required by these Bylaws or by the Board of Directors.

Section 4: Secretary. The Secretary shall be the custodian of all the Corporation's papers, contracts, agreements, and documents. As may be requested, the Secretary or the Secretary's designated Assistant Secretary shall attest to all deeds and other papers authorized to be executed by the Board of Directors, and shall when authorized affix thereto the Seal of the Corporation, which Seal shall be in his/her custody. The Secretary shall also perform such other usual and customary duties as may be required by these Bylaws or by the Board of Directors.

Section 5: Vacancies. The President shall have the power to fill all vacancies among the officers of the Corporation.

ARTICLE V
COMMITTEES OF THE BOARD OF DIRECTORS

Section 1: Committee Functions. Committees of the Board of Directors shall be standing, working or special. The Chair of the Board of Directors shall appoint the members of each standing , working or special committee and a committee chair. At committee meetings, a quorum shall be the presence of one-half of the number of members of the committee. Committee members may participate in a committee meeting by means of a conference telephone or similar communications equipment if all persons participating in the meeting can hear and speak to each other at the same time; participation in a committee meeting by these means constitutes presence in person at the meeting. Each committee meeting shall have an agenda and shall submit minutes of its meetings to the Board of Directors. All committee members shall serve for a term of one year or until their successors are appointed and qualified.

Section 2. Standing Committees. Standing committees shall be a Finance & Audit Committee, a Compensation Committee, a Community Benefit Committee, and a Nominating Committee.

(a) Finance & Audit Committee. The Finance & Audit Committee shall be concerned with all financial matters of the Corporation. The Finance & Audit Committee shall include the Board Officers, a physician Board member, as well as such others as the Chair of the Board of Directors shall appoint. The President shall be a permanent invitee to all meetings of the Finance & Audit Committee.

(b) Compensation Committee. The Compensation Committee shall be concerned with the management of the basic compensation, incentive payments and benefit programs of senior management. The committee shall provide a report to the Board on such frequency as requested by the Board regarding the matters reviewed and actions taken by the Committee. The Committee shall not include board members who have a conflict of interest with any proposed compensation arrangement to be discussed by the Committee. This Committee shall perform its duties consistent with the Corporation's Conflict of Interest Policy as set forth in Article VI hereto.

(c) Community Benefit Committee. The Community Benefit Committee shall be concerned with the delivery of community benefits by the Corporation. The Committee shall perform an ongoing assessments of the needs of the community and the programs that the Corporation can offer to meet those needs.

(d) Nominating Committee. The Nominating Committee shall be concerned with the identification and nomination of appropriate individuals to the Board of Directors. The Board Officers shall sit on the Nominating Committee as non-voting members. This committee shall review the qualifications of all prospective directors and shall nominate, in good faith, one or more candidates for each vacancy as it occurs. The Nominating Committee shall submit a report of its nominations for directors to be voted upon by the Member. At any time, the Member shall evaluate each nominee and conduct the election of directors in good faith.

Section 3. Working Committees. The Board of Directors may authorize and appoint working committees to address matters of ongoing concern. Working committees may consist of directors and non-directors, such as physicians; however, they shall not be committees of the Corporation's Board of Directors within the meaning of Section 2-411 of the Corporations and Associations Article of the Annotated Code of Maryland. All committees engaging in performance improvement, quality improvement, or peer review, constitute medical review committees within the meaning of Section 14-501 of the Health Occupations Article of the Annotated Code of Maryland.

Section 4: Special Committees. Special committees shall be appointed by the Chair of the Board of Directors, as the occasion demands and may include non-board members. A special committee shall limit its activities to the accomplishment of the task for which it is appointed and shall have no power to act except as specifically conferred by action of the Board of Directors. Upon completion of the task for which appointed, such special committee shall stand discharged.

ARTICLE VI
CONFLICTS OF INTEREST

Section 1: Disclosure. Any director (a "Disclosing Director") who determines he or she may have any duality of interest or possible conflict of interest shall promptly disclose that duality or conflict to the other directors and make such disclosure a matter of record by communicating in writing to the Chair of the Board. Annually, each director shall make a written disclosure of all personal financial interests that may result in a conflict of interest with his or her obligations as a director.

Section 2: Participation in Decision. Any Disclosing Director shall not vote or use his/her personal influence on the matter, and he/she shall not be counted in determining the quorum for the meeting, even when permitted by law. The minutes of the meeting shall reflect that all disclosures made, the abstention from voting by the Disclosing Director, and the quorum following exclusion of the Disclosing Director.

Section 3: Participation in Debate. The foregoing requirements shall not be construed as preventing the Disclosing Director from briefly stating his/her position in the matter, nor from answering pertinent questions of other directors since his/her knowledge may be of great assistance.

Section 4: Dissemination of Policy. The Board of Directors shall adopt a Conflicts of Interest Policy that includes at least the provisions set forth in these Bylaws. Any new director will be advised of this Policy upon entering on the duties of his/her office.

ARTICLE VII
MANAGEMENT

Section 1: Administration. All of the businesses of the Corporation shall be managed at all times in compliance with the mission of the Corporation. In addition to the duties set forth in Article IV of these Bylaws, the Administrator shall be the representative of the Board of Directors in the management of the businesses of the Corporation and shall act as the duly authorized representative of the Board of Directors in all matters in which the Board of Directors has not formally designated some other person to act.

Section 2: Authority of the Administrator. In addition to the authority set forth in Article IV of these Bylaws, the authority and responsibility of the Administrator shall include:

(a) Developing and submitting to the Board of Directors for approval plans of general organization for the conduct of operations of the Corporation;

(b) Preparing annual budgets showing the expected revenue and expenditures as required by the Board of Directors;

(c) Selecting, employing, controlling and discharging employees and developing and maintaining personnel policies and practices for the Corporation;

(d) Maintaining physical properties in a good and safe state of repair and operating condition;

(e) Supervising business affairs to ensure that funds are collected and expended to the best possible advantage;

(f) Working continually with other health care professionals to the end that high quality care is rendered to the patients at all times, including, but not limited to, the establishment of a process for prompt resolution of patient grievances;

(g) Preparing periodic reports reflecting the professional services and financial activities of the various businesses of the Corporation and such reports as may be required by the Board of Directors;

(h) Preparing plans for the achievement of the Corporation's specific objectives and periodically reviewing and evaluating those plans;

(j) Representing the Corporation in its relationships with other health agencies; and

(k) Performing other duties that may be necessary or in the best interests of the Corporation.

ARTICLE VIII
MISCELLANEOUS

Section 1: Indemnification. As used in this Article VIII, any word or words defined in Section 2-418 of the Corporation and Associations Article of the Annotated Code of Maryland, as amended ("Indemnification Section"), shall have the same meaning as provided in the Indemnification Section. The Corporation shall indemnify a director, officer, employee or agent of the Corporation in connection with a proceeding to the fullest extent permitted by and in accordance with the Indemnification Section. Such right of indemnification shall be in addition to, and not in restriction or limitation of, any other privileges or power which the Corporation may have with respect to the indemnification or reimbursement of directors, officers, agents or employees. Such right of indemnification shall apply retroactively and to potential liabilities incurred prior to the date of the adoption of this Bylaw.

Section 2: Checks. All checks, drafts or other orders for payment of money, notes or other evidences of indebtedness, issued in the name of or payable to the Corporation, shall be signed or endorsed by such person or persons and in such manner as shall be determined by resolution of the Board of Directors.

Section 3: Execution of Legal Documents. The officers of the Corporation may sign any deeds or mortgages or other legal documents under authority given them by the Board of Directors. Unless so authorized by the Board of Directors, no officer, agent or employee shall have any power or authority to bind the Corporation by any contract or engagement or to pledge its credit or to render it liable for any purpose in any amount.

Section 4: Securities. The officers of the Corporation are authorized to vote, represent and exercise on behalf of the Corporation all rights incident to any and all voting securities of any other corporation or corporations standing in the name of the Corporation. The authority granted by these Bylaws to the officers to vote or represent the Corporation arising from any voting securities held by the Corporation or any other corporation or corporations may be exercised by

the officers in person or by any person authorized so to do by proxy or power of attorney duly executed by the officer.

Section 5: Records. The Corporation shall keep correct and complete books and records of account, and shall also keep the minutes of the proceedings of the Member, the Board of Directors, and committees having any of the authority of the Board of Directors; and shall keep at its registered office or principal office a record giving the names and addresses of the directors and the Member entitled to vote. All books and records of the Corporation may be inspected by any Member or director, and by the agent or attorney of any such Member or director, for any proper purpose at any reasonable time in accordance with Maryland law.

Section 6: Audited Financial Report. The President shall cause an annual audited financial report to be submitted to the Board no later than one hundred eighty (180) days after the close of the each fiscal year of the Corporation containing such information as shall be specified by the Board of Directors.

Section 7: Fiscal Year. The Board of Directors shall have the power to fix and change the fiscal year of the Corporation.

ARTICLE IX
REVIEW/AMENDMENT OF BYLAWS

The Board of Directors shall have the power and authority to amend, alter or repeal these Bylaws or any provision thereof, and may make additional Bylaws, subject to the consent of such by the Member pursuant to Article II, Section 2(a) hereof.

The foregoing Bylaws were approved by the Board of Trustees of Adventist HealthCare, Inc., on July 18, 2013

Secretary
Board of Trustees
Adventist HealthCare, Inc.

EXHIBIT 6

RULES AND REGULATIONS OF THE GOVERNING BOARD OF

Washington Adventist Hospital

The Governing Board of Washington Adventist Hospital (the "Hospital") hereby adopts the following Rules and Regulations.

PURPOSE

The purpose of the Governing Board is to recommend and implement Hospital policy, promote performance improvement, provide quality patient care, and provide for organizational management and planning of the Hospital.

STRUCTURE

The Hospital is owned and operated by Adventist HealthCare, Inc., a Maryland nonprofit corporation (the "Corporation").

ARTICLE I
THE GOVERNING BOARD
FUNCTIONS AND DUTIES

The functions and duties of the Governing Board (hereinafter referred to collectively as the "Governing Board" or individual members as "Member") shall be as directed from time to time by the Board of Trustees of the Corporation (hereinafter "Board of Trustees"), consistent with the standards of the Joint Commission on Accreditation of Healthcare Organizations (hereinafter "JCAHO"), and applicable laws and regulations. Such functions shall include, but not be limited to, those stated below.

ARTICLE II
GOVERNING BOARD - STRUCTURE AND PROCEDURES

Section 1. **Composition**. The Governing Board shall be appointed by the Board of Trustees and shall be composed of no more than seventeen (17) members, including the CEO of the Corporation, who will serve as Chair, the Hospital President/COO; the Executive Vice President of General Administration for the Corporation; the CFO of the Corporation; the President and President-elect of the Medical Staff of the Hospital ("Medical Staff"); an appointee of the Chair of the Board of Trustees of the Corporation; representatives of the community served by the Hospital,

one of which shall be the president of the Hospital Foundation; and physicians on the Medical Staff (the "Community Members").

Section 2. **Appointment**. Subject to Section 4 below, members of the Governing Board, except those members whose terms will not then be expiring, shall be appointed annually by the Board of Trustees or its designee. Members shall serve until their resignation, removal or other disqualification from service or until their respective successors are appointed.

Section 3. **Conflict of Interest**. The Governing Board shall develop and implement a written Conflict of Interest Policy that provides for full disclosure of the ownership and control of the Hospital and of any health care delivery organizations that are corporately and functionally related to the Hospital. The policy shall include guidelines for the resolution of any existing or apparent conflict of interest. All Governing Board members shall be required to disclose possible conflicts of interest prior to their appointment to the Governing Board and periodically throughout their term(s).

Section 4. **Terms of Service.** Service on the Governing Board shall be in accordance with the following provisions:

a. **Staggered Terms**. Members shall serve staggered terms so that approximately one-third of the members complete their terms as of the end of any given "Governing Board Year"(as defined below). Newly appointed or reappointed members shall serve three-year terms except when the appointment fills a vacancy as to which less than three years remain. Solely for the purpose of the initial appointment of the Community Members, one-third (1/3) of the Community Members will serve an initial term of one (1) year, one-third of the Community Members will serve of an initial term of two (2) years, and one-third (1/3) of the Community Members will serve an initial term of three (3) years. Notwithstanding anything in this Section 4 to the contrary, the Board of Trustees may at any time increase, decrease or otherwise adjust the term(s) of any Governing Board member as the Board of Trustees, in its sole discretion, deems necessary or desirable.

b. **Governing Board Year**. The Governing Board Year shall be the same as the calendar year.

c. **Service of Governing Board Year**. For purposes of this Section 4, service during any part of a Governing Board Year shall be deemed service for a full Governing Board Year, whether such partial service results from being appointed to fill out an unexpired term or from any other cause.

d. **Nominations, Recommendations and Appointment**. Prior to the first day of the new Governing Board Year, the Governing Board shall submit to the Board of Trustees, or its designee, the Governing Board's recommendations regarding appointment or reappointment. The Board of Trustees, or its designee, shall consider said recommendations and make appointments and reappointments prior to or as of the end of the term of the incumbents whose terms are then expiring.

e. **Maximum Consecutive Service**. The maximum number of Governing Board Terms which may be served, after which the member shall be ineligible for appointment until at least one (1) year of nonmembership has elapsed, is as follows:

(1) For the ex-officio members: No limit.

(3) For all other members: Two (2).

Section 5. **Resignation and Removal**.

a. **Resignation**. Any member may resign by written notice to the Chair of the Governing Board or the Hospital CEO effective at the time specified in the notice.

b. **Removal**. Any member of the Governing Board may be removed, with or without cause, at any time by the Board of Trustees.

c. **Attendance at Meetings**. Absence of a member from two (2) or more consecutive meetings, without cause, may constitute grounds for the removal of the member. Each member of the Governing Board shall attend at least three (3) regular Governing Board meetings in each Governing Board Year, unless excused by the Chair for good cause. Except in emergencies, a Governing Board member shall notify the Chair or his designee in advance of any meeting from which said member will be absent, to obtain an excused absence. Failure to meet the foregoing attendance requirement may result in the removal of the member from the Governing Board by the Board of Trustees.

Section 6. **Vacancies**. All vacancies on the Governing Board shall be filled by the Board of Trustees after considering the recommendation, if any, of the Governing Board.

Section 7. **Regular Meetings**. Regular meetings of the Governing Board shall be held quarterly at the Hospital or at such other place as may be designated by the Board of Trustees or the Governing Board.

Section 8. **Other Representation at Governing Board Meetings**. The Governing Board recognizes that one or more members of the Board of Trustees shall be entitled to attend each regular and special meeting of the Governing Board, without voting rights.

Section 9. **Special Meetings**. Special meetings may be called by the Chair of the Governing Board at his discretion, by the Vice Chair in the Chair's absence, or if requested for good cause and a majority of the Governing Board members. Members shall be given written or oral notice of such special meetings, as time permits.

Section 10. **Waiver of Notice**. The transaction of any meeting of the Governing Board, however called and noticed or wherever held, shall be as valid as a meeting duly held after regular call and notice if a quorum is present and if, either before or after the meeting, each of the members not present signs a written waiver of notice, a consent to hold such meeting, or an approval of the minutes thereof. All such waivers, consents or approvals shall be filed with the Governing Board records or made part of the minutes of the meeting.

Section 11. **Quorum**. A majority of the voting members of the Governing Board shall constitute a quorum for the transaction of business, and the action of a majority of the voting Governing Board members present at any meeting at which there is a quorum, when duly assembled, is valid.

Section 12. **Adjournment**. If a quorum is not present at any Governing Board meeting, the members present may adjourn the meeting from time to time, without notice other than announcement at the meeting, until a quorum is present. Notice of the time and place of an adjourned meeting need not be given to absent members if the time and place is fixed at the adjourned meeting, except as provided in the next sentence. If the meeting is adjourned for more than twenty-four (24) hours, notice of any adjournment to another time or place shall be given prior to the time of the adjourned meeting to the members who were not present at the time of the adjournment.

Section 13. **Action Without Meeting**. Any action required or permitted to be taken by the Governing Board may be taken without a meeting if all voting members of the Governing Board individually or collectively consent in writing to such action. Such written consent or consents shall have the same force and effect as a unanimous vote of the Governing Board and shall be filed with the minutes of the proceedings of the Governing Board. A telegram, telex, cablegram or similar transmission by a Governing Board member, or a photographic, photostatic, facsimile or other similar reproduction of a writing signed by a member, shall be regarded as signed by the member for the purposes of this Section.

Section 14. **Compensation**. Each member of the Governing Board will not receive compensation for his/her participation on the Governing Board.

Section 15. **Meetings by Telephone**. Any regular or special meeting of the Governing Board may be held by means of telephone conference call or similar communication equipment, provided that all persons participating in the meeting can hear and communicate with each other.

Section 16. **Minutes.** The Governing Board shall keep, or cause to be kept, and maintain regular minutes of their proceedings.

Section 17. **Construction**. If any provision of these Rules and Regulations shall be held illegal, invalid or inoperative, then, so far as is reasonable and possible (a) the remainder of the Rules and Regulations shall be and remain legal, valid and operative and (b) effect shall be given the intent

manifested by the provision held illegal, invalid or inoperative and to that end, such illegal, invalid or inoperative provision shall be deemed to have been replaced by a provision that is as similar to such illegal, invalid or inoperative provision as possible and still be legal, valid and operative.

Section 18. Preeminence. To the extent that any provision of these Rules and Regulations is inconsistent with any provision of the Corporation□s bylaws, the provision of the Corporate bylaws shall govern.

Section 19. Emergencies. Notwithstanding any other provision of these Rules and Regulations to the contrary, during an emergency period following major catastrophe resulting in the loss by death, mental or physical incapacity or otherwise, or the isolation of members of the Governing Board, a majority of the remaining members (who have not been rendered incapable of acting by death, physical or mental incapacity, isolation or otherwise) shall constitute a quorum of the Governing Board. During such emergency period reasonable attempts shall be made to give notice to members, but actions taken at a meeting held during such period shall not be rendered invalid solely because of failure to give notice as otherwise required.

ARTICLE III
OFFICERS OF THE GOVERNING BOARD

Section 1. Officers. The officers of the Governing Board shall include a Chair, a Vice-Chair and a Secretary. The Chair shall be the CEO of the Corporation; the Vice Chair shall be the appointee of the Chair of the Board of Trustees of the Corporation; and the Secretary shall be the President/COO of the Hospital. The officers shall perform the duties customarily associated with their offices or as specifically assigned by the Governing Board.

Section 2. Resignation and Removal.

a. **Resignation**. Any officer may resign by written notice to the Chair of the Governing Board or the Hospital President /COO at the time specified in the notice.

b. **Removal**. The Board of Trustees may, at any time, with or without cause, remove any officer.

Section 3. Vacancies. A vacancy in any office because of death, resignation, removal, disqualification, or any other cause shall be filled by the Board of Trustees.

Section 4. Chair. The Chair shall preside at all meetings of the Governing Board and shall perform such other duties as may be assigned by the Governing Board.

Section 5. **Vice Chair**. The Vice Chair shall assist the Chair in the conduct of the business of the Governing Board, shall preside at Governing Board meetings in the Chair's absence, and shall perform such other duties as may be assigned by the Governing Board.

Section 6. **Secretary**. The Secretary shall keep, or cause to be kept, a book of minutes for the purpose of recording the proceedings of the Governing Board. The Secretary shall give, or cause to be given, notice of all special meetings of the Governing Board, and shall perform such other duties as may be assigned by the Governing Board.

ARTICLE IV
ORGANIZATION OF THE MEDICAL STAFF

The Governing Board shall organize the physicians and other practitioners granted clinical privileges at the Hospital into a Medical Staff under Medical Staff Bylaws approved by the Governing Board in accordance with Article VI hereof. Each member of the Medical Staff shall have appropriate authority and responsibility for the care of his or her patients, subject to such limitations as are contained in these Rules and Regulations and in the Bylaws, Rules and Regulations of the Medical Staff, and subject to any further limitations attached to his or her appointment.

ARTICLE V
MEDICAL STAFF APPOINTMENTS

Section 1. **Governing Board Authority**. The Governing Board shall have authority and responsibility for all appointments and reappointments of Medical Staff members and assignment of clinical privileges in accordance with the Medical Staff Bylaws, Rules and Regulations.

Section 2. **Standards and Procedures for Consideration of Applications**. The standards and procedures adopted by the Governing Board shall be applied by the Hospital and its Medical Staff in considering and acting upon applications for staff membership and clinical privileges.

Section 3. **General Policy**. The Governing Board shall consider the Medical Staff recommendations in the exercise of the Governing Board's authority to appoint members of the Medical Staff. Whenever a Governing Board decision is not in accordance with the last recommendation or action of the Medical Staff, the matter shall be resolved as follows:

a. In matters involving membership and/or clinical privileges of Medical Staff members, or clinical privileges of other health care professionals, the Governing Board shall submit the matter to a joint committee for review and recommendation. Such committee, unless otherwise required by law or the Medical Staff Bylaws, shall consist of two Medical Staff members (who are not Governing Board members) chosen by the Chair or Chief of the Medical Staff and three

Governing Board members chosen by the Chair of the Governing Board. The committee shall make its review and recommendation to the Governing Board within forty-five (45) days of submission of the matter to the committee from the Governing Board. Thereafter the Governing Board shall render its final decision in the matter and shall communicate this final decision to the Medical Staff Executive Committee and any directly affected practitioner, consistent with the Medical Staff Bylaws.

b. In all other matters, the Governing Board may, in its sole discretion, either (i) refer the matter, on terms as it may direct, to a joint committee such as described above or to the Governing Board Planning Committee, if any, as specified under Article VIII Section 4 hereinbelow, or (ii) decide the matter otherwise as it deems best. If the matter is referred to a committee, such committee shall report back within such time specified by the Governing Board, after which time the Governing Board may render its final decision.

Section 4. Hearing Procedures; Health Practice Matters; Final Decision. The Governing Board shall be the official body to render final decisions in Medical Staff hearing and appeal procedures at the Hospital, and in all other decisions affecting staff membership, privileges, categories of other health professionals allowed to practice in the Hospital, enforcement of these Rules and Regulations, the Medical Staff Bylaws, Rules and Regulations and the policies of the Governing Board, and establishment of overall policies in operating the Hospital.

Section 5. Medico-Administrative Officials. From time to time, the Hospital may engage one or more physicians as medico-administrative officials under such terms and conditions as are specified in an engagement agreement. The engagement agreement shall require that any such medico-administrative official be a member of the Medical Staff. Further, the official's membership and privileges shall be processed and delineated on the basis of the qualifications set forth in the standards adopted by the Governing Board, primarily the Medical Staff Bylaws. Unless otherwise provided in the engagement agreement, neither the Medical Staff membership nor privileges of a medico-administrative official shall be terminated without the same hearing and appellate review opportunities as are provided for other members of the Medical Staff.

ARTICLE VI
MEDICAL STAFF BYLAWS

There shall be Bylaws, Rules and Regulations for the Medical Staff which set forth its organization and government. Ordinarily, proposed Bylaws, Rules and Regulations shall be recommended by the Medical Staff for adoption by the Governing Board. The Governing Board may, at any time, initiate proposals for Bylaws, Rules and Regulations, or amendments thereto, and the Governing Board shall present these proposals to the Medical Staff for review and comment.

ARTICLE VII
QUALITY OF PROFESSIONAL SERVICES

AND PATIENT CARE EVALUATION

Section 1. **General Policy**. The Governing Board shall, in the exercise of its overall responsibility, assign to the Medical Staff reasonable authority to ensure appropriate professional care to Hospital patients. Subject to limitations of these Rules and Regulations and the Bylaws, Rules and Regulations of the Medical Staff, and subject further to any limitations attached to an individual's appointment or engagement, only an individual permitted by law to provide patient care services independently and without direction or supervision, or a member of the house staff or other allied health professionals acting under the supervision of a licensed practitioner with clinical privileges, may provide direct medical care to patients. Governing Board ratification is required prior to the delegation to allied health professionals of the responsibility for performance of certain practices related to medicine.

Section 2. **Medical Care Evaluation Reports.** The Governing Board shall require, consider, and if necessary act upon, Medical Staff reports of medical care evaluation, utilization review and other matters relating to the quality of care rendered in the Hospital. The executive committee of the Medical Staff shall, through its Chair or his designee, cause the preparation and presentation of such required reports to the Governing Board at each Governing Board meeting or otherwise. The Hospital President/COO shall provide the Medical Staff with the necessary administrative assistance to facilitate such reporting, regular analysis of the clinical practice, and utilization review activities within the Hospital.

Section 3. **JCAHO and Legal Requirements.** The Governing Board shall direct that all reasonable and necessary steps be taken by the Medical Staff and Hospital administration for meeting JCAHO accreditation standards and complying with applicable laws and regulations. If requested by the Hospital President/COO, Governing Board members shall participate in JCAHO summation conferences unless excused for good cause. The Governing Board shall take all reasonable steps to comply with all applicable federal, state and local laws and regulations.

ARTICLE VIII
GOVERNING BOARD OPERATION

Section 1. **General Functions**. The Governing Board shall have responsibility for the business and affairs of the Hospital to the extent delegated by the Board of Trustees. The Governing Board shall delegate responsibility and authority for the day-to-day management of the Hospital to the Hospital President/COO.

Section 2. **Committees**.

a. **Designation**. The Governing Board, at its discretion, may designate one (1) or more committees, each of which shall be composed of two (2) or more members, to serve at the pleasure of the Governing Board. The Governing Board may designate one (1) or more members as

alternate members of any committee. With respect to any committees that review issues affecting the discharge of Medical Staff responsibilities, those committees must include Medical Staff members.

b. **Delegation**. The Governing Board may delegate to any such committee any of the Governing Board's powers and authority except for amending these Rules and Regulations.

c. **Proceedings**. The Governing Board may prescribe appropriate rules, not inconsistent with these Rules and Regulations, by which proceedings of any such committee shall be conducted. The provisions of these Rules and Regulations relating to notice of meetings of the Governing Board and waiver of such notice, adjournments of meetings of the Governing Board, written consents to Governing Board meetings and approval of minutes, action by the Governing Board by consent in writing without a meeting, the place of holding meetings, the quorum for meetings, the vote required at such meetings, and the withdrawal of members after commencement of a meeting shall apply to committees of the Governing Board and action by such committees. In addition, any member of the Governing Board acting as the Chair or as Secretary of the committee or any two (2) members of the committee may call meetings of the committee. Regular meetings of any committee may be held without notice if the time and place of such meetings are fixed by the Governing Board or the committee.

Section 3. **Medico-Administrative Liaison**. The Hospital President/COO shall function as a liaison between the Governing Board and the Medical Staff.

Section 4. **Planning Function**. The Governing Board shall participate in and support an institutional planning process to periodically evaluate the Hospital's goals, policies and programs. At the Governing Board's discretion, this planning function may be performed by a committee (the "Governing Board Planning Committee") which includes representatives of the Governing Board, administration, nursing, other appropriate advisers, and the Medical Staff.

Section 5. **Performance Improvement (PI).** The Governing Board shall require the Medical Staff and staffs of the Hospital departments/services to implement and report on the activities and mechanisms for monitoring and evaluating the quality of patient care, for identifying opportunities to improve patient care, and for identifying and resolving problems. The Governing Board, through the Hospital President/COO, shall support these activities and mechanisms. The Governing Board shall provide for resources and support systems for the quality assessment and improvement and risk management functions related to patient care and safety. The Governing Board shall consider and, if necessary, act upon the results reported from PI activities, which activities shall strive to satisfy the following objectives: (i) quality patient care provided by members of the medical and allied professional staffs, employees of the Hospital and all others who provide patient care services at this Hospital, (ii) use of planned and systematic procedures to objectively assess the quality of care provided, (iii) implementation of corrective action when problems or opportunities for improvement are identified, and (iv) the provision of one level of patient care throughout the Hospital.

Section 6. **Patient Care**. The Governing Board shall participate in and support an institutional process to periodically review, evaluate, and revise key Hospital policies and procedures to address integrated patient care.

Section 7. **Orientation and Continuing Education.** All members of the Governing Board shall participate in an initial orientation and continuing education programs as part of membership responsibilities. These programs will be provided through the Hospital President/COO as needed, but no less than annually. Initial orientation shall include an explanation of the functions and responsibilities of the Governing Board. Relevant topics for continuing education include the Governing Board's responsibility for the PI program and its effectiveness, and appointment, reappointment and granting privileges to medical and allied professional staff members. If requested by the Chair of the Governing Board, all or any members of the Governing Board from the prior year may be called upon to attend the first Governing Board meeting of the new Governing Board Year as non-voting members for the sole purpose of orienting the new Governing Board members to their responsibilities.

Section 8. **Facility Plans and Budgets.** The Governing Board, together with the Hospital President/COO, shall develop short-term and long-term financial management plans including, but not limited to, annual capital and operating budgets, and a long-range master plan, to the end that the Hospital may effectively serve its community. Such plans shall be submitted to the Board of Trustees or its designee for review and approval.

ARTICLE IX
PRESIDENT/CHIEF OPERATING OFFICER

Section 1. **Appointment**. The CEO of the Corporation or his designee shall appoint a chief operating officer of the Hospital (referred to herein as the "Hospital President/COO") in accordance with such criteria as may be adopted by the Board of Trustees subject to review by the Governing Board.

Section 2. **Qualifications**. The appointed Hospital President/COO shall have the knowledge and skills necessary to perform the duties required of the Hospital's senior leader. Among other criteria, education and relevant experience are important qualifications.

Section 3. **Responsibilities**. The Hospital President/COO shall represent the Hospital in all aspects of its operations. He/she shall make periodic reports to the Governing Board, if any, but his/her line of authority shall derive from the CEO of the Corporation. The duties of the Hospital PRESIDENT/COO shall include but not be limited to the following:

a. **Policies**. Implementation of policies of the Board of Trustees and the Governing Board as approved by the Board of Trustees or its designee, especially those relating to the physical and financial resources of the Hospital.

b. **Liaison**. Liaison among the Board of Trustees, Governing Board, administrative staff and the Medical Staff and between the Hospital and the local community.

c. **Management**. Organization and management of the Hospital and its services, departments and subdivisions, delegation of duties and establishment of formal means of accountability of subordinates.

d. **Compliance with Laws and Regulations**. The Hospital President/COO shall review and act promptly upon the reports of authorized planning, regulatory and inspection agencies and shall report to the Governing Board on the overall activities of, and developments and inspections affecting, the Hospital. The Hospital President/COO shall undertake corrective action for any deficiencies reported by such agencies, and documentation of such corrective action shall be made available to the JCAHO for the Hospital's accreditation survey.

ARTICLE X
PERSONNEL

Section 1. **Policies**. The Personnel Policies of the Hospital shall be reviewed periodically by the Hospital President/COO and Governing Board, but no less often than once a year, and the date of the most recent review shall be indicated on the written policies. A procedure shall be established for notifying employees of personnel policies and changes thereto.

Section 2. **Conflict Resolution Process**. The Governing Board shall participate in and support a conflict resolution process for resolving conflicts between the Governing Board and the individuals under the Governing Board's leadership. The Governing Board shall periodically meet to review the effectiveness of this process and recommend any revisions to the Board of Trustees.

ARTICLE XI
VOLUNTEER ORGANIZATIONS

Section 1. **Hospital Auxiliary**. The Governing Board may authorize the formation and continuing operation of a volunteer auxiliary. The auxiliary shall develop and adopt an organizational structure and bylaws, rules and regulations. The auxiliary's bylaws, rules and regulations shall become effective when approved by the Governing Board. The Governing Board shall, within a reasonable time after the submission of the auxiliary's bylaws, rules and regulations to the Governing Board for approval, review such documents and either approve the same or notify the appropriate auxiliary personnel of deficiencies in such documents. The Governing Board or its

representative shall submit to the auxiliary any required changes in such documents and may appoint a representative to assist the organization in the preparation of acceptable documents. Upon receipt of acceptable documents, the Governing Board shall, within a reasonable time, grant approval of the auxiliary's bylaws, rules and regulations.

Section 2. **Other Volunteer Services**. The Hospital President/COO or his designee shall be responsible for the establishment of a mechanism for controlling the activities of individuals or organized groups who perform volunteer services in the Hospital, but who are not in the status of Hospital auxiliary personnel.

ARTICLE XII
REVIEW OF DOCUMENTS

Section 1. **General.** At least every two (2) years, the Governing Board shall review these Rules and Regulations and the Bylaws, Rules and Regulations of the Medical Staff of the Hospital. Necessary changes shall be made in such documents in accordance with the amendment procedures set forth therein. Such documents shall be dated to indicate the time of the last review.

Section 2. **Professional Service Contracts.** The Governing Board shall periodically review the quality of service rendered by hospital-based physicians and other professional service contractors. The Governing Board shall also review and make recommendations on any contractual matter referred to it by the Board of Trustees. The CEO of the Corporation, through the Hospital President/COO or other designee, shall have final authority with respect to all contracts affecting the Hospital.

ARTICLE XIII
PATIENTS' BILL OF RIGHTS

The Governing Board hereby adopts the Statement on Patients'Rights of the JCAHO as its own statement on the rights of patients.

ARTICLE XIV
EVALUATION OF PERFORMANCE

The Governing Board shall evaluate its own performance by comparing its performance to the JCAHO standards on an annual basis.

ARTICLE XV
INSURANCE

The Corporation will include members of the Governing Board as insured persons under the appropriate general and professional and/or Trustees and officers liability insurance coverage.

ARTICLE XVI
INDEMNIFICATION

The Corporation shall, to the maximum extent permitted by law, indemnify each of the Governing Board members against expenses, judgments, fines, settlements, and other amounts actually and reasonably incurred in connection with any proceedings arising by reason of the fact that such person is or was a member of the Governing Board; provided that the Governing Board member acted within the scope of his or her duties, in good faith and in a manner reasonably believed to be in the best interests of the Hospital.

ARTICLE XVII
AMENDMENTS AND ADOPTION

Section 1. **Amendments**. The Governing Board may adopt amendments to these Rules and Regulations, subject to the approval of the Board of Trustees.

Section 2. **Adoption**. The foregoing Rules and Regulations were adopted by the Governing Board on _____, 2010 and supersedes any and all previous Rules and Regulations.

_____
Chair, Governing Board of Washington Adventist Hospital

The foregoing rules and regulations were approved by the Board of Trustees of Adventist HealthCare, Inc., on _____, 2010.

_____
Chair, Board of Trustees of Adventist HealthCare, Inc.

EXHIBIT 7

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Financial Assistance

(Formerly "Charity Care")

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Effective Date	01/08	Policy No:	AHC 3.19
Cross Referenced:	Previously: Financial Assistance Policy (see AHC 3.19.1 for Decision Rules / Application)	Origin:	PFS / FC
Reviewed:	02/09, 9/19/13, 10/10/17	Authority:	EC
Revised:	05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13, 2/01/16, 11/09/17	Page: 1 of 14	

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FINANCIAL ASSISTANCE POLICY SUMMARY

SCOPE:

This policy applies to the following Adventist HealthCare facilities: Shady Grove Adventist Hospital, Germantown Emergency Center, Washington Adventist Hospital, Adventist Behavioral Health, and Adventist Rehabilitation Hospital of Maryland, collectively referred to as AHC.

PURPOSE:

In keeping with AHC's mission to demonstrate God's care by improving the health of people and communities Adventist HealthCare provides financial assistance to low to mid income patients in need of our services. AHC's Financial Assistance Plan provides a systematic and equitable way to ensure that patients who are uninsured, underinsured, have experienced a catastrophic event, and/or and lack adequate resources to pay for services can access the medical care they need.

Adventist HealthCare provides emergency and other non-elective medically necessary care to individual patients without discrimination regardless of their ability to pay, ability to qualify for financial assistance, or the availability of third-party coverage. In the event that third-party coverage is not available, a determination of potential eligibility for Financial Assistance will be initiated prior to, or at the time of admission. This policy identifies those circumstances when AHC may provide care without charge or at a discount based on the financial need of the individual.

Printed public notification regarding the program will be made annually in Montgomery County, Maryland and Prince George's County, Maryland newspapers and will be posted in the Emergency Departments, the Business Offices and Registration areas of the above named facilities.

This policy has been adopted by the governing body of AHC in accordance with the regulations and requirements of the State of Maryland and with the regulations under Section 501(r) of the Internal Revenue Code.

This financial assistance policy provides guidelines for:

- Financial assistance to self-pay individual patients receiving emergency and other non-elective medically necessary services based on medical necessity and financial need.
- prompt-pay discounts (%) that may be charged to self-pay patients who receive medically necessary services that are not considered emergent or non-elective.
- special consideration, where appropriate, for those individuals who might gain special consideration due to catastrophic care.

BENEFITS:

Enhance community service by providing quality medical services regardless of a patient's (or their guarantors') ability to pay. Decrease the unnecessary or inappropriate placement of accounts with collection agencies when a charity care designation is more appropriate.

DEFINITIONS:

- **Medically Necessary:** health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine
- **Emergency Medical Services**: treatment of individuals in crisis health situations that may be life threatening with or without treatment
- **Non-elective services:** a medical condition that without immediate attention:
    - Places the health of the individual in serious jeopardy
    - Causes serious impairment to bodily functions or serious dysfunction to a bodily organ.
    - And may include, but are not limited to:
        - Emergency Department Outpatients
        - Emergency Department Admissions
        - IP/OP follow-up related to previous Emergency visit
- **Catastrophic Care**: a severe illness requiring prolonged hospitalization or recovery. Examples would include coma, cancer, leukemia, heart attack or stroke. These illnesses usually involve high costs for hospitals, doctors and medicines and may incapacitate the person from working, creating a financial hardship
- **Prompt Pay Discount**: The state of Maryland allows a 1% prompt-pay discount for those patients who pay for medical services at the time the service is rendered.
- **FPL** (Federal Poverty Level): is the set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the

United States, this level is determined by the Department of Health and Human Services.

- **Uninsured Patient**: Person not enrolled in a healthcare service coverage insurance plan. May or may not be eligible for charitable care.
- **Self-pay Patient**: an Uninsured Patient who does not qualify for AHC Financial Assistance due to income falling above the covered FPL income guidelines

POLICY

1. General Eligibility

1.1. All patients, regardless of race, creed, gender, age, sexual orientation, national origin or financial status, may apply for Financial Assistance.

1.2. It is part of Adventist HealthCare's mission to provide necessary medical care to those who are unable to pay for that care. The Financial Assistance program provides for care to be either free or rendered at a reduced charge to:

1.2.1. those most in need based upon the current Federal Poverty Level (FPL) assessment, (i.e., individuals who have income that is less than or equal to 200% of the federal poverty level (See Attachment A for current FPL).

1.2.2. those in some need based upon the current FPL, (i.e., individuals who have income that is between 201% and 600% of the current FPL guidelines

1.2.3. patients experiencing a financial hardship (medical debt incurred over the course of the previous 12 months that constitutes more than 25% of the family's income), and/or

1.2.4. absence of other available financial resources to pay for urgent or emergent medical care

1.3. This policy requires that a patient or their guarantor to cooperate with, and avail themselves of all available programs (including those offered by AHC, Medicaid, workers compensation, and other state and local programs) which might provide coverage for services, prior to final approval of Adventist HealthCare Financial Assistance.

1.4. **Eligibility for Emergency Medical Care:** Patients may be eligible for financial assistance for Emergency Medical Care under this Policy if:

1.4.1. They are uninsured, have exhausted, or will exhaust all available insurance benefits; and

1.4.2. Their annual family income does not exceed 200% of the current Federal Poverty Guidelines to qualify for full financial assistance or 600% of the current Federal Poverty Guidelines for partial financial assistance; and

1.4.3. They apply for financial assistance within the Financial Assistance Application Period (i.e. within the period ending on the 240th day after the first post-discharge billing statement is provided to a patient).

1.5. **Eligibility for non-emergency Medically Necessary Care:** Patients may be eligible for financial assistance for non-emergency Medically Necessary Care under this Policy if:

1.5.1. They are uninsured, have exhausted, or will exhaust all available insurance benefits; and

1.5.2. Their annual family income does not exceed 200% of the current Federal Poverty Guidelines to qualify for full financial assistance or 600% of the current Federal Poverty Guidelines for partial financial assistance; and

1.5.3. They apply for financial assistance within the Financial Assistance Application Period (i.e. within the period ending on the 240th day after the first post-discharge billing statement is provided to a patient) and

1.5.4. The treatment plan was developed and provided by an AHC care team

1.6. **Considerations:**

1.6.1. Insured Patients who incur high out of pocket expenses (deductibles, co-insurance, etc.) may be eligible for financial assistant applied to the patient payment liability portion of their medically necessary services

1.6.2. Pre-approved financial assistance for medical services scheduled past the 2nd midnight post an ER admission are reviewed by the

appropriate staff based on medical necessity criteria established in this policy, and may or may not be approved for financial assistance.

1.7. **Exclusions:** Patients are INELIGIBLE for financial assistance for Emergency Medical Care or other non-emergency Medically Necessary Care under this policy if:

1.7.1. Purposely providing false or misleading information by the patient or responsible party; or

1.7.2. Providing information gained through fraudulent methods in order to qualify for financial assistance (EXAMPLE: using misappropriated identification and/or financial information, etc.)

1.7.3. The patient or responsible party refuses to cooperate with any of the terms of this Policy; or

1.7.4. The patient or responsible party refuses to apply for government insurance programs after it is determined that the patient or responsible party is likely to be eligible for those programs; or

1.7.5. The patient or responsible party refuses to adhere to their primary insurance requirements where applicable.

1.8. **Special Considerations (Presumptive Eligibility)**: Adventist Healthcare make available financial assistance to patients based upon their "assumed eligibility" if they meet on of the following criteria:

1.8.1. Patients, *unless otherwise eligible for Medicaid or CHI*P, who are beneficiaries of the means-tested social services programs listed below are eligible for free care, provided that the patient submits proof of enrollment within 30 days unless a 30 day extension is requested. Assistance will remain in effect as long as the patient is an active beneficiary of one of the programs below:

1.8.1.1. Households with children in the free or reduced lunch program;

1.8.1.2. Supplemental Nutritional Assistance Program (SNAP);

1.8.1.3. Low-income-household energy assistance program;

1.8.1.4. Women, Infants and Children (WIC)

1.8.2. Patients who are beneficiaries of the Montgomery County programs listed below are eligible for financial assistance after meeting the copay requirements mandated by the program, provided that the patient submits proof of enrollment within 30 days unless a 30 day extension is requested. Assistance will remain in effect as long as the patient is an active beneficiary of one of the programs below:

1.8.2.1. Montgomery Cares;

1.8.2.2. Project Access;

1.8.2.3. Care for Kids

1.8.3. Additionally, patients who fit one or more of the following criteria may be eligible for financial assistance for emergency or non-emergency Medically Necessary Care under this policy with or without a completed application, and regardless of financial ability. IF the patient is:

1.8.3.1. categorized as homeless or indigent

1.8.3.2. unable to provide the necessary financial assistance eligibility information due to mental status or capacity

1.8.3.3. unresponsive during care and is discharged due to expiration

1.8.3.4. individual is eligible by the State to receive assistance under the Violent Crimes Victims Compensation Act or the Sexual Assault Victims Compensation Act;

1.8.3.5. a victim of a crime or abuse (other requirements will apply)

1.8.3.6. Elderly and a victim of abuse

1.8.3.7. an unaccompanied minor

1.8.3.8. is currently eligible for Medicaid, but was not at the date of service

For any individual presumed to be eligible for financial assistance in accordance with this policy, all actions described in the "Eligibility" Section

and throughout this policy would apply as if the individual had submitted a completed Financial Assistance Application form.

1.9. **Amount Generally Billed:** An individual who is eligible for assistance under this policy for emergency or other medically necessary care will never be charged more than the amounts generally billed (AGB) to an individual who is not eligible for assistance. The charges to which a discount will apply are set by the State of Maryland's rate regulation agency (HSCRC) and are the same for all payers (i.e. commercial insurers, Medicare, Medicaid or self-pay) with the exception of Adventist Rehabilitation Hospital of Maryland which charges for patients eligible for assistance under this policy will be set at the most recent Maryland Medicaid interim rate at the time of service as set by the Department of Health and Mental Hygiene.

2. **Policy Transparency:** Financial Assistance Policies are transparent and available to the individuals served at any point in the care continuum in the primary languages that are appropriate for the Adventist HealthCare service area.

2.1. As a standard process, Adventist HealthCare will provide Plain Language Summaries of the Financial Assistance Policy

2.1.1. During ED registration

2.1.2. During financial counseling sessions

2.1.3. Upon request

2.2. Adventist HealthCare facilities will prominently and conspicuously post complete and current versions of the Plain Language Summary of the Financial Assistance policy

2.2.1. At all registrations sites

2.2.2. In specialty area waiting rooms

2.2.3. In specialty area patient rooms

2.3. Adventist HealthCare facilities will prominently and conspicuously post complete and current versions of the following on their respective websites in English and in the primary languages that are appropriate for the Adventist HealthCare service area:

2.3.1. Financial Assistance Policy (FAP)

2.3.2. Financial Assistance Application Form (FAA Form)

2.3.3. Plain Language Summary of the Financial Assistance Policy (PLS)

3. Policy Application and Determination Period

3.1. The Financial Assistance Policy applies to charges for medically necessary patient services that are rendered by one of the referenced Adventist HealthCare facilities. A patient (or guarantor) may apply for Financial Assistance at any time within **240 days after the date it is determined that the patient owes a balance.**

3.2. Probable eligibility will be communicated to the patient within 2 business days of the submission of an application.

3.3. Each application for Financial Assistance will be reviewed, and a determination made based upon an assessment of the patient's (or guarantor's) ability to pay. This could include, without limitations the needs of the patient and/or guarantor, available income and/or other financial resources. Final Financial Assistance decisions and awards will be communicated to the patient within 10 business days of the submission of a completed application for Financial Assistance.

3.4. Pre-approved financial assistance for scheduled medical services is approved by the appropriate staff based on criteria established in this policy

3.5. **Policy Eligibility Period:** If a patient is approved for financial assistance under this Policy, their financial assistance under this policy **shall not exceed past 12 months from the date of the eligibility award letter**. Patients requiring financial assistance past this time must reapply and complete the application process in total.

4. **POLICY EXCLUSIONS:** Services not covered by the AHC Financial Assistance Policy include, but are not limited to:

4.1. Services deemed not medically necessary by AHC clinical team

4.2. Services not charged and billed by an Adventist HealthCare facility listed within this policy are not covered by this policy. Examples include, but at are

not limited to; charges from physicians, anesthesiologists, emergency department physicians, radiologists, cardiologists, pathologists, and consulting physicians requested by the admitting and attending physicians.

4.3. Cosmetic, other elective procedures, convenience and/or other Adventist HealthCare facility services which are not medically necessary, are excluded from consideration as a free or discounted service.

4.4. Patients or their guarantors who are eligible for County, State, Federal or other assistance programs will not be eligible for Financial Assistance for services covered under those programs.

4.5. Services Rendered by Physicians who provide services at one of the AHC locations are NOT covered under this policy.

4.5.1. Physician charges are billed **separately** from hospital charges.

Roles and Responsibilities

4.6. **Adventist HealthCare responsibilities**

4.6.1. AHC has a financial assistance policy to evaluate and determine an individual's eligibility for financial assistance.

4.6.2. AHC has a means of communicating the availability of financial assistance to all individuals in a manner that promotes full participation by the individual.

4.6.3. AHC workforce members in Patient Financial Services and Registration areas understand the AHC financial assistance policy and are able to direct questions regarding the policy to the proper hospital representatives.

4.6.4. AHC requires all contracts with third party agents who collect bills on behalf of AHC to include provisions that these agents will follow AHC financial assistance policies.

4.6.5. The AHC Revenue Cycle Function provides organizational oversight for the provision of financial assistance and the policies/processes that govern the financial assistance process.

4.6.6. After receiving the individual's request for financial assistance, AHC notifies the individual of the eligibility determination within a reasonable period of time.

4.6.7. AHC provides options for payment arrangements.

4.6.8. AHC upholds and honors individuals' right to appeal decisions and seek reconsideration.

4.6.9. AHC maintains (and requires billing contractors to maintain) documentation that supports the offer, application for, and provision of financial assistance for a minimum period of seven years.

4.6.10. AHC will periodically review and incorporate federal poverty guidelines for updates published by the United States Department of Health and Human Services.

4.7. **Individual Patient's Responsibilities**

4.7.1. To be considered for a discount under the financial assistance policy, the individual must cooperate with AHC to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for healthcare, such as Medicare, Medicaid, third-party liability, etc.

4.7.2. To be considered for a discount under the financial assistance policy, the individual must provide AHC with financial and other information needed to determine eligibility (this includes completing the required application forms and cooperating fully with the information gathering and assessment process).

4.7.3. An individual who qualifies for a partial discount must cooperate with the hospital to establish a reasonable payment plan.

4.7.4. An individual who qualifies for partial discounts must make good faith efforts to honor the payment plans for their discounted hospital bills. The individual is responsible to promptly notify AHC of any change in financial situation so that the impact of this change may be evaluated against financial assistance policies governing the provision of financial assistance.

5. Identification Of Potentially Eligible Individuals

5.1. Identification through socialization and outreach

5.1.1. Registration and pre-registration processes promote identification of individuals in need of financial assistance.

5.1.2. Financial counselors will make best efforts to contact all self-pay inpatients during the course of their stay or within 4 days of discharge.

5.1.3. The AHC hospital facility's PLS will be distributed along with the FAA Form to every individual before discharge from the hospital facility.

5.1.4. Information on how to obtain a copy of the PLS will be included with billing statements that are sent to the individuals

5.1.5. An individual will be informed about the AHC hospital facility's FAP in oral communications regarding the amount due for his or her care.

5.1.6. The individual will be provided with at least one written notice (notice of actions that may be taken) that informs the individual that the hospital may take action to report adverse information about the individual to consumer credit reporting agencies/credit bureaus if the individual does not submit a FAA Form or pay the amount due by a specified deadline. This deadline cannot be earlier than 120 days after the first billing statement is sent to the individual. The notice must be provided to the individual at least 30 days before the deadline specified in the notice.

5.2. **Requests for Financial Assistance**: Requests for financial assistance may be received from multiple sources (including the patient, a family member, a community organization, a church, a collection agency, caregiver, Administration, etc.).

5.2.1. Requests received from third parties will be directed to a financial counselor.

5.2.2. The financial counselor will work with the third party to provide resources available to assist the individual in the application process.

5.2.3. If available, an estimated charges letter will be provided to individuals who request it.

5.2.4. **AUTOMATED CHARITY PROCESS** for Accounts sent to outsourced agencies: Adventist HealthCare recognizes that a portion of the uninsured or underinsured patient population may not engage in the traditional financial assistance application process. If the required information is not provided by the patient, Adventist HealthCare may employ an automated, predictive scoring tool to qualify patients for financial assistance. The Payment Predictability Score (PPS) predicts the likelihood of a patient to qualify for Financial Assistance based on publicly available data sources. PPS provides an estimate of the patient's likely socio-economic standing, as well as, the patient's household income size. Approval used with PPS applies only to accounts being reviewed by Patient Financial Services. All other dates of services for the same patient or guarantor will follow the standard Adventist HealthCare collection process.

6. **Executive Approval Board:** Financial assistance award considerations that fall outside the scope of this policy must be reviewed and approved by AHC CFO of facility rendering services, AHC Vice President of Revenue Management, and AHC VP of Patient Safety/Quality.

7. **POLICY REVIEW AND MAINTAINENCE:**

7.1. This policy will be reviewed on a bi-annual basis

7.2. The review team includes Adventist Health entity CFOs and VP of Revenue Management for Adventist Health

7.3. Updates, edits, and/or additions to this policy must be reviewed and agreed upon, by the review team and then by the governing committee designated by the Board prior to adoption by AHC.

7.4. Updated policies will be communicated and posted as outlined in section 2- Policy Transparency of this document.

CONTACT INFORMATION AND ADDITIONAL RESOURCES

Adventist HealthCare Patient Financial Services Department
820 W Diamond Ave, Suite 500
Gaithersburg, MD 20878
(301) 315-3660

The following information can be found at Adventist HealthCare's Public Notice of Financial Assistance & Charity Care:

Document Title
AHC Financial Assistance Plain Language Summary - English
AHC Financial Assistance Plain Language Summary - Spanish
AHC Federal Poverty Guidelines
AHC Financial Assistant Application - English
AHC Financial Assistant Application - Spanish
List of Providers not covered under AHC's Financial Assistance Policy

Document Information

Document Title

AHC 3.19 Financial Assistance

Document Description

N/A

Approval Information

Approved On: 11/09/2017

Approved By: Veronica Harker, Risk Management Specialist

Approval Expires: 11/08/2019

Approval Type: Manual Entry

Document Location: / Adventist HealthCare / AHC Corporate Policies / Finance

Keywords: N/A

Printed By: Guest User

Standard References: N/A

Note: This copy will expire in 24 hours

EXHIBIT 8

ADVENTIST HEALTH CARE, INC.

Manual de política corporativa

Asistencia financiera

(Anteriormente "Atención de beneficencia")

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Fecha de entrada en vigencia	01/08	Nro. de política:	AHC 3.19
Referencia: Anteriormente: Política de asistencia financiera		Origen:	PFS
(consulte AHC 3.19.1 para ver las Reglas de decisión/aplicación)			
Revisada:	02/09, 19/9/13, 7/17	Autoridad:	EC
Modificada:	10/09, 15/06/10, 2/3/11, 02/10/13, 1/2/16, 11/17	Página:	1 de 14

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RESUMEN DE LA POLÍTICA DE ASISTENCIA FINANCIERA

ALCANCE:

Esta política rige para los siguientes centros de Adventist HealthCare: Shady Grove Adventist Hospital, Germantown Emergency Center, Washington Adventist Hospital, Adventist Behavioral Health, y Adventist Rehabilitation Hospital of Maryland, a los que conjuntamente se los denomina AHC.

PROPÓSITO:

En concordancia con la misión de AHC de demostrar los cuidados de Dios mejorando la salud de las personas y las comunidades, Adventist HealthCare brinda asistencia financiera a los pacientes de bajos y medianos ingresos que necesitan nuestros servicios. El Plan de asistencia financiera de AHC constituye una manera sistemática y equitativa de garantizar que los pacientes sin seguro, que tengan un seguro insuficiente, que hayan sufrido un evento catastrófico o no cuenten con los recursos adecuados para pagar los servicios puedan acceder a la atención médica que necesitan.

Adventist HealthCare brinda atención médica de emergencia y cuidados no electivos médicamente necesarios a pacientes individuales sin discriminación, independientemente de su capacidad de pagar, su capacidad de calificar para recibir asistencia financiera o la disponibilidad de cobertura de terceros. En el caso de que la cobertura de terceros no estuviera disponible, se iniciará una determinación de posible elegibilidad para recibir Asistencia financiera antes o al momento de la internación. Esta política identifica las circunstancias para las cuales AHC podría proporcionar atención sin cargo o con descuento en base a la necesidad financiera de la persona.

Se realizará una notificación pública impresa sobre el programa anualmente en periódicos del Condado de Montgomery, Maryland y el Condado de Prince George, Maryland y se publicará en los Departamentos de Emergencias, las Oficinas Comerciales y las áreas de Registro de los centros mencionados anteriormente.

Esta política ha sido adoptada por el órgano rector de AHC de conformidad con las regulaciones y requisitos del Estado de Maryland y con las regulaciones de la Sección 501(r) del Código de Rentas Internas.

Esta política de asistencia financiera proporciona pautas para:

- Asistencia financiera a pacientes individuales que pagan por su cuenta que reciben servicios de emergencia u otros servicios no electivos médicamente necesarios en base a necesidad médica y financiera.
- Descuentos por pago puntual (%) que podrían ser cobrados a pacientes que pagan por su cuenta que reciben servicios médicamente necesarios que no se consideran de emergencia o no electivos.
- Consideración especial, cuando sea adecuado, para aquellas personas que reciban una consideración especial debido a cuidados intensivos.

BENEFICIOS:

Mejorar el servicio a la comunidad ofreciendo servicios médicos de calidad independientemente de la capacidad de pago del paciente (o del garante). Reducir la colocación innecesaria o inadecuada de cuentas con agencias de recaudación cuando una designación de atención de caridad es más adecuada.

DEFINICIONES:

- **Médicamente necesario:** servicios o suministros de atención médica necesarios para prevenir, diagnosticar o tratar una enfermedad, lesión, afección, o sus síntomas y que cumplen con las normas aceptadas de medicina.
- **Servicios médicos de emergencia:** tratamiento de personas en situaciones médicas de crisis que podrían ser mortales con o sin tratamiento.
- **Servicios no electivos:** una afección médica que sin atención inmediata:
    - Pone la salud de la persona en grave peligro.
    - Causa un trastorno grave de la función corporal o un deterioro grave a un órgano del cuerpo.
    - Y pueden incluir, entre otros:
        - Pacientes externos del Departamento de Emergencias
        - Internaciones del Departamento de Emergencias
        - Tratamiento de seguimiento para pacientes internos o externos relacionado con una visita previa al Departamento de Emergencias
- **Cuidados intensivos**: una enfermedad grave que requiere una hospitalización o recuperación prolongadas. Algunos ejemplos incluyen el coma, cáncer, leucemia, ataque cardíaco o accidente cerebrovascular. Por lo general, estas enfermedades implican un gran costo en hospitales, médicos y medicamentos y podrían hacer que una persona sea incapaz de trabajar, y por lo tanto, causarle problemas económicos.

- **Descuento por pago puntual**: El estado de Maryland permite un descuento por pago puntual del 1 % para los pacientes que pagan los servicios médicos al momento de recibirlos.
- **FPL** (Nivel federal de pobreza): es el monto mínimo de ingresos brutos que una familia necesita para comida, ropa, transporte, vivienda y otras necesidades. En los Estados Unidos, el Departamento de Salud y Servicios Humanos determina este nivel.
- **Paciente sin seguro**: Una persona que no está inscripta en un plan de seguro de cobertura médica. Puede o no ser elegible para recibir atención de beneficencia.
- **Paciente que paga por su cuenta**: Un paciente sin seguro que no califica para recibir Asistencia financiera de AHC debido a que sus ingresos superan lo establecido por las pautas de ingresos del Nivel federal de pobreza (FPL).

POLÍTICA

1. Elegibilidad general

1.1. Todos los pacientes, independientemente de su raza, credo, sexo, edad, orientación sexual, nacionalidad o situación financiera, pueden solicitar Asistencia financiera.

1.2. Brindar atención médica necesaria a aquellos que no pueden pagarla es parte de la misión de Adventist HealthCare. El programa de Asistencia financiera establece que la atención será gratuita o a un precio reducido para:

1.2.1. Quienes más lo necesitan de conformidad con la evaluación actual del Nivel federal de pobreza (FPL), es decir, aquellas personas que tienen ingresos inferiores o iguales al 200 % del Nivel federal de pobreza (Consultar Anexo A para ver el FPL actual).

1.2.2. Quienes lo necesitan de conformidad con el Nivel federal de pobreza actual (es decir, personas que tienen ingresos entre 201 % y 600 % de las pautas actuales del FPL).

1.2.3. Pacientes que sufren dificultades económicas (deuda médica incurrida durante los últimos 12 meses que constituye más del 25 % de los ingresos familiares), y/o

1.2.4. La ausencia de otros recursos financieros para pagar por atención médica urgente o de emergencia

1.3. Esta política exige que un paciente o su garante coopere y aproveche todos los programas disponibles (incluso aquellos ofrecidos por AHC, Medicaid, seguro de los trabajadores y otros programas estatales y locales) que podrían ofrecer cobertura para los servicios, antes de la aprobación final de Asistencia financiera de Adventist HealthCare.

1.4. **Elegibilidad para Atención médica de emergencia:** Los pacientes podrían ser elegibles para recibir asistencia financiera para Atención médica de emergencia de conformidad con esta Política si:

1.4.1. No tienen seguro, han agotado, o agotarán todos los beneficios de seguro disponibles; y

1.4.2. Sus ingresos familiares anuales no superan el 200 % de las Pautas federales de pobreza para calificar para asistencia financiera completa o el 600 % de las Pautas federales de pobreza para calificar para asistencia financiera parcial; y

1.4.3. Solicitan asistencia financiera dentro del Periodo de solicitud de asistencia financiera (es decir, en el periodo que termina el día 240 luego de que el paciente reciba el primer estado de cuenta posterior al alta).

1.5. **Elegibilidad para Atención médicamente necesaria que no sea de emergencia:** Los pacientes podrían ser elegibles para recibir asistencia financiera para Atención médicamente necesaria que no sea de emergencia de conformidad con esta Política si:

1.5.1. No tienen seguro, han agotado, o agotarán todos los beneficios de seguro disponibles; y

1.5.2. Sus ingresos familiares anuales no superan el 200 % de las Pautas federales de pobreza para calificar para asistencia financiera completa o el 600 % de las Pautas federales de pobreza para calificar para asistencia financiera parcial; y

1.5.3. Solicitan asistencia financiera dentro del Periodo de solicitud de asistencia financiera (es decir, en el periodo que termina el día 240 luego de que el paciente reciba el primer estado de cuenta posterior al alta); y

1.5.4. El plan de tratamiento fue desarrollado y brindado por un equipo de atención de AHC.

1.6. **Consideraciones:**

1.6.1. Los pacientes asegurados que incurran gastos de bolsillo altos (deducibles, coseguro, etc.) podrían ser elegibles para recibir asistencia financiera aplicada a la parte de responsabilidad a pagar por el paciente de sus servicios médicamente necesarios.

1.6.2. El personal apropiado analizará la asistencia financiera preaprobada para servicios médicos programados pasada la 2da noche luego de una admisión al Departamento de Emergencias en función de los criterios de necesidad médica establecidos en esta política, y la asistencia financiera podría ser aprobada o no.

1.7. **Exclusiones:** De conformidad con esta política, los pacientes son INELEGIBLES para recibir asistencia financiera para Atención médica de emergencia u otra Atención médicamente necesaria que no sea de emergencia si:

1.7.1. El paciente o responsable proporciona información falsa o engañosa intencionalmente; o

1.7.2. Se proporciona información obtenida a través de métodos fraudulentos para calificar para la asistencia financiera (EJEMPLO: utilizar una identificación o información financiera adquiridas indebidamente, etc.)

1.7.3. El paciente o responsable se niega a cooperar con cualquiera de los términos de esta Política; o

1.7.4. El paciente o responsable se niega a enviar su solicitud para programas de seguros del gobierno luego de haberse determinado que es probable que el paciente o responsable sea elegible para dichos programas; o

1.7.5. El paciente o responsable se niega a cumplir los requisitos de su seguro primario cuando corresponda.

1.8. **Consideraciones especiales (Presunta elegibilidad)**: Adventist HealthCare pone asistencia financiera a disposición de los pacientes en función de su «supuesta elegibilidad» si cumplen con los siguientes criterios:

1.8.1. Los pacientes, *a menos que de otro modo sean elegibles para Medicaid o CHIP*, que son beneficiarios de los programas de servicios sociales en los que se verifican los ingresos son elegibles para recibir atención gratuita, siempre y cuando el paciente presente un comprobante de inscripción dentro de 30 días, a menos que se solicite una extensión de 30 días. La Asistencia continuará en vigencia mientras el paciente siga siendo un beneficiario activo de uno de los siguientes programas:

1.8.1.1. Familias con hijos en el Programa de almuerzo gratuito o a precio reducido;

1.8.1.2. Programa de Asistencia Nutricional Suplementaria (SNAP);

1.8.1.3. Programa de asistencia energética para hogares de bajos ingresos;

1.8.1.4. Mujeres, infantes y niños (WIC)

1.8.2. Los pacientes que son beneficiarios de los siguientes programas del condado de Montgomery son elegibles para recibir asistencia financiera luego de cumplir con los requisitos de copagos exigidos por el programa, siempre y cuando el paciente presente un comprobante de inscripción dentro de 30 días, a menos que se solicite una extensión de 30 días. La Asistencia continuará en vigencia mientras el paciente siga siendo un beneficiario activo de uno de los siguientes programas:

1.8.2.1. Montgomery Cares;

1.8.2.2. Project Access;

1.8.2.3. Care for Kids

1.8.3. Además, es posible que los pacientes que cumplan con uno o más de los siguientes criterios sean elegibles para recibir asistencia financiera para Atención de emergencia o atención médicamente necesaria que no sea de emergencia de conformidad con esta política con o sin una

solicitud completa, e independientemente de la capacidad financiera. SI el paciente:

1.8.3.1. está categorizado como una persona sin hogar o indigente

1.8.3.2. no puede proporcionar la información necesaria de elegibilidad para asistencia financiera debido a su estado o capacidad mental

1.8.3.3. no responde durante la atención y es dado de alta debido al vencimiento

1.8.3.4. según el Estado, es elegible para recibir asistencia bajo la Ley de indemnización para víctimas de crímenes violentos o la Ley de indemnización para víctimas de agresión sexual;

1.8.3.5. es una víctima de un crimen o abuso (regirán otros requisitos)

1.8.3.6. es anciano y víctima de un abuso

1.8.3.7. es un menor no acompañado

1.8.3.8. es actualmente elegible para Medicaid, pero no lo era al momento del servicio

Para cualquier persona que se presuma que es elegible para recibir asistencia financiera de conformidad con esta política, regirán todas las acciones descritas en la sección «Elegibilidad» y en otras partes de esta política de la misma manera que si la persona hubiese presentado un formulario completo de solicitud de Asistencia financiera.

1.9. **Monto generalmente facturado:** Nunca se le cobrará a una persona que es elegible para recibir asistencia bajo esta política para atención de emergencia u otro tipo de atención médicamente necesaria más que los montos que se cobran generalmente (AGB) a una persona que no sea elegible para recibir asistencia. La agencia de reglamentación de tarifas del estado de Maryland (HSCRC) establece los cargos a los que se aplicará un descuento y son iguales para todos los pagadores (es decir, compañía de seguros comerciales, Medicare, Medicaid o pacientes que pagan por su cuenta) con la excepción de Adventist Rehabilitation Hospital of Maryland, cuyos cargos a pacientes elegibles para recibir asistencia bajo esta política se establecerán a la tasa provisional actual

de Medicaid de Maryland al momento del servicio, según lo determinado por el Departamento de Salud y Salud Mental.

2. **Transparencia de la política:** Las Políticas de Asistencia financiera son transparentes y están disponibles para las personas atendidas en cualquier momento durante la atención en los idiomas primarios adecuados para el área de servicio de Adventist HealthCare.

   2.1. Como parte de un proceso estándar, Adventist HealthCare proporcionará Resúmenes en lenguaje sencillo de la Política de Asistencia financiera.

      2.1.1. Durante el registro en el Departamento de Emergencias

      2.1.2. Durante sesiones de asesoramiento financiero

      2.1.3. A petición

   2.2. Los centros de Adventist HealthCare publicarán de manera visible versiones completas y actuales del Resumen en lenguaje sencillo de la política de Asistencia financiera.

      2.2.1. En todos las oficinas de registro

      2.2.2. En las salas de espera de áreas de especialidad

      2.2.3. En las habitaciones de pacientes de áreas de especialidad

   2.3. Los centros de Adventist HealthCare publicarán de manera visible versiones completas y actuales de lo siguiente en sus respectivos sitios web en inglés y en los idiomas primarios que son adecuados para el área de servicio de Adventist HealthCare:

      2.3.1. Política de Asistencia financiera:

      2.3.2. Formulario de solicitud de Asistencia financiera

      2.3.3. Resumen en lenguaje sencillo de la Política de asistencia financiera:

3. Periodo de solicitud y determinación de la Política

   3.1. La Política de Asistencia financiera rige para cargos por servicios médicamente necesarios para pacientes que son prestados por uno de los centros de Adventist HealthCare mencionados. Un paciente (o garante) puede enviar una

solicitud para recibir Asistencia financiera en cualquier momento dentro de **240 días desde que se determina que el paciente tiene un saldo deudor.**

3.2. Se comunicará la elegibilidad probable al paciente dentro de 2 días laborales desde la presentación de la solicitud.

3.3. Se analizarán todas las solicitudes de Asistencia financiera y se llegará a una determinación en función de la evaluación de la capacidad de pagar del paciente (o garante). Esto podría incluir, sin limitaciones, las necesidades del paciente o garante, los ingresos disponibles u otros recursos financieros. Las decisiones y adjudicaciones finales sobre Asistencia financiera se comunicarán al paciente dentro de 10 días laborales de la presentación de una solicitud completa para Asistencia financiera.

3.4. La asistencia financiera preaprobada para servicios médicos programados es aprobada por el personal adecuado en base a los criterios establecidos en esta política

3.5. **Periodo de elegibilidad de la política:** Si se aprueba la asistencia financiera de un paciente bajo esta Política, su asistencia financiera de conformidad con esta política no deberá exceder los 12 meses **desde la fecha de la carta de adjudicación**. Los pacientes que requieran asistencia financiera pasado este tiempo deberán volver a enviar la solicitud y completar el proceso de solicitud nuevamente.

4. **EXCLUSIONES DE LA POLÍTICA:** Los siguientes son algunos de los servicios no cubiertos por la Política de Asistencia financiera de AHC:

4.1. Servicios que el equipo clínico de AHC determine que no son médicamente necesarios

4.2. Los servicios no cobrados y facturados por un centro de Adventist HealthCare enumerado en esta política no están cubiertos bajo esta política. Los siguientes son algunos de los ejemplos: cargos de médicos, anestesiólogos, médicos del departamento de emergencias, radiólogos, cardiólogos, patólogos y médicos de consulta solicitados por el médico que realiza el ingreso del paciente y el médico adjunto.

4.3. Los servicios cosméticos, otros procedimientos electivos, de conveniencia u otros servicios de centros de Adventist HealthCare que no sean médicamente

necesarios están excluidos de ser considerados para un servicio gratuito o con descuento.

4.4. Los pacientes o sus garantes que son elegibles para programas de asistencia del condado, estatales, federales o de otras fuentes no serán elegibles para recibir Asistencia financiera por servicios cubiertos por esos programas.

4.5. Los servicios prestados por médicos que ofrecen servicios en uno de los centros de AHC NO están cubiertos bajo esta política.

4.5.1. Los cargos de los médicos se facturan de manera **separada** a los cargos del hospital.

Funciones y responsabilidades

4.6. **Responsabilidades de Adventist HealthCare**

4.6.1. AHC tiene una política de asistencia financiera para evaluar y determinar la elegibilidad de una persona para recibir asistencia financiera.

4.6.2. AHC tiene una manera de comunicar la disponibilidad de asistencia financiera a todas las personas para fomentar una participación absoluta de la persona.

4.6.3. Los miembros del personal de Servicios Financieros para Pacientes y las áreas de Registro conocen la política de asistencia financiera de AHC y pueden dirigir preguntas sobre la política a los representantes adecuados del hospital.

4.6.4. AHC exige que todos los contratos con agentes externos que cobran facturas en nombre de AHC incluyan disposiciones que establezcan que dichos agentes cumplirán las políticas de asistencia financiera de AHC.

4.6.5. La Función del ciclo de ingresos de AHC posibilita una supervisión institucional para la prestación de asistencia financiera y las políticas/procesos que rigen el proceso de asistencia financiera.

4.6.6. Luego de recibir la solicitud de asistencia financiera de la persona, AHC le notifica sobre la determinación de elegibilidad dentro de un periodo razonable de tiempo.

4.6.7. AHC brinda opciones para planes de pago.

4.6.8. AHC respeta y honra el derecho de las personas a apelar las decisiones y solicitar que se reconsideren.

4.6.9. AHC mantiene (y requiere que los contratistas de facturación mantengan) documentación que respalda la oferta, la solicitud y la prestación de asistencia financiera por un periodo mínimo de siete años.

4.6.10. AHC analizará e incorporará periódicamente actualizaciones de las pautas federales de pobreza publicadas por el Departamento de Salud y Servicios Humanos de los Estados Unidos

4.7. **Responsabilidades individuales de los pacientes**

4.7.1. Para que se le considere para recibir un descuento bajo la política de asistencia financiera, la persona debe cooperar con AHC para proporcionar la información y documentación necesarias para solicitar otros recursos financieros existentes que podrían estar disponibles para pagar la atención médica, como Medicare, Medicaid, responsabilidad de terceros, etc.

4.7.2. Para que se le considere para recibir un descuento bajo la política de asistencia financiera, la persona debe brindarle a AHC información financiera y de otros tipos necesaria para determinar su elegibilidad (esto incluye completar los formularios de solicitud requeridos y cooperar completamente con el proceso de recopilación de información y evaluación).

4.7.3. La persona que califique para recibir un descuento parcial debe cooperar con el hospital para establecer un plan de pago razonable.

4.7.4. La persona que califique para recibir descuentos parciales debe esforzarse de buena fe para honrar el plan de pago de sus facturas de hospital con descuento. La persona es responsable de notificar oportunamente a AHC de cualquier cambio en su situación financiera

para que el impacto de este cambio pueda ser evaluado en función de las políticas de asistencia financiera que rigen para la prestación de asistencia financiera.

5. Identificación de personas potencialmente elegibles

5.1. Identificación a través de socialización y divulgación

5.1.1. Los procesos de inscripción y preinscripción fomentan la identificación de personas que necesitan asistencia financiera.

5.1.2. Los asesores financieros se esforzarán por contactar a todos los pacientes internos que paguen sus propias cuentas durante el curso de su internación o dentro de 4 días de haber recibido el alta.

5.1.3. Se distribuirá el Resumen en lenguaje sencillo con el Formulario de solicitud de asistencia financiera de AHC a todos los pacientes antes de recibir el alta del centro hospitalario.

5.1.4. Se incluirá información sobre cómo obtener una copia de la Política de asistencia financiera con los estados de cuenta que se envían a las personas

5.1.5. Se informará a la persona de la Política de asistencia financiera del centro hospitalario de AHC en las comunicaciones orales sobre el monto adeudado por su atención.

5.1.6. Se le dará a la persona por lo menos un aviso por escrito (aviso de las medidas que podrían tomarse) que le informa que el hospital podría tomar medidas para denunciar información adversa sobre la persona a agencias de informes crediticios del consumidor/agencias de crédito si la persona no presenta un Formulario de solicitud de asistencia financiera o paga el monto adeudado antes de una fecha límite especificada. La fecha límite no puede ser anterior a 120 días luego de que se envíe el primer estado de cuenta a la persona. Se debe enviar el aviso a la persona por lo menos 30 días antes de la fecha límite especificada en el aviso.

5.2. **Pedidos de Asistencia financiera**: Se pueden recibir pedidos de asistencia financiera de varias fuentes (como el paciente, un familiar, una organización

comunitaria, una iglesia, una agencia de cobros, un cuidador, la Administración, etc.)

5.2.1. Los pedidos recibidos de terceros se dirigirán a un asesor financiero.

5.2.2. El asesor financiero trabajará junto con este tercero para proporcionar los recursos disponibles para asistir a la persona en el proceso de solicitud.

5.2.3. Si está disponible, se le dará una carta que contenga los cargos estimados a la persona que la solicite.

5.2.4. **PROCESO AUTOMATIZADO DE BENEFICENCIA** para Cuentas enviadas a agencias contratadas: Adventist HealthCare reconoce que una parte de la población sin seguro o que tenga un seguro insuficiente podría no involucrarse en el proceso tradicional de solicitud de asistencia financiera. Si la información requerida no es suministrada por el paciente, Adventist HealthCare podría utilizar una herramienta de puntuación predictiva automatizada para clasificar a los pacientes para asistencia financiera. El Puntaje de Previsibilidad de Pago (PPS) predice la probabilidad de que un paciente califique para recibir Asistencia financiera en base a fuentes públicas de información. El PPS ofrece una estimación de la posible situación socioeconómica de un paciente, como el tamaño del ingreso del hogar del paciente. La aprobación mediante PPS rige solo para cuentas que estén siendo analizadas por Servicios Financieros para Pacientes. Todas las otras fechas de servicios del mismo paciente o garante seguirán el proceso estándar de cobro de Adventist HealthCare.

6. **Junta ejecutiva de aprobación:** Las consideraciones de otorgamiento de asistencia financiera que no estén abarcadas por esta política deberán ser analizadas y aprobadas por el Director Financiero (CFO) del centro de AHC que presta los servicios, el Vicepresidente de Gestión de Ingresos de AHC, y el Vicepresidente de Seguridad del Paciente y Calidad de AHC.

7. **REVISIÓN Y MANTENIMIENTO DE LA POLÍTICA:**

7.1. Esta política se revisará bianualmente.

7.2. El equipo de revisión incluye a los Directores Financieros (CFO) de las entidades de Adventist HealthCare y al Vicepresidente de Gestión de Ingresos de Adventist Health

7.3. Las actualizaciones, modificaciones o adiciones a esta política deberán ser revisadas y acordadas por el equipo de revisión y luego por el comité rector designado por la Junta antes de que AHC la adopte.

7.4. Las actualizaciones se comunicarán y publicarán como se establece en la sección 2 - Transparencia de la política, de este documento.

INFORMACIÓN DE CONTACTO Y RECURSOS ADICIONALES

Adventist HealthCare Patient Financial Services Department
820 W Diamond Ave, Suite 500
Gaithersburg, MD 20878
(301) 315-3660

Se puede encontrar la siguiente información en Aviso público de Adventist HealthCare sobre Asistencia financiera y Atención de beneficencia:

Títulos de los documentos
Resumen en lenguaje sencillo de la Asistencia financiera de AHC - inglés
Resumen en lenguaje sencillo de la Asistencia financiera de AHC - español
Pautas federales de pobreza de AHC
Solicitud de Asistencia financiera de AHC - inglés
Solicitud de Asistencia financiera de AHC - español
Lista de proveedores que no están cubiertos bajo la Política de Asistencia financiera de AHC

EXHIBIT 9

Ad # 12113987 Name ATTN: CHERYL MCKY ADVENTIST HEALTHCARE I Size 33 Lines T0003
Class 820 PO# Authorized by Account 2010239567

PROOF OF PUBLICATION

District of Columbia, ss., Personally appeared before me, a Notary Public in and for the said District, Travona James well known to me to be BILLING SUPERVISOR of The Washington Post, a daily newspaper published in the City of Washington, District of Columbia, and making oath in due form of law that an advertisement containing the language annexed hereto was published in said newspaper on the dates mentioned in the certificate herein.

I Hereby Certify that the attached advertisement was published in The Washington Post, a daily newspaper, upon the following date(s) at a cost of $128.62 and was circulated in the Washington metropolitan area.

Published 1 time(s). Date(s):06 of July 2017

Account 2010239567

Witness my hand and official seal this 6th day of July 2017

MICHELLE SINCLAIR NOTARY PUBLIC MY COMMISSION EXPIRES 1/01/2020 DISTRICT OF COLUMBIA

My commission expires _____

PUBLIC NOTICE Adventist HealthCare, Inc., and its entities provide access to all persons requiring care regardless of their ability to pay. Patients unable to pay for any portion of their bill may quality for financial assistance even if they are employed and/or insured. An application for financial assistance can be completed by any patient. The amount of assistance will be based on current Federal Income Poverty Guidelines. Applications are available throughout the Hospital or by calling (301) 315-3660. Further, no persons shall, on the grounds of race, color, religion, age, sex, national origin, ancestry, sexual orientation, or disability, be excluded from participation in, be denied benefits of, or otherwise be subjected to discrimination in the provision of any care, service or employment.

Alexandria - Fairfax County
BIG COMMUNITY YARD SALE
7137 Beulah Street, Alexandria, VA. 07/08/2017 7am-1pm, 607-279-3077

358 Moving Sale

Gaithersburg—Sale 8316 Plum Creek Dr Gaithersburg, MD, 07/08/2017, 8am-3pm
Furniture, art, china, crystal, silver

360 Estate Sales

1438 Highwood Dr McLean, VA
TM SALES Thur - Sun, 9-4
Steinway Upright Piano Thorens, Marantz & McIntosh stereo equipment Full house of Mid-Century furn, many signed Model ships, Antique & Coffee table books for more info see **www.estatesales.net**

Clifton Fri & Sat, 10-4, Sun 1-4
WELLS ESTATE SALES
is proud to present a fabulous primative Americano sale! Incl. loveseat, chests, banquet DR table & chairs, antique beds incl 4 poster, amazing oil paintings, Hinkle Harris secretary, towles (Old Master), wingback chairs, old toys, books, clothes, linens, lamps & whole housewares. **Outdoor Statuary** worth the drive. Tools. Craftsman lawn cart. Colt Rd to 6505 Stallion Rd. #'s 9:30 Friday see website estatesales.net. **703-536-7816**

Clifton, VA - 6608 Lady Slipper Ln
Fri-Sun, 10-3 Full house sale.
www.caringtransitionsnova.com
for pics and details.

Springfield Fri & Sat, 10-4, Sun 1-4
WELLS ESTATE SALES
presents a beautiful sale with quality items incl Gorham (Rhondo) Sterling, & silver plate Wegewood china (Queensware) Baccarat Crystal, Hummels & Lladro, sofas, chairs, 2 beautiful leather sectional sofas, LR, DR & office furn., kitchen table & chairs, oriental rugs Pool table & accessories. Men's clothes, chairlifts, housewares,tools, patio furn. **2000 Cadillac Seville STS**, much more! 8501 Shadeway Pl #'s 9:30 Friday see website estatesales.net. **703-536-7816**

610 Dogs for Sale

Bernedoodle—Puppies! 8 weeks old. **540-908-5372 mrsshank24@gmail.com**

BOUVIER DES FLANDRES—AKC PUPS 1 MALE/1 FEMALE, 4 Months Old 301-274-9232 Vet Checked Up To Date On All Shots 301-274-9232

Jack Russell Yorkies On Sale — 304-904-6289 Many breeds avail. Some 10% off w/cash pay CC, cash, easy financing on our web. wvpuppy.com

Labrador—$750, 9 weeks old, 434-409-0077. Husky Yellow Male. 1 Black Female and 1 Black Male. Registerable. Vet-checked, up to date on all vaccinations and dewormers. No shipping available

Labrador Retriever Yellow puppies, AKC, 8 weeks old, wormed, 1st shots, 40 miles west of Frederick Md. $400 Call 301-678-5814

LABRADOR RETRIEVER English-style, AKC, black lab pups with champion bloodlines. Raised in home with sire, dam & caring family $800 Avail 7/8. Pics plus at akc.com (21738 zip) **443-280-8280**

OLD ENGLISH BULLDOG PUPS - 4 Males & 6 Female. Avail 07/31 Accepting deposit $50. Shots, IOEBA registered. $800. Call **703-987-7084**

Rottweiler, AKC —3 M & 1 F. Born 6/17, Ready 8/12. OFA Hip/Elbows/Heart. Multiple World Champs in Line. $1500,703-853-2074

Shiba Inu pups- ACA Registered. 11 weeks, red/cream, great personality, 1st shots and vet checked, $400. **Call 540-879-2228.**

Standard Poodle Puppies -AKC Born 5/22, ready 7/18. Health guarantee. $950. **Call 540-207-1394 or email LChicco55@gmail.com**

Weimaraner, AKC—Puppies, 8 wks, 5 silver boys, 1 silver female & 1 blue female. AKC Limited Registration, $1300, Call/text 540-383-1778

WHEATEN TERRIER & Wheatini blending" Soft/No shed/aller crt/ppr trnd soc lap dg. see parents 8 wks /12 mo M/F. **Fursonality.com 540-286-0633**

CLERK, Circuit Court
Montgomery County, Maryland

IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

IN THE MATTER OF MERIAM MOSSAD MICHEAL MOSSAD FOR CHANGE OF NAME TO: MERIAM HELAL FAMILY LAW 145975FL

PUBLICATION NOTICE

The above Petitioner has filed a Petition for change of Name in which he/she seeks to change his/her name from Meriam Mossad Micheal Mossad to Meriam Helal. The petitioner is seeking a name change because I want to take my step-father's name.
Any person may file an objection to the Petition on or before the 21st day of July, 2017. The objection must be supported by an affidavit and served upon the Petitioner in accordance with Maryland Rule 1-321. failure to file an objection or affidavit within the time allowed my result in a judgement by default or the grant of the relief sought.
This Notice is to be published the the Washington Post newspaper of general circulation in Montgomery County, Maryland, one successive week on or before the 6th day of July, 2017.

/s/ Barbara H. Meiklejohn
CLERK, Circuit Court
Montgomery County, Maryland

IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

IN THE MATTER OF WINSTON HAO-NINING YEUNG FOR CHANGE OF NAME TO: WINSTON AN YEUNG FAMILY LAW 145972FL Shwu-Ling Yeung Petitioner

PUBLICATION NOTICE

The above Petitioner has filed a Petition for change of Name of a Minor in which he/she seeks to change his/her name from Winston Hao-Nining Yeung to Winston An Yeung. The petitioner is seeking a name change because Better meaning and easy to remember.
Any person may file an objection to the Petition on or before the 21st day of July, 2017. The objection must be supported by an affidavit and served upon the Petitioner in accordance with Maryland Rule 1-321. failure to file an objection or affidavit within the time allowed my result in a judgement by default or the grant of the relief sought.
This Notice is to be published the the Washington Post newspaper of general circulation in Montgomery County, Maryland, one successive week on or before the 6th day of July, 2017.

/s/ Barbara H. Meiklejohn
CLERK, Circuit Court
Montgomery County, Maryland

IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

IN THE MATTER OF ELIZABETH A. BECKERT-KIND FOR CHANGE OF NAME TO: ELIZABETH ANNE KIND FAMILY LAW 145855FL

PUBLICATION NOTICE

The above Petitioner has filed a Petition for change of Name in which he/she seeks to change his/her name from Elizabeth A. Beckert-Kind to Elizabeth Anne Kind. The petitioner is seeking a name change because I no longer want my maiden name to be part of my last name.
Any person may file an objection to the Petition on or before the 21st day of July, 2017. The objection must be supported by an affidavit and served upon the Petitioner in accordance with Maryland Rule 1-321. failure to file an objection or affidavit within the time allowed my result in a judgement by default or the grant of the relief sought.
This Notice is to be published the the Washington Post newspaper of general circulation in Montgomery County, Maryland, one successive week on or before the 6th day of July, 2017.

/s/ Barbara H. Meiklejohn
CLERK, Circuit Court
Montgomery County, Maryland

JN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

IN THE MATTER OF PHILLIP JAMES KENDALL-KUPPE FOR CHANGE OF NAME TO: PHILLIP JAMES KENDALL FAMILY LAW: 145827FL

PUBLICATION NOTICE

The above Petitioner has filed a Petition for change of Name in which he/she seeks to change his/her name from Phillip James Kendall-Kuppe to Phillip James Kendall. The petitioner is seeking a name change because want to simplify last name for self, wife and

as follows
1. Breach of Contract, and
2. Attorney Fees.
You are required to make defense to such pleading no later than forty days from the date of this publication, and upon your failure to do so the party seeking service against will apply to the court for the relief sought.
This the 29th day of June, 2017.
SHARP GRAHAM BAKER & VARNELL, LLP
By: Starkey Sharp
Attorney for the Plaintiff
Post Office Drawer 1027
Kitty Hawk, NC 27949
Tel. No (252) 261-2126
NCSB No. 8020

STATE OF CONNECTICUT
Superior Court/Juvenile Matters
ORDER OF NOTICE

NOTICE TO UNIDENTIFIED PERSON

of parts unknown

A petition/motion has been filed seeking termination of the above unidentified person's parental rights in the male minor child born on **8/17/2015** in Washington DC to **Alba Z**

The petition, whereby the court's decision can impact your parental rights, if any, regarding the minor child will be heard on 7/20/2017 at 12:00 PM at Superior Court Juvenile Matters 123 Hoyt Street Stamford CT 06905

It is therefore, ORDERED, that notice of the hearing of this petition/motion be given by publishing this Order of Notice once, immediately upon receipt, in the WashingtonPost a newspaper having a circulation in the town/city of: **Baltimore MD**

Name of Judge
Randolph J.

Date: 6/14/2017

Right to Counsel: Upon proof of inability to pay for a lawyer, the court will provide one for you at court expense. Any such request should be made immediately at the court office where your hearing is held.

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA PROBATE DIVISION WASHINGTON, D.C. 20001-2131 2017 ADM 414

CECELIA E. JONES PRO SE

NOTICE OF STANDARD PROBATE

Notice is hereby given that a petition has been filed in this Court by Joseph H. Green, Jr. for standard probate, including the appointment of one or more personal representatives. Unless a responsive pleading in the form of a complaint or an objection in accordance with Superior Court Probate Division Rule 407 is filed in this Court within 30 days from the date of first publication of this notice, the Court may take the action hereinafter set forth.
Order any interested person to show cause why the provisions of the lost or destroyed will dated March 22, 2011 should not be admitted to probate as expressed in the petition.

Joseph H. Green, Jr.
7400 14th St. NW,
Washington DC 20012
(202) 487-7750
PETITIONER
Anne Meister
REGISTER OF WILLS

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA PROBATE DIVISION WASHINGTON, D.C. 20001-2131 2017 ADM 712

UKBAB TSEGA PRO SE

NOTICE OF APPOINTMENT, NOTICE TO CREDITORS AND NOTICE TO UNKNOWN HEIRS

Samuel Beraki, whose address is 3403 16th Street NW Apt 105 Washington DC 20010, was appointed personal representative of the estate of Ukbab Tsega, who died on November 1, 2015 without a will and will serve without Court supervision. All unknown heirs and heirs whose whereabouts are unknown shall enter their appearance in this proceeding. Objections to such appointment shall be filed with the Register of Wills, D.C., 515 5th Street, NW, Building A, 3rd Floor, Washington DC 20001, on or before January 6, 2018. Claims against the decedent shall be presented to the undersigned with a copy to the Register of Wills or filed with the Register of Wills with a copy to the undersigned, on or before January 6, 2018, or be forever barred. Persons believed to be heirs or legatees of the decedent who do not receive a copy of this notice by mail within 25 days of its first publication shall so inform the Register of Wills, including name, address and rela-

16, 2017. Service of process may be made upon Deborah Jackson, 3409 Wheeler Rd. SE, Washington, DC 20032 whose designation as District of Columbia agent has been filed with the Register of Wills, D.C.
The decedent owned the following District of Columbia real property:
The decedent owned District of Columbia personal property. Claims against the decedent may be presented to the undersigned and filed with the Register of Wills for the District of Columbia, Building A, 515 5th, NW, 3rd Floor, Washington DC 20001 within 6 months from the date of first publication of this notice.

Debra A. Carroll
Personal Representative
Anne Meister
Register of Wills

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA PROBATE DIVISION WASHINGTON, D.C. 20001-2131 2017 ADM 760

JONATHAN LEROY DAWSON PRO SE

NOTICE OF STANDARD PROBATE

Notice is hereby given that a petition has been filed in this Court by Gina Gould on behalf of Branch Banking and Trust Company for standard probate, including the appointment of one or more personal representatives. Unless a responsive pleading in the form of a complaint or an objection in accordance with Superior Court Probate Division Rule 407 is filed in this Court within 30 days from the date of first publication of this notice, the Court may take the action hereinafter set forth.
In the absence of a will or proof satisfactory to the Court of due execution, enter an order determining that the decedent died intestate appoint a supervised representative.

Tracy Buck (DC Bar #1021540)
8601 Westwood Center Drive,
Suite 255, Vienna, VA 22182
(301) 907-8000
PETITIONER
Anne Meister
REGISTER OF WILLS

820 Official Notices

ABC LICENSE: AVR Crystal City Hotel I LLC and AVR Crystal City Hotel II LLC trading as The Westin Crystal City 1800 Jefferson Davis Highway Arlington (Arlington County) Virginia 22202-3506. The above establishment is applying to the VIRGINIA DEPARTMENT OF ALCOHOLIC BEVERAGE CONTROL (ABC) for a Mixed Beverage Restaurant, Wine and Beer On-and Off- Premises. Allan V. Rose, President. **NOTE: Objections to the issuance of this license must be submitted to ABC no later than 30 days from the publishing date of the first of two required newspaper legal notices. Objections should be registered at www.abc.virginia.gov or 800-552-3200.**

PUBLIC NOTICE
Adventist HealthCare, Inc., and its entities provide access to all persons requiring care regardless of their ability to pay. Patients unable to pay for any portion of their bill may quality for financial assistance even if they are employed and/or insured. An application for financial assistance can be completed by any patient. The amount of assistance will be based on current Federal Income Poverty Guidelines. Applications are available throughout the Hospital or by calling (301) 315-3660.
Further, no persons shall, on the grounds of race, color, religion, age, sex, national origin, ancestry, sexual orientation, or disability, be excluded from participation in, be denied benefits of, or otherwise be subjected to discrimination in the provision of any care, service or employment.

The National Fallen Firefighters Foundation (NFFF), a 501(c)(3) nonprofit organization headquartered in the state of Maryland, publishes contract opportunities and open positions for employment on the Foundation website at **www.firehero.org/about-us/opportunities/ [firehero.org]**. All opportunities are posted for fourteen days, prior to opening of submissions. The Foundation provides equal employment opportunities for all applicants and does not discriminate based on race, color, religion, sex, national origin, ancestry, age, disability, veteran status, marital status, or sexual orientation. The Foundation also makes accommodations for qualified individuals with disabilities in accordance with applicable law.

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specified at 40 CFR 423.13(
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can be scheduled. The
**Maryland Department of
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more, Maryland 21230-17
Chief, Industrial and Gen**
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and work) of the person
any other party whom the
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a waiver of the right to a
determination for this perm
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will be considered in the pr
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Richardson at the above a
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may request an interprete
Mr. Richardson at (410) 53
written request to the abo
days prior to the scheduled
Information supporting the
ing the draft permit and f
contacting Mr. Richardson
to make an appointment
Richardson at the above ad
be obtained at a cost of $0.3

851 Prince Georges Count

IN THE CIRCUIT COURT FOR PRINCE GEORGE'S COUNTY, MARYLAND

ROBERT E. FRAZIER, et al
Substitute Trustees
Plaintiffs,
V.
JOANNE P. POWELL,
Defendant(s)

CASE NO. CAEF14-05776

NOTICE

Notice is hereby issued this **21st day of June, 2017**, that the sale of the property in this case, **13602 Royal Court, Laurel, Maryland 20708**, reported by Robert E. Frazier, Gene Jung, Laura D. Harris, Thomas W. Hodge, Thomas J. Gartner, Robert M. Oliveri, David M. Williamson and Keith M. Yacko, Substitute Trustees, be ratified and confirmed, unless cause to the contrary be shown on or before the **21st day of July, 2017** provided a copy of this Notice be inserted in The Washington Post, a newspaper published in Prince George's County, Maryland, once in each of three (3) successive weeks on or before the **21st day of July, 2017**.

The report states the amount of sale to be **$451,500.00**.

Sydney J. Harrison (#619)
Clerk of the Circuit Court
for Prince Georges County, MD

BROCK & SCOTT, PLLC
474 Viking Drive
Suite 203
Virginia Beach, VA 23452
(757) 213-2959
July 6, 13, 20, 2017 12115633

EXHIBIT 10

El Tiempo Latino

WASHINGTON D.C. METRO AREA'S NEWSPAPER IN SPANISH

1440 G STREET NW, 9TH FLOOR • WASHINGTON DC 20005

WWW.ELTIEMPOLATINO.COM

Affidavit of Performance

To: Ms. Cheryl McKy
Public Relations & Marketing
Adventist Healthcare Inc.
820 W. Diamond Ave, Ste 600
Gaithersburg, MD 20878

From: Zulema Tijero, El Tiempo Latino
VP of Advertising
1440 G St NW #8192
Washington DC 20005

Date: July 21, 2017

Dear Ms. McKy:

This is the Affidavit of Performance for Insertion Order #1756, 2c x 5 B/W Notificacion Publica that ran in El Tiempo Latino 7/07/17, on page B6.

Should you have any questions about the performance of this order please contact me at zulema@eltiempolatino.com .

Sincerely,

Zulema Tijero, VP of Advertising
El Tiempo Latino

El Tiempo Latino

WASHINGTON D.C. METRO AREA'S NEWSPAPER IN SPANISH

1440 G STREET NW, 9TH FLOOR • WASHINGTON DC 20005

WWW.ELTIEMPOLATINO.COM

July 21, 2017

El Tiempo Latino certifies that it is the publisher of El Tiempo Latino newspaper, that it is a newspaper of general circulation, published weekly in the Virginia, Maryland and District of Columbia area, and that El Tiempo Latino has been published continuously for more than one year prior to the date of first publication of the notice mentioned in the letter attached.

This certifies that the person signing below, Wendy L. Hawa is the duly authorized agent of El Tiempo Latino newspaper and Zulema Tijero, VP of Sales and Advertising at El Tiempo Latino newspaper.

Wendy Hawa Wendy Hawa, Asst. to Zulema Tijero

Witness my hand and official seal this 21 day of July, 2017.

My commission expires 8/14/2021.


CLASIFICADOS

VDOT

SOLICITUD DE PROPUESTAS

NOTIFICACIÓN PÚBLICA

DISTRICT OF COLUMBIA: SS
SUBSCRIBED AND SWORN TO BEFORE ME
THIS 21 DAY OF July, 17.

NOTARY PUBLIC
My Commission Expires 8/14/21

My Commission Expires
August 14, 2021

Anuncio Público

VDOT
Virginia Department of Transportation

SOLICITUD DE PROPUESTAS
del ID del Contrato: C00109486DB99
PR15 - 076 - 236, P101, R201, C501
Estacionamiento "Park and Ride" en la I-66 con la Ruta 15

El Departamento de Transporte de Virginia (The Virginia Department of Transportation (VDOT)) está solicitando propuestas de firmas calificadas y con experiencia en diseño y construcción de autopistas e instalaciones complementarias, para el proyecto de Diseño-Construcción de un Estacionamiento con Conexión al Transporte Público Colectivo (Park and Ride) en la intersección de la I-66 con la Ruta 15. El proyecto está ubicado en el cuadrante noreste de la Intersección de la I-66 y la Ruta 15 en la Ciudad de Haymarket y el Condado de Prince William, Virginia. El propósito de este proyecto es proporcionar un espacio de estacionamiento para los pasajeros en vehículos de uso compartido (carpoolers) que usan los carriles (HOV) de la I-66 y servicios futuros de tránsito en el área, lo cual ahorrará tiempo y aliviará la congestión en la I-66. El proyecto consiste en la construcción de un nuevo Estacionamiento de "Park and Ride" de 230 plazas, con acceso desde el Heathcote Boulevard, e incluirá un área para recoger y dejar pasajeros (kiss-and-ride), bahías y áreas de giro para autobuses, casetas para pasajeros, estacionamiento y casilleros para ciclistas, un sistema de manejo del estacionamiento, una carretera de acceso / entrada, aceras, drenaje, instalaciones para manejo de aguas pluviales e iluminación. El tráfico que utiliza el estacionamiento de Park and Ride para trabajadores viajeros estará compuesto por vehículos de pasajeros, autobuses, peatones, y ciclistas.

NOTIFICACIÓN PÚBLICA

Adventist HealthCare, Inc. y sus entidades proporcionan acceso a todas las personas que necesiten atención sin importar su capacidad de pago. Los pacientes que no puedan pagar por cualquier porción de su factura podrían calificar para recibir asistencia financiera incluso si están empleados y/o cuentan con seguro. Cualquier paciente puede presentar una solicitud de asistencia financiera. El monto de la asistencia se basará en las pautas federales de pobreza según el ingreso. Las solicitudes están a disposición del público por todo el hospital o al llamar al **(301) 315-3660.**

Adicionalmente, ninguna persona será excluida de participar, o rechazada para recibir beneficios, ni de otra manera se verá sujeta a discriminación para la prestación de cualquier atención, servicio o empleo sobre la base de su raza, color, religión, edad sexo, origen nacional, ascendencia, orientación sexual o discapacidad.

MONTGOMERY COUNTY DEPARTMENT OF TRANSPORTATION
100 Edison Park Drive, 4th Floor, Gaithersburg, Maryland
Manager III, Transportation Systems Engineering Team Leader
$74,445 - $136,069
Closing Date: July 19, 2017

The Department of Transportation provides project planning, engineering design, construction management, and subsequent operation and maintenance of the County's transportation infrastructure.

Employee will be responsible for leading, managing and directing the planning, implementation and day-to-day functions of the Traffic Systems Engineering Team within the Transportation Systems Management Section. This five-person team is responsible for the design, construction and maintenance of Traffic signal systems and the County FiberNet program. Duties include leading, supervising and managing a team of County professional and paraprofessional staff, engineering technicians, consultants, and contractors who are responsible for planning, designing, operating and maintaining the County's signal system and FiberNet; developing and maintaining traffic signal timing and phasing; developing and monitoring budgets; establishing and maintaining effective contacts with officials of local, state, and federal government in support of the aforementioned programs, meeting and corresponding with citizens, community associations, and elected officials to address complex issues regarding Traffic signal technologies to improve operational efficiency; manage the preparation of studies and evaluations regarding signalized locations; provide for confirmation of deployment and maintenance

EXHIBIT 11

MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. 15-077

Issued to:

Adventist Rehabilitation Hospital Of Maryland

Type of Facility: Special Hospital - Rehabilitation
Addresses;

9909 Medical Center Drive
Rockville, MD 20850
55 beds
and
Washington Adventist Hospital
7600 Carroll Avenue
Takoma Park, MD 20912
32 beds

Date Issued: **September 2, 2016**

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, Title 19 Section 318 Annotated Code of Maryland, 1982 Edition, and subsequent supplements and is subject to any and all statutory provisions, including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Expiration Date: **December 12, 2019**

Patricia Tomko May M.D

Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

HOSPITAL LICENSE

This Certifies That

ADVENTIST HEALTHCARE
820 W. DIAMOND AVE, SUITE 600
GAITHERSBURG, MD 20870

is licensed to operate an Acute General Hospital Facility at:

ADVENTIST REHABILITATION HOSPITAL OF MARYLAND
9909 MEDICAL CENTER DR
ROCKVILLE, MD 20850

This license is issued under the authority of Chapter 25, of the Montgomery County Code, 2004, as amended.

Uma S. Ahluwalia, Director

Effective Date: 1/2/2018 Expiration Date: 1/2/2019 License No: 542

THIS LICENSE BECOMES VOID IF THE STATE LICENSE/CERTIFICATE IS DENIED OR REVOKED.

This license is not transferable, must be conspicuously posted on the premises, and renewed prior to the expiration date.

EXHIBIT 12

carf INTERNATIONAL

October 24, 2017

Kirsten Edler, MSN, AGPCNP-BC
Adventist HealthCare Rehabilitation, Inc.
9909 Medical Center Drive
Rockville, MD 20850

Dear Ms. Edler:

It is my pleasure to inform you that Adventist HealthCare Rehabilitation, Inc. has been issued CARF accreditation based on its recent survey. The Three-Year Accreditation applies to the following program(s)/service(s):

Inpatient Rehabilitation Programs - Hospital (Adults)
Inpatient Rehabilitation Programs - Hospital (Children and Adolescents)
Inpatient Rehabilitation Programs - Hospital: Amputation Specialty Program (Adults)
Inpatient Rehabilitation Programs - Hospital: Brain Injury Specialty Program (Adults)
Inpatient Rehabilitation Programs - Hospital: Spinal Cord Specialty Program (Adults)
Inpatient Rehabilitation Programs - Hospital: Stroke Specialty Program (Adults)

This accreditation will extend through October 31, 2020. This achievement is an indication of your organization's dedication and commitment to improving the quality of the lives of the persons served. Services, personnel, and documentation clearly indicate an established pattern of conformance to standards.

The accreditation report is intended to support a continuation of the quality improvement of your organization's program(s)/service(s). It contains comments on your organization's strengths as well as any consultation and recommendations. A Quality Improvement Plan (QIP) demonstrating your organization's efforts to implement the survey recommendation(s) must be submitted within the next 90 days to retain accreditation. The QIP form is posted on Customer Connect (*customerconnect.carf.org*), CARF's secure, dedicated website for accredited organizations and organizations seeking accreditation. Please log on to Customer Connect and follow the guidelines contained in the QIP form.

Your organization should take pride in achieving this high level of accreditation. CARF will recognize this accomplishment in its listing of organizations with accreditation and encourages your organization to make its accreditation known throughout the community. Communication of the accreditation to your referral and funding sources, the media, and local and federal government officials can promote and distinguish your organization. Enclosed are some materials that will help you publicize this achievement.

Your organization's complimentary accreditation certificate will be sent separately. You may use the enclosed form to order additional certificates.

If you have any questions regarding your organization's accreditation or the QIP, you are encouraged to seek support from Cathy Ellis by email at cellis@carf.org or telephone at (888) 281-6531, extension 5004.

CARF International Headquarters
6951 E. Southpoint Road
Tucson, AZ 85756-9407, USA

www.carf.org

CARF encourages your organization to continue fully and productively using the CARF standards as part of its ongoing commitment to accreditation. CARF commends your organization's commitment and consistent efforts to improve the quality of its program(s)/service(s) and looks forward to working with your organization in its ongoing pursuit of excellence.

Sincerely,

Brian J. Boon, Ph.D.

Brian J. Boon, Ph.D.
President/CEO

Enclosures

EXHIBIT 13

October 12, 2016

Re: # 316296
CCN: #213029
Program: Hospital
Accreditation Expiration Date: September 03, 2019

Brent Reitz
Vice President and Administrator
Adventist Rehabilitation Hospital of Maryland, Inc,
9909 Medical Center Drive
Rockville, Maryland 20850

Dear Mr. Reitz:

This letter confirms that your August 30, 2016 - September 02, 2016 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on October 06, 2016, The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of September 03, 2016.

The Joint Commission is also recommending your organization for continued Medicare certification effective September 03, 2016. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following locations:

Adventist Healthcare PH&R Orthotics & Prosthetics
d/b/a Adventist Healthcare PH&R Orthotics & Prosthetics
2421 Linden Lane, Silver Spring, MD, 20910

Adventist Rehabilitation Hospital at Rio Sport and Health
d/b/a Adventist Rehabilitation Hospital at Rio Sport and Health
9811 Washingtonian Blvd, Gaithersburg, MD, 20878

Adventist Rehabilitation Hospital of Maryland, Inc.
d/b/a Adventist Healthcare Physical Health and Rehabilitation
9909 Medical Center Drive, Rockville, MD, 20850

Adventist Rehabilitation Hospital of Maryland, Inc.
d/b/a Adventist Healthcare Physical Health and Rehabilitation
7600 Carroll Avenue, Takoma Park, MD, 20912

Adventist Rehabilitation Hospital of Maryland, Inc.
d/b/a Adventist Healthcare Physical Health and Rehabilitation
831 East University Blvd, Suite 14, Silver Spring, MD, 20903

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 3 /Survey and Certification Staff

EXHIBIT 14

BRAIN INJURY ASSOCIATION OF MARYLAND

June 26, 2018

Brent Reitz
President
Adventist HealthCare Rehabilitation
9909 Medical Center Dr
Rockville, MD 20850

Dear Brent:

As an organization that supports and is a resource to those your hospital's serves, we are writing to express our support for Adventist HealthCare Rehabilitation's plans to move its 42 beds in Takoma Park to the new facility in White Oak.

Based upon our experience as an organization, we believe your proposal is a solid plan that deserves approval from State health officials as it is obvious that the hospital needs a new, more accessible campus with better parking and with private rooms and other necessary elements of a 21st century rehabilitation hospital. While the staff provide, and patients receive, excellent care at Adventist HealthCare Rehabilitation located in Washington Adventist Hospital, the current hospital infrastructure is aging.

Adventist HealthCare Rehabilitation is an important part of the health care system for Montgomery County and a lifeline for thousands of people in the region. The sooner this is approved, the sooner the community can benefit from a 21st century rehabilitation facility that is more accessible.

Again, we reiterate our support for the hospital's plans and look forward to the opening of the new rehabilitation facility on the campus of White Oak Medical Center.

Sincerely,

Bryan Thomas Pugh
Executive Director
Brain Injury Association of Maryland

The Labquest Partnership
10733 Kinloch Road, Silver Spring, MD 20903

June 28, 2018

Brent Reitz
President
Adventist HealthCare Rehabilitation
9909 Medical Center Dr
Rockville, MD 20850

Dear Mr. Reitz:

For almost three decades the Labquest Partnership has served as the lead coordinating body and information clearinghouse for all interested parties in support of the development of the Federal Research Center at White Oak. This includes all projects designed to support the community's emerging innovation hub for biomedical advancement such as the new White Oak Medical Center. As an organization that supports and is a resource to those your hospital serves, we write to express our support for Adventist HealthCare Rehabilitation's plans to move its 42 beds in Takoma Park to the new facility in White Oak.

We believe such a move will provide a much needed service for county residents in a modern, accessible setting, with ample parking, private rooms and other necessary elements of a 21st century rehabilitation hospital. The Adventist HealthCare Rehabilitation located in Washington Adventist Hospital provides excellent care, but patients and providers deserve the many benefits of a new location with state-of-the-art amenities.

Adventist HealthCare Rehabilitation is an important part of the health care system for Montgomery County and a lifeline for thousands of people in the region. We await your proposal's approval so that our community can benefit from a modern-day rehabilitation facility.

Once again, we would like to reiterate our support for the hospital's plans and look forward to the opening of the new rehabilitation facility on the campus of White Oak Medical Center.

Sincerely,

Betsy L. Bretz

Betsy Bretz
Labquest Chair
Executive Directors Dan Marren, Rob Richardson, Marc Bloom

June 28, 2018

Brent Reitz
President
Adventist HealthCare Rehabilitation
9909 Medical Center Dr.
Rockville, MD 20850

Dear Brent,

As an organization that supports and is a resource to those your hospital serves, we are writing to express our support for Adventist HealthCare Rehabilitation's plans to move its 42 beds in Takoma Park to the new Adventist HealthCare White Oak Medical Center.

We believe your proposal will provide a much-needed service for county residents in a modern, accessible setting, with ample parking, private rooms and other necessary elements of a 21st century rehabilitation hospital. The Adventist HealthCare Rehabilitation currently located in Washington Adventist Hospital provides excellent care, but patients and providers deserve the many benefits of a new location with modern amenities.

Adventist HealthCare Rehabilitation is an important part of the health care system for Montgomery County and the region, and is a lifeline for thousands of people in the region. As a regional service, White Oak is perfectly situated to serve a large portion of residents in both Montgomery and Prince George's Counties. Many future patients will benefit from the hospitals proximity to major roadways and public transit. Your proposal will expand access to critical rehabilitation services for many Marylanders. The sooner this is approved, the sooner the community can benefit from a 21st century rehabilitation facility.

Again, we reiterate our support for the hospital's plans and look forward to the opening of the new rehabilitation facility on the campus of White Oak Medical Center.

Sincerely,

Gustavo Torres
Executive Director

8600 Old Georgetown Road
Bethesda, Maryland 20814
301-896-3100
www.suburbanhospital.org

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

June 20, 2018

Brent Reitz
President
Adventist HealthCare Rehabilitation
9909 Medical Center Dr
Rockville, MD 20850

Dear Brent:

As an organization that supports and is a resource to those your hospital's serves, we are writing to express our support for Adventist HealthCare Rehabilitation's plans to move its 42 beds in Takoma Park to the new facility in White Oak.

Based upon our experience as an organization, we believe your proposal is a solid plan that deserves approval from State health officials as it is obvious that the hospital needs a new, more accessible campus with better parking and with private rooms and other necessary elements of a 21st century rehabilitation hospital. While the staff provide, and patients receive, excellent care at Adventist HealthCare Rehabilitation located in Washington Adventist Hospital, the current hospital infrastructure is aging.

Adventist HealthCare Rehabilitation is an important part of the health care system for Montgomery County and a lifeline for thousands of people in the region. The sooner this is approved, the sooner the community can benefit from a 21st century rehabilitation facility that is more accessible.

Again, we reiterate our support for the hospital's plans and look forward to the opening of the new rehabilitation facility on the campus of White Oak Medical Center.

Sincerely,

Ann G George, LCSW-C
Social Worker
Progressive Care Unit
Intensive Care Unit

June 20, 2018

Brent Reitz
President
Adventist HealthCare Rehabilitation
9909 Medical Center Dr
Rockville, MD 20850

Dear Brent:

As a physician who supports and is a resource to those your hospital's serves, I would like to express my support for Adventist HealthCare Rehabilitation's plans to move its 42 beds in Takoma Park to the new facility in White Oak.

Based on my experience, your proposal is a solid plan that warrants approval from State health officials as the hospital needs a new, more accessible campus with better parking and with private rooms and other necessary elements of a 21st century rehabilitation hospital. While the staff provide, and patients receive, excellent care at Adventist HealthCare Rehabilitation located in Washington Adventist Hospital, the current hospital infrastructure is aging.

Adventist HealthCare Rehabilitation is an important part of the health care system for Montgomery County and a lifeline for thousands of people in the region. The sooner this is approved, the sooner the community can benefit from a more accessible 21st century rehabilitation facility.

Again, I would like to reiterate my support for the hospital's plans and look forward to the opening of the new rehabilitation facility on the campus of White Oak Medical Center.

Sincerely,

Lana L Rigby MD
Physiatrist
Holy Cross Hospital

EXHIBIT 15

Exhibit 15

2018 05 31 - RP

Washington Adventist Hospital Replacement Project Construction Costs Compared to Marshall Valuation Service Benchmark - WASHINGTON ADVENTIST REPLACEMENT HOSPITAL

A	B	C	D	E	F	G	H
MVS Adjusted for Final Design Area, Actual Capitalized Interest, and Addition of CUP Costs	**MVS as per MHCC REVIEW**	**FINAL DESIGN & CAPITALIZED INTEREST**	**ADD CENTRAL PLANT COSTS**	**FINAL DESIGN & CENTRAL PLANT (Note 5)**	**ADJUSTED MVS (B + E)**	**ADD Level 6 & Level 7**	**ADJUSTED MVS (F + G)**
Project Budget Item	**Cost**	**Adjust**	**Adjust**	**Adjust**	**Cost**	**Adjust**	**Cost**
Building	**$ 135,200,000**	**$ -**	**$ 26,750,000**	**$ 25,300,000**	**$ 160,500,000**	**$ 13,566,680**	**$ 174,066,680**
Fixed Equipment	**Incl above**		**Incl above**		**Incl above**	**Incl above**	**Incl above**
Site Preparation	**$ 10,400,000**		**$ 1,380,000**	**$ 1,382,000**	**$ 11,782,000**	**$ -**	**$ 11,782,000**
Architectural, Engineering & Consultant Fees	**$ 13,200,000**		**$ 1,675,000**		**$ 14,875,000**	**$ 1,626,480**	**$ 16,501,480**
Permits	**$ 700,000**		**$ 110,000**	**$ 280,000**	**$ 980,000**	**$ 289,152**	**$ 1,269,152**
Capitalized Construction Interest (Notes 1, 2 & 6)	**$ 28,248,645**	**$ 21,051,531**	**$ 1,614,744**		**$ 22,666,275**	**$ -**	**$ 22,666,275**
Total	**$ 187,748,645**				**$ 210,803,275**		**$ 226,285,587**
Adjustments (Note 3	**$ 19,450,000**		**$ 6,117,200**		**$ 25,567,200**	**$ -**	**$ 25,567,200**
Adjusted Total for MVS Comparison	**$ 168,198,645**				**$ 185,236,075**		**$ 200,718,387**
Building Square Footage (Note 4	**427,662**	**28,765**	**16,520**		**472,947**	**38,864**	**511,811**
Adjusted Project Cost Per Square Foot	**$ 393.53**				**$ 391.66**		**$ 392.17**
MVS Benchmark Cost Per Square Foot	$ 398.51				$ 398.51		$ 398.51
Total Over (Under) MVS Benchmark	**$ (4.98)**				**$ (6.85)**		**$ (6.34)**

Note 1: *CON application estimated Capitalized Interest to be $45M. MHCC calculated $28M out of $45M Capitalized Interest (56.8%) attributable to Project + same proportion of $4.5M Placement Fee. Actual capitalized interest at bond issue was $34M + $2.8M Placement Fee. Applying MHCC apportionment to actual transaction costs results in $21M for original project capitalized interest and placement fee, plus the entire* ***actual*** *CUP financing costs of $2.03M. This incorporates the* ***actual*** *finance costs of $21M in lieu of the $28M* ***estimate*** *.*

Note 2: *Total for* ***actual*** *CUP Capitalized Interest and Placement Fee is $2,028,572.49. Extraordinary Items are $6.1M of the $29.9M Project Costs, or 20.4%. Capitalized Interest and Placement Fee have been reduced proportionately for the Capitalized Interest attributable to the Extraordinary Items. $2,028572.49 less $413,828.79 (20.4%) = $1,614,743.70.*

Note 3: *See attached table for Extraordinary Items deducted from CUP budget. For the ARH 6th & 7th Level add,* ***no additional*** *Extraordinary items identified.*

Note 4: *CON application estimated building area at 427,662 SF prior to Schematic Design. Design Development refinements added 28,765 SF. The Central Utility Plant adds 16,520 SF for a current total of 472,947 SF. See AHC "Notification of Change" to MHCC, dated June 15, 2017, for details. MHCC replied via letter, dated June 23, 2017, confirming permissibility of space. The 6th & 7th Level adds 38,864 SF for a total of 511,811 SF*

Note 5: *Incorporated the Final CUP Designs and Costs.*

Note 6: *The 6th & 7th Floor Addition will not be financed and will be funded with available AHC capital/cash. For this calculation the building cost includes an allotted portion of the contingency.*

EXHIBIT 16

Exhibit 16

EXTRAORDINARY ABOVE-MVS COSTS

Washington Adventist Hospital Replacement Project - Central Plant, No additional Extraordinary costs identified for ARH 6th & 7th level add

Project Budget Item	Cost	Explanation of Requirement	Scope of Work
(1) Costs of buying land such as escrow fees, legal fees, property taxes, right of way costs, demolition, storm drains, rough grading.			
Storm Drains	$ 100,000	MVS excludes storm drains.	New storm drain system incl. pipe, excavation, culverts & manholes.
Rough Grading	$ 50,000	MVS excludes rough grading in excess of building pads.	Rough grading and fill materials around the pad.
Deforestation - Tree Clearing	$ 10,000	Site is totally wooded.	Clear and grub building pad area.
Sediment and Erosion Control	$ 5,000	Montgomery County requirement to meet NPDES standards.	Sediment and erosion control measures and maintenance.
(2) Pilings or hillside foundations, soil compaction and vibration, terracing.			
Hillside Foundation	$ 375,000	MVS excludes hillside foundations.	A concrete retaining wall is required around the Central Plant. Wall is approximately 100' x 20' x 12".
(3) Cost of land planning, interest/taxes on land, feasibility studies, CON, environ impact reports, haz mat testing, appraisal and consulting fees.			
Montgomery County Land Use Costs, Including Design	$ 50,000	MVS excludes cost of land planning. Special Exception, re-platting and add'l site plan approvals are required.	County application fees, design & legal consultants, community outreach, recordation costs.
(4) Financing discounts, funds for operating startup, project bond issues, permanent financing, developmental overhead.			
None of these costs are included in the main building estimate.			
(5) Yard improvements including septic systems, signs, landscaping, paving, walls, yard lighting, pools or other recreational facilities.			
Landscaping	$ -	MVS excludes site landscaping.	0
Yard Lighting	$ 5,000	MVS excludes site lighting.	Site lighting fixtures.
(6) Off-site costs including roads, utilities, park fees, jurisdictional hookup, tap-in, impact or entitlement fees and assessments.			
Off-site Costs: Utilities	$ 750,000	MVS excludes cost of bringing utilities from off-site to the site.	This amount is apportioned from total cost of Pepco bringing 13.2 power to site.
(7) Furnishings and fixtures, usually not found in the general contract, that are particular to a definite tenant.			
	$ -		
(8) Marketing costs to create first occupancy.			
None of these costs are included in the main building estimate.			
Additional required adjustments.			
1MW Co-Gen Unit.	$ 2,625,000	Not typical in Central Plants.	MVS valuation - Section 14, Page 41 - $2,625 per KW.
Design Costs associated with Co-Gen Unit	$ 157,500	Not typical in Central Plants.	Design costs based on 6% of value.

Exhibit 16

EXTRAORDINARY ABOVE-MVS COSTS

Washington Adventist Hospital Replacement Project - Central Plant, No additional Extraordinary costs identified for ARH 6th & 7th level add

Project Budget Item	Cost	Explanation of Requirement	Scope of Work
Redundant Generator and Associated Electrical Gear	$ 350,000	MVS includes for Generator for Critical and Life Safety Loads	(1) ea 1500 KW Genset for N+1 state.
Redundant Boiler	$ 225,000	N+1 is not typical MVS minimum standard.	(1) ea Boiler for N+1 state.
Redundant Chiller	$ 250,000	N+1 is not typical MVS minimum standard.	(1) ea Chiller for N+1 state.
Redundant Cooling Tower	$ 175,000	N+1 is not typical MVS minimum standard.	(1) ea Cooling Tower for N+1 state.
Redundant Pumps	$ 120,000	N+1 is not typical MVS minimum standard.	Redundant Pumps package for N+1 state.
Design Associate with Redundant Systems	$ 67,200	N+1 is not typical MVS minimum standard.	$1,120,000 (cost of redundant system) * 6% design factor.
LEED Design	$ 802,500	MVS Section 99, Page 1	MVS allows up to 7%. Factored at 3% of Project Bldg Costs.
Total Adjustments to Cost	**$ 6,117,200**		

		SITE COST		ADJUSTED SITE COST	
SITE ADJUSTMENTS	$ 920,000	$	4,138,000	$	3,218,000
		BUILDING COST		ADJUSTED BUILDING COST	
BUILDING ADJUSTMENTS	$ 5,197,200	$	16,600,000	$	11,402,800
	$ 6,117,200				

EXHIBIT 17

Appendix C

Adventist HealthCare Rehabilitation

Summary of Volume Statistics and Average Charges

	Discharges	Days	I/P Revenue	ALOS	Avg. Per Diem	Beds	Occupancy
CY 2013	**501**	6,591	13,425.2	13.16	2,037	22	82%
CY 2014	**678**	8,569	17,268.5	12.64	2,015	32	73%
CY 2015	**706**	9,561	18,622.7	13.54	1,948	32	82%
CY 2016	**635**	8,968	21,285.0	14.12	2,373	32	77%
CY 2017	**678**	9,538	21,156.3	14.07	2,218	32	82%
Total 4 Year Growth	**35.3%**	44.7%	57.6%	6.9%	8.9%		
Average Annual Growth	**7.86%**	9.68%	12.04%	1.69%	2.15%		

Assumptions & Drivers

Current State - NO Inflation (Table J1)

	Historical			Projection				
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
IP Hospital Revenue	18,622,983	21,285,048	21,168,093	20,737,540	25,516,895	26,532,245	26,998,307	27,473,246
OP Hospital Revenue	(99)	-	-	-	-	-	-	-
EIPA Factor ("Equivalent IP Admission")	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
Regulated Deductions:								
Contractual Allowances	36.16%	33.10%	31.59%	31.59%	31.59%	31.59%	31.59%	31.59%
Charity	1.40%	0.70%	0.34%	0.34%	0.34%	0.34%	0.34%	0.34%
Bad Debt	2.04%	1.30%	0.67%	0.67%	0.67%	0.67%	0.67%	0.67%
Pro Fee Deductions:								
Contractual Allowances	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Charity	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Bad Debt	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
IP Revenue per Admission	$ 26,378	$ 33,520	$ 31,221	$ 31,221	$ 31,221	$ 31,221	$ 31,221	$ 31,221
OP Revenue per EIPD ("Equivalent IP Day")	1,947.81	-	-	-	-	-	-	-
Physician Revenue per EIPD	-	-	-	-	-	-	-	-
			2,219	2,219	2,219	2,219	2,219	2,219
Other Operating Revenue Growth				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Revenue Inflation Update				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Rehab Growth		*-10.06%*	*6.77%*	*1.70%*	*23.00%*	*4.36%*	*1.69%*	*1.78%*
Rehab Discharges	706	635	678	690	849	886	901	917
Rehab Days	9,561	8,968	9,538	9,344	11,498	11,955	12,165	12,379
Rehab ADC	26.19	24.50	26.13	25.60	31.50	32.66	33.33	33.92
Rehab ALOS	13.54	14.12	14.07	13.54	13.54	13.49	13.50	13.50
Length of Stay		*4.3%*	*-0.4%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
EIPA	706	635	678	690	849	886	901	917
EIPD	9,561	8,968	9,538	9,344	11,498	11,955	12,165	12,379
Adjusted Occupied Bed	26.2	24.6	26.1	25.6	31.5	32.7	33.3	33.9
Acute Licensed Beds	32	32	32	35	42	42	42	42
Acute Occupancy Rate	81.9%	76.8%	81.7%	72.5%	75.0%	77.8%	79.4%	80.8%
Non-pro fee FTEs	75.81	81.41	91.58	90.64	110.39	114.47	116.80	118.86
FTEs per AOB	2.89	3.31	3.50	3.50	3.50	3.50	3.50	3.50
Salary per FTE	75,128	76,915	72,864	72,864	72,864	72,864	72,864	72,864
Salary Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*

Assumptions & Drivers

Current State - NO Inflation (Table J1)

	Historical			Projection				
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Benefit %	22.0%	20.0%	20.1%	20.1%	20.1%	20.1%	20.1%	20.1%
Supply per EIPD	$ 55	$ 37	$ 33	$ 33	$ 33	$ 33	$ 33	$ 33
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Contract Labor per EIPD	$ 27	$ 29	$ 7	$ 7	$ 7	$ 7	$ 7	$ 7
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
General & Administrative	$ 312,051	$ 397,360	$ 282,299	$ 282,299	$ 364,689	$ 447,079	$ 447,079	$ 447,079
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Professional Fees per EIPD	$ 18.79	$ 5.83	$ 6.25	$ 6	$ 6	$ 6	$ 6	$ 6
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Building and Maintenance	$ 454,036	$ 456,976	$ 435,016	$ 435,016	$ 1,246,580	$ 2,493,160	$ 2,493,160	$ 2,493,160
Inflation				*0.00%*	*186.56%*	*100.00%*	*0.00%*	*0.00%*
Insurance	$ 27,185	$ 27,003	$ 27,360	$ 27,360	$ 27,360	$ 27,360	$ 27,360	$ 27,360
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Depreciation and Amortization	$ 209,206	$ 257,200	$ 268,452	$ 268,452	$ 1,065,720	$ 1,863,440	$ 1,863,440	$ 1,863,440
Inflation				*0.00%*	*197.16%*	*49.71%*	*0.00%*	*0.00%*
IT Depreciation	$ 130,899	$ 146,638	$ 149,074	$ 149,074	$ 207,074	$ 265,074	$ 265,074	$ 265,074
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
IT Services	$ 464,479	$ 460,605	$ 624,287	$ 624,287	$ 624,287	$ 624,287	$ 624,287	$ 624,287
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Interest Expense	$ 53,265	$ 57,765	$ 45,475	$ 45,475	$ 654,160	$ 1,262,845	$ 1,262,845	$ 1,262,845
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Other - Overhead Allocation	$ 324,516	$ 396,370	$ 844,668	$ 844,668	$ 844,668	$ 844,668	$ 844,668	$ 844,668
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Purchased Services	$ 586,645	$ 641,047	$ 623,302	$ 623,302	$ 1,760,375	$ 1,830,830	$ 1,830,830	$ 1,830,830
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*

Adventist HealthCare Rehabilitation
Historical and Projected P&L - Current State TP
CY 2015 through CY 2021 projected - UNINFLATED

	Historical			Projection	Projection			
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Inpatient Revenue	$ 18,622,983	$ 21,285,048	$ 21,168,093	$ 20,737,540	$ 25,516,895	$ 26,532,245	$ 26,998,307	$ 27,473,246
Outpatient Revenue	(99)	-	-	-	-	-	-	-
Physician Revenue	-	-	-	-	-	-	-	-
Gross Patient Revenue	$ 18,622,884	$ 21,285,048	$ 21,168,093	$ 20,737,540	$ 25,516,895	$ 26,532,245	$ 26,998,307	$ 27,473,246
HSCRC Assessments/Pass-thrus	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Contractual Allowances	6,733,389	7,044,897	6,687,431	6,551,411	8,061,306	8,382,076	8,529,314	8,679,357
Charity Care	260,222	148,995	71,891	70,429	86,660	90,109	91,692	93,305
Deductions from Revenue	$ 6,993,611	$ 7,193,892	$ 6,759,322	$ 6,621,839	$ 8,147,967	$ 8,472,184	$ 8,621,006	$ 8,772,662
Net Patient Revenue before Bad Debt	$ 11,629,273	$ 14,091,156	$ 14,408,771	$ 14,115,701	$ 17,368,929	$ 18,060,061	$ 18,377,301	$ 18,700,585
Bad Debt	380,710	276,705	141,668	138,787	170,772	177,568	180,687	183,865
Net Patient Revenue	**$ 11,248,563**	**$ 13,814,451**	**$ 14,267,103**	**$ 13,976,914**	**$ 17,198,157**	**$ 17,882,493**	**$ 18,196,614**	**$ 18,516,719**
		22.81%	*3.28%*	*-2.03%*	*23.05%*	*3.98%*	*5.81%*	*3.55%*
Other Operating Revenue	55,502	78,800	112,324	112,324	112,324	112,324	112,324	112,324
Total Operating Revenue	**$ 11,304,065**	**$ 13,893,251**	**$ 14,379,427**	**$ 14,089,238**	**$ 17,310,481**	**$ 17,994,817**	**$ 18,308,938**	**$ 18,629,043**
		22.90%	*3.50%*	*-2.02%*	*22.86%*	*3.95%*	*5.77%*	*3.52%*
Salaries and Wages	$ 5,695,459	$ 6,261,618	$ 6,672,853	$ 6,604,361	$ 8,441,053	$ 9,135,592	$ 9,305,361	$ 9,455,077
Employee Benefits	1,254,860	1,249,888	1,342,842	1,329,059	1,782,109	2,005,312	2,039,477	2,069,606
Supplies	524,824	328,478	313,685	307,305	378,129	393,175	400,082	407,120
Contract Labor	254,292	261,535	62,023	60,761	74,765	77,740	79,106	80,497
General & Administrative	312,051	397,360	282,299	282,299	364,689	447,079	447,079	447,079
Professional Fees	179,623	52,308	59,583	58,371	71,824	74,682	75,994	77,330
Purchased Services	586,645	641,047	623,302	623,302	1,760,375	1,830,830	1,830,830	1,830,830
Building and Maintenance	454,036	456,976	435,016	435,016	1,246,580	2,493,160	2,493,160	2,493,160
Insurance	27,185	27,003	27,360	27,360	27,360	27,360	27,360	27,360
Depreciation and Amortization	209,206	257,200	268,452	268,452	1,065,720	1,863,440	1,863,440	1,863,440
IT Depreciation	130,899	146,638	149,074	149,074	149,074	149,074	149,074	149,074
IT Services	464,479	460,605	624,287	624,287	624,287	624,287	624,287	624,287
Interest Expense	53,265	57,765	45,475	45,475	654,160	1,262,845	1,262,845	1,262,845
Other - Overhead Allocation	324,516	396,370	844,668	844,668	844,668	844,668	844,668	844,668
Total Operating Expenses	**$ 10,471,340**	**$ 10,994,791**	**$ 11,750,919**	**$ 11,659,790**	**$ 17,484,792**	**$ 21,229,244**	**$ 21,442,761**	**$ 21,632,372**
		5.00%	*6.88%*	*-0.78%*	*49.96%*	*21.42%*	*22.64%*	*1.90%*
Income (loss) from operations	**$ 832,725**	**$ 2,898,460**	**$ 2,628,508**	**$ 2,429,448**	**$ (174,312)**	**$ (3,234,427)**	**$ (3,133,823)**	**$ (3,003,329)**
	7.4%	*20.9%*	*18.3%*	*17.2%*	*-1.0%*	*-18.0%*	*-17.1%*	*-16.1%*

Assumptions & Drivers

Current State - with Inflation (Table K1)

	Historical			Projection				
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
IP Hospital Revenue	18,622,983	21,285,048	21,168,093	21,401,142	26,570,437	27,669,150	28,295,958	28,937,694
OP Hospital Revenue	(99)	-	-	-	-	-	-	-
EIPA Factor ("Equivalent IP Admission")	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
Regulated Deductions:								
Contractual Allowances	36.16%	33.10%	31.59%	31.59%	31.59%	31.59%	31.59%	31.59%
Charity	1.40%	0.70%	0.34%	0.34%	0.34%	0.34%	0.34%	0.34%
Bad Debt	2.04%	1.30%	0.67%	0.67%	0.67%	0.67%	0.67%	0.67%
Pro Fee Deductions:								
Contractual Allowances	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Charity	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Bad Debt	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
IP Revenue per Admission	$ 26,378	$ 33,520	$ 31,221	$ 32,220	$ 33,252	$ 34,316	$ 34,316	$ 35,414
OP Revenue per EIPD ("Equivalent IP Day")	1,947.81	-	-	-	-	-	-	-
Physician Revenue per EIPD	-	-	-	-	-	-	-	-
			2,219	2,290	2,311	2,314	2,326	2,338
Other Operating Revenue Growth				*1.50%*	*1.50%*	*1.50%*	*1.50%*	*1.50%*
Revenue Inflation Update				*3.20%*	*0.90%*	*0.15%*	*0.50%*	*0.50%*
Rehab Growth		*-10.06%*	*6.77%*	*1.70%*	*23.00%*	*4.36%*	*1.69%*	*1.78%*
Rehab Discharges	706	635	678	690	849	886	901	917
Rehab Days	9,561	8,968	9,538	9,344	11,498	11,955	12,165	12,379
Rehab ADC	26.19	24.50	26.13	25.60	31.50	32.66	33.33	33.92
Rehab ALOS	13.54	14.12	14.07	13.54	13.54	13.49	13.50	13.50
Length of Stay		*4.3%*	*-0.4%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
EIPA	706	635	678	690	849	886	901	917
EIPD	9,561	8,968	9,538	9,344	11,498	11,955	12,165	12,379
Adjusted Occupied Bed	26.2	24.6	26.1	25.6	31.5	32.7	33.3	33.9
Acute Licensed Beds	32	32	32	35	42	42	42	42
Acute Occupancy Rate	81.9%	76.8%	81.7%	72.5%	75.0%	77.8%	79.4%	80.8%
Non-pro fee FTEs	75.81	81.41	91.58	90.64	110.39	114.47	116.80	118.86
FTEs per AOB	2.89	3.31	3.50	3.50	3.50	3.50	3.50	3.50
Salary per FTE	75,128	76,915	72,864	74,248	75,659	77,096	78,561	80,054
Salary Inflation				*1.90%*	*1.90%*	*1.90%*	*1.90%*	*1.90%*

Assumptions & Drivers

Current State - with Inflation (Table K1)

	Historical			Projection				
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Benefit %	22.0%	20.0%	20.1%	20.1%	20.1%	20.1%	20.1%	20.1%
Supply per EIPD	$ 55	$ 37	$ 33	$ 34	$ 35	$ 35	$ 36	$ 37
Inflation				*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*
Contract Labor per EIPD	$ 27	$ 29	$ 7	$ 7	$ 7	$ 7	$ 7	$ 7
Inflation				*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*
General & Administrative	$ 312,051	$ 397,360	$ 282,299	$ 289,356	$ 378,980	$ 470,845	$ 482,616	$ 494,681
Inflation				*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*
Professional Fees per EIPD	$ 18.79	$ 5.83	$ 6.25	$ 6	$ 7	$ 7	$ 7	$ 7
Inflation				*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*
Building and Maintenance	$ 454,036	$ 456,976	$ 435,016	$ 445,891	$ 1,246,580	$ 2,493,160	$ 2,555,489	$ 2,619,376
Inflation				*2.50%*	*179.57%*	*100.00%*	*2.50%*	*2.50%*
Insurance	$ 27,185	$ 27,003	$ 27,360	$ 28,044	$ 28,745	$ 29,464	$ 30,200	$ 30,955
Inflation				*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*
Depreciation and Amortization	$ 209,206	$ 257,200	$ 268,452	$ 268,452	$ 1,065,720	$ 1,863,440	$ 1,863,440	$ 1,863,440
Inflation				*0.00%*	*197.16%*	*49.71%*	*0.00%*	*0.00%*
IT Depreciation	$ 130,899	$ 146,638	$ 149,074	$ 149,074	$ 207,074	$ 265,074	$ 265,074	$ 265,074
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
IT Services	$ 464,479	$ 460,605	$ 624,287	$ 639,894	$ 649,493	$ 659,235	$ 669,124	$ 679,160
Inflation				*2.50%*	*1.50%*	*1.50%*	*1.50%*	*1.50%*
Interest Expense	$ 53,265	$ 57,765	$ 45,475	$ 45,475	$ 654,160	$ 1,262,845	$ 1,262,845	$ 1,262,845
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Other - Overhead Allocation	$ 324,516	$ 396,370	$ 844,668	$ 865,785	$ 878,771	$ 891,953	$ 905,332	$ 918,912
Inflation				*2.50%*	*1.50%*	*1.50%*	*1.50%*	*1.50%*
Purchased Services	$ 586,645	$ 641,047	$ 623,302	$ 638,885	$ 1,775,957	$ 1,890,811	$ 1,938,081	$ 1,986,533
Inflation				*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*

Adventist HealthCare Rehabilitation
Historical and Projected P&L - Current State TP
CY 2015 through CY 2021 projected - INFLATED

	Historical			Projection	Projection			
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Inpatient Revenue	$ 18,622,983	$ 21,285,048	$ 21,168,093	$ 21,401,142	$ 26,570,437	$ 27,669,150	$ 28,295,958	$ 28,937,694
Outpatient Revenue	(99)	-	-	-	-	-	-	-
Physician Revenue	-	-	-	-	-	-	-	-
Gross Patient Revenue	$ 18,622,884	$ 21,285,048	$ 21,168,093	$ 21,401,142	$ 26,570,437	$ 27,669,150	$ 28,295,958	$ 28,937,694
HSCRC Assessments/Pass-thrus	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Contractual Allowances	6,733,389	7,044,897	6,687,431	6,761,056	8,394,141	8,741,247	8,939,269	9,142,006
Charity Care	260,222	148,995	71,891	72,682	90,238	93,970	96,099	98,278
Deductions from Revenue	$ 6,993,611	$ 7,193,892	$ 6,759,322	$ 6,833,738	$ 8,484,380	$ 8,835,217	$ 9,035,367	$ 9,240,284
Net Patient Revenue before Bad Debt	$ 11,629,273	$ 14,091,156	$ 14,408,771	$ 14,567,403	$ 18,086,057	$ 18,833,933	$ 19,260,591	$ 19,697,410
Bad Debt	380,710	276,705	141,668	143,228	177,823	185,176	189,371	193,666
Net Patient Revenue	**$ 11,248,563**	**$ 13,814,451**	**$ 14,267,103**	**$ 14,424,176**	**$ 17,908,234**	**$ 18,648,756**	**$ 19,071,220**	**$ 19,503,744**
		22.81%	*3.28%*	*1.10%*	*24.15%*	*4.14%*	*6.49%*	*4.58%*
Other Operating Revenue	55,502	78,800	112,324	114,009	115,719	117,455	117,455	119,217
Total Operating Revenue	**$ 11,304,065**	**$ 13,893,251**	**$ 14,379,427**	**$ 14,538,185**	**$ 18,023,953**	**$ 18,766,211**	**$ 19,188,675**	**$ 19,622,960**
		22.90%	*3.50%*	*1.10%*	*23.98%*	*4.12%*	*6.46%*	*4.57%*
Salaries and Wages	$ 5,695,459	$ 6,261,618	$ 6,672,853	$ 6,729,844	$ 8,749,619	$ 9,620,116	$ 9,970,845	$ 10,309,682
Employee Benefits	1,254,860	1,249,888	1,342,842	1,354,311	1,844,204	2,102,818	2,173,398	2,241,586
Supplies	524,824	328,478	313,685	314,987	397,272	423,407	441,615	460,618
Contract Labor	254,292	261,535	62,023	62,281	78,550	83,718	87,318	91,075
General & Administrative	312,051	397,360	282,299	289,356	378,980	470,845	482,616	494,681
Professional Fees	179,623	52,308	59,583	59,830	75,460	80,424	83,883	87,492
Purchased Services	586,645	641,047	623,302	638,885	1,775,957	1,890,811	1,938,081	1,986,533
Building and Maintenance	454,036	456,976	435,016	445,891	1,246,580	2,493,160	2,555,489	2,619,376
Insurance	27,185	27,003	27,360	28,044	28,745	29,464	30,200	30,955
Depreciation and Amortization	209,206	257,200	268,452	268,452	1,065,720	1,863,440	1,863,440	1,863,440
IT Depreciation	130,899	146,638	149,074	149,074	149,074	149,074	149,074	149,074
IT Services	464,479	460,605	624,287	639,894	649,493	659,235	669,124	679,160
Interest Expense	53,265	57,765	45,475	45,475	654,160	1,262,845	1,262,845	1,262,845
Other - Overhead Allocation	324,516	396,370	844,668	865,785	878,771	891,953	905,332	918,912
Total Operating Expenses	**$ 10,471,340**	**$ 10,994,791**	**$ 11,750,919**	**$ 11,892,109**	**$ 17,972,586**	**$ 22,021,309**	**$ 22,613,260**	**$ 23,195,432**
		5.00%	*6.88%*	*1.20%*	*51.13%*	*22.53%*	*25.82%*	*5.33%*
Income (loss) from operations	**$ 832,725**	**$ 2,898,460**	**$ 2,628,508**	**$ 2,646,075**	**$ 51,368**	**$ (3,255,098)**	**$ (3,424,586)**	**$ (3,572,472)**
	7.4%	*20.9%*	*18.3%*	*18.2%*	*0.3%*	*-17.3%*	*-17.8%*	*-18.2%*

Assumptions & Drivers

White Oak - NO Inflation (Table J2)

	Historical			Projection				
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
IP Hospital Revenue	18,622,983	21,285,048	21,168,093	20,737,540	25,516,895	26,532,245	26,998,307	27,473,246
OP Hospital Revenue	(99)	-	-	-	-	-	-	-
EIPA Factor ("Equivalent IP Admission")	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
Regulated Deductions:								
Contractual Allowances	36.16%	33.10%	31.59%	31.59%	31.59%	31.59%	31.59%	31.59%
Charity	1.40%	0.70%	0.34%	0.34%	0.34%	0.34%	0.34%	0.34%
Bad Debt	2.04%	1.30%	0.67%	0.67%	0.67%	0.67%	0.67%	0.67%
Pro Fee Deductions:								
Contractual Allowances	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Charity	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Bad Debt	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
IP Revenue per Admission	$ 26,378	$ 33,520	$ 31,221	$ 31,221	$ 31,221	$ 31,221	$ 31,221	$ 31,221
OP Revenue per EIPD ("Equivalent IP Day")	1,947.81	-	-	-	-	-	-	-
Physician Revenue per EIPD	-	-	-	-	-	-	-	-
			2,219	2,219	2,219	2,219	2,219	2,219
Other Operating Revenue Growth				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Revenue Inflation Update				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Rehab Growth		*-10.06%*	*6.77%*	*1.70%*	*23.00%*	*4.36%*	*1.69%*	*1.78%*
Rehab Discharges	706	635	678	690	849	886	901	917
Rehab Days	9,561	8,968	9,538	9,344	11,498	11,955	12,165	12,379
Rehab ADC	26.19	24.50	26.13	25.60	31.50	32.66	33.33	33.92
Rehab ALOS	13.54	14.12	14.07	13.54	13.54	13.49	13.50	13.50
Length of Stay		*4.3%*	*-0.4%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
EIPA	706	635	678	690	849	886	901	917
EIPD	9,561	8,968	9,538	9,344	11,498	11,955	12,165	12,379
Adjusted Occupied Bed	26.2	24.6	26.1	25.6	31.5	32.7	33.3	33.9

Assumptions & Drivers

White Oak - NO Inflation (Table J2)

	Historical			Projection				
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Acute Licensed Beds	32	32	32	35	42	42	42	42
Acute Occupancy Rate	81.9%	76.8%	81.7%	72.5%	75.0%	77.8%	79.4%	80.8%
Non-pro fee FTEs	75.81	81.41	91.58	90.64	110.39	114.47	116.80	118.86
FTEs per AOB	2.89	3.31	3.50	3.50	3.50	3.50	3.50	3.50
Salary per FTE	75,128	76,915	72,864	72,864	72,864	72,864	72,864	72,864
Salary Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Benefit %	22.0%	20.0%	20.1%	20.1%	20.1%	20.1%	20.1%	20.1%
Supply per EIPD	$ 55	$ 37	$ 33	$ 33	$ 33	$ 33	$ 33	$ 33
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Contract Labor per EIPD	$ 27	$ 29	$ 7	$ 7	$ 7	$ 7	$ 7	$ 7
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
General & Administrative	$ 312,051	$ 397,360	$ 282,299	$ 282,299	$ 364,689	$ 282,299	$ 282,299	$ 282,299
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Professional Fees per EIPD	$ 18.79	$ 5.83	$ 6.25	$ 6	$ 6	$ 6	$ 6	$ 6
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Building and Maintenance	$ 454,036	$ 456,976	$ 435,016	$ 435,016	$ 1,246,580	$ 1,850,000	$ 1,850,000	$ 1,850,000
Inflation				*0.00%*	*186.56%*	*48.41%*	*0.00%*	*0.00%*
Insurance	$ 27,185	$ 27,003	$ 27,360	$ 27,360	$ 27,360	$ 27,360	$ 27,360	$ 27,360
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Depreciation and Amortization	$ 209,206	$ 257,200	$ 268,452	$ 268,452	$ 1,065,720	$ 683,452	$ 683,452	$ 683,452
Inflation				*0.00%*	*197.16%*	*0.00%*	*0.00%*	*0.00%*
IT Depreciation	$ 130,899	$ 146,638	$ 149,074	$ 149,074	$ 207,074	$ 149,074	$ 149,074	$ 149,074
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
IT Services	$ 464,479	$ 460,605	$ 624,287	$ 624,287	$ 624,287	$ 624,287	$ 624,287	$ 624,287
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Interest Expense	$ 53,265	$ 57,765	$ 45,475	$ 45,475	$ 654,160	$ 45,475	$ 45,475	$ 45,475
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Other - Overhead Allocation	$ 324,516	$ 396,370	$ 844,668	$ 844,668	$ 844,668	$ 844,668	$ 844,668	$ 844,668
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Purchased Services	$ 586,645	$ 641,047	$ 623,302	$ 623,302	$ 1,227,066	$ 993,466	$ 993,466	$ 993,466
Inflation				*0.00%*	*0.00%*	*-100.00%*	*0.00%*	*0.00%*

Adventist HealthCare Rehabilitation
Historical and Projected P&L - Future State White Oak
CY 2015 through CY 2021 projected - UNINFLATED

	Historical			Projection	Projection			
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Inpatient Revenue (Regulated GBR)	$ 18,622,983	$ 21,285,048	$ 21,168,093	$ 20,737,540	$ 25,516,895	$ 26,532,245	$ 26,998,307	$ 27,473,246
Outpatient Revenue (Regulated GBR)	(99)	-	-	-	-	-	-	-
Physician Revenue	-	-	-	-	-	-	-	-
Gross Patient Revenue	$ 18,622,884	$ 21,285,048	$ 21,168,093	$ 20,737,540	$ 25,516,895	$ 26,532,245	$ 26,998,307	$ 27,473,246
HSCRC Assessments/Pass-thrus	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Contractual Allowances	6,733,389	7,044,897	6,687,431	6,551,411	8,061,306	8,382,076	8,529,314	8,679,357
Charity Care	260,222	148,995	71,891	70,429	86,660	90,109	91,692	93,305
Deductions from Revenue	$ 6,993,611	$ 7,193,892	$ 6,759,322	$ 6,621,839	$ 8,147,967	$ 8,472,184	$ 8,621,006	$ 8,772,662
Net Patient Revenue before Bad Debt	$ 11,629,273	$ 14,091,156	$ 14,408,771	$ 14,115,701	$ 17,368,929	$ 18,060,061	$ 18,377,301	$ 18,700,585
Bad Debt	380,710	276,705	141,668	138,787	170,772	177,568	180,687	183,865
Net Patient Revenue	**$ 11,248,563**	**$ 13,814,451**	**$ 14,267,103**	**$ 13,976,914**	**$ 17,198,157**	**$ 17,882,493**	**$ 18,196,614**	**$ 18,516,719**
		22.81%	*3.28%*	*-2.03%*	*23.05%*	*3.98%*	*5.81%*	*3.55%*
Other Operating Revenue	55,502	78,800	112,324	112,324	112,324	112,324	112,324	112,324
Total Operating Revenue	**$ 11,304,065**	**$ 13,893,251**	**$ 14,379,427**	**$ 14,089,238**	**$ 17,310,481**	**$ 17,994,817**	**$ 18,308,938**	**$ 18,629,043**
		22.90%	*3.50%*	*-2.02%*	*22.86%*	*3.95%*	*5.77%*	*3.52%*
Salaries and Wages	$ 5,695,459	$ 6,261,618	$ 6,672,853	$ 6,604,361	$ 8,441,053	$ 8,340,952	$ 8,510,721	$ 8,660,437
Employee Benefits	1,254,860	1,249,888	1,342,842	1,329,059	1,782,109	1,678,529	1,712,694	1,742,823
Supplies	524,824	328,478	313,685	307,305	378,129	393,175	400,082	407,120
Contract Labor	254,292	261,535	62,023	60,761	74,765	77,740	79,106	80,497
General & Administrative	312,051	397,360	282,299	282,299	364,689	282,299	282,299	282,299
Professional Fees	179,623	52,308	59,583	58,371	71,824	74,682	75,994	77,330
Purchased Services	586,645	641,047	623,302	623,302	1,227,066	993,466	993,466	993,466
Building and Maintenance	454,036	456,976	435,016	435,016	1,246,580	1,850,000	1,850,000	1,850,000
Insurance	27,185	27,003	27,360	27,360	27,360	27,360	27,360	27,360
Depreciation and Amortization	209,206	257,200	268,452	268,452	1,065,720	683,452	683,452	683,452
IT Depreciation	130,899	146,638	149,074	149,074	149,074	149,074	149,074	149,074
IT Services	464,479	460,605	624,287	624,287	624,287	624,287	624,287	624,287
Interest Expense	53,265	57,765	45,475	45,475	654,160	45,475	45,475	45,475
Other - Overhead Allocation	324,516	396,370	844,668	844,668	844,668	844,668	844,668	844,668
Total Operating Expenses	**$ 10,471,340**	**$ 10,994,791**	**$ 11,750,919**	**$ 11,659,790**	**$ 16,951,484**	**$ 16,065,159**	**$ 16,278,677**	**$ 16,468,288**
		5.00%	*6.88%*	*-0.78%*	*45.38%*	*-5.23%*	*-3.97%*	*2.51%*
Income (loss) from operations	**$ 832,725**	**$ 2,898,460**	**$ 2,628,508**	**$ 2,429,448**	**$ 358,997**	**$ 1,929,658**	**$ 2,030,262**	**$ 2,160,756**
	7.4%	*20.9%*	*18.3%*	*17.2%*	*2.1%*	*10.7%*	*11.1%*	*11.6%*

Assumptions & Drivers

Rehab at White Oak - with Inflation (Table K2)

	Historical			Projection				
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
IP Hospital Revenue	18,622,983	21,285,048	21,168,093	21,401,142	26,570,437	27,669,150	28,295,958	28,937,694
OP Hospital Revenue	(99)	-	-	-	-	-	-	-
EIPA Factor ("Equivalent IP Admission")	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
Regulated Deductions:								
Contractual Allowances	36.16%	33.10%	31.59%	31.59%	31.59%	31.59%	31.59%	31.59%
Charity	1.40%	0.70%	0.34%	0.34%	0.34%	0.34%	0.34%	0.34%
Bad Debt	2.04%	1.30%	0.67%	0.67%	0.67%	0.67%	0.67%	0.67%
Pro Fee Deductions:								
Contractual Allowances	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Charity	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Bad Debt	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
IP Revenue per Admission	$ 26,378	$ 33,520	$ 31,221	$ 32,220	$ 33,252	$ 34,316	$ 34,316	$ 35,414
OP Revenue per EIPD ("Equivalent IP Day")	1,947.81	-	-	-	-	-	-	-
Physician Revenue per EIPD	-	-	-	-	-	-	-	-
			2,219	2,290	2,311	2,314	2,326	2,338
Other Operating Revenue Growth				*1.50%*	*1.50%*	*1.50%*	*1.50%*	*1.50%*
Revenue Inflation Update				*3.20%*	*0.90%*	*0.15%*	*0.50%*	*0.50%*
Rehab Growth		*-10.06%*	*6.77%*	*1.70%*	*23.00%*	*4.36%*	*1.69%*	*1.78%*
Rehab Discharges	706	635	678	690	849	886	901	917
Rehab Days	9,561	8,968	9,538	9,344	11,498	11,955	12,165	12,379
Rehab ADC	26.19	24.50	26.13	25.60	31.50	32.66	33.33	33.92
Rehab ALOS	13.54	14.12	14.07	13.54	13.54	13.49	13.50	13.50
Length of Stay		*4.3%*	*-0.4%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
EIPA	706	635	678	690	849	886	901	917
EIPD	9,561	8,968	9,538	9,344	11,498	11,955	12,165	12,379

Assumptions & Drivers

Rehab at White Oak - with Inflation (Table K2)

	Historical			Projection				
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Adjusted Occupied Bed	26.2	24.6	26.1	25.6	31.5	32.7	33.3	33.9
Acute Licensed Beds	32	32	32	35	42	42	42	42
Acute Occupancy Rate	81.9%	76.8%	81.7%	72.5%	75.0%	77.8%	79.4%	80.8%
Non-pro fee FTEs	75.81	81.41	91.58	90.64	110.39	114.47	116.80	118.86
FTEs per AOB	2.89	3.31	3.50	3.50	3.50	3.50	3.50	3.50
Salary per FTE	75,128	76,915	72,864	74,248	75,659	77,096	78,561	80,054
Salary Inflation				*1.90%*	*1.90%*	*1.90%*	*1.90%*	*1.90%*
Benefit %	22.0%	20.0%	20.1%	20.1%	20.1%	20.1%	20.1%	20.1%
Supply per EIPD	$ 55	$ 37	$ 33	$ 34	$ 35	$ 35	$ 36	$ 37
Inflation				*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*
Contract Labor per EIPD	$ 27	$ 29	$ 7	$ 7	$ 7	$ 7	$ 7	$ 7
Inflation				*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*
General & Administrative	$ 312,051	$ 397,360	$ 282,299	$ 289,356	$ 378,980	$ 296,590	$ 304,005	$ 311,605
Inflation				*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*
Professional Fees per EIPD	$ 18.79	$ 5.83	$ 6.25	$ 6	$ 7	$ 7	$ 7	$ 7
Inflation				*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*
Building and Maintenance	$ 454,036	$ 456,976	$ 435,016	$ 445,891	$ 1,246,580	$ 1,850,000	$ 1,896,250	$ 1,943,656
Inflation				*2.50%*	*179.57%*	*48.41%*	*2.50%*	*2.50%*
Insurance	$ 27,185	$ 27,003	$ 27,360	$ 28,044	$ 28,745	$ 29,464	$ 30,200	$ 30,955
Inflation				*2.50%*	*2.50%*	*2.50%*	*2.50%*	*2.50%*
Depreciation and Amortization	$ 209,206	$ 257,200	$ 268,452	$ 268,452	$ 1,065,720	$ 683,452	$ 683,452	$ 683,452
Inflation				*0.00%*	*197.16%*	*0.00%*	*0.00%*	*0.00%*
IT Depreciation	$ 130,899	$ 146,638	$ 149,074	$ 149,074	$ 207,074	$ 149,074	$ 149,074	$ 149,074
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
IT Services	$ 464,479	$ 460,605	$ 624,287	$ 639,894	$ 649,493	$ 659,235	$ 669,124	$ 679,160
Inflation				*2.50%*	*1.50%*	*1.50%*	*1.50%*	*1.50%*
Interest Expense	$ 53,265	$ 57,765	$ 45,475	$ 45,475	$ 654,160	$ 45,475	$ 45,475	$ 45,475
Inflation				*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Other - Overhead Allocation	$ 324,516	$ 396,370	$ 844,668	$ 865,785	$ 878,771	$ 891,953	$ 905,332	$ 918,912
Inflation				*2.50%*	*1.50%*	*1.50%*	*1.50%*	*1.50%*
Purchased Services	$ 586,645	$ 641,047	$ 623,302	$ 638,885	$ 1,258,620	$ 993,466	$ 1,018,303	$ 1,043,760

Assumptions & Drivers

Rehab at White Oak - with Inflation (Table K2)

	Historical			Projection				
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Inflation				*2.50%*	*2.50%*	*-100.00%*	*2.50%*	*2.50%*

Adventist HealthCare Rehabilitation
Historical and Projected P&L - Future State White Oak
CY 2015 through CY 2021 projected - INFLATED

	Historical			Projection	Projection			
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Inpatient Revenue (Regulated GBR)	$ 18,622,983	$ 21,285,048	$ 21,168,093	$ 21,401,142	$ 26,570,437	$ 27,669,150	$ 28,295,958	$ 28,937,694
Outpatient Revenue (Regulated GBR)	(99)	-	-	-	-	-	-	-
Physician Revenue	-	-	-	-	-	-	-	-
Gross Patient Revenue	$ 18,622,884	$ 21,285,048	$ 21,168,093	$ 21,401,142	$ 26,570,437	$ 27,669,150	$ 28,295,958	$ 28,937,694
HSCRC Assessments/Pass-thrus	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Contractual Allowances	6,733,389	7,044,897	6,687,431	6,761,056	8,394,141	8,741,247	8,939,269	9,142,006
Charity Care	260,222	148,995	71,891	72,682	90,238	93,970	96,099	98,278
Deductions from Revenue	$ 6,993,611	$ 7,193,892	$ 6,759,322	$ 6,833,738	$ 8,484,380	$ 8,835,217	$ 9,035,367	$ 9,240,284
Net Patient Revenue before Bad Debt	$ 11,629,273	$ 14,091,156	$ 14,408,771	$ 14,567,403	$ 18,086,057	$ 18,833,933	$ 19,260,591	$ 19,697,410
Bad Debt	380,710	276,705	141,668	143,228	177,823	185,176	189,371	193,666
Net Patient Revenue	**$ 11,248,563**	**$ 13,814,451**	**$ 14,267,103**	**$ 14,424,176**	**$ 17,908,234**	**$ 18,648,756**	**$ 19,071,220**	**$ 19,503,744**
		22.81%	*3.28%*	*1.10%*	*24.15%*	*4.14%*	*6.49%*	*4.58%*
Other Operating Revenue	55,502	78,800	112,324	114,009	115,719	117,455	117,455	119,217
Total Operating Revenue	**$ 11,304,065**	**$ 13,893,251**	**$ 14,379,427**	**$ 14,538,185**	**$ 18,023,953**	**$ 18,766,211**	**$ 19,188,675**	**$ 19,622,960**
		22.90%	*3.50%*	*1.10%*	*23.98%*	*4.12%*	*6.46%*	*4.57%*
Salaries and Wages	$ 5,695,459	$ 6,261,618	$ 6,672,853	$ 6,729,844	$ 8,749,619	$ 8,825,476	$ 9,176,205	$ 9,515,042
Employee Benefits	1,254,860	1,249,888	1,342,842	1,354,311	1,844,204	1,776,035	1,846,615	1,914,803
Supplies	524,824	328,478	313,685	314,987	397,272	423,407	441,615	460,618
Contract Labor	254,292	261,535	62,023	62,281	78,550	83,718	87,318	91,075
General & Administrative	312,051	397,360	282,299	289,356	378,980	296,590	304,005	311,605
Professional Fees	179,623	52,308	59,583	59,830	75,460	80,424	83,883	87,492
Purchased Services	586,645	641,047	623,302	638,885	1,258,620	993,466	1,018,303	1,043,760
Building and Maintenance	454,036	456,976	435,016	445,891	1,246,580	1,850,000	1,896,250	1,943,656
Insurance	27,185	27,003	27,360	28,044	28,745	29,464	30,200	30,955
Depreciation and Amortization	209,206	257,200	268,452	268,452	1,065,720	683,452	683,452	683,452
IT Depreciation	130,899	146,638	149,074	149,074	149,074	149,074	149,074	149,074
IT Services	464,479	460,605	624,287	639,894	649,493	659,235	669,124	679,160
Interest Expense	53,265	57,765	45,475	45,475	654,160	45,475	45,475	45,475
Other - Overhead Allocation	324,516	396,370	844,668	865,785	878,771	891,953	905,332	918,912
Total Operating Expenses	**$ 10,471,340**	**$ 10,994,791**	**$ 11,750,919**	**$ 11,892,109**	**$ 17,455,249**	**$ 16,787,769**	**$ 17,336,851**	**$ 17,875,082**
		5.00%	*6.88%*	*1.20%*	*46.78%*	*-3.82%*	*-0.68%*	*6.48%*
Income (loss) from operations	**$ 832,725**	**$ 2,898,460**	**$ 2,628,508**	**$ 2,646,075**	**$ 568,704**	**$ 1,978,443**	**$ 1,851,824**	**$ 1,747,878**
	7.4%	*20.9%*	*18.3%*	*18.2%*	*3.2%*	*10.5%*	*9.7%*	*8.9%*

EXHIBIT 18

COPY

MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. 15-031

Issued to:

Adventist Healthcare Washington Adventist Hospital
7600 Carroll Avenue
Takoma Park, MD 20912

Type of Facility: Acute General Hospital

Date Issued: August 19, 2016

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, Title 19 Section 318 Annotated Code of Maryland, 1982 Edition, and subsequent supplements and is subject to any and all statutory provisions, including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Expiration Date: November 19, 2019

Patricia Tomko May MD

Director

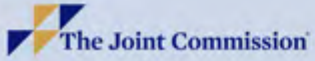
Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

EXHIBIT 19

Quality Check

Organizations that have achieved
The Gold Seal of Approval® from
The Joint Commission®

Quality Report


The Joint Commission

Quality Report

Washington Adventist Hospital

HCO ID: 6302
7600 Carroll Ave.
Takoma Park, MD, 20912
(301) 891-6186
www.adventisthealthcare.com

Summary of Quality Information

Accreditation Programs

View Accreditation History

Behavioral Health Care

Accreditation Decision
Accredited

Effective Date
10/19/2016

Last Full Survey Date
8/18/2016

Last On-Site Survey Date
8/18/2016

Hospital

Accreditation Decision
Accredited

Effective Date
8/20/2016

Last Full Survey Date
8/19/2016

Last On-Site Survey Date
8/19/2016

Sites

Washington Adventist Hospital

7600 Carroll Ave.
Takoma Park, MD, 20912

Available Services

- Behavioral Health (Day Programs - Adult)
- Behavioral Health (Non 24 Hour Care - Adult)
- Behavioral Health (24-hour Acute Care/Crisis Stabilization - Adult)
- Behavioral Health (Partial - Adult)
- Brachytherapy (Imaging/Diagnostic Services)
- Cardiac Catheterization Lab (Surgical Services)
- Cardiac Surgery (Surgical Services)
- Cardiothoracic Surgery (Surgical Services)
- Cardiovascular Unit (Inpatient)
- Community Integration (Non 24 Hour Care)
- CT Scanner (Imaging/Diagnostic Services)
- Dialysis Unit (Inpatient)
- Ear/Nose/Throat Surgery (Surgical Services)
- EEG/EKG/EMG Lab (Imaging/Diagnostic Services)
- Family Support (Non 24 Hour Care)
- Gastroenterology (Surgical Services)
- General Laboratory Tests
- Gynecological Surgery (Surgical Services)
- Gynecology (Inpatient)
- Hematology/Oncology Unit (Inpatient)
- Inpatient Unit (Inpatient)
- Interventional Radiology (Imaging/Diagnostic Services)
- Labor & Delivery (Inpatient)
- Magnetic Resonance Imaging (Imaging/Diagnostic Services)
- Medical /Surgical Unit (Inpatient)
- Medical ICU (Intensive Care Unit)
- Neurosurgery (Surgical Services)

- Neurosurgery (Surgical Services)
- Normal Newborn Nursery (Inpatient)
- Nuclear Medicine (Imaging/Diagnostic Services)
- Ophthalmology (Surgical Services)
- Orthopedic Surgery (Surgical Services)
- Orthopedic/Spine Unit (Inpatient)
- Outpatient Clinics (Outpatient)
- Peer Support (Non 24 Hour Care)
- Plastic Surgery (Surgical Services)
- Positron Emission Tomography (PET) (Imaging/Diagnostic Services)
- Post Anesthesia Care Unit (PACU) (Inpatient)
- Radiation Oncology (Imaging/Diagnostic Services)
- Teleradiology (Imaging/Diagnostic Services)
- Thoracic Surgery (Surgical Services)
- Ultrasound (Imaging/Diagnostic Services)
- Urology (Surgical Services)
- Vascular Surgery (Surgical Services)

Washington Adventist Hospital Conference Center

Washington Adventist Hospital Conference Center
7620 Carroll Avenue
Takoma Park, MD, 20912

Available Services

- Outpatient Clinics (Outpatient)

Other Clinics/Practices Located at This Site:

- Washington Adventist Hospital Cardiac Rehabilitation Service
- Women's Health Center

Special Quality Awards

Due to our commitment to accurate data reporting, The Joint Commission is suspending the reporting of Specialty Quality Awards until further notice

- 2013 Gold Plus Get With The Guidelines - Stroke

Cooperative Agreements

Hospital - Accredited by American College of Surgeons-Commission on Cancer (ACoS-COC)

National Patient Safety Goals and National Quality Improvement Goals

Show Keys +

Symbol Key

- This organization achieved the best possible results
- This organization's performance is above the target range/value
- This organization's performance is similar to the target range/value
- This organization's performance is below the target range/value

(N/A) This measure is not applicable for this organization

(N/D) Not displayed

Measures Footnote Key

1. The measure or measure set was not reported.
2. The measure set does not have an overall result.
3. The number is not enough for comparison purposes.
4. The measure meets the Privacy Disclosure Threshold rule.
5. The organization scored above 90% but was below most other organizations.
6. The measure results are not statistically valid.
7. The measure results are based on a sample of patients.
8. The number of months with measure data is below the reporting requirement.
9. The measure results are temporarily suppressed pending resubmission of updated data.
10. Test Measure: a measure being evaluated for reliability of the individual data elements or awaiting National Quality Forum Endorsement.
11. There were no eligible patients that met the denominator criteria.

The Joint Commission only reports measures endorsed by the National Quality Forum.
* This information can also be viewed at Hospital Compare.

** Indicates per 1000 hours of patient care.
*** The measure was not in effect for this quarter.
---- Null value or data not displayed.

Hospital

2016 National Patient Safety Goals

Nationwide Comparison:

Statewide Comparison: N/A

Behavioral Health Care

2016 National Patient Safety Goals

Nationwide Comparison:

Statewide Comparison: N/A

Reporting Period: October 2016 - September 2017

National Quality Improvement Goals:

Emergency Department

National Comparison: N/D [2]

Statewide Comparison: N/D [2]

Immunization

National Comparison: N/D [2]

Statewide Comparison: N/D [2]

Perinatal Care

National Comparison: N/D [2]

Statewide Comparison: N/D [2]

New Changes to Quarterly Measure

Download Quarterly Measure Results

The Joint Commission only reports measures endorsed by the National Quality Forum.

* State results are not calculated for the National Patient Safety Goals.

EXHIBIT 20

Adventist HealthCare, Inc. and Controlled Entities

Financial Statements and
Supplementary Information

December 31, 2016 and 2015

BAKER TILLY

Candor. Insight. Results.

Please Note: The A-133 Single Audit is still in progress at the time of submission for Fiscal Year 2016

Adventist HealthCare, Inc. and Controlled Entities

Table of Contents
December 31, 2016 and 2015

BAKER TILLY

Independent Auditors' Report

Board of Trustees
Adventist HealthCare, Inc. and Controlled Entities

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Adventist HealthCare, Inc. and controlled entities (collectively, the "Corporation"), which comprise the consolidated balance sheets as of December 31, 2016 and 2015, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Adventist HealthCare, Inc. and controlled entities as of December 31, 2016 and 2015, and the results of their operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating and combining information presented on pages 45 to 49 is presented for purposes of additional analysis rather than to present the financial position, results of operations, and cash flows of the individual companies and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Baker Tilly Virchow Krause, LLP

Wilkes-Barre, Pennsylvania
April 27, 2017

Adventist HealthCare, Inc and Controlled Entities

Consolidated Balance Sheets
December 31, 2016 and 2015

	2016	2015
Assets		
Current Assets		
Cash and cash equivalents	$ 30,198,079	$ 45,638,591
Short-term investments	188,594,181	138,418,552
Assets whose use is limited	2,870,341	4,031,128
Patient accounts receivable, net of estimated allowance for doubtful collections of $27,415,000 in 2016 and $25,654,000 in 2015	91,827,593	102,100,614
Other receivables, net of estimated allowance for doubtful collections of $2,436,000 in 2016 and $2,110,000 in 2015	15,244,017	16,022,107
Inventories	10,211,601	10,780,540
Prepaid expenses and other current assets	7,366,320	6,358,773
Total current assets	346,312,132	323,350,305
Property and Equipment, Net	431,961,901	414,113,940
Assets Whose Use is Limited		
Under trust indentures and capital lease purchase financing facilities, held by trustees and banks	269,595,205	5,953,215
Professional liability trust fund	12,233,224	10,187,116
Deferred compensation fund	1,466,041	1,473,131
Cash and Cash Equivalents Temporarily Restricted for Capital Acquisitions	2,264,115	3,133,692
Investments and Investments in Unconsolidated Subsidiaries	13,283,684	11,081,925
Land Held for Healthcare Development	48,706,305	91,597,768
Intangible Assets, Net	8,966,166	10,200,288
Deposits and Other Noncurrent Assets	5,784,836	8,661,741
Total assets	$ 1,140,573,609	$ 879,753,121

See notes to consolidated financial state ents

Adventist HealthCare, Inc. and Controlled Entities

Consolidated Balance Sheets
December 31, 2016 and 2015

	2016	2015
Liabilities and Net Assets		
Current Liabilities		
Accounts payable and accrued expenses	$ 83,843,748	$ 85,048,695
Accrued compensation and related items	34,851,454	33,158,923
Interest payable	2,021,390	2,331,260
Due to third party payors	18,665,027	20,160,658
Estimated self-insured professional liability	1,150,302	2,258,544
Current maturities of long-term obligations	12,749,886	31,540,973
Total current liabilities	153,281,807	174,499,053
Construction Payable	3,027,323	50,410
Long-Term Obligations, Net		
Bonds payable	515,091,030	223,933,403
Notes payable	26,381,525	30,613,911
Capital lease obligations	16,263,001	7,988,423
Derivative Financial Instruments	2,073,079	22,275,775
Other Liabilities	14,864,817	13,243,151
Estimated Self-Insured Professional Liability	11,715,201	10,033,037
Total liabilities	742,697,783	482,637,163
Net Assets		
Unrestricted	391,327,657	389,780,097
Temporarily restricted	6,206,748	6,584,440
Permanently restricted	341,421	751,421
Total net assets	397,875,826	397,115,958
Total liabilities and net assets	$ 1,140,573,609	$ 879,753,121

See notes to consolidated financial state ents

Adventist HealthCare, Inc. and Controlled Entities

Consolidated Statements of Operations
ears Ended December 31, 2016 and 2015

	2016	2015
Unrestricted Revenues		
Net patient service revenue	$ 773,827,332	$ 733,607,247
Provision for doubtful collections	(35,002,586)	(33,692,615)
Net patient service revenue less provision for doubtful collections	738,824,746	699,914,632
Other revenue	41,106,399	40,698,648
Total unrestricted revenues	779,931,145	740,613,280
Expenses		
Salaries and wages	345,296,234	317,652,919
Employee benefits	65,852,367	63,612,408
Contract labor	36,319,743	34,903,249
Medical supplies	100,324,519	98,430,779
General and administrative	117,809,537	111,635,023
Building and maintenance	42,794,430	41,449,614
Insurance	5,297,256	5,282,490
Interest	10,362,411	9,561,370
Depreciation and amortization	36,746,661	34,524,212
Total expenses	760,803,158	717,052,064
Income from operations	19,127,987	23,561,216
Other Income (Expense)		
Investment income	3,129,171	863,598
Loss on extinguishment of debt	(686,357)	-
Other income (expense)	44,281	(406,795)
Total other income	2,487,095	456,803
Revenues in excess of expenses from continuing operations	21,615,082	24,018,019
Change in net unrealized losses on investments other than trading securities	(1,430,441)	(2,281,694)
Change in net unrealized gain (loss) on derivative financial instruments	2,352,325	(1,644,513)
Net assets released from restriction for purchase of property and equipment	1,217,796	922,266
Deferred compensation plan liability adjustment	(521,260)	(1,575,015)
Other unrestricted net asset activity	(1,458,904)	(649,457)
Increase in unrestricted net assets from continuing operations	21,774,598	18,789,606
Loss from discontinued operations	(20,227,038)	(5,759,673)
Increase in unrestricted net assets	$ 1,547,560	$ 13,029,933

See notes to consolidated financial state ents

Adventist HealthCare, Inc. and Controlled Entities

Consolidated Statements of Changes in Net Assets
Years Ended December 31, 2016 and 2015

	2016	2015
Unrestricted Net Assets		
Revenues in excess of expenses from continuing operations	$ 21,615,082	$ 24,018,019
Change in net unrealized losses on investments other than trading securities	(1,430,441)	(2,281,694)
Change in net unrealized gain (loss) on derivative financial instruments	2,352,325	(1,644,513)
Net assets released from restriction for purchase of property and equipment	1,217,796	922,266
Deferred compensation plan liability adjustment	(521,260)	(1,575,015)
Other unrestricted net asset activity	(1,458,904)	(649,457)
Increase in unrestricted net assets from continuing operations	21,774,598	18,789,606
Loss from discontinued operations	(20,227,038)	(5,759,673)
Increase in unrestricted net assets	1,547,560	13,029,933
Temporarily Restricted Net Assets		
Restricted gifts and donations	3,438,671	4,380,775
Net assets released from restriction for purchase of property and equipment	(1,217,796)	(922,266)
Net assets released from restriction used for operations	(2,075,440)	(2,749,219)
Change in value of beneficial interest in trusts and charitable gift annuity obligation	(30,449)	(194,353)
Change in discount of pledges receivable and provision for doubtful pledges	(496,776)	(121,993)
Donor restricted investment income	4,098	1,748
(Decrease) increase in temporarily restricted net assets	(377,692)	394,692
Permanently Restricted Net Assets		
Other permanently restricted net asset activity	(410,000)	410,000
Increase in net assets	759,868	13,834,625
Net Assets, Beginning	397,115,958	383,281,333
Net Assets, Ending	$ 397,875,826	$ 397,115,958

See notes to consolidated financial state ents

Adventist HealthCare, Inc. and Controlled Entities

Consolidated Statements of Cash Flows
Years Ended December 31, 2016 and 2015

	2016	2015
Cash Flows from Operating Activities		
Increase in net assets	$ 759,868	$ 13,834,625
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Provision for doubtful collections	36,284,410	37,500,712
Depreciation and amortization	38,098,970	39,518,378
Amortization of deferred financing costs	189,890	242,541
Deferred compensation plan liability adjustment	521,260	1,575,015
Loss on extinguishment of debt	686,357	-
Restricted contributions and grants	(1,878,488)	(2,695,169)
Earnings recognized from unconsolidated subsidiaries and affiliates	(2,335,147)	(3,272,652)
Amortization of physician income guarantees	31,530	34,363
Gain on sale of interest in unconsolidated subsidiary	-	(1,664,925)
Net realized loss on investments	710,869	2,766,296
Change in net unrealized gains and losses on investments other than trading securities	1,430,441	2,281,694
Change in net unrealized (gain) loss on derivative financial instruments	(2,352,325)	1,644,513
Change in value of beneficial interest in trusts and charitable gift annuity	30,449	194,353
Change in discount on pledges receivable and provision for doubtful pledges	496,776	121,993
Loss on sale of HRMC	16,967,178	-
Changes in assets and liabilities:		
Patient accounts receivable, net	(26,011,792)	(32,334,820)
Other receivables, net	628,056	(2,672,003)
Inventories, prepaid expenses and other current assets	(2,229,881)	(566,015)
Accounts payable and accrued expenses	(3,167,435)	9,881,623
Accrued compensation and related items	1,749,437	(4,038,781)
Interest payable	(309,870)	23,460
Estimated self-insured professional liability	573,922	665,358
Due to third party payors	(1,495,631)	(426,283)
Other noncurrent assets and liabilities	(3,889,927)	(415,534)
Net cash provided by operating activities	55,488,917	62,198,742

See notes to consolidated financial state ents

Adventist HealthCare, Inc and Controlled Entities

Consolidated Statements of Cash Flows
Years nded December 31, 2016 and 2015

	2016	2015
Cash Flows from Investing Activities		
Purchase of property and equipment	$ (45,840,372)	$ (40,688,717)
Increase in investments and investments in unconsolidated subsidiaries	(52,498,944)	(9,742,785)
Additions to land held for healthcare development	(4,729,611)	(13,397,853)
Proceeds from sale of interest in unconsolidated subsidiary	-	3,172,286
Proceeds from sale of land for healthcare development	5,938,458	13,225,064
Proceeds from sale of HRMC	47,000,550	-
Distributions from investments in unconsolidated subsidiaries	389,555	1,032,016
Purchase of investment in unconsolidated subsidiary	(2,435,579)	-
Purchase of radiology company	-	(8,000,000)
(Increase) decrease in trustee held funds and restricted cash	(264,548,939)	1,497,722
Net cash used in investing activities	(316,724,882)	(52,902,267)
Cash Flows from Financing Activities		
Payment of financing costs	(3,509,604)	(140,598)
Proceeds from issuance of bonds	296,979,390	-
Repayments on long-term obligations, net	(32,710,743)	(28,270,988)
Proceeds from capital lease facility	32,922	-
Payment of termination fee for derivative financial instrument	(16,875,000)	-
Proceeds from restricted contributions and grants	1,878,488	2,695,169
Net cash provided by (used in) financing activities	245,795,453	(25,716,417)
Net decrease in cash and cash equivalents	(15,440,512)	(16,419,942)
Cash and Cash Equivalents, Beginning	45,638,591	62,058,533
Cash and Cash Equivalents, Ending	$ 30,198,079	$ 45,638,591
Supplemental Disclosure of Cash Flow Information		
Interest paid	$ 12,490,712	$ 12,062,707
Supplemental Disclosure of Noncash Investing and Financing Activities		
Capital lease obligation incurred for equipment	$ 14,740,520	$ 4,682,336
Construction payable for property and equipment	$ 3,027,323	$ 50,410
Long-term debt refinanced	$ 110,035,000	$ -

See notes to consolidated financial statements

1. Nature of Operations and Summary of Significant Accounting Policies

Nature of Operations

Adventist HealthCare, Inc. ("AHC") is a nonstock membership corporation organized to effectuate coordinated administration of hospitals and other health care organizations through the provision of key management and administrative services. The mission of AHC is to demonstrate God's care by improving the health of people and communities through a ministry of physical, mental and spiritual healing. AHC is tax-exempt under Section 501(c)(3) of the Internal Revenue Code. AHC is not exempt from income taxes for unrelated business income. AHC's sole corporate member is Mid-Atlantic Adventist HealthCare, Inc. AHC is comprised of several operating divisions and controlled entities, as follows:

Shady Grove Medical Center ("SGMC") is a 256-bed acute care hospital located in Rockville, Maryland.

Washington Adventist Hospital ("WAH") is a 236-bed acute care hospital located in Takoma Park, Maryland.

Hackettstown Community Hospital d.b.a. Hackettstown Regional Medical Center ("HRMC") is a 111-bed not-for-profit acute care hospital organized under the laws of the State of New Jersey. On March 31, 2016, the Corporation sold the operating assets to an unrelated third party, and discontinued the operations of the facility. See Note 3 for further details.

Behavioral Health & Wellness Services ("BH&WS") is comprised of two separate facilities located in Maryland. BH&WS - Rockville is a 117-bed psychiatric hospital. BH&WS - Eastern Shore is an acute care and residential mental health resource for children and adolescents, which had 15 acute care psychiatric beds and 59 residential treatment rooms. In November, 2016, the Corporation made the decision to discontinue the operations of the BH&WS - Eastern Shore location. See Note 3 for further details.

Rehabilitation ("Rehab") operates one inpatient hospital with two sites in Maryland, as well as two outpatient locations. Rehab - Rockville is a 55-bed rehabilitation facility and Rehab - Takoma Park is a 32-bed rehabilitation facility.

The Corporation acquired Shady Grove Radiological Consultants, PA ("SGR") on August 1, 2015 for a purchase price of $8,000,000. SGR was a medical practice specializing in radiological imaging services. During 2016, the imaging sites were renamed Adventist HealthCare Imaging ("Imaging"). Imaging operates six clinical sites and provides inpatient and outpatient imaging services at SGMC and WAH.

Clinical Integration Services ("CIS") is comprised of Adventist Medical Group ("AMG"). AMG is a not-for-profit entity that provides physician professional health services to the communities it serves. AHC has contracted with Medical Faculty Associates, Inc. ("MFA") to employ the AMG employees, through a wholly owned affiliate of MFA, in exchange for certain economic support to facilitate the growth by MFA of the AMG physician practices. In addition, CIS includes the administration needed to facilitate the coordination of patient care across conditions, providers and settings.

The Other Health Services operating division is comprised of two entities. Lifework Strategies ("LWS") provides employee assistance and employee wellness programs to client employees. LWS's mission is to help individuals live healthier, happier and more productive lives. Capital Choice Pathology Lab ("CCPL") provides full pathology production services to client hospitals.

The Support Center is comprised of the Corporate Office ("CO") and the AHC benefit business unit. The CO provides corporate and centralized shared service functions that benefit the entire AHC system. AHC benefit business unit administers the self- insurance health benefit program including health insurance, dental and vision coverage for AHC and controlled entities.

The Lourie Center for Infants and Young Children ("Lourie Center") is a not-for-profit organization that specializes in the diagnosis, treatment and prevention of developmental and emotional disorders in children from birth through ten years of age.

Adventist Home Care Services, Inc. ("AHCS") is a nonstock membership corporation organized to provide home health services in Maryland and includes Adventist Home Assistance ("AHA"). AHA provides non clinical assistance to homebound patients who cannot perform certain daily activities on their own.

On October 1, 2013, Adventist HealthCare Urgent Care Centers, Inc. ("Urgent Care"), a Maryland non-profit corporation and Adventist Health System/Sunbelt, Inc. d/b/a Florida Hospital Centra Care, a Florida non-profit corporation, entered into a management services and license agreement to establish free standing urgent care centers in Montgomery and Prince Georges County, Maryland. In 2016, Urgent Care operated three urgent care centers located in Germantown, Laurel, and Rockville, Maryland. These centers provide ambulatory services to patients without life threatening conditions, as well as occupational health screenings to the community.

One Health Quality Alliance ("OHQA") is a physician-led clinically integrated network designed to deliver value to payors, employers and consumers through the highest quality care at a lower cost. Through this alliance, participating physicians gain access to resources to support the transition to value-based care, while maintaining their independence. Through this collaboration, OHQA aims to improve the health of patient populations and communities, while enhancing the patient experience and reducing the costs of health care. The OHQA currently has over 450 physician members, most of whom are on the medical staff of the Corporation, including primary care, orthopedics and other community and hospital based specialists.

Mid-Atlantic Primary Care Accountable Care Organization ("ACO") is managed by AHC and cares for approximately 13,500 patients through its 1,000 providers. The ACO is a program designed to provide a high level of access and coordination of care for Medicare fee for service patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. The final performance year for the ACO was 2016. The ACO will cease to exist once the final CMS reports are distributed sometime mid to late 2017.

The Foundations operating division is comprised of Washington Adventist Hospital Foundation, Inc., Shady Grove Medical Center Foundation, Inc., Hackettstown Community Hospital Foundation, Inc., and Adventist Behavioral Health & Wellness Services Foundation (collectively, the "Foundations"). Each are separate nonstock corporations that operate for the furtherance of each named hospital's health care objectives primarily through the solicitation of contributions, gifts and bequests. The Foundations also exist to help fund new equipment purchases and capital improvement projects for their respective hospitals. On March 31, 2016, the Corporation sold the operating assets of Hackettstown Community Hospital Foundation, Inc. to an unrelated third party, and discontinued the operations of the foundation. See Note 3 for further details.

All of the operating divisions and controlled entities mentioned above are tax-exempt under Section 501(c)(3) of the Internal Revenue Code.

Principles of Consolidation

The consolidated financial statements for 2016 and 2015 include the accounts of AHC, the controlling parent, SGMC, WAH, HRMC, BH&WS, Rehab, Imaging, CIS, LWS, CCPL the Support Center, the Lourie Center, AHCS, Urgent Care, OHQA, ACO and the Foundations, which include their majority-owned subsidiaries and controlled affiliates (collectively, the "Corporation"). All significant intercompany balances and transactions have been eliminated in the consolidated financial statements of the Corporation.

Subsequent Events

The Corporation evaluated subsequent events for recognition or disclosure through April 27, 2017, the date the consolidated financial statements were issued.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Risk Factors

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations is subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time. Government activity continues to increase with respect to investigations and allegations concerning possible violations by healthcare providers of fraud and abuse statutes and regulations, which could result in the imposition of significant fines and penalties as well as significant repayments for patient services previously billed. Management is not aware of any material incidents of noncompliance; however, the possible future financial effects of this matter on the Corporation, if any, are not presently determinable.

Maryland Health Services Cost Review Commission

Certain hospital charges are subject to review and approval by the Maryland Health Services Cost Review Commission ("HSCRC"). The HSCRC has jurisdiction over hospital reimbursement in Maryland by agreement with the Centers for Medicare and Medicaid Services ("CMS"). This agreement is based on a waiver from the Medicare Prospective Payment System reimbursement principles granted under Section 1814(b) of the Social Security Act. Management has filed the required forms with the Commission and believes SGMC, WAH, and Shady Grove Germanton Emergency Center are in compliance with Commission requirements.

In January 2014, the Centers for Medicare and Medicaid Services approved a modernized waiver that grants Maryland (via the HSCRC) the authority to regulate hospital revenue within a rigorous per capita expenditure limit. Maryland's All Payer Model Agreement builds on decades of innovation and equity in healthcare payment and delivery – with an aim to enhance patient care, improve health outcomes and lower costs.

As a result of the new waiver, the HSCRC introduced new revenue arrangements, including the Global Budget Revenue ("GBR") model. The GBR methodology encourages hospitals to focus on population health strategies by establishing a fixed annual revenue cap for each GBR hospital. The agreement establishes a fixed amount of revenue at the beginning of the rate year. It is evergreen in nature and covers both regulated inpatient and outpatient revenues. Annual Revenue is calculated from a base year and is adjusted annually for inflation, infrastructure requirements, population changes, performance in quality-based programs and changes in levels of uncompensated care. Revenue may also be adjusted annually for market levels and shifts of services from one health system to another and from a regulated setting to an unregulated setting (or vice versa).

In April 2014, Adventist Healthcare entered into a Global Budget Revenue Agreement with the HSCRC for SGMC, WAH and Shady Grove Germantown Emergency Center, retroactive to July 1, 2013. This agreement sets a fixed amount of revenue for each entity for the period July 1, 2013 through June 30, 2014 and is subsequently updated on an annual basis every July 1.

The HSCRC has placed into its methodology a rate system which, among other things, causes SGMC, WAH, and Shady Grove Germanton Emergency Center to calculate the amount of revenue lost or gained due to variances from approved rates. Revenue lost due to undercharges in rates is recouped through increases in prospective rates. Similarly, revenue gained due to overcharges in rates is paid back, wholly or in part, through reductions in prospective rates. The Corporation reported net undercharges of $4,097,913 and $774,097 as of December 31, 2016 and 2015, respectively. These price variances reflect the variance between actual patient charges and the pro-rata share of the approved rate orders. The net amounts are reported as a component of net patient service revenue and patient accounts receivable in the accompanying consolidated financial statements. Since the HSCRC's rate year extends from July 1 through June 30, these amounts will continue to fluctuate until the end of the rate year as actual patient charges deviate from the total approved Global Budget Revenue Agreement amounts at which time any over/under charges are amortized on the straight-line basis over the following rate year.

Under Maryland law, charges of specialty hospitals such as BH&WS and Rehab are subject to review and approval by the HSCRC. HSCRC regulations also include a provision whereby a hospital may apply for an exemption from the requirements to charge for services in accordance with the HSCRC regulations. Certain conditions regarding the percentage of revenue related to Medicare and Medicaid patients and total revenues must be met to receive the initial exemption and must be met each year thereafter. Reporting requirements as established by the HSCRC continue if an exemption regarding charging for services is received. The Corporation's management believes BH&WS-Eastern Shore and Rehab met the conditions for exemption during 2016 and 2015. BH&WS-Rockville is subject to HSCRC rate setting. Unit rates are set for all payers, however Medicare and Medicaid are not required to reimburse at HSCRC rates. Medicare is reimbursed under the Inpatient Psychiatric Prospective payment system and Medicaid is reimbursed as a percent of charges, per COMAR 10.09.06.09, and is currently set at 94% of charges.

Cash and Cash Equivalents

Cash and cash equivalents include investments in money market funds and certificates of deposit purchased with original maturities of less than 90 days, excluding assets whose use is limited.

Patient Accounts Receivable

Patient accounts receivable are reported at net realizable value. Accounts are written off when they are determined to be uncollectible based upon management's assessment of individual accounts. In evaluating the collectability of patient accounts receivable, the Corporation analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful collections and provision for doubtful collections. For patient accounts receivable associated with services provided to patients who have third-party coverage, the Corporation analyzes contractually due amounts and provides an allowance for doubtful collections and provision for doubtful collections, if necessary. For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Corporation records a provision for doubtful collections in the period of service on the basis of its past experience, which indicates that many patients are unable to pay the portion of their bill for which they are financially responsible. The difference between the billed rates and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful collections.

The Corporation's allowance for doubtful collections for self-pay patients as a percentage of self-pay accounts receivable was 52% and 45% at December 31, 2016 and 2015, respectively. In addition, the Corporation's self-pay account bad debt writeoffs, net of recoveries, increased from $30,099,159 in 2015 to $31,701,926 in 2016 which was the result of increased services provided to self-pay patients and therefore increased revenue from self-pay patients, offset by small positive trends experienced in the collection of amounts from self-pay patients in 2016.

Other Receivables

Other receivables represent amounts due to the Corporation for charges other than providing health care services to patients and pledges from donors. These services include, but are not limited to, fees from educational programs, rental of health care facility space, interest earned, and management services provided to unconsolidated subsidiaries. Other receivables are written off when they are determined to be uncollectible based on management's assessment of individual accounts. The allowance for doubtful collections is estimated based upon historical collection experience and other managerial information.

Assets Whose Use Is Limited

Assets whose use is limited includes assets held by bond trustees under trust indentures, assets set aside as required by the Corporation's self-funded professional liability trust, and assets set aside for deferred compensation agreements. Amounts available to meet current liabilities of the Corporation have been reclassified as current assets in the accompanying consolidated balance sheets.

Investments and Investment Risk

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the accompanying consolidated balance sheets. Cash and cash equivalents and certificates of deposit are carried at cost which approximates fair value. Investments in joint ventures are accounted for using the equity or cost method of accounting depending on the Corporation's ownership interest. Investment income or loss (including realized gains and losses on investments, write-downs of the cost basis of investments due to an other-than-temporary decline in fair value, interest, and dividends) is included in the determination of revenues in excess of expenses from continuing operations unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the determination of revenues in excess of expenses from continuing operations unless the investments are trading securities. Donor-restricted investment income is reported as an increase in temporarily restricted net assets. Investments available for current operations have been classified as short-term investments in the accompanying consolidated balance sheets.

The Corporation's investments are comprised of a variety of financial instruments. The fair values reported in the consolidated balance sheets are subject to various risks including changes in the equity markets, the interest rate environment, and general economic conditions. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the fair value of investment securities, it is reasonably possible that the amounts reported in the accompanying consolidated financial statements could change materially in the near term.

Inventories

Inventories of drugs, medical supplies and surgical supplies are valued at the lower of cost or market. Cost is determined primarily by the weighted average cost method.

Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful lives of the assets using the straight-line method. Equipment under capital leases is amortized on the straight-line method over the shorter period of the lease term or estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the accompanying consolidated statements of operations.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Impairment losses are recognized in the consolidated statements of operations as a component of revenues in excess of expenses from continuing operations as they are determined. The Corporation reviews its long-lived assets whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. In that event, the Corporation calculates the estimated future net cash flows to be generated by the asset. If those future net cash flows are less than the carrying value of the asset, an impairment loss is recognized for the difference between the estimated fair value and the carrying value of the asset. There were no impairment losses reported in 2016 or 2015.

Intangible Assets

The Corporation's intangible assets primarily include costs in excess of net assets acquired related to certain business acquisitions. The Corporation is amortizing certain intangible assets over a period not to exceed 40 years. Amortization of these intangible assets was $273,535 in 2016 and $272,726 in 2015. Accumulated amortization of intangible assets was $3,386,559 and $3,113,024 as of December 31, 2016 and 2015, respectively.

On August 1, 2015, AHC acquired certain assets of SGR, a company that operated a number of radiological imaging centers. The acquisition was accounted for at fair market value as of the acquisition date and goodwill was recorded as the difference between the purchase price paid less the fair value of the assets recorded. The amount of goodwill recorded as a result of the acquisition was approximately $5,435,000. The results from operations of the imaging centers are included in the consolidated financial statements commencing with the acquisition date. Goodwill, which is included in intangible assets in the accompanying consolidated balance sheet, is reviewed annually for impairment or more frequently if events or circumstances indicate the carrying amount of the goodwill will not be recoverable.

Goodwill related to HRMC of $867,660 was written off in 2016 related to the sale of HRMC (Note 3) and is included in loss from discontinued operations in the accompanying consolidated statements of operations.

Goodwill related to BH&WS Eastern Shore of $241,359 was written off in 2016 related to the closure of this location (Note 3) and is included in loss from discontinued operations in the accompanying consolidated statements of operations.

Deferred Financing Costs

Due to the Financial Accounting Standards Board's ("FASB") issuance of Accounting Standards Update ("ASU") No. 2015-03, *Interest-Imputations of Interest: Simplifying the Presentation of Debt Issuance Costs*, the Corporation changed its method of presenting deferred financing costs. Prior to the issuance of ASU No. 2015-03, the Corporation presented deferred financing costs as an asset in its consolidated balance sheets. As required by ASU No. 2015-03, the Corporation now presents deferred financing costs as a direct reduction of its long-term debt. The effect of the required retrospective application of this change in presentation was to decrease the Corporation's deferred financing costs and long-term debt by $2,206,562 as of December 31, 2015. In addition, amortization expense of the deferred financing costs was reclassed to interest expense in accordance with ASU No. 2015-03 which resulted in a decrease in depreciation and amortization and an increase in interest expense of $242,541 in 2015.

Costs incurred in connection with the issuance of long-term obligations have been deferred and are being amortized over the term of the related obligation using the straight-line method. Deferred financing costs of $3,509,604 were paid in relation to the Series 2016A and 2016B Bonds issued in 2016. In addition, deferred financing costs of $686,357 were written-off in 2016 related to redemption of the Series 2005A and 2011B Bonds and are included in the loss on extinguishment of debt in the accompanying consolidated statements of operations in 2016.

Amortization expense was $189,890 and $242,541 in 2016 and 2015, respectively. Amortization for HRMC was $5,799 and $23,194 in 2016 and 2015, respectively, and is included in loss from discontinued operations in the consolidated statements of operations. Accumulated amortization of deferred financing costs was $2,661,473 and $4,505,899 at December 31, 2016 and 2015, respectively.

Due to Third Party Payors

The Corporation receives advances from third party payors to provide working capital for services rendered to the beneficiaries of such services. These advances are principally determined based on the timing differences between the provision of care and the anticipated payment date of the claim for service in accordance with HSCRC's rate regulations. These advances are subject to periodic adjustment.

For HRMC, the Medicare and Medicaid programs pay for primarily all inpatient and outpatient services at predetermined rates. Regulations require annual retroactive settlements for cost-based reimbursement through cost reports filed by HRMC. These retroactive settlements are estimated and recorded in the consolidated financial statements in the year in which they occur. The estimated settlements recorded at December 31, 2016 and 2015 could differ from actual settlements based on the results of cost report audits.

For certain Corporation subsidiaries, services provided on behalf of Medicaid beneficiaries are ultimately reimbursed at cost. For cost reimbursement programs, statements of reimbursable costs are filed with the program to compute the difference between reimbursable cost and interim payments, in order to determine a final settlement for services rendered to patients covered under the Medicaid program. Reimbursements are affected by limitations relating to charges and the reasonableness of costs (subject to limitations) and are subject to audits by the agencies administering the applicable program.

The Corporation's working capital advances and all expected third party payor settlement activity are classified as current liabilities in the accompanying consolidated balance sheets.

Derivative Financial Instruments

The Corporation has entered into two interest rate swap agreements, which are considered derivative financial instruments, to manage its interest rate exposure on certain long-term obligations (Note 11). The interest rate swap agreements are reported at fair value in the accompanying consolidated balance sheets. One of the interest rate swap agreements was designated as a cash flow hedge and was terminated in 2016. The related effective changes in fair value for the cash flow hedge are reported in the accompanying consolidated statements of operations as an unrealized gain or loss on cash flow derivative financial instruments and the ineffective portion of the change in fair value is reported as a component of interest expense. For the interest rate swap not designated as a cash flow hedge, changes in fair value are reported as a component of other non-operating income (expense).

Estimated Self-Insured Professional Liability

The provision for estimated self-insured professional liability includes estimates of the ultimate costs for both reported claims and claims incurred but not reported, including costs associated with litigating or settling claims. Anticipated insurance recoveries associated with reported claims are reported separately in the Corporation's consolidated balance sheets at net realizable value.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Corporation has been limited by donors to a specific time period or purpose, including the purchase of capital renovations and equipment, providing health education to the community, and designation for the furtherance of programs provided by specific operating departments. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation in perpetuity.

Revenues in Excess of Expenses from Continuing Operations

The consolidated statements of operations include the determination of revenues in excess of expenses from continuing operations. Revenues in excess of expenses from continuing operations is the Corporation's performance indicator. Changes in unrestricted net assets which are excluded from the determination of revenues in excess of expenses from continuing operations, consistent with industry practice, include the loss from discontinued operations, unrealized gains and losses on investments other than trading securities, the effective portion of the unrealized gain (loss) on derivative financial instruments, the deferred compensation plan liability adjustment, transfers with unconsolidated subsidiaries, contributions of long-lived assets (including contributions which by donor restriction were to be used for the purpose of acquiring such long-lived assets), and other unrestricted net asset activity.

Net Patient Service Revenue

The Corporation reports net patient service revenue at the estimated net realizable amounts from patients, third party payors, and others for services rendered, including an estimate for retroactive adjustments that may occur as a result of future audits, reviews and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered, and such amounts are adjusted in future periods as adjustments become known or as years are no longer subject to such audits, review and investigations. Net patient service revenue reported in the accompanying consolidated statements of operations is reduced both by (1) estimated allowances for the excess of charges over anticipated patient or third party payor payments and (2) a provision for doubtful collections. Certain of the health care services provided by the Corporation are reimbursed by third party payors on the basis of the lower of cost or charges, with costs subject to certain imposed limitations.

Patient accounts receivable are reported at net realizable value and include charges for accounts due from Medicare, Medicaid, other commercial and managed care insurers, and self-paying patients (Note 16). Patient accounts receivable also includes management's estimate of the impact of certain undercharges to be recouped or overcharges to be paid back for inpatient and outpatient services in subsequent years rates as discussed earlier. The Corporation also deducts from patient accounts receivable an estimated allowance for doubtful collections related to patients and allowances for the excess of charges over the payments to be received from third party payors.

The Corporation has agreements with third-party payors that provide for payments to the Corporation at amounts different from its established rates. The Corporation recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of these established rates for the services rendered. For uninsured patients that do not qualify for charity care, the Corporation recognizes revenues on the basis of its standard rates, discounted in accordance with the Corporation's financial assistance policy. On the basis of historical experience, a significant portion of the Corporation's uninsured patients will be unable to pay for the services provided. Thus, the Corporation records a significant provision for doubtful collections related to uninsured patients in the period the services are provided. Patient service revenues, net of contractual allowances and discounts (but before the provision for doubtful collections), recognized in 2016 and 2015 from these major payor sources, are as follows:

	Patient Service Revenues (Net of Contractual Allowances and Discounts)				
	Medicare	Medicaid	Other Third Party Payors	Self-Pay and Other	Total
December 31, 2016	$ 304,061,127	$ 67,425,014	$ 396,777,024	$ 33,464,551	$ 801,727,716
December 31, 2015	$ 257,907,521	$ 80,961,064	$ 437,216,900	$ 51,828,507	$ 827,913,992

Patient service revenues (net of contractual allowances and discounts) for HRMC were $22,165,831 in 2016 and $88,604,596 in 2015. Patient service revenues (net of contractual allowances and discounts) for BH&WS - Eastern Shore were $5,734,553 in 2016 and $5,702,149 in 2015. These amounts have been classified in loss from discontinued operations in the consolidated statements of operations.

Income Taxes

The Corporation accounts for uncertainty in income taxes using a recognition threshold of more-likely-than-not to be sustained upon examination by the appropriate taxing authority. Measurement of the tax uncertainty occurs if the recognition threshold is met. Management determined there were no tax uncertainties that met the recognition threshold in 2016 or 2015.

The Corporation's policy is to recognize interest related to unrecognized tax benefits in interest expense and penalties in operating expenses.

Charity Care

The Corporation provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Such patients are identified based on financial information obtained from the patient (or their guarantor) and subsequent analysis which includes the patient's ability to pay for services rendered. Because the Corporation does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as a component of net patient service revenue or patient accounts receivable.

The Corporation maintains records to identify and monitor the level of charity care it provides. The costs associated with the charity care services provided are estimated by applying a cost-to-charge ratio to the amount of gross uncompensated charges for the patients receiving charity care. The level of charity care provided by the Corporation amounted to approximately $9,395,000 in 2016 and $20,515,000 in 2015.

Donor Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received or when the underlying conditions have been substantially met. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations as net assets released from restrictions. Restricted funds to be used for capital acquisitions have been reported as noncurrent assets in the accompanying consolidated balance sheets, while other restricted cash and investments are included with the cash and cash equivalents of unrestricted net assets.

Investment income that is earned on donor restricted net assets and subject to similar restrictions is reported as temporarily restricted net assets. Gifts, grants, and bequests not restricted by donors are reported as other operating income.

Advertising Costs

The Corporation expenses advertising costs as they are incurred.

Reclassifications

Certain amounts relating to 2015 have been reclassified to conform to the 2016 reporting format.

2. Adoption of Accounting Standards

Revenue Recognition

In May 2014, the FASB issued ASU No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*. ASU No. 2014-09 supersedes the revenue recognition requirements in Topic 605, Revenue Recognition, and most industry-specific guidance. Under the requirements of ASU No. 2014-09, the core principle is that entities should recognize revenue to depict the transfer of promised goods or services to customers (patients) in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The Hospital will be required to retrospectively adopt the guidance in ASU No. 2014-09 for years beginning after December 15, 2017. The Corporation has not yet determined the impact of adoption of ASU No. 2014-09 on its consolidated financial statements.

Fair Value Measurements

In May 2015, the FASB issued ASU No. 2015-07, *Fair Value Measurement (Topic 820): Disclosures for Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*. ASU 2015-07 removes the requirement to include investments in the fair value hierarchy for which fair value is measured using the net asset value per share practical expedient under Accounting Standards Codification 820. ASU 2015-07 is effective for the Corporation for years beginning after December 15, 2015 with early adoption permitted. ASU No. 2015-03 was retrospectively adopted in 2016 and did not have a material impact on the Corporation's consolidated financial statements.

Financial Instruments

During January 2016, the FASB issued ASU No. 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities*. ASU No. 2016-01: a) requires equity investments (except those accounted for under the equity method of accounting or those that result in consolidation of the investee) to be measured at fair value with changes in fair value recognized in net income; (b) simplifies the impairment assessment of equity investments without readily determinable fair values by requiring a qualitative assessment to identify impairment; (c) eliminates the requirement to disclose the fair value of financial instruments measured at amortized cost for entities that are not public business entities; (d) eliminates the requirement for public business entities to disclose the method(s) and significant assumptions used to estimate the fair value that is required to be disclosed for financial instruments measured at amortized cost on the balance sheet; (e) requires public business entities to use the exit price notion when measuring the fair value of financial instruments for disclosure purposes; (f) requires an entity to present separately in other comprehensive income the portion of the total change in the fair value of a liability resulting from a change in the instrument-specific credit risk when the entity has elected to measure the liability at fair value in accordance with the fair value option for financial instruments; (g) requires separate presentation of financial assets and financial liabilities by measurement category and form of financial asset (that is, securities or loans and receivables) on the balance sheet or the accompanying notes to the financial statements; and (h) clarifies that an entity should evaluate the need for a valuation allowance on a deferred tax asset related to available-for-sale securities in combination with the entity's other deferred tax assets. ASU No. 2016-01 is effective for annual periods and interim periods within those annual periods beginning after December 15, 2017. Early adoption of certain amendments is permitted for financial statements of fiscal years or interim periods that have not yet been issued. The Corporation is currently assessing the effect that ASU No. 2016-01 will have on its consolidated financial statements.

Statement of Cash Flows

During August 2016, the FASB issued ASU No. 2016-15, *Classification of Certain Cash Receipts and Cash Payments*. ASU No. 2016-15 addresses eight cash flow issues with specific guidance on how certain cash receipts and cash payments should be presented on the statement of cash flows. ASU No. 2016-15 is effective for annual periods and interim periods within those annual periods beginning after December 15, 2017. Early adoption is permitted. The Corporation is currently assessing the effect that ASU No. 2016-15 will have on its consolidated statement of cash flows.

Not-for-Profit Financial Statement Presentation

In August 2016, FASB issued ASU No. 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statement of Not-for-Profit Entities*. The new guidance is intended to improve and simplify the current net asset classification requirements and information presented in financial statements and notes that is useful in assessing a not-for-profit's liquidity, financial performance and cash flows. ASU No 2016-14 is effective for fiscal years beginning after December 15, 2017, with early adoption permitted. ASU 2016-14 is to be applied retrospectively with transition provisions. The Corporation is assessing the impact ASU No. 2016-14 will have on its consolidated financial statements.

Lease Accounting

In February 2016, FASB issued ASU No. 2016-02, *Leases (Topic 8 2)*. ASU No. 2016-02 was issued to increase transparency and comparability among organizations by recognizing lease assets and lease liabilities on the balance sheet and disclosing key information about leasing arrangements. Under the provisions of ASU No. 2016-02, a lessee is required to recognize a right-to-use asset and lease liability, initially measured at the present value of the lease payments, in the balance sheet. In addition, lessees are required to provide qualitative and quantitative disclosures that enable users to understand more about the nature of the Corporation's leasing activities. The Corporation will be required to retrospectively adopt the guidance in ASU No. 2016-02 for years beginning after December 15, 2018. The Corporation has not yet determined the impact of adoption of ASU No. 2016-02 on its consolidated financial statements.

3. Discontinued Operations

Effective January 28, 2014, the Corporation entered into an affiliation agreement with an unrelated third party for the future sale of HRMC and Hackettstown Community Hospital Foundation, Inc. pending state regulatory review. In March 2016, the State of New Jersey gave final approval for the sale. On March 31, 2016, the Corporation sold the operating assets to the unrelated third party, and discontinued the operations of the facility. The Corporation received net proceeds from the sale of approximately $44,500,000, which is net of a contribution paid by the Corporation of $2,500,000 to Hackettstown Community Hospital Foundation, Inc. The Corporation recorded a loss on sale of $16,967,178 in 2016 which is included in the loss from discontinued operations in the accompanying consolidated statements of operations. The largest component of the loss on sale is related to the write-off of costs associated with HRMC's electronic medical records system, which totaled approximately $11,518,000. The net carrying value of property and equipment related to HRMC as of December 31, 2015 was $38,683,898 and consisted of the following:

	2015
Land and improvements	$ 2,457,668
Building and improvements	60,751,271
Office furniture and equipment	58,269,238
Computer software and hardware	6,115,260
Equipment under capital leases	19,332
Total	127,612,769
Less accumulated depreciation and amortization	(90,838,703)
	36,774,066
Construction in progress	1,909,832
	$ 38,683,898

The following amounts related to discontinued operations are included in the loss from discontinued operations in the accompanying consolidated statements of operations:

	2016	2015
Total unrestricted revenues	$ 22,901,438	$ 90,608,328
Total expenses	(22,769,646)	(92,885,048)
Other non-operating loss, including loss on sale in 2016 of $16,967,178	(17,063,626)	(591,005)
Revenues less than expenses	$ (16,931,834)	$ (2,867,725)

During November 2016, AHC discontinued operations at the BH&WS - Eastern Shore facility and made the decision to no longer provide services on Maryland's eastern shore. The net carrying value of property and equipment related to BH&WS -Eastern Shore as of December 31, 2015 was $375,975 and consisted of the following:

	2015
Building and improvements	$ 149,450
Office furniture and equipment	542,160
Computer software and hardware	85,678
Total	777,288
Less accumulated depreciation and amortization	(402,908)
	374,380
Construction in progress	1,595
	$ 375,975

The majority of the property and equipment was disposed as a result of the closure and a loss of approximately $358,000 was recognized and included in the loss from discontinued operations in the accompanying consolidated statements of operations. In addition, goodwill of approximately $241,000 related to BH&WS Eastern Shore was written off and included in the loss from discontinued operations in the accompanying consolidated statements of operations.

The following amounts related to discontinued operations are included in loss from discontinued operations in the accompanying consolidated statements of operations:

	2016	2015
Total unrestricted revenues	$ 6,706,337	$ 6,608,852
Total expenses	(10,001,541)	(9,500,800)
Revenues less than expenses	$ (3,295,204)	$ (2,891,948)

4. Investments

Short-Term Investments

The Corporation's short-term investments at December 31, 2016 and 2015 are comprised of the following:

	2016	2015
Cash and cash equivalents	$ 3,653,630	$ 31,151,134
Marketable certificates of deposit	-	489,531
CBAM Resolute Fund Ltd.	-	96,238
Fixed Income:		
Corporate bonds	48,547,456	-
Asset backed securities	29,703,673	102,479,904
U.S. government securities, U.S. treasury notes	83,195,405	4,201,745
Mutual Funds:		-
Equity - balanced	19,683,702	-
Equity - growth	3,810,315	-
Total	$ 188,594,181	$ 138,418,552

Assets Whose Use is Limited

The composition of assets whose use is limited at December 31, 2016 and 2015 is set forth in the following tables:

	2016	2015
Under trust indentures and capital lease purchase financing facilities, held by trustees and banks:		
Cash and cash equivalents	$ 265,926,780	$ 1,493,090
U.S. government securities, U.S. treasury notes	5,388,464	6,232,709
Total	271,315,244	7,725,799
Less funds held for current liabilities	1,720,039	1,772,584
Noncurrent portion of assets held under trust indentures and capital lease purchase financing facilities	$ 269,595,205	$ 5,953,215
Professional liability trust fund:		
Cash and cash equivalents	$ 864,028	$ 311,134
Mutual funds:		
Equity - balanced	9,191,703	9,006,583
Fixed income - multi-sector	3,327,795	3,127,943
Total	13,383,526	12,445,660
Less funds held for current liabilities	1,150,302	2,258,544
Noncurrent portion of professional liability trust fund	$ 12,233,224	$ 10,187,116
Deferred compensation fund:		
Mutual funds, Equity - growth	$ 1,466,041	$ 1,473,131

The indenture requirements of certain tax exempt financings provide for the establishment and maintenance of various accounts with a trustee (Note 10). These arrangements require the trustee to control the payment of interest and the ultimate repayment of respective debt to bondholders.

The composition of trustee held and escrow funds at December 31, 2016 and 2015 is as follows:

	2016	2015
Debt service reserve funds	$ 28,118,144	$ 5,829,278
Principal and interest funds	35,363,487	1,896,521
Project fund	207,833,613	-
Total	$ 271,315,244	$ 7,725,799

Unrestricted investment income and gains and losses for investments, assets whose use is limited, and cash and cash equivalents are comprised of the following in 2016 and 2015:

	2016	2015
Investment income:		
Interest and dividends, net	$ 3,853,355	$ 3,678,861
Interest on trustee held funds	62,244	48,179
Net realized losses on sale of investments	(710,869)	(2,766,296)
Total	$ 3,204,730	$ 960,744
Other changes in unrestricted net assets,		
Change in net unrealized losses on investments other than trading securities	$ (1,430,441)	$ (2,281,694)

Investment income for HRMC was $75,559 and $97,146 in 2016 and 2015, respectively, which is included in loss from discontinued operations in the consolidated statements of operations. Included in these amounts are net realized losses on sale of investments $60,700 and $554,813, interest on trustee held funds of $4,030 and $22,502, and interest and dividends, net of $132,229 and $629,457 in 2016 and 2015, respectively.

5. Fair Value Measurements and Financial Instruments

Fair Value Measurements

The Corporation measures its short-term investments, assets whose use is limited, investments, beneficial interest in trusts, and derivative financial instruments at fair value on a recurring basis in accordance with accounting principles generally accepted in the United States of America.

Fair value is defined as the price that would be received to sell an asset or the price that would be paid to transfer a liability in an orderly transaction between market participants at the measurement date. The framework that the authoritative guidance establishes for measuring fair value includes a hierarchy used to classify the inputs used in measuring fair value. The hierarchy prioritizes the inputs used in determining valuations into three levels. The level in the fair value hierarchy within which the fair value measurement falls is determined based on the lowest level input that is significant to the fair value measurement.

The levels of the fair value hierarchy are as follows:

Level 1 - Fair value is based on unadjusted quoted prices in active markets that are accessible to the Corporation for identical assets. These generally provide the most reliable evidence and are used to measure fair value whenever available.

Level 2 - Fair value is based on significant inputs, other than Level 1 inputs, that are observable either directly or indirectly for substantially the full term of the asset through corroboration with observable market data. Level 2 inputs include quoted market prices in active markets for similar assets, quoted market prices in markets that are not active for identical or similar assets, and other observable inputs.

Level 3 - Fair value would be based on significant unobservable inputs. Examples of valuation methodologies that would result in Level 3 classification include option pricing models, discounted cash flows, and other similar techniques.

The fair value of the Corporation's financial instruments was measured using the following inputs at December 31:

	2016				
	Carrying Value	Fair Value	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
Reported at Fair Value					
Assets:					
Cash and cash equivalents	$ 270,610,738	$ 270,610,738	$ 270,610,738	$ -	$ -
Mutual funds:					
Fixed income - multi-sector	3,327,795	3,327,795	3,327,795	-	-
Equity - growth	5,284,502	5,284,502	5,284,502	-	-
Equity - other	716,929	716,929	716,929	-	-
Equity - mid-cap	6,803	6,803	6,803	-	-
Equity - balanced	28,875,405	28,875,405	28,875,405	-	-
U.S. government securities:					
U.S. treasury notes	88,583,869	88,583,869	-	88,583,869	-
Mortgage backed securities	29,703,673	29,703,673	-	29,703,673	-
Corporate bonds and other debt securities	48,547,456	48,547,456	-	48,547,456	-
Beneficial interest in trusts	1,310,686	1,310,686	-	-	1,310,686
	$ 476,967,856	$ 476,967,856	$ 308,822,172	$ 166,834,998	$ 1,310,686
Liabilities,					
Derivative financial instruments	$ 2,073,079	$ 2,073,079	$ -	$ 2,073,079	$ -
Disclosed at Fair Value					
Cash and cash equivalents	$ 30,198,079	$ 30,198,079	$ 30,198,079	$ -	$ -
Pledges receivable	3,669,290	3,562,332	-	-	-
Long-term debt, excluding capital leases (Note 10):					
Fixed rate revenue bonds	488,299,967	521,087,175	-	521,087,175	-
Variable rate revenue bonds	23,985,000	23,985,000	-	23,985,000	-
Note payable	23,613,911	23,613,911	-	-	23,613,911
Secured lines of credit	7,032,921	7,032,921	-	-	7,032,921

	2015				
	Carrying Value	Fair Value	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
Reported at Fair Value					
Assets:					
Cash and cash equivalents	$ 33,030,209	$ 33,030,209	$ 33,030,209	$ -	$ -
Marketable certificates of deposit	916,322	916,322	-	916,322	-
Mutual funds:					
Fixed income - multi-sector	3,127,943	3,127,943	3,127,943	-	-
Equity - growth	1,537,557	1,537,557	1,537,557	-	-
Equity - balanced	9,006,583	9,006,583	9,006,583	-	-
U.S. government securities:					
U.S. treasury notes	10,434,454	10,434,454	-	10,434,454	-
Asset backed securities	103,296,953	103,296,953	-	103,296,953	-
Corporate bonds and other debt securities	36,756	36,756	-	36,756	-
Beneficial interest in trusts	1,373,458	1,373,458	-	-	1,373,458
	$ 162,760,235	$ 162,760,235	$ 46,702,292	$ 114,684,485	$ 1,373,458
Liabilities,					
Derivative financial instruments	$ 22,275,775	$ 22,275,775	$ -	$ 22,275,775	$ -
Disclosed at Fair Value					
Cash and cash equivalents	$ 45,638,591	$ 45,638,591	$ 45,638,591	$ -	$ -
Pledges receivable	3,451,711	3,346,687	-	-	3,346,687
Long-term debt, excluding capital leases (Note 10):					
Fixed rate revenue bonds	94,329,029	102,914,580	-	102,914,580	-
Variable rate revenue bonds	141,140,000	141,140,000	-	141,140,000	-
Note payable	24,346,297	24,346,297	-	-	24,346,297
Secured lines of credit	23,000,000	23,000,000	-	-	23,000,000

The following table presents the fair value measurements for beneficial interest in trusts that have unobservable inputs at December 31, 2016 and 2015:

Balance, January 1, 2015	$ 1,567,811
Decrease in value, included in changes in temporarily restricted net assets	(194,353)
Balance, December 31, 2015	1,373,458
Decrease in value, included in changes in temporarily restricted net assets	(30,449)
Write-off of HRMC's beneficial interest in trusts	(32,323)
Balance, December 31, 2016	$ 1,310,686

The following represents a reconciliation of the assets reported at fair value included in the fair value table within the accompanying consolidated balance sheets at December 31:

	2016	2015
Short-term investments (Note 4)	$ 188,594,181	$ 138,418,552
Assets whose use is limited (Note 4):		
Current portion	2,870,341	4,031,128
Under trust indentures, held by trustees	269,595,205	5,953,215
Professional liability trust fund	12,233,224	10,187,116
Deferred compensation fund	1,466,041	1,473,131
Investments held by foundations	898,178	1,419,873
Beneficial interest in trusts	1,310,686	1,373,458
	476,967,856	162,856,473
Less CBAM Resolute Fund Ltd., measured at net asset value	-	96,238
	$ 476,967,856	$ 162,760,235

The Corporation did not have any financial assets or financial liabilities measured at fair value.

The following is a description of the valuation methodologies used for assets and liabilities measured at fair value and for financial instruments disclosed at fair value. There have been no changes in methodologies used at December 31, 2016 and 2015.

Cash and cash equivalents: The carrying amounts approximate fair value because of the short maturity of these financial instruments.

Marketable certificates of deposit and mutual funds: Valued based on quoted market prices.

U.S. government securities, corporate bonds and other debt securities: Valued based on estimated quoted market prices of similar securities.

Beneficial interest in trusts: Beneficial interest in trusts are valued based on the fair value of the trusts underlying assets which represents a proxy for discounted present value of future cash flows. Beneficial interest in trusts are included in deposits and other noncurrent assets in the accompanying consolidated balance sheets.

Pledges receivable: Valued based on the original pledge amount, adjusted by a discount rate that a market participant would demand and an evaluation of uncollectible pledges. Pledges receivables are included in prepaid and other current assets and deposits and other noncurrent assets in the accompanying consolidated balance sheets.

Long-term debt: The fair value of the fixed rate debt is estimated based on market data provided by the Corporation's financial consultants. Fair values of the remaining long-term debt are considered to approximate their carrying amounts in the accompanying consolidated balance sheets.

The Corporation was invested in the CBAM Resolute Fund, Ltd. ("Resolute Fund"). The fund is valued based on the net asset value per share of the fund which is based on the fair value of their underlying assets derived principally from or corroborated by observable market data by correlation or other means. In regards to the Fund, there are no unfunded purchase commitments or restrictions on the sale of the investments. The Corporation liquidated its remaining investment in the Resolute Fund in 2016.

The following represents the investment strategy of the Resolute Fund and the Corporation's investment measured at fair value at December 31, 2015:

Fund	Investment Strategy	2015
CBAM Resolute Fund, Ltd	To create an alternative source of income by harnessing risk premiums in global option markets. In pursuit of this objective, the fund will employ its option income strategy which utilizes actively-managed option-based investment structures to create absolute return profiles. This market-neutral strategy is designed to have minimal correlation to underlying market returns over an extended period of time and may be applied in a range of global markets including equities (both individual stocks and baskets of stocks), commodities, interest rates, foreign currencies and other markets where options are traded. The fund may trade and invest in the underlying instruments, related instruments (e.g. futures, forwards and exchange-traded funds or notes), and long and short call options and put options on the underlying or related instruments. The fund will seek to capitalize on a combination of systemic risk premium in global option markets and yields from active cash management.	$ 96,238

The Corporation measures its derivative financial instruments at fair value based on proprietary models of an independent third-party valuation specialist. The fair value takes into consideration the prevailing interest rate environment and the specific terms and conditions of the derivative financial instrument, and considers the credit risk of the Corporation and counterparty. The method used to determine the fair value calculates the estimated future payments required by the derivative financial instrument and discounts these payments using an appropriate discount rate. The value represents the estimated exit price the Corporation would pay to terminate the agreement.

6. Property and Equipment and Accumulated Depreciation and Amortization

Property and equipment and accumulated depreciation and amortization at December 31, 2016 and 2015 consist of the following:

	2016	2015
Land and improvements	$ 27,532,713	$ 16,711,792
Buildings and improvements	448,226,562	488,364,688
Office furniture and equipment	183,173,853	249,979,263
Computer software and hardware	129,964,265	137,582,678
Equipment under capital leases	24,749,717	23,021,853
Total	813,647,110	915,660,274
Less accumulated depreciation and amortization	(440,159,685)	(526,883,809)
Total	373,487,425	388,776,465
Construction in progress	58,474,476	25,337,475
	$ 431,961,901	$ 414,113,940

Interest incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. During 2016 and 2015, the Corporation incurred interest expense, including amortization expense related to deferred financing costs, of approximately $12,012,000 and $11,231,000, respectively, of which approximately $1,650,000 was capitalized in 2016 and $1,670,000 in 2015. HRMC incurred interest expense of approximately $337,000, including amortization expense related to deferred financing costs, in 2016 and $1,337,000 in 2015 which is included in loss from discontinued operations in the accompanying consolidated statements of operations. There were no amounts capitalized for HRMC in 2016 and 2015. Investment earnings of approximately $16,000 and $13,000 were offset against capitalized interest in 2016 and 2015, respectively.

Depreciation expense, including amortization of equipment under capital leases, was $37,825,000 in 2016 and $39,287,000 in 2015. Depreciation expense, including amortization of equipment under capital leases, for HRMC was $1,247,000 in 2016 and $4,870,000 in 2015 and is included in loss from discontinued operations in the accompanying consolidated statements of operations. Depreciation expense, including amortization of equipment under capital leases, for BH&WS - Eastern Shore was $54,000 in 2016 and $49,000 in 2015 and is included in loss from discontinued operations in the accompanying consolidated statements of operations. Accumulated amortization of equipment under capital lease as of December 31, 2016 and 2015 was $19,353,513 and $18,188,002, respectively.

Construction in progress as of December 31, 2016 consists primarily of major renovation and expansion projects of clinical facilities. Purchase commitments related to these and other miscellaneous projects were approximately $94,883,000 at December 31, 2016. The cost of these projects is expected to be funded through the construction fund established through bond proceeds as well as transfers from the Corporation's related foundations and operations.

7. Investments and Investments in Unconsolidated Subsidiaries

The Corporation's investments and investments in unconsolidated subsidiaries include the following at December 31, 2016 and 2015:

	2016	2015
Investment in healthcare entities	$ 5,887,970	$ 4,896,152
Investment in Premier	6,595,929	4,868,701
Investments held by foundations and other	799,785	1,317,072
Total	$ 13,283,684	$ 11,081,925

Investment in Healthcare Entities

The Corporation recognized earnings of $509,587 and $1,371,874 during 2016 and 2015, respectively, related to its ownership interest in the healthcare entities accounted for under the equity method. The Corporation recognized earnings of $98,332 during 2016, which are included in the loss from discontinued operations in the consolidated statement of operations, related to HRMC's ownership interest in healthcare entities accounted for under the equity method. A brief description of these investments is presented below:

Chesapeake Potomac Regional Cancer Center ("CPRCC") - CPRCC provides outpatient radiation oncology services to patients in Maryland. The Corporation has a 20% ownership interest in CPRCC.

Doctors Regional Cancer Center ("DRCC") - DRCC provides outpatient radiation oncology services to patients in Bowie and Lanham, Maryland. The Corporation has a 20% ownership interest in DRCC.

Shady Grove Medical Building, LLC ("SGMB") - SGMB was organized for the purpose of developing and constructing a cancer care center on the campus of Shady Grove Medical Center. The Corporation has a 50% ownership interest in SGMB.

Riverside Health, Inc. ("RHI") - RHI is a Medicaid managed care organization providing health services to its members. The Corporation sold its ownership interest on August 18, 2015 and recognized a gain on the sale of $1,664,925, which is included in investment income in the accompanying consolidated statements of operations. The Corporation had a 20% ownership interest in RHI prior to the date of sale.

The Corporation has invested $255,906 in Advanced Health Collaborative, LLC for a 20% ownership interest. This organization was formed to share ideas and explore opportunities to enhance quality of healthcare in the state of Maryland.

The Corporation has invested $2,179,672 in Advanced Health Collaborative II, LLC ("AHC II") for a 25% interest. AHC II was formed to hold a 24% interest in Maryland Health Advantage, LLC which is a Medicare preferred provider network providing health services to its members.

Summarized financial information related to these entities is presented below:

	2016	2015
Net revenue	$ 17,258,901	$ 17,359,701
Revenues in excess of expenses	1,705,494	1,316,138
Total assets	29,861,576	30,758,798
Total liabilities	15,834,676	17,283,483

Investment in Premier

The Corporation is a partner in Premier, Inc. ("Premier"), a health care system group purchasing organization. In 2013, the Corporation recorded its Premier investment under the cost method of accounting. In October 2013, Premier converted from a privately held company to a public company through the issuance of an Initial Public Offering. At the time of conversion, the Corporation was issued 493,810 Class B common units of which 78,946 units were sold.

The remaining 414,864 Class B common units held by the Corporation are exchangeable for Class A common stock over a 7-year quarterly vesting period. The Corporation recognized a gain of $1,727,228 and $1,900,778 during 2016 and 2015, respectively, based on the market value of the units available for exchange. In addition, the Corporation recognized earnings of $802,812 and $832,617 during 2016 and 2015, respectively, related to distributions. Both the gain and the distributions are included in other revenue in the accompanying consolidated statements of operations.

Investments Held by Foundations and Other

The Foundations also hold marketable debt and equity securities for funds not required to be expended in less than 90 days. These marketable securities are subject to credit and market risks.

8. Land Held for Healthcare Development

Land held for healthcare development at December 31, 2016 and 2015 consists of the following:

	2016	2015
Land - Clarksburg, Maryland	$ 48,706,305	$ 49,915,152
Land - Silver Spring, Maryland	-	39,776,601
Land - Laurel, Maryland	-	1,906,015
Total	$ 48,706,305	$ 91,597,768

Land - Clarksburg, Maryland

From 2002 through 2011, the Corporation acquired various parcels of land in Clarksburg, Maryland totaling approximately 200 acres. Several parcels of the land are fully owned by the Corporation, and the remainder is owned by Cabin Branch Commons, LLC ("Cabin Branch"), of which the Corporation owns 45%. In May 2013, the Corporation and Cabin Branch entered into a Purchase and Sale Agreement (the "Sale Agreement") with an unrelated third party to sell 48.8 acres of the land located in Clarksburg. In June 2015, the Corporation and Cabin Branch closed on the sale of the land at a purchase price of $28,250,000. The Corporation's portion of the proceeds was $25,101,980. As of December 31, 2015, the Corporation received $13,225,064 of their portion of the purchase price, with the additional proceeds being held in escrow and received upon the completion of certain infrastructure improvements to the property, for which the Corporation and Cabin Branch are collectively responsible. During 2016, the Corporation received additional proceeds from the escrow totaling $5,938,458 as reimbursement for such infrastructure improvements made to the property during 2016. Total proceeds received through December 31, 2016 totaled $19,163,522.

The total amount of assets related to the parcel of land sold by the Corporation, net of proceeds received, was $17,911,500 and $11,973,042 at December 31, 2016 and 2015, respectively. No gain or loss was recognized on the sale of the land as of December 31, 2016 and 2015.

Land - Silver Spring, Maryland

In July 2006, the Corporation purchased a parcel of land for purposes of building a replacement hospital for Washington Adventist Hospital. The land, which is located near the Calverton-White Oak area of Silver Spring, was purchased for approximately $11,000,000. In December 2015, the Maryland Health Care Commission granted formal approval of the Corporation's plan to build the new facility. As of December 31, 2015, the Corporation had total costs capitalized related to the land and improvements of $39,776,601, which was included in land held for healthcare development in the consolidated balance sheet.

During 2016, the Corporation commenced construction on the new facility and reclassified the costs associated with the land and improvements from land held for healthcare development to property and equipment in the accompanying consolidated balance sheet.

Land - Laurel, Maryland

In January 2014, the Corporation entered into a purchase agreement with an unrelated third party to buy land located in Laurel, Maryland for purposes of constructing an urgent care facility. On June 25, 2015, the Corporation closed on the purchase of the land for a total purchase price of $1,906,015. As of December 31, 2015, the Corporation classified these costs as land held for healthcare development in the consolidated balance sheet.

During 2016, the Corporation commenced and completed construction of the new urgent care facility and reclassified the costs associated with the land from land held for healthcare development to property and equipment in the accompanying consolidated balance sheet.

9. Short-Term Financing

The Corporation has a $3,000,000 unsecured line of credit with a commercial bank, with interest at LIBOR plus 1.50% (2.27 % at December 31, 2016). There were no borrowings outstanding under this line of credit as of December 31, 2016 or 2015.

10. Long Term Obligations

Long term obligations as of December 31, 2016 and 2015 are comprised of the following:

	2016	2015
Fixed rate revenue bonds	$ 488,299,967	$ 94,329,029
Variable rate revenue bonds	23,985,000	141,140,000
Secured lines of credit	7,032,921	23,000,000
Note payable	23,613,911	24,346,297
Capital lease purchase financing facilities	-	144,289
Other long term liabilities	21,524,170	13,323,657
Total obligations	564,455,969	296,283,272
Plus bond premium	10,869,392	-
Less:		
Current maturities	(12,749,886)	(31,540,973)
Deferred financing costs	(4,839,919)	(2,206,562)
Noncurrent portion of long term obligations, net	$ 557,735,556	$ 262,535,737

Fixed Rate Revenue onds

Fixed rate revenue bonds consist of the Maryland Health and Higher Educational Facilities Authority Refunding Revenue Bonds. Fixed rate revenue bonds consist of the following at December 31:

	Par Amounts	Interest Rates	2016	2015
Adventist Healthcare, Inc.:				
Series 2011A	$ 57,205,000	5-6.25%	$ 57,205,000	$ 57,205,000
Series 2013	15,623,500	3.21%	11,384,967	12,844,029
Series 2014A	24,280,000	3.56%	23,565,000	24,280,000
Series 2016A	269,750,000	5.00%	269,750,000	-
Series 2016B	126,395,000	3.23%	126,395,000	-
Total			$ 488,299,967	$ 94,329,029

The above bond issues are subject to trust indentures which impose various covenants on SGMC, WAH, HRMC, BH&WS, Rehab, Imaging, CIS, Other Health Services and the Support Center (collectively, the "Obligated Group") which include restrictions on the transfer or disposition of property, the incurrence of additional liabilities, and the achievement of certain pre-established financial indicators. Management believes it has complied with these required financial covenants for the years ended December 31, 2016 and 2015. Debt service reserve funds are required on the Series 2011A and the Series 2016A bonds.

Variable Rate Revenue onds

Variable rate revenue bonds consist of the following at December 31:

	2016	2015
Maryland Health and Higher Educational Facilities Authority Revenue Bonds:		
Series 2005A, Adventist HealthCare, Inc.	$ -	$ 78,000,000
Series 2011B, Adventist HealthCare, Inc.	-	38,155,000
Maryland Health and Higher Educational Facilities Authority Revenue Refunding Bonds, Series 2014B, Adventist HealthCare, Inc.	23,985,000	24,985,000
Total	$ 23,985,000	$ 141,140,000

In December 2016, the Series 2005A and 2011B bonds were refunded with the issuance of the Series 2016B Bond. The Series 2016B bond was issued as a direct placement with a commercial bank. As a result of this refunding, a loss on extinguishment of debt was recognized in 2016 for approximately $686,357 which was comprised of the remaining unamortized deferred financing costs related to the Series 2005A and 2011B bonds.

The Series 2014B Bonds bear interest at a variable rate of one month LIBOR plus 2.3% (2.92% at December 31, 2016). The Series 2014B bonds are subject to an Amended and Restated Master Trust Indenture that imposes various covenants on the Obligated Group which include restrictions on the transfer or disposition of property, the incurrence of additional liabilities, and the achievement of certain pre-established financial indicators. Management believes it has complied with these required financial covenants for the years ended December 31, 2016 and 2015.

The bonds subject to the Amended and Restated Master Trust Indenture are secured by the unrestricted revenues of the Obligated Group as well as a mortgage interest in the facilities of SGMC, WAH, HRMC, BH&WS and Rehab. In conjunction with the closing of the transfer of HRMC to Atlantic Health System as of March 31, 2016, HRMC is no longer a member of the Obligated Group, and as such, the mortgage on HRMC was released.

Secured Lines of Credit

The Corporation has secured lines of credit outstanding as follows:

$20,000,000 line of credit with a commercial bank that bears interest at LIBOR plus 2.00%. The balance on the working capital line was $12,500,000 at December 31, 2015. This line of credit was repaid in June 2016.

$16,000,000 line of credit that bears interest at LIBOR plus 2.00% (2.87% at December 31, 2016) and expires on June 30, 2018. The balance on the line of credit was $7,032,921 and $10,500,000 at December 31, 2016 and 2015, respectively.

Note Payable

In December 2014, the corporation entered into a taxable term note for $25,000,000 with a commercial bank, which is secured by a Master Note issued under the Amended and Restated Master Trust Indenture dated as of February 1, 2003. The note bears interest at one month LIBOR plus 2.45% (3.14% as of December 31, 2016). The amortization on the note extends to December 18, 2034, however, the note matures on December 18, 2024. As of December 31, 2016 and 2015, the outstanding balance was $23,613,911 and $24,346,297, respectively.

Capital Lease Purchase Financing Facilities

As of December 31, 2015, the Corporation had a capital lease purchase financing facility with a commercial bank. The facility was established in February 2011 for $10,000,000, bears interest at a rate of 3.47% and has a five year repayment period. Under the terms of the agreement, the commercial bank deposited funds into escrow accounts for the purpose of funding future purchases of new or used medical or medical-related equipment. The commercial bank retains title to the equipment and is considered to be the owner; however, the Corporation is responsible for all related expenses, including but not limited to, insurance, maintenance, and taxes. The balance of this facility was $144,289 at December 31, 2015. This facility was repaid in 2016.

Other Long Term Liabilities

This category consists of several capital lease obligations and notes payable on various types of medical and IT equipment. The financed equipment serves as security on these leases. Interest rates on these other long term liabilities range from 3.40% - 6.83%.

Scheduled principal repayments of long-term obligations at December 31, 2016 are as follows:

Years ending December 31:	
2017	$ 12,749,886
2018	12,937,493
2019	7,307,038
2020	12,732,354
2021	12,023,467
Thereafter	506,705,731
Total	$ 564,455,969

11. Derivative Financial Instruments

During 2016, the Corporation had two interest rate swap agreements, which are considered derivative financial instruments. The agreements were entered into in order to manage interest rate exposure. The principal objective of the swap agreements is to minimize the risks associated with financing activities by reducing the impact of changes in interest rates on its debt portfolio. The notional amount of the swap agreements is used to measure the interest to be paid or received and does not represent the amount of exposure to credit loss. Exposure to credit loss is limited to the receivable, if any, which may be generated as a result of the swap agreement. One of the Corporation's interest rate swap agreements was terminated during 2016 and the remaining interest rate swap agreement is reported at fair value in the consolidated balance sheets.

The interest rate swap agreement with a notional amount of $78,000,000 was designated by the Corporation as a cash flow hedge, which qualified it for hedge accounting treatment under accounting principles generally accepted in the United States of America. The effective portion of the change in fair value of the cash flow hedge is reported in the consolidated statements of operations and changes in net assets as an unrealized gain or loss on cash flow derivative financial instrument. The ineffective portion of the change in fair value is reported in the accompanying consolidated statements of operations as a component of interest expense. On December 9, 2016, the Corporation terminated this swap with the counterparty at a value of $16,875,000. The Corporation borrowed the termination fee, which was included as a component of the proceeds for the 2016B bonds, previously described in Note 10. No gain or loss was recognized on the termination of the swap. As of December 31, 2016, $12,971,579 remained in unrestricted net assets. This amount will be amortized over the remaining term of the hedge, or through January 2035, beginning in January 2017.

The net cash paid or received under the swap agreements is recognized as either an adjustment to interest expense or other income. The net cash paid under the interest rate swap agreements was $3,791,973 in 2016 and $4,200,383 in 2015. For 2016 and 2015, $2,548,804 and $2,686,473, respectively, are reported as a component of interest expense in the accompanying consolidated statements of operations. These amounts represent the net cash paid related to the swap agreement that was accounted for, prior to the termination, using hedge accounting. The remaining amounts for 2016 and 2015 are reported as a component of other income (expense) in the accompanying consolidated statements of operations, which is related to the swap agreement that does not qualifies for hedge accounting.

At December 31, 2016 and 2015, the Corporation's derivative financial instruments and related fair values are as follows:

	2016	2015
Agreement for the notional amount of $50,880,000 requiring the Corporation to pay a fixed interest rate of 3.457% while receiving variable interest rates based upon 67% of LIBOR, maturing January 2021	$ (2,073,079)	$ (3,066,432)
Agreement for the notional amount of $78,000,000 requiring the Corporation to pay a fixed interest rate of 3.567% while receiving variable interest rates based upon 67% of LIBOR, maturing January 2035 and qualifying for cash flow hedge accounting treatment; this agreement was terminated in 2016	-	(19,209,343)
Total	$ (2,073,079)	$ (22,275,775)

The fair value of the interest rate swap agreements is estimated to be the amount the Corporation would receive or pay to terminate the swap agreements at the reporting date and was based on information supplied by an independent third party valuation agent (Note 5). Additionally, the fair value reflects a credit risk assessment required under accounting principles generally accepted in the United States of America. Gains or losses resulting from hedge ineffectiveness are recognized in revenues in excess of expenses from continuing operations. No gains were recognized as of December 31, 2016 and 2015, respectively, as a result of hedge ineffectiveness. Gains or losses resulting from interest rate swap agreements not qualifying for cash flow hedge accounting treatment are entirely recognized as a component of revenues in excess of expenses from continuing operation. The impact of swaps not qualifying for hedge accounting treatment on the consolidated statements of operations were gains of $1,035,104 in 2016 and $909,937 in 2015.

On October 3, 2008, the counterparty for the Corporation's fixed pay swap maturing in January 2035, Lehman Brothers, Inc., commenced proceedings under Chapter 11 of the Bankruptcy Code. This action triggered an Event of Default under the ISDA Master Agreement in effect with said party and gave the Corporation the right to terminate the transaction. On October 16, 2008, the Corporation terminated this agreement and concurrently entered into an agreement with a new counterparty that assumed all existing terms and conditions of the original agreement. The termination of the original swap agreement resulted in a loss of $472,023 which is included in unrestricted net assets in the consolidated balance sheets. This loss is being amortized over the remaining term of the designated period of the hedge, or through January 2035. As of December 31, 2016 and 2015, accumulated amortization of $143,855 and $125,873, respectively, is included in other changes in net assets and interest expense in the consolidated statements of operations and changes in net assets.

12. Leases

The Corporation has entered into various operating leases primarily for office space as well as certain equipment items. Rental expense for operating leases was $21,263,623 in 2016 and $22,130,309 in 2015. Rental expense for operating leases of HRMC was $540,820 in 2016 and $2,103,863 in 2015 and is included in loss from discontinued operations in the accompanying consolidated statements of operations. Rental expense for operating leases of BH&WS - Eastern Shore was $692,074 in 2016 and $678,097 in 2015 and is included in loss from discontinued operations in the accompanying consolidated statements of operations. The building lease for BH&WS Eastern Shore expired in 2016 and was not renewed. Future minimum payments under non-cancelable operating leases with initial terms of one year or more consist of the following during the years ending December 31:

Years ending December 31:	
2017	$ 13,197,057
2018	13,130,331
2019	12,703,135
2020	12,685,006
2021	12,584,572
Thereafter	50,480,996
Total	$ 114,781,097

The Corporation has also entered into various sub-lease agreements with tenants that occupy space in the Corporation's buildings. The terms of these sub-leases vary and extend through 2030. Rental income was $4,506,295 in 2016 and $4,536,740 in 2015, which has been reported as a component of other operating revenue in the consolidated statements of operations. Future rent payments expected to be received by the Corporation during the years ending December 31, are as follows:

Years ending December 31:	
2017	$ 4,020,673
2018	3,594,930
2019	3,115,743
2020	2,766,704
2021	2,381,246
Thereafter	4,303,364
Total	$ 20,182,660

13. Retirement, Health Plan and Life Insurance

Defined Contribution Retirement Plan

The Corporation sponsors a 401(a) defined contribution retirement plan, which covers substantially all full-time employees. After twelve months of full-time or regular part-time employment of at least 1,000 base hours, the Corporation will contribute a total of 2% of eligible employees' compensation, plus a matching employer contribution equal to 50% of employee contributions (to the 403(b) plan) up to 6% of base salary. The Corporation also has a 403(b) retirement savings plan for employees. Employee contributions are made to the 403(b) retirement savings plan. Retirement plan expense was $8,760,252 in 2016 and $8,657,979 in 2015. Retirement plan expense for HRMC was $174,378 in 2016 and $786,073 in 2015 which is included in loss from discontinued operations in the consolidated statements of operations. Retirement plan expense for BH&WS - Eastern Shore was $60,686 in 2016 and $63,748 in 2015 which is included in loss from discontinued operations in the consolidated statements of operations.

Supplemental Executive Retirement Plan

The Corporation also has a Supplemental Executive Retirement Plan ("SERP") that became effective in 2015 and covers a group of key executives. SERP expense was $300,900 in 2016 and $496,857 in 2015. In addition, a SERP liability adjustment was recorded for $521,260 in 2016 and $1,575,015 in 2015, which was recognized in other changes in net assets in the consolidated statement of changes in net assets. At December 31, 2016 and 2015, the Corporation's liability for the SERP was $2,894,032 and $2,071,872, respectively, which is included in other liabilities in the consolidated balance sheet.

Executive Retention 457(F) Plan

Effective January 1, 2015, the Corporation established the Executive Retention 457(F) Plan (the "457(F) Plan"). The 457(F) Plan is a tax-deferred plan offered to key executives, whereby annual employer contributions are made to the Plan. Plan participants become vested in the contributions and receive plan payments in the second calendar year after the contribution is made, if the participant is still employed. The final contribution will be made to the Plan for the year in which the plan participant becomes 62. The 457(F) plan expense was $1,501,925 in 2016 and $1,712,760 in 2015. The Corporation's liability for the 457(F) plan at December 31, 2016 and 2015 was $2,975,057 and $1,473,131, respectively, which is included in other liabilities in the consolidated balance sheet.

Salary Deferral (457(b)) Plan

Employees who contribute the maximum allowable amount to the 403(b) retirement plan have an opportunity to contribute additional funds on a tax-deferred basis to a 457(b) retirement plan up to the maximum tax-sheltered opportunity. There are no employer contributions to this plan.

Health Plan

The Corporation maintains a self-insurance employee program for its health insurance coverage. The Corporation accrues the estimated costs of incurred and reported and incurred but not reported claims, after consideration of its stop-loss insurance coverage, based upon data provided by the third-party administrator of the program and historical claims experience.

Life Insurance

Full-time and part-time employees are insured, through a third-party carrier, for an amount equal to one times their base salary at time of enrollment up to $450,000 for full-time employees and $10,000 for part-time employees. In addition, if death is caused by accident, the employee is insured for an additional benefit equal to the amount of their life insurance.

14. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for betterments to plant facilities and purchases of equipment or to support operating programs sponsored by the Corporation and its affiliates.

Permanently restricted net assets have been restricted by donor to be maintained by the Corporation in perpetuity.

Net assets were released from donor restriction by satisfying their restricted purposes in the amount of $3,293,236 in 2016 and $3,671,485 in 2015.

15. Commitments and Contingencies

Litigation and Claims

The Corporation is subject to asserted and unasserted claims (in addition to litigation) encountered in the ordinary course of business. In the opinion of management and after consultation with legal counsel, the Corporation has established adequate reserves related to all known matters. The outcome of any potential investigative, regulatory or prosecutorial activity that may occur in the future cannot be predicted with certainty. However, any associated potential future losses resulting from such activity could have a material adverse effect on the Corporation's future financial position, results of operations and liquidity.

Insurance

The Corporation's primary coverage for professional liability is provided through a self-funded insurance retention trust (the "Trust") established on January 1, 1993. The Trust is funded based on actuarial estimates and provides coverage of $2,000,000 per occurrence with no annual aggregate limitation. The Trust also provides general liability coverage up to $1,000,000 per occurrence and $3,000,000 in the aggregate. The Corporation also carries umbrella excess liability insurance on a claims made basis with a commercial carrier, with limits of $20,000,000 per occurrence and in aggregate.

It is the Corporation's policy to accrue for the ultimate cost of uninsured asserted and unasserted malpractice claims, if any, when incidents occur. Based on a review of the Corporation's prior experience and incidents occurring through December 31, 2016, management determined that the fully-funded professional liability reserve reported at December 31, 2016 and 2015 is adequate in light of the program's excess umbrella policy currently in force and historical claims experience. The estimated professional liability for both asserted and unasserted claims was $12,865,503 and $12,291,581 at December 31, 2016 and 2015, respectively. The discount rate used in determining these liabilities was 2.5% at both December 31, 2016 and 2015.

The Corporation is self-insured for unemployment and workers' compensation benefits. The liability for unemployment and worker's compensation claims payable is an estimate based on the Corporation's past experience and is included in the accompanying consolidated balance sheets. It is reasonably possible that the estimates used could change materially in the near term.

Remediation

Certain buildings, which were constructed prior to the passage of the Clean Air Act, contain encapsulated asbestos material. Current law requires that this asbestos be removed in an environmentally safe fashion prior to demolition and renovation of these buildings. At this time, the Corporation has no plans to demolish or renovate these buildings and, as such, cannot reasonably estimate the fair value of the liability for such asbestos removal.

16. usiness and Credit Concentrations

The Corporation grants credit to patients, substantially all of whom are local residents. The Corporation generally does not require collateral or other security in extending credit; however, it routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits receivable under their health insurance programs, plans or policies.

At December 31, 2016 and 2015, concentrations of gross receivables from third-party payors and others are as follows:

	2016	2015
Medicare	22 %	23 %
Medicaid	12	8
Other third party payers	45	46
Self-pay and others	21	23
	100 %	100 %

Net patient service revenue, by payor class, consisted of the following for the years ended December 31:

	2016	2015
Medicare	38 %	31 %
Medicaid	9	10
Other third party payers	49	53
Self-pay and others	4	6
	100 %	100 %

The Corporation maintains its cash and cash equivalents with several financial institutions. Cash and cash equivalents on deposit with any one financial institution are insured up to $250,000.

17. Functional Expenses

A summary of the Corporation's operating expenses by function for the years ended December 31, is as follows:

	2016	2015
Hospital acute and ambulatory services	$ 545,995,612	$ 541,212,738
Home care services	19,113,770	17,803,358
Other health care services	184,260,531	148,552,492
Other, including general and administrative	10,751,002	8,598,175
Fundraising	682,243	885,301
Total	$ 760,803,158	$ 717,052,064

The Corporation also incurred hospital acute and other health care services expenses related to HRMC and BH&WS Eastern Shore that were included in loss from discontinued operations in the consolidated statements of operations. HRMC hospital acute services expenses were $22,769,646 in 2016 and $92,885,048 in 2015. BH&WS Eastern Shore other healthcare services expenses were $10,001,541 in 2016 and $9,500,800 in 2015.

Adventist HealthCare, Inc. and Controlled Entities
Consolidating Schedule, Balance Sheet
December 31, 2016

	Shady Grove Medical Center	Washington Adventist Hospital	Hackettstown Regional Medical Center	Behavioral Health & Wellness Services	Rehabilitation	Imaging Services	Clinical Integration Services	Other Health Services	Support Center	Eliminating Entries	Total Combined Obligated Group	Lourie Center	Adventist Home Care Services	Urgent Care Centers	One Health Quality Alliance	Mid-Atlantic Primary Care	Adventist HealthCare, Inc Foundations	Eliminating Entries	Consolidated Adventist HealthCare, Inc.
Assets																			
Cash and cash equivalents	$ 162,569,536	$ (4,375,336)	$ 75,410,198	$ (1,951,564)	$ 15,601,912	$ (19,623,335)	$ (85,598,619)	$ 625,185	$ (111,534,445)	$ -	$ 31,123,512	$ (981,127)	$ 5,488,617	(4,423,066)	$ (1,854,468)	$ (1,060,901)	$ 1,905,512	$ -	$ 30,198,079
Short-term investments	-	-	-	-	-	-	-	-	188,594,181	-	188,594,181	-	-	-	-	-	-	-	188,594,181
Assets whose use is limited	-	-	-	-	-	-	-	-	2,870,341	-	2,870,341	-	-	-	-	-	-	-	2,870,341
Patient accounts receivable, net of estimated allowance for doubtful collections of $27,415,000	46,396,538	22,432,105	1,670,169	3,587,194	4,756,602	4,018,723	4,955,722	(519)	-	-	87,216,534	-	4,138,351	472,708	-	-	-	-	91,827,593
Other receivables, net of estimated allowance for doubtful collections of $2,436,000	2,985,245	3,841,522	193,247	1,046,727	129,762	1,556,722	141,116	632,736	2,570,163	(487,545)	12,609,695	1,687,087	59,067	-	-	-	888,168	-	15,244,017
Due from third party payors	-	-	-	221,343	181,248	-	-	-	-	(402,591)	-	-	-	-	-	-	-	-	-
Inventories	5,503,604	4,403,265	-	90,779	78,202	-	-	135,751	-	-	10,211,601	-	-	-	-	-	-	-	10,211,601
Prepaid expenses and other current assets	637,617	882,581	-	35,592	85,397	111,746	56,638	115,028	5,072,497	-	6,997,096	58,187	266,763	44,364	-	-	-	-	7,366,320
Total current assets	218,092,540	27,184,137	78,673,614	3,030,051	20,833,033	(13,936,144)	(80,445,143)	1,508,181	87,572,737	(890,136)	339,622,870	764,147	9,952,798	(3,905,994)	(1,854,468)	(1,060,901)	2,793,680	-	346,312,132
Property and Equipment, Net	179,666,190	95,103,363	-	13,451,801	9,492,821	8,912,398	1,790,051	245,157	114,286,688	-	422,948,469	1,686,283	1,097,935	6,229,204	-	-	-	-	431,961,891
Assets Whose Use is Limited																			
Under trust indentures and capital lease purchase financing facilities, held by trustees and banks	840,466	264,510,715	-	490,272	443,579	-	-	-	3,310,173	-	269,595,205	-	-	-	-	-	-	-	269,595,205
Professional liability trust fund	-	-	-	-	-	-	-	-	12,233,224	-	12,233,224	-	-	-	-	-	-	-	12,233,224
Deferred compensation fund	-	-	-	-	-	-	-	-	1,466,041	-	1,466,041	-	-	-	-	-	-	-	1,466,041
Cash and Cash Equivalents Temporarily Restricted for Capital Acquisitions	331,568	-	-	-	23,377	-	-	-	-	-	354,945	860,371	-	-	-	-	1,048,799	-	2,264,115
Investments and Investments in Unconsolidated Subsidiaries	1,031,001	-	-	-	-	-	-	-	11,452,898	-	12,483,899	-	-	-	-	-	799,785	-	13,283,684
Land Held for Healthcare Development	-	-	-	-	-	-	-	-	48,706,305	-	48,706,305	-	-	-	-	-	-	-	48,706,305
Intangible Assets, Net	1,120,690	-	-	1,307,651	877,706	5,435,091	-	49,740	17,960	-	8,808,838	-	157,328	-	-	-	-	-	8,966,166
Deposits and Other Noncurrent Assets	2,114,370	31,351	-	26,674	32,000	-	43,803	32,754	840,156	-	3,121,308	5,054	30,828	200,582	-	-	2,427,064	-	5,784,836
Total assets	$ 403,196,825	$ 386,829,566	$ 78,673,614	$ 18,306,449	$ 31,702,516	$ 411,345	$ (78,611,289)	$ 1,835,832	$ 279,886,382	$ (890,136)	$ 1,119,341,104	$ 3,315,855	$ 11,238,889	$ 2,523,792	$ (1,854,468)	$ (1,060,901)	$ 7,069,328	$ -	$ 1,140,573,608

Adventist HealthCare, Inc. and Controlled Entities
Consolidating Schedule, Balance Sheet
December 31, 2016

	Shady Grove Medical Center	Washington Adventist Hospital	Hackettstown Regional Medical Center	Behavioral Health & Wellness Services	Rehabilitation	Imaging Services	Clinical Integration Services	Other Health Services	Support Center	Eliminating Entries	Total Combined Obligated Group	Louis Center	Adventist Home Care Services	Urgent Care Centers	One Health Quality Alliance	Mid-Atlantic Primary Care	Adventist HealthCare, Inc. Foundations	Eliminating Entries	Consolidated Adventist HealthCare, Inc.
Liabilities and Net Assets																			
Current Liabilities																			
Accounts payable and accrued expenses	$ 26,721,885	$ 15,683,170	$ 3,139,004	$ 1,513,246	$ 695,997	$ 2,777,390	$ 2,418,627	$ 504,552	$ 26,244,226	$ -	$ 79,698,097	$ 113,327	$ 1,108,416	$ 2,904,446	$ 8,600	$ 3,000	$ 15,862	$ -	$ 83,843,748
Accrued compensation and related items	11,635,375	8,568,736	-	2,379,754	2,404,534	169,631	961,902	219,393	6,839,312	(487,545)	32,691,092	563,933	1,528,696	67,733	-	-	-	-	34,851,454
Interest payable	-	-	-	-	-	-	-	-	2,021,390	-	2,021,390	-	-	-	-	-	-	-	2,021,390
Due to third party payors	10,695,773	7,270,658	743,371	857,816	-	-	-	-	-	(402,591)	18,665,027	-	-	-	-	-	-	-	18,665,027
Estimated self-insured professional liability	-	-	-	-	-	-	-	-	1,150,302	-	1,150,302	-	-	-	-	-	-	-	1,150,302
Current maturities of long-term obligations	5,018,904	2,696,293	-	181,090	-	712,640	-	-	4,014,482	-	12,603,409	-	-	146,477	-	-	-	-	12,749,886
Total current liabilities	54,071,937	34,218,857	3,374,375	4,911,906	3,100,531	3,659,661	3,380,529	723,945	40,269,712	(890,136)	146,821,317	677,260	2,637,112	3,118,656	8,600	3,000	15,862	-	153,283,807
Construction Payable	1,028,978	1,815,738	-	-	182,606	-	-	-	-	-	3,027,323	-	-	-	-	-	-	-	3,027,323
Long-Term Obligations, Net																			
Bonds payable	(185,565)	287,383,114	-	(63,539)	(57,488)	-	-	-	228,030,643	-	515,107,165	-	-	(16,135)	-	-	-	-	515,091,030
otes payable	3,500,000	-	-	-	-	-	-	-	18,305,220	-	21,805,220	-	-	4,576,305	-	-	-	-	26,381,525
Capital lease obligations	3,433,823	1,431,695	-	954,463	-	1,767,055	-	-	8,685,965	-	16,263,001	-	-	-	-	-	-	-	16,263,001
Internal debt	125,267,625	55,272,417	-	6,022,769	4,347,854	-	-	-	(190,910,665)	-	-	-	-	-	-	-	-	-	-
Derivative Financial Instruments	-	-	-	-	-	-	-	-	2,073,079	-	2,073,079	-	-	-	-	-	-	-	2,073,079
Other Liabilities	3,168,391	1,311,034	-	-	154,326	-	591,423	-	9,580,531	-	14,805,705	-	-	-	-	-	59,112	-	14,864,817
Estimated Self-Insured Professional Liability	-	-	-	-	-	-	-	-	11,715,201	-	11,715,201	-	-	-	-	-	-	-	11,715,201
Total liabilities	190,285,190	381,432,855	3,374,375	11,825,599	7,727,829	5,426,716	3,971,952	723,945	127,749,686	(890,136)	731,618,011	677,260	2,637,112	7,678,826	8,600	3,000	74,974	-	742,697,783
Net Assets (Deficit																			
Unrestricted	212,482,059	4,704,757	73,299,238	6,480,850	24,184,556	(5,005,371)	(82,583,241)	1,111,887	152,128,074	-	386,802,810	2,079,626	8,601,777	(5,155,034)	(1,863,068)	(1,063,901)	1,925,447	-	391,327,657
Temporarily restricted	429,576	891,954	-	-	(209,869)	-	-	-	8,622	-	920,283	217,558	-	-	-	-	5,068,907	-	6,206,748
Permanently restricted	-	-	-	-	-	-	-	-	-	-	-	341,421	-	-	-	-	-	-	341,421
Total net assets (deficit)	212,911,635	5,596,711	73,299,238	6,480,850	23,974,687	(5,005,371)	(82,583,241)	1,111,887	152,136,696	-	387,723,093	2,638,605	8,601,777	(5,155,034)	(1,863,068)	(1,063,901)	6,994,354	-	397,875,826
Total liabilities and net assets	$ 403,196,825	$ 386,829,566	$ 76,673,614	$ 18,306,449	$ 31,702,516	$ 411,345	$ (78,611,289)	$ 1,835,832	$ 279,886,382	$ (890,136)	$ 1,119,341,104	$ 3,315,865	$ 11,238,889	$ 2,523,792	$ (1,854,468)	$ (1,060,901)	$ 7,069,328	$ -	$ 1,140,573,609

Adventist HealthCare, Inc. and Controlled Entities
Consolidating Schedule - Statement of Operations
Year Ended December 31, 2018

	Shady Grove Medical Center	Washington Adventist Hospital	Hackettstown Regional Medical Center	Behavioral Health & Wellness Services	Rehabilitation	Imaging Services	Clinical Integration Services	Other Health Services	Support Center	Eliminating Entries	Total Combined Obligated Group	Lourie Center	Adventist Home Care Services	Urgent Care Centers	One Health Quality Alliance	Mid-Atlantic Primary Care	Adventist HealthCare, Inc. Foundations	Eliminating Entries	Consolidated Adventist HealthCare, Inc.
Unrestricted Revenues																			
Net patient service revenue	$ 362,514,412	$ 239,218,642	$ 22,165,831	$ 43,091,390	$ 44,021,961	$ 28,456,889	$ 33,645,937	$ 56,382	$ -	$ (27,963,242)	$ 745,707,802	$ 896,408	$ 25,051,378	$ 2,169,944	$ -	$ -	$ -	$ -	$ 773,827,332
Provision for doubtful collections	(14,675,131)	(12,093,457)	(1,155,866)	(1,581,367)	(934,245)	(2,434,235)	(2,527,940)	(331,185)		1,281,824	(34,851,538)	(117,092)	(129,098)	(104,861)					(35,002,586)
Net patient service revenue less provision for doubtful collections	348,239,281	227,124,985	21,010,225	41,510,023	43,087,716	26,022,654	31,017,997	(274,803)		(26,681,418)	711,056,064	779,316	24,924,280	2,065,083					738,824,746
Other revenue	7,437,665	4,844,730	1,891,213	7,591,105	3,011,361	1,785,187	466,216	7,469,411	8,667,054	(8,679,843)	34,324,179	10,691,430	161,038	411			4,865,842	(8,816,501)	41,106,399
Total unrestricted revenues	355,676,943	231,769,715	22,901,438	49,101,128	46,099,081	27,807,841	31,421,673	7,194,608	8,667,054	(35,361,261)	745,380,243	11,380,746	25,115,321	2,065,494			4,865,842	(8,816,501)	779,931,145
Expenses																			
Salaries and wages	126,465,576	86,113,620	9,287,373	26,932,376	25,286,568	15,148,683	31,369,143	2,334,815	13,313,907	(15,885,383)	320,106,123	5,747,450	16,985,724	1,702,697	533,582	226,664			345,296,234
Employee benefits	26,856,253	17,760,406	2,684,781	5,653,270	4,857,552	2,708,447	1,375,106	441,325	3,056,826	(4,257,156)	61,179,810	1,229,904	2,965,784	358,619	90,456	27,542			65,852,367
Contract labor	16,811,762	13,733,545	748,229	1,922,624	918,387	451,229	1,978,089	876,185	(626,504)	(1,844,115)	34,948,816	651,582	437,147	273,569				8,227	36,319,743
Medical supplies	54,212,082	38,774,735	3,534,740	1,644,260	1,295,638	1,200,869	2,139,338	832,782	(20,777)	(3,869,228)	99,735,369	163,149	344,947	141,096					100,324,519
General and administrative	36,413,117	27,766,912	1,994,698	6,187,661	4,258,266	4,998,578	10,211,310	1,348,846	31,913,889	(3,423,708)	119,648,949	2,365,467	1,684,843	776,846	27,252	28,552	4,717,377	(10,841,749)	147,809,537
Building and maintenance	25,225,001	8,312,499	1,402,417	3,390,806	1,724,681	4,651,569	547,107	516,477	1,119,560	(4,591,898)	40,498,219	736,277	818,866	839,368	100	300		(92,736)	42,794,430
Insurance	1,952,519	1,368,439	147,816	185,722	91,149	538,194	969,660	4,844	48,124	(156,787)	5,138,400	9,156	72,886	77,026					5,297,268
Interest	5,453,687	1,748,744	336,851	274,690	197,944	72,090			2,475,287	(336,451)	10,220,442	141,969							10,362,411
Depreciation and amortization	15,294,595	4,922,893	1,246,563	1,834,275	1,616,474	826,361	495,380	77,222	11,953,897	(1,946,826)	36,244,834	141,119	144,938	215,736					36,746,641
IT depreciation	5,504,516	3,727,827	324,947	721,318	496,093			29,367	(10,883,119)	(464,274)	(544,775)		80,592					464,271	
IT services	14,561,748	9,341,515	848,093	1,387,995	1,555,143			161,705	(28,319,900)	(1,144,487)	(1,668,186)		523,696					1,144,487	
Management fees	8,174,833	5,531,471	713,597	1,525,447	1,338,265	19,758	465,107	137,684	(18,685,652)	(509,982)	(1,789,672)	379,844	828,721	147,116				500,991	
Total expenses	334,869,690	219,126,645	22,769,648	49,658,682	43,686,181	30,587,777	49,271,233	6,894,252	5,583,518	(38,474,893)	723,718,311	11,767,948	24,285,857	4,671,356	651,592	277,108	4,717,377	(8,816,561)	760,803,158
Income (loss) from operations	20,807,253	12,643,070	131,790	(557,550)	2,409,900	(2,779,936)	(17,847,560)	300,356	3,083,535	3,113,632	21,661,932	82,798	829,464	(2,605,862)	(651,592)	(277,108)	148,465		19,127,987
Other Income (Expense)																			
Investment income (loss)	1,458,457	(68,380)	75,559	4,968	116,338				1,513,831	(75,559)	3,026,211	9,020	58,017				35,923		3,129,171
Loss on extinguishment of debt									(686,357)		(686,357)								(686,357)
Other income (expense)	(500,502)	(298,049)	(17,139,185)	(25,123)	(15,809)				686,764	17,139,185	44,281								44,281
Total other income (expense)	958,955	(366,429)	(17,063,626)	(20,155)	97,529				1,774,238	17,063,626	2,384,135	9,020	58,017				35,923		2,487,095
Revenues in excess of (less than) expenses from continuing operations	21,767,208	12,283,281	(16,931,836)	(577,705)	2,507,429	(2,779,936)	(17,847,560)	300,356	4,797,773	20,227,038	24,046,067	91,818	887,481	(2,605,862)	(651,592)	(277,108)	184,388	-	21,615,082
Change in net unrealized gains (losses) on investments other than trading securities	(960,182)	(7,494)	73,439	(4,918)	(87,641)			184	(373,601)		(1,379,617)	3,999	(27,255)				(27,568)		(1,430,441)
Change in net unrealized gain on derivative financial instruments									2,352,326		2,352,326								2,352,326
Transfer from (to) subsidiaries			42,671,465						(42,085,904)		585,561				(346,571)			238,930	
Net assets released from restriction for purchase of property and equipment	299,662	609,476		50,764							1,213,796								1,213,796
Deferred compensation plan liability adjustment									(521,260)		(521,260)								(521,260)
Other unrestricted net asset activity		3		(399,872)	(3)	(348,944)	399,883	1,472	(2,096,926)		(3,039,495)	3	1,336,458					238,930	(1,458,904)
Increase (decrease) in unrestricted net assets from continuing operations	21,686,088	13,104,266	25,813,069	(892,231)	2,520,383	(3,128,880)	(17,447,677)	302,032	(38,527,195)	20,227,038	23,286,517	95,820	2,196,684	(2,605,862)	(998,163)	(277,108)	94,820		21,774,598
Loss from discontinued operations										(20,227,038)	(20,227,038)								(20,227,038)
Increase (decrease) in unrestricted net assets	$ 21,686,088	$ 13,104,266	$ 25,813,069	$ (892,231)	$ 2,520,383	$ (3,128,880)	$ (17,447,677)	$ 302,032	$ (38,527,195)	$ -	$ 3,059,479	$ 95,820	$ 2,196,684	$ (2,605,862)	$ (998,163)	$ (277,108)	$ 94,820	$ -	$ 1,547,560

Adventist HealthCare, Inc. Foundations

Combining Schedule, Balance Sheet
ecember 31, 2016

	Shady Grove Medical Center Foundation, Inc.	Washington Adventist Hospital Foundation, Inc.	Hackettstown Community Hospital Foundation, Inc.	Behavioral Health & Wellness Services Foundation, Inc.	Eliminating Entries	Combined Adventist HealthCare, Inc. Foundations
Assets						
Current Assets						
Cash and cash equivalents	$ 948,177	$ 760,061	$ -	$ 197,274	$ -	$ 1,905,512
Current portion pledges receivable, less allowance for doubtful pledges of $132,000	451,794	391,597	-	43,458	-	886,849
Other receivables	-	1,319	-	-	-	1,319
Prepaid expenses and other current assets	-	-	-	-	-	-
Total current assets	1,399,971	1,152,977	-	240,732	-	2,793,680
Cash and Cash Equivalents Temporarily Restricted for Capital Acquisitions	-	1,009,936	-	38,863	-	1,048,799
Investments	794,068	5,717	-	-	-	799,785
Beneficial Interest in Trusts	98,459	707,354	-	-	-	805,813
Noncurrent Portion of Pledges Receivable	766,901	854,350	-	-	-	1,621,251
Total assets	$ 3,059,399	$ 3,730,334	$ -	$ 279,595	$ -	$ 7,069,328
Liabilities and Net Assets						
Current Liabilities						
Accounts payable and accrued expenses	$ 15,780	$ -	$ -	$ 82	$ -	$ 15,862
Liability to Charitable Gift Annuitants	59,112	-	-	-	-	59,112
Total liabilities	74,892	-	-	82	-	74,974
Net Assets						
Unrestricted	1,679,509	129,289	-	116,649	-	1,925,447
Temporarily restricted	1,304,998	3,601,045	-	162,864	-	5,068,907
Permanently restricted	-	-	-	-	-	-
Total net assets	2,984,507	3,730,334	-	279,513	-	6,994,354
Total liabilities and net assets	$ 3,059;399	$ 3,730,334	$ -	$ 279,595	$ -	$ 7,069,328

Adventist HealthCare, Inc. Foundations

Combining Schedule, Statement of Operations
Year Ended December 31, 2016

	Shady Grove Medical Center Foundation, Inc.	Washington Adventist Hospital Foundation, Inc.	Hackettstown Community Hospital Foundation, Inc.	Behavioral Health & Wellness Services Foundation, Inc.	Eliminating Entries	Combined Adventist HealthCare, Inc. Foundations
Changes in Unrestricted Net Assets						
Unrestricted Revenues, Gains, And Other Support						
Contributions, net	$ 545,112	$ 222,195	$ 2,541,295	$ 19,736	$ -	$ 3,328,338
Investment income	35,724	-	-	199	-	35,923
Net assets released from restrictions	438,587	336,709	533,803	168,405	-	1,477,504
Total unrestricted revenues, gains, and other support	1,019,423	558,904	3,075,098	188,340	-	4,841,765
Expenses						
General administrative expenses	216,077	106,457	10,083	220	-	332,837
In-kind gifts expended	209,263	140,143	-	-	-	349,406
Total expenses before transfers to the hospitals	425,340	246,600	10,083	220	-	682,243
Transfers to the hospitals	436,367	276,385	3,149,729	172,653	-	4,035,134
Total expenses	861,707	522,985	3,159,812	172,873	-	4,717,377
Revenues in excess of (less than) expenses	157,716	35,919	(84,714)	15,467	-	124,388
Change in net unrealized losses on investments other than trading securities	(27,568)	-	-	-	-	(27,568)
Increase (decrease) in unrestricted net assets	130,148	35,919	(84,714)	15,467	-	96,820
Unrestricted net assets, beginning	1,549,361	93,370	84,714	101,182	-	1,828,627
Unrestricted net assets, ending	$ 1,679,509	$ 129,289	$ -	$ 116,649	$ -	$ 1,925,447
Changes in Temporarily Restricted Net Assets						
Contributions, net	$ 427,381	$ 1,616,782	$ -	$ 72,406	$ -	$ 2,116,569
Net assets released from restrictions	(438,587)	(336,709)	(123,803)	(168,405)	-	(1,067,504)
Change in value of beneficial interest in trusts	-	(15,569)	-	-	-	(15,569)
Change in discount of pledges receivable and provision for doubtful pledges	(422,415)	(74,361)	-	-	-	(496,776)
Investment income and unrealized gain on investments	4,098	-	-	-	-	4,098
Increase (decrease) in temporarily restricted net assets	(429,523)	1,190,143	(123,803)	(95,999)	-	540,818
Temporarily restricted net assets, beginning	1,734,521	2,410,902	123,803	258,863	-	4,528,089
Temporarily restricted net assets, ending	$ 1,304,998	$ 3,601,045	$ -	$ 162,864	$ -	$ 5,068,907
Changes in Permanently Restricted Net Assets						
Contributions, net	$ -	$ -	$ -	$ -	$ -	$ -
Net assets released from restriction	-	-	(410,000)	-	-	(410,000)
Decrease in permanently restricted net assets	-	-	(410,000)	-	-	(410,000)
Permanently restricted net assets, beginning	-	-	410,000	-	-	410,000
Permanently restricted net assets, ending	$ -	$ -	$ -	$ -	$ -	$ -

Adventist HealthCare, Inc. and Controlled Entities

Financial Statements and
Supplementary Information

December 31, 2017 and 2016

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Candor. Insight. Results.

Adventist HealthCare, Inc. and Controlled Entities

Table of Contents
December 31, 2017 and 2016

Independent Auditors' Report

Board of Trustees
Adventist HealthCare, Inc. and Controlled Entities

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Adventist HealthCare, Inc. and controlled entities (collectively, the "Corporation"), which comprise the consolidated balance sheets as of December 31, 2017 and 2016, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Adventist HealthCare, Inc. and controlled entities as of December 31, 2017 and 2016, and the results of their operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating and combining information presented on pages 42 to 46 is presented for purposes of additional analysis rather than to present the financial position, results of operations, and cash flows of the individual companies and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Baker Tilly Virchow Krause, LLP

Wilkes-Barre, Pennsylvania
April 25, 2018

Adventist HealthCare, Inc. and Controlled Entities

Consolidated Balance Sheets
December 31, 2017 and 2016

	2017	2016
Assets		
Current Assets		
Cash and cash equivalents	$ 40,714,884	$ 30,198,079
Short-term investments	197,803,029	188,594,181
Assets whose use is limited	2,923,796	2,870,341
Patient accounts receivable, net of estimated allowance for doubtful collections of $22,487,000 in 2017 and $27,415,000 in 2016	93,209,946	91,827,593
Other receivables, net of estimated allowance for doubtful collections of $628,000 in 2017 and $2,436,000 in 2016	16,070,981	15,244,017
Inventories	9,410,777	10,211,601
Prepaid expenses and other current assets	7,653,048	7,366,320
Total current assets	367,786,461	346,312,132
Property and Equipment, Net	511,609,795	431,961,901
Assets Whose Use is Limited		
Under trust indentures and capital lease purchase financing facilities, held by trustees and banks	244,332,570	269,595,205
Professional liability trust fund	11,878,591	12,233,224
Deferred compensation fund	1,403,371	1,466,041
Cash and Cash Equivalents Temporarily Restricted for Capital Acquisitions	2,322,753	2,264,115
Investments and Investments in Unconsolidated Subsidiaries	15,665,245	13,283,684
Land Held for Healthcare Development	47,660,070	48,706,305
Intangible Assets, Net	8,343,130	8,966,166
Deposits and Other Noncurrent Assets	5,610,693	5,784,836
Total assets	$ 1,216,612,679	$ 1,140,573,609

See notes to consolidated financial statements

Adventist HealthCare, Inc. and Controlled Entities

Consolidated Balance Sheets
December 31, 2017 and 2016

	2017	2016
Liabilities and Net Assets		
Current Liabilities		
Accounts payable and accrued expenses	$ 86,818,184	$ 83,843,748
Accrued compensation and related items	37,260,446	34,851,454
Interest payable	9,747,294	2,021,390
Due to third party payors	17,818,402	18,665,027
Estimated self-insured professional liability	1,179,664	1,150,302
Current maturities of long-term obligations	13,019,860	12,749,886
Total current liabilities	165,843,850	153,281,807
Construction Payable	14,828,539	3,027,323
Long-Term Obligations, Net		
Bonds payable	551,211,489	515,091,030
Notes payable	22,089,282	26,381,525
Capital lease obligations	11,229,970	16,263,001
Derivative Financial Instruments	1,145,303	2,073,079
Other Liabilities	11,963,765	14,864,817
Estimated Self-Insured Professional Liability	13,082,881	11,715,201
Total liabilities	791,395,079	742,697,783
Net Assets		
Unrestricted	417,328,975	391,327,657
Temporarily restricted	7,547,204	6,206,748
Permanently restricted	341,421	341,421
Total net assets	425,217,600	397,875,826
Total liabilities and net assets	$ 1,216,612,679	$ 1,140,573,609

See notes to consolidated financial statements

Adventist HealthCare, Inc. and Controlled Entities

Consolidated Statements of Operations
Years Ended December 31, 2017 and 2016

	2017	2016
Unrestricted Revenues		
Net patient service revenue	$ 801,836,667	$ 773,827,332
Provision for doubtful collections	(31,782,541)	(35,002,586)
Net patient service revenue less provision for doubtful collections	770,054,126	738,824,746
Other revenue	38,064,322	41,106,399
Total unrestricted revenues	808,118,448	779,931,145
Expenses		
Salaries and wages	360,720,746	345,296,234
Employee benefits	68,630,252	65,852,367
Contract labor	39,039,683	36,319,743
Medical supplies	103,013,363	100,324,519
General and administrative	122,036,220	117,809,537
Building and maintenance	41,922,317	42,794,430
Insurance	5,674,763	5,297,256
Interest	10,353,452	10,362,411
Depreciation and amortization	36,463,353	36,746,661
Total expenses	787,854,149	760,803,158
Income from operations	20,264,299	19,127,987
Other Income (Expense)		
Investment income	8,232,502	3,129,171
Loss on extinguishment of debt	-	(686,357)
Other (expense) income	(1,994,397)	44,281
Total other income	6,238,105	2,487,095
Revenues in excess of expenses from continuing operations	26,502,404	21,615,082
Change in net unrealized gains (losses) on investments other than trading securities	2,582,625	(1,430,441)
Change in net unrealized gain on derivative financial instruments	700,697	2,352,325
Net assets released from restriction for purchase of property and equipment	1,152,590	1,217,796
Deferred compensation plan liability adjustment	(512,305)	(521,260)
Other unrestricted net asset activity	(1,762,971)	(1,458,904)
Increase in unrestricted net assets from continuing operations	28,663,040	21,774,598
Loss from discontinued operations	(2,661,722)	(20,227,038)
Increase in unrestricted net assets	$ 26,001,318	$ 1,547,560

See notes to consolidated financial statements

Adventist HealthCare, Inc. and Controlled Entities

Consolidated Statements of Changes in Net Assets
Years Ended December 31, 2017 and 2016

	2017	2016
Unrestricted Net Assets		
Revenues in excess of expenses from continuing operations	$ 26,502,404	$ 21,615,082
Change in net unrealized gains (losses) on investments other than trading securities	2,582,625	(1,430,441)
Change in net unrealized gain on derivative financial instruments	700,697	2,352,325
Net assets released from restriction for purchase of property and equipment	1,152,590	1,217,796
Deferred compensation plan liability adjustment	(512,305)	(521,260)
Other unrestricted net asset activity	(1,762,971)	(1,458,904)
Increase in unrestricted net assets from continuing operations	28,663,040	21,774,598
Loss from discontinued operations	(2,661,722)	(20,227,038)
Increase in unrestricted net assets	26,001,318	1,547,560
Temporarily Restricted Net Assets		
Restricted gifts and donations	4,933,934	3,438,671
Net assets released from restriction for purchase of property and equipment	(1,152,590)	(1,217,796)
Net assets released from restriction used for operations	(2,480,828)	(2,075,440)
Change in value of beneficial interest in trusts and charitable gift annuity obligation	18,397	(30,449)
Change in discount of pledges receivable and provision for doubtful pledges	11,309	(496,776)
Donor restricted investment income	10,234	4,098
Increase (decrease) in temporarily restricted net assets	1,340,456	(377,692)
Permanently Restricted Net Assets		
Other permanently restricted net asset activity	-	(410,000)
Increase in net assets	27,341,774	759,868
Net Assets, Beginning	397,875,826	397,115,958
Net Assets, Ending	$ 425,217,600	$ 397,875,826

See notes to consolidated financial statements

Adventist HealthCare, Inc. and Controlled Entities

Consolidated Statements of Cash Flows
Years Ended December 31, 2017 and 2016

	2017	2016
Cash Flows from Operating Activities		
Increase in net assets	$ 27,341,774	$ 759,868
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Provision for doubtful collections	31,782,541	36,284,410
Depreciation and amortization	36,453,533	38,098,970
Amortization of deferred financing costs	200,349	189,890
Deferred compensation plan liability adjustment	512,305	521,260
Loss on extinguishment of debt	-	686,357
Restricted contributions and grants	(3,782,795)	(1,878,488)
Earnings recognized from unconsolidated subsidiaries and affiliates	(2,040,340)	(2,335,147)
Amortization of physician income guarantees	9,105	31,530
Net realized (gain) loss on investments	(3,628,355)	710,869
Change in net unrealized (gains) losses on investments other than trading securities	(2,582,625)	1,430,441
Change in net unrealized gain on derivative financial instruments	(700,697)	(2,352,325)
Change in value of beneficial interest in trusts and charitable gift annuity	(18,397)	30,449
Change in discount on pledges receivable and provision for doubtful pledges	(11,309)	496,776
Loss on disposal of BH&WS Eastern Shore	2,911,706	-
Loss on sale of HRMC	-	16,967,178
Changes in assets and liabilities:		
Patient accounts receivable, net	(33,960,881)	(26,011,792)
Other receivables, net	(836,069)	628,056
Inventories, prepaid expenses and other current assets	514,096	(2,229,881)
Accounts payable and accrued expenses	2,880,926	(3,167,435)
Accrued compensation and related items	2,408,992	1,749,437
Interest payable	7,725,904	(309,870)
Estimated self-insured professional liability	1,397,042	573,922
Due to third party payors	(846,625)	(1,495,631)
Other noncurrent assets and liabilities	(3,415,492)	(3,889,927)
Net cash provided by operating activities	$ 62,314,688	$ 55,488,917

See notes to consolidated financial statements

Adventist HealthCare, Inc. and Controlled Entities

Consolidated Statements of Cash Flows
Years Ended December 31, 2017 and 2016

	2017	2016
Cash Flows from Investing Activities		
Purchase of property and equipment	$ (105,592,446)	$ (45,840,372)
Increase in investments and investments in unconsolidated subsidiaries	(3,959,138)	(52,498,944)
Additions to land held for healthcare development	(6,675,741)	(4,729,611)
Proceeds from sale of land for healthcare development	7,721,976	5,938,458
Proceeds from sale of HRMC	-	47,000,550
Distributions from investments in unconsolidated subsidiaries	321,113	389,555
Purchase of investment in unconsolidated subsidiary	(674,626)	(2,435,579)
Decrease (increase) in trustee held funds and restricted cash	26,520,312	(264,548,939)
Net cash used in investing activities	(82,338,550)	(316,724,882)
Cash Flows from Financing Activities		
Payment of financing costs	(423,227)	(3,509,604)
Proceeds from issuance of bonds	40,000,000	296,979,390
Repayments on long-term obligations, net	(12,818,901)	(32,710,743)
Proceeds from capital lease facility	-	32,922
Payment of termination fee for derivative financial instrument	-	(16,875,000)
Proceeds from restricted contributions and grants	3,782,795	1,878,488
Net cash provided by financing activities	30,540,667	245,795,453
Net increase (decrease) in cash and cash equivalents	10,516,805	(15,440,512)
Cash and Cash Equivalents, Beginning	30,198,079	45,638,591
Cash and Cash Equivalents, Ending	$ 40,714,884	$ 30,198,079
Supplemental Disclosure of Cash Flow Information		
Interest paid	$ 4,138,018	$ 12,490,712
Supplemental Disclosure of Noncash Investing and Financing Activities		
Capital lease obligation incurred for equipment	$ 469,249	$ 14,740,520
Construction payable for property and equipment	$ 14,828,539	$ 3,027,323
Long-term debt refinanced	$ -	$ 110,035,000

See notes to consolidated financial statements

1. Nature of Operations and Summary of Significant Accounting Policies

Nature of Operations

Adventist HealthCare, Inc. ("AHC") is a nonstock membership corporation organized to effectuate coordinated administration of hospitals and other health care organizations through the provision of key management and administrative services. The mission of AHC is to extend God's care through the ministry of physical, mental and spiritual healing. AHC is tax-exempt under Section 501(c)(3) of the Internal Revenue Code. AHC is not exempt from income taxes for unrelated business income. AHC's sole corporate member is Mid-Atlantic Adventist HealthCare, Inc. AHC is comprised of several operating divisions and controlled entities, as follows:

Shady Grove Medical Center ("SGMC") is a 266-bed acute care hospital located in Rockville, Maryland.

Washington Adventist Hospital ("WAH") is a 236-bed acute care hospital located in Takoma Park, Maryland.

Hackettstown Community Hospital d.b.a. Hackettstown Regional Medical Center ("HRMC") is a 111-bed not-for-profit acute care hospital organized under the laws of the State of New Jersey. On March 31, 2016, the Corporation sold the operating assets to an unrelated third party, and discontinued the operations of the facility. See Note 3 for further details.

Behavioral Health & Wellness Services ("BH&WS") is comprised of two separate facilities located in Maryland. BH&WS - Rockville is a 107-bed psychiatric hospital. BH&WS - Eastern Shore is an acute care and residential mental health resource for children and adolescents, which had 15 acute care psychiatric beds and 59 residential treatment rooms. In November, 2016, AHC made the decision to discontinue the operations of the BH&WS - Eastern Shore location. See Note 3 for further details.

Rehabilitation ("Rehab") operates one inpatient hospital with two sites in Maryland, as well as two outpatient locations. Rehab - Rockville is a 55-bed rehabilitation facility and Rehab - Takoma Park is a 32-bed rehabilitation facility.

Adventist HealthCare Imaging ("Imaging") operates six clinical sites and provides inpatient and outpatient imaging services at SGMC and WAH.

Clinical Integration Services ("CIS") is comprised of Adventist Medical Group ("AMG"). AMG is a not-for-profit entity that provides primary care and specialty care physician professional health services to the communities it serves. AHC contracted with Medical Faculty Associates, Inc. ("MFA") to employ the AMG employees, through a wholly owned affiliate of MFA, in exchange for certain economic support to facilitate the growth by MFA of the AMG physician practices. In December 2017, however, AHC terminated its contract with MFA as it relates to the primary care, physiatry and endocrinology practices. The termination is effective July 2018, at which time the primary care, physiatry and endocrinology practices will be operated by AHC. The remaining specialty care practices will continue to be operated by MFA, with the respective operating results recorded in SGMC and WAH. CIS also includes the administration needed to facilitate the coordination of patient care across conditions, providers and settings.

The Other Health Services operating division is comprised of two entities. Lifework Strategies ("LWS") provides employee assistance and employee wellness programs to client employees. LWS's mission is to help individuals live healthier, happier and more productive lives. Capital Choice Pathology Lab ("CCPL") provides full pathology production services to client hospitals.

The Support Center is comprised of the Corporate Office ("CO") and the AHC benefit business unit. The CO provides corporate and centralized shared service functions that benefit the entire AHC system. The AHC benefit business unit administers the self-insurance health benefit program including health insurance, dental and vision coverage for AHC and controlled entities.

The Lourie Center for Infants and Young Children ("Lourie Center") is a not-for-profit organization that specializes in the diagnosis, treatment and prevention of developmental and emotional disorders in children from birth through ten years of age.

Adventist Home Care Services, Inc. ("AHCS") is a nonstock membership corporation organized to provide home health services in Maryland and includes Adventist Home Assistance ("AHA"). AHA provides non clinical assistance to homebound patients who cannot perform certain daily activities on their own.

The Urgent Care operating division is comprised of three urgent care centers located in Germantown, Laurel, and Rockville, Maryland. These centers provide ambulatory services to patients without life threatening conditions, as well as occupational health screenings to the community. The operating division started in October 2013 when Adventist HealthCare Urgent Care Centers, Inc. ("Urgent Care"), a Maryland non-profit corporation and Adventist Health System/Sunbelt, Inc. d/b/a Florida Hospital Centra Care, a Florida non-profit corporation, entered into a management services and license agreement to establish free standing urgent care centers in Montgomery and Prince Georges County, Maryland. This agreement was terminated effective October 10, 2017 and going forward an unrelated third party will assist in management of these centers.

One Health Quality Alliance ("OHQA") is a physician-led clinically integrated network designed to deliver value to payors, employers and consumers through the highest quality care at a lower cost. Through this alliance, participating physicians gain access to resources to support the transition to value-based care, while maintaining their independence. Through this collaboration, OHQA aims to improve the health of patient populations and communities, while enhancing the patient experience and reducing the costs of health care. The OHQA currently has over 450 physician members, most of whom are on the medical staff of AHC, including primary care, orthopedics and other community and hospital based specialists.

Mid-Atlantic Primary Care Accountable Care Organization ("ACO") was managed by AHC and cared for approximately 13,500 patients through its 1,000 providers. The ACO was a program designed to provide a high level of access and coordination of care for Medicare fee for service patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. The final performance year for the ACO was calendar year 2016, with a final distribution of $3,140,869 made to its members in October 2017, after which the ACO no longer existed. AHC's portion of this payment was approximately $1,356,000 and is included in other income in the accompanying consolidated statements of operations in 2017.

The Foundations operating division is comprised of Washington Adventist Hospital Foundation, Inc., Shady Grove Medical Center Foundation, Inc., and Adventist Behavioral Health & Wellness Services Foundation, Inc. (collectively, the "Foundations"). Each are separate nonstock corporations that operate for the furtherance of each named hospital's health care objectives primarily through the solicitation of contributions, gifts and bequests. The Foundations also exist to help fund new equipment purchases and capital improvement projects for their respective hospitals. Prior to March 31, 2016, the Foundations also included the operations of the Hackettstown Community Hospital Foundation, Inc. ("HRMC Foundation"). On March 31, 2016, however, AHC sold the operating assets of the HRMC Foundation to an unrelated third party and discontinued the operations of the foundation. See Note 3 for further details.

All of the operating divisions and controlled entities mentioned above are tax-exempt under Section 501(c)(3) of the Internal Revenue Code.

Principles of Consolidation

The consolidated financial statements for 2017 and 2016 include the accounts of AHC, the controlling parent, SGMC, WAH, HRMC, BH&WS, Rehab, Imaging, CIS, LWS, CCPL, the Support Center, the Lourie Center, AHCS, Urgent Care, OHQA, ACO and the Foundations, which include their majority-owned subsidiaries and controlled affiliates (collectively, the "Corporation"). All significant intercompany balances and transactions have been eliminated in the consolidated financial statements of the Corporation.

Subsequent Events

The Corporation evaluated subsequent events for recognition or disclosure through April 25, 2018, the date the consolidated financial statements were issued.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Risk Factors

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations is subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time. Government activity continues to increase with respect to investigations and allegations concerning possible violations by healthcare providers of fraud and abuse statutes and regulations, which could result in the imposition of significant fines and penalties as well as significant repayments for patient services previously billed. Management is not aware of any material incidents of noncompliance; however, the possible future financial effects of this matter on the Corporation, if any, are not presently determinable.

Maryland Health Services Cost Review Commission

Certain hospital charges are subject to review and approval by the Maryland Health Services Cost Review Commission ("HSCRC"). The HSCRC has jurisdiction over hospital reimbursement in Maryland by agreement with the Centers for Medicare and Medicaid Services ("CMS"). This agreement is based on a waiver from the Medicare Prospective Payment System reimbursement principles granted under Section 1814(b) of the Social Security Act. Management has filed the required forms with the Commission and believes all entities that fall under the HSCRC's jurisdiction are in compliance with applicable requirements.

In January 2014, the Centers for Medicare and Medicaid Services approved a modernized waiver that grants Maryland (via the HSCRC) the authority to regulate hospital revenue within a rigorous per capita expenditure limit. Maryland's All Payer Model Agreement builds on decades of innovation and equity in healthcare payment and delivery – with an aim to enhance patient care, improve health outcomes and lower costs.

As a result of the new waiver, the HSCRC introduced new revenue arrangements, including the Global Budget Revenue ("GBR") model. The GBR methodology encourages hospitals to focus on population health strategies by establishing a fixed annual revenue cap for each GBR hospital. The agreement establishes a fixed amount of charging authority (i.e. revenue) at the beginning of the rate year. It is evergreen in nature and covers both regulated inpatient and outpatient revenues. Annual revenue is calculated from a base year and is adjusted annually for inflation, infrastructure requirements, population changes, performance in quality-based programs and changes in levels of uncompensated care. Revenue may also be adjusted annually for market levels and shifts of services from one health system to another and from a regulated setting to an unregulated setting (or vice versa).

In April 2014, Adventist Healthcare entered into a Global Budget Revenue Agreement with the HSCRC for SGMC, WAH and Shady Grove Germantown Emergency Center, retroactive to July 1, 2013. This agreement sets a fixed amount of revenue for each entity for the period July 1, 2013 through June 30, 2014 and is subsequently updated on an annual basis every July 1.

The HSCRC requires rate-regulated hospitals under its jurisdiction to calculate the amount of revenue lost or gained due to variances from approved rates. Revenue lost due to undercharges in rates is recouped through increases in prospective rates. Similarly, revenue gained due to overcharges in rates is paid back, wholly or in part, through reductions in prospective rates. The Corporation reported net undercharges of $3,043,105 and $4,183,452 as of December 31, 2017 and 2016, respectively. These price variances reflect the variance between actual patient charges and the pro-rata share of approved rate orders. The net amounts are reported as a component of net patient service revenue and patient accounts receivable in the accompanying consolidated financial statements. Since the HSCRC's rate year extends from July 1 through June 30, these amounts will continue to fluctuate until the end of the rate year as actual patient charges deviate from the total approved charging authority. At the conclusion of the rate year, any over/under charges are amortized on the straight-line basis over the following rate year when the price variance adjustments are actually built into each entity's rate order.

Under Maryland law, charges of specialty hospitals such as BH&WS and Rehab are subject to review and approval by the HSCRC. HSCRC regulations also include a provision whereby a hospital may apply for an exemption from the requirements to charge for services in accordance with HSCRC regulations. Certain conditions regarding the percentage of revenue related to Medicare and Medicaid patients and total revenues must be met to receive the initial exemption and must be met each year thereafter. Reporting requirements as established by the HSCRC continue even if an exemption regarding charging for services is received. The Corporation's management believes BH&WS-Eastern Shore and Rehab met the conditions for exemption during 2017 and 2016.

BH&WS-Rockville is subject to HSCRC rate setting. For 2016 and 2017, BH&WS-Rockville did not enter into a Global Budget Revenue Agreement. Instead, BH&WS-Rockville continues to generate charging authority based on the volume of services it provides to patients. Unit rates are set for all payers, however Medicare and Medicaid are not required to reimburse at HSCRC rates. Services provided to Medicare beneficiaries are reimbursed under the Inpatient Psychiatric Facility Prospective Payment System. Services provided to Medicaid patients are cost-settled for outpatient services and reimbursed for inpatient services at a rate of 94% percent of charges (as set forth in the Code of Maryland Regulations 10.09.06.09).

Cash and Cash Equivalents

Cash and cash equivalents include investments in money market funds and certificates of deposit purchased with original maturities of less than 90 days, excluding assets whose use is limited.

Patient Accounts Receivable

Patient accounts receivable are reported at net realizable value. Accounts are written off when they are determined to be uncollectible based upon management's assessment of individual accounts. In evaluating the collectability of patient accounts receivable, the Corporation analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful collections and provision for doubtful collections. For patient accounts receivable associated with services provided to patients who have third-party coverage, the Corporation analyzes contractually due amounts and provides an allowance for doubtful collections and provision for doubtful collections, if necessary. For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Corporation records a provision for doubtful collections in the period of service on the basis of its past experience, which indicates that many patients are unable to pay the portion of their bill for which they are financially responsible. The difference between the billed rates and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful collections.

The Corporation's allowance for doubtful collections for self-pay patients as a percentage of self-pay accounts receivable was 44% and 52% at December 31, 2017 and 2016, respectively. In addition, the Corporation's self-pay account bad debt writeoffs, net of recoveries, decreased from $31,701,926 in 2016 to $31,495,503 in 2017 which was the result of small positive trends experienced in the collection of amounts from self-pay patients in 2017.

Other Receivables

Other receivables represent amounts due to the Corporation for charges other than providing health care services to patients and pledges from donors. These services include, but are not limited to, fees from educational programs, rental of health care facility space, interest earned, and management services provided to unconsolidated subsidiaries. Other receivables are written off when they are determined to be uncollectible based on management's assessment of individual accounts. The allowance for doubtful collections is estimated based upon historical collection experience and other managerial information.

Assets Whose Use Is Limited

Assets whose use is limited includes assets held by bond trustees under trust indentures, assets set aside as required by the Corporation's self-funded professional liability trust, and assets set aside for deferred compensation agreements. Amounts available to meet current liabilities of the Corporation have been reclassified as current assets in the accompanying consolidated balance sheets.

Investments and Investment Risk

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the accompanying consolidated balance sheets. Cash and cash equivalents and certificates of deposit are carried at cost which approximates fair value. Investments in joint ventures are accounted for using the equity or cost method of accounting depending on the Corporation's ownership interest. Investment income or loss (including realized gains and losses on investments, write-downs of the cost basis of investments due to an other-than-temporary decline in fair value, interest, and dividends) is included in the determination of revenues in excess of expenses from continuing operations unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the determination of revenues in excess of expenses from continuing operations unless the investments are trading securities. Donor-restricted investment income is reported as an increase in temporarily restricted net assets. Investments available for current operations have been classified as short-term investments in the accompanying consolidated balance sheets.

The Corporation's investments are comprised of a variety of financial instruments. The fair values reported in the consolidated balance sheets are subject to various risks including changes in the equity markets, the interest rate environment, and general economic conditions. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the fair value of investment securities, it is reasonably possible that the amounts reported in the accompanying consolidated financial statements could change materially in the near term.

Inventories

Inventories of drugs, medical supplies and surgical supplies are valued at the lower of cost or net realizable value. Cost is determined primarily by the weighted average cost method.

Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful lives of the assets using the straight-line method. Equipment under capital leases is amortized on the straight-line method over the shorter period of the lease term or estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the accompanying consolidated statements of operations.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Impairment losses are recognized in the consolidated statements of operations as a component of revenues in excess of expenses from continuing operations as they are determined. The Corporation reviews its long-lived assets whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. In that event, the Corporation calculates the estimated future net cash flows to be generated by the asset. If those future net cash flows are less than the carrying value of the asset, an impairment loss is recognized for the difference between the estimated fair value and the carrying value of the asset. There were no impairment losses reported in 2017 or 2016.

Intangible Assets

The Corporation's intangible assets primarily include costs in excess of net assets acquired related to certain business acquisitions. The Corporation is amortizing certain intangible assets over a period not to exceed 40 years. Amortization of these intangible assets was $221,457 in 2017 and $273,535 in 2016. Accumulated amortization of intangible assets was $3,608,016 and $3,386,559 as of December 31, 2017 and 2016, respectively.

Goodwill, which is included in intangible assets in the accompanying consolidated balance sheet, is reviewed annually for impairment or more frequently if events or circumstances indicate the carrying amount of the goodwill will not be recoverable.

Goodwill related to HRMC of $867,660 was written off in 2016 related to the sale of HRMC (Note 3) and is included in loss from discontinued operations in the accompanying consolidated statements of operations.

Goodwill related to BH&WS Eastern Shore of $411,579 and $241,359 were written off in 2017 and 2016, respectively, related to the closure of this location (Note 3) and is included in loss from discontinued operations in the accompanying consolidated statements of operations.

Deferred Financing Costs

Costs incurred in connection with the issuance of long-term obligations have been deferred and are being amortized over the term of the related obligation using the straight-line method. Deferred financing costs of $423,227 and $3,509,604 were paid in 2017 and 2016, respectively, in relation to the Series 2016A and 2016B Bonds issued in 2016. In addition, deferred financing costs of $686,357 were written-off in 2016 related to redemption of the Series 2005A and 2011B Bonds and are included in the loss on extinguishment of debt in the accompanying consolidated statements of operations in 2016. Deferred financing costs remaining as of December 31, 2017 and 2016 totaled $5,062,797 and $4,839,919, respectively, and are included in the consolidated balance sheets as a reduction of bonds payable.

Amortization expense was $200,349 and $189,890 in 2017 and 2016, respectively, and is included as a component of interest expense in the consolidated statements of operations. Amortization for HRMC was $5,799 in 2016 and is included in loss from discontinued operations in the consolidated statements of operations. Accumulated amortization of deferred financing costs was $2,861,822 and $2,661,473 at December 31, 2017 and 2016, respectively, and is included as a component of bonds payable in the consolidated balance sheets.

Due to Third Party Payors

The Corporation receives advances from third party payors to provide working capital for services rendered to the beneficiaries of such services. These advances are principally determined based on the timing differences between the provision of care and the anticipated payment date of the claim for service in accordance with HSCRC's rate regulations. These advances are subject to periodic adjustment.

For certain Corporation subsidiaries, services provided on behalf of Medicaid beneficiaries are ultimately reimbursed at cost. For cost reimbursement programs, statements of reimbursable costs are filed with the program to compute the difference between reimbursable cost and interim payments, in order to determine a final settlement for services rendered to patients covered under the Medicaid program. Reimbursements are affected by limitations relating to charges and the reasonableness of costs (subject to limitations) and are subject to audits by the agencies administering the applicable program.

The Corporation's working capital advances and all expected third party payor settlement activity are classified as a net current liability in the accompanying consolidated balance sheets.

Derivative Financial Instruments

The Corporation has an interest rate swap agreement, which is considered a derivative financial instrument, to manage its interest rate exposure on certain long-term obligations (Note 11). The interest rate swap agreement is reported at fair value in the accompanying consolidated balance sheets. The interest rate swap agreement is not designated as a cash flow hedge. Changes in fair value are reported as a component of other non-operating (expense) income. The Corporation had an interest rate swap agreement that was designated as a cash flow hedge and terminated in 2016 (Note 10).

Estimated Self-Insured Professional Liability

The provision for estimated self-insured professional liability includes estimates of the ultimate costs for both reported claims and claims incurred but not reported, including costs associated with litigating or settling claims. Anticipated insurance recoveries associated with reported claims are reported separately in the Corporation's consolidated balance sheets at net realizable value.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Corporation has been limited by donors to a specific time period or purpose, including the purchase of capital renovations and equipment, providing health education to the community, and designation for the furtherance of programs provided by specific operating departments. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation in perpetuity.

Revenues in Excess of Expenses from Continuing Operations

The consolidated statements of operations include the determination of revenues in excess of expenses from continuing operations. Revenues in excess of expenses from continuing operations is the Corporation's performance indicator. Changes in unrestricted net assets which are excluded from the determination of revenues in excess of expenses from continuing operations, consistent with industry practice, include the loss from discontinued operations, unrealized gains and losses on investments other than trading securities, the effective portion of the unrealized gain (loss) on derivative financial instruments, the deferred compensation plan liability adjustment, transfers with unconsolidated subsidiaries, contributions of long-lived assets (including contributions which by donor restriction were to be used for the purpose of acquiring such long-lived assets), and other unrestricted net asset activity.

Net Patient Service Revenue

The Corporation reports net patient service revenue at the estimated net realizable amounts from patients, third party payors, and others for services rendered, including an estimate for retroactive adjustments that may occur as a result of future audits, reviews and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period they become known, and such amounts are adjusted in future periods as adjustments become finalized or as years are no longer subject to such audits, review and investigations. Net patient service revenue reported in the accompanying consolidated statements of operations is reduced by (1) estimated allowances for the excess of charges over anticipated patient or third party payor payments and (2) a provision for doubtful collections. Certain of the health care services provided by the Corporation are reimbursed by third party payors on the basis of the lower of cost or charges, with costs subject to certain imposed limitations.

Patient accounts receivable are reported at net realizable value and include charges for accounts due from Medicare, Medicaid, other commercial and managed care insurers, and self-paying patients (Note 16). Patient accounts receivable also includes management's estimate of the impact of certain undercharges to be recouped or overcharges to be paid back for inpatient and outpatient services in subsequent years rates as discussed earlier. The Corporation also deducts from patient accounts receivable an estimated allowance for doubtful collections related to patients and allowances for the excess of charges over the payments to be received from third party payors.

The Corporation has agreements with third-party payors that provide for payments to the Corporation at amounts different from its established rates. The Corporation recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of these established rates for the services rendered. For uninsured patients that do not qualify for charity care, the Corporation recognizes revenues on the basis of its standard rates, discounted in accordance with the Corporation's financial assistance policy. On the basis of historical experience, a significant portion of the Corporation's uninsured patients will be unable to pay for the services provided. Thus, the Corporation records a significant provision for doubtful collections related to uninsured patients in the period the services are provided. Patient service revenues, net of contractual allowances and discounts (but before the provision for doubtful collections), recognized in 2017 and 2016 from these major payor sources, are as follows:

	Patient Service Revenues (Net of Contractual Allowances and Discounts)				
	Medicare	Medicaid	Other Third Party Payors	Self-Pay and Other	Total
December 31, 2017	$ 299,641,313	$ 84,024,467	$ 386,516,398	$ 31,654,489	$ 801,836,667
December 31, 2016	$ 304,061,127	$ 67,425,014	$ 396,777,024	$ 33,464,551	$ 801,727,716

Patient service revenues (net of contractual allowances and discounts) for HRMC were $22,165,831 in 2016. Patient service revenues (net of contractual allowances and discounts) for BH&WS - Eastern Shore were $5,734,553 in 2016. These amounts have been classified in loss from discontinued operations in the consolidated statements of operations.

Income Taxes

The Corporation accounts for uncertainty in income taxes using a recognition threshold of more-likely-than-not to be sustained upon examination by the appropriate taxing authority. Measurement of the tax uncertainty occurs if the recognition threshold is met. Management determined there were no tax uncertainties that met the recognition threshold in 2017 or 2016.

The Corporation's policy is to recognize interest related to unrecognized tax benefits in interest expense and penalties in operating expenses.

Charity Care

The Corporation provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Such patients are identified based on financial information obtained from the patient (or their guarantor) and subsequent analysis which includes the patient's ability to pay for services rendered. Because the Corporation does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as a component of net patient service revenue or patient accounts receivable.

The Corporation maintains records to identify and monitor the level of charity care it provides. The costs associated with the charity care services provided are estimated by applying a cost-to-charge ratio to the amount of gross uncompensated charges for the patients receiving charity care. The level of charity care provided by the Corporation amounted to approximately $7,748,000 in 2017 and $9,395,000 in 2016.

Donor Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received or when the underlying conditions have been substantially met. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations as net assets released from restrictions. Restricted funds to be used for capital acquisitions have been reported as noncurrent assets in the accompanying consolidated balance sheets, while other restricted cash and investments are included with the cash and cash equivalents of unrestricted net assets.

Investment income that is earned on donor restricted net assets and subject to similar restrictions is reported as temporarily restricted net assets. Gifts, grants, and bequests not restricted by donors are reported as other operating income.

Advertising Costs

The Corporation expenses advertising costs as they are incurred.

Reclassifications

Certain amounts relating to 2016 have been reclassified to conform to the 2017 reporting format.

2. Adoption of Accounting Standards

Revenue Recognition

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*. ASU No. 2014-09 supersedes the revenue recognition requirements in Topic 605, Revenue Recognition, and most industry-specific guidance. Under the requirements of ASU No. 2014-09, the core principle is that entities should recognize revenue to depict the transfer of promised goods or services to customers (patients) in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The Corporation will be required to retrospectively adopt the guidance in ASU No. 2014-09 for years beginning after December 15, 2017. The Corporation has not yet determined the impact of adoption of ASU No. 2014-09 will have on its consolidated financial statements.

Financial Instruments

During January 2016, the FASB issued ASU No. 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities*. ASU No. 2016-01: a) requires equity investments (except those accounted for under the equity method of accounting or those that result in consolidation of the investee) to be measured at fair value with changes in fair value recognized in net income; (b) simplifies the impairment assessment of equity investments without readily determinable fair values by requiring a qualitative assessment to identify impairment; (c) eliminates the requirement to disclose the fair value of financial instruments measured at amortized cost for entities that are not public business entities; (d) eliminates the requirement for public business entities to disclose the method(s) and significant assumptions used to estimate the fair value that is required to be disclosed for financial instruments measured at amortized cost on the balance sheet; (e) requires public business entities to use the exit price notion when measuring the fair value of financial instruments for disclosure purposes; (f) requires an entity to present separately in other comprehensive income the portion of the total change in the fair value of a liability resulting from a change in the instrument-specific credit risk when the entity has elected to measure the liability at fair value in accordance with the fair value option for financial instruments; (g) requires separate presentation of financial assets and financial liabilities by measurement category and form of financial asset (that is, securities or loans and receivables) on the balance sheet or the accompanying notes to the financial statements; and (h) clarifies that an entity should evaluate the need for a valuation allowance on a deferred tax asset related to available-for-sale securities in combination with the entity's other deferred tax assets. ASU No. 2016-01 is effective for annual periods and interim periods within those annual periods beginning after December 15, 2017. Early adoption of certain amendments is permitted for financial statements of fiscal years or interim periods that have not yet been issued. The Corporation has not yet determined the impact of adoption of ASU No. 2016-01 will have on its consolidated financial statements.

Not-for-Profit Financial Statement Presentation

In August 2016, FASB issued ASU No. 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statement of Not-for-Profit Entities*. The new guidance is intended to improve and simplify the current net asset classification requirements and information presented in financial statements and notes that is useful in assessing a not-for-profit's liquidity, financial performance and cash flows. ASU No 2016-14 is effective for fiscal years beginning after December 15, 2017, with early adoption permitted. ASU No. 2016-14 is to be applied retrospectively with transition provisions. The Corporation has not yet determined the impact of adoption of ASU No. 2016-14 will have on its consolidated financial statements.

Statement of Cash Flows

During August 2016, the FASB issued ASU No. 2016-15, *Classification of Certain Cash Receipts and Cash Payments*. ASU No. 2016-15 addresses eight cash flow issues with specific guidance on how certain cash receipts and cash payments should be presented on the statement of cash flows. ASU No. 2016-15 is effective for annual periods and interim periods within those annual periods beginning after December 15, 2017. Early adoption is permitted. The Corporation has not yet determined the impact of adoption of ASU No. 2016-15 will have on its consolidated statement of cash flows.

Restricted Cash

During November 2016 the FASB issued ASU No. 2016-18, *Statement of Cash Flows (Topic 30), Restricted Cash.* ASU No. 2016-18 requires that a statement of cash flows explain the change during the period in the total cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. Amounts generally described as restricted cash and restricted cash equivalents should be included with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total amounts showing on the statement of cash flows. ASU No. 2016-18 is effective for fiscal years beginning after December 15, 2017, and interim periods within those fiscal years. Early adoption is permitted. The ASU should be applied using the retrospective transition method to each period presented. The Corporation has not yet determined the impact of adoption of ASU No. 2016-18 will have on its consolidated statement of cash flows.

Lease Accounting

In February 2016, FASB issued ASU No. 2016-02, *Leases (Topic 842)*. ASU No. 2016-02 was issued to increase transparency and comparability among organizations by recognizing lease assets and lease liabilities on the balance sheet and disclosing key information about leasing arrangements. Under the provisions of ASU No. 2016-02, a lessee is required to recognize a right-to-use asset and lease liability, initially measured at the present value of the lease payments, in the balance sheet. In addition, lessees are required to provide qualitative and quantitative disclosures that enable users to understand more about the nature of the Corporation's leasing activities. The Corporation will be required to retrospectively adopt the guidance in ASU No. 2016-02 for years beginning after December 15, 2018. The Corporation has not yet determined the impact of adoption of ASU No. 2016-02 will have on its consolidated financial statements.

Goodwill

During January 2017, FASB issued ASU No. 2017-04, *Simplifying the Test for Goodwill Impairment*. ASU No. 2017-04 simplifies how an entity is required to test goodwill for impairment by eliminating Step 2 from the goodwill impairment test. ASU No. 2017-04 is effective for annual or any interim goodwill impairment tests in fiscal years beginning after December 15, 2021. Early adoption is permitted for interim or annual goodwill impairment tests performed on testing dates after January 1, 2017. The Corporation does not believe that the adoption of ASU No. 2017-04 will have a material effect on its consolidated financial statements.

3. Discontinued Operations

On March 31, 2016, the Corporation sold the operating assets of HRMC and the HRMC Foundation to an unrelated third party, and discontinued the operations of the facility. The Corporation received net proceeds from the sale of approximately $44,500,000, which was net of a contribution paid by the Corporation of $2,500,000 to the HRMC Foundation. The Corporation recorded a loss on sale of $16,967,178 in 2016 which was included in the loss from discontinued operations in the accompanying consolidated statements of operations. The largest component of the loss on sale in 2016 is related to the write-off of costs associated with HRMC's electronic medical records system, which totaled approximately $11,518,000. During 2017, the Corporation recorded a gain from discontinued operations of $249,984 related to the final settlement of receivables and payables that existed at the time of sale. The amount is included in the net loss from discontinued operations in the accompanying consolidated statements of operations.

The following amounts related to discontinued operations are included in the gain (loss) from discontinued operations in the accompanying consolidated statements of operations:

	2017	2016
Total unrestricted revenues	$ -	$ 22,901,438
Total expenses	-	(22,769,646)
Other non-operating income (loss), including loss on sale in 2016 of $16,967,178	249,984	(17,063,626)
Revenues in excess of (less than) expenses	$ 249,984	$ (16,931,834)

During 2016, AHC discontinued operations at the BH&WS – Eastern Shore facility and made the decision to no longer provide services on Maryland's eastern shore. The following amounts related to discontinued operations are included in loss from discontinued operations in the accompanying consolidated statements of operations:

	2017	2016
Total unrestricted revenues	$ -	$ 6,706,337
Total expenses	-	(10,001,541)
Other non-operating loss	(2,911,706)	-
Revenues less than expenses	$ (2,911,706)	$ (3,295,204)

The majority of the property and equipment was disposed as a result of the closure and a loss of approximately $1,611,000 and $358,000 for 2017 and 2016, respectively, was recognized and included in the loss from discontinued operations in the accompanying consolidated statements of operations. In addition, goodwill of approximately $412,000 and $241,000 related to BH&WS Eastern Shore was written off and included in the loss from discontinued operations in the accompanying consolidated statements of operations in 2017 and 2016, respectively.

4. Investments

Short-Term Investments

The Corporation's short-term investments at December 31, 2017 and 2016 are comprised of the following:

	2017	2016
Cash and cash equivalents	$ 827,792	$ 3,653,630
Fixed Income:		
Corporate bonds	72,558,705	48,547,456
Asset backed securities	34,501,068	29,703,673
U.S. government securities,		
U.S. treasury notes	61,937,170	83,195,405
Mutual Funds:		
Equity - balanced	17,575,243	19,683,702
Equity - growth	10,403,051	3,810,315
Total	$ 197,803,029	$ 188,594,181

Assets Whose Use is Limited

The composition of assets whose use is limited at December 31, 2017 and 2016 is set forth in the following tables:

	2017	2016
Under trust indentures and capital lease purchase financing facilities, held by trustees and banks:		
Cash and cash equivalents	$ 56,604,016	$ 265,926,780
U.S. government securities,		
U.S. treasury notes	166,238,057	5,388,464
U.S. government agency notes	23,234,629	-
Total	246,076,702	271,315,244
Less funds held for current liabilities	1,744,132	1,720,039
Noncurrent portion of assets held under trust indentures and capital lease purchase financing facilities	$ 244,332,570	$ 269,595,205

	2017	2016
Professional liability trust fund:		
Cash and cash equivalents	$ 228,643	$ 864,028
Mutual funds:		
Equity - balanced	801,545	9,191,703
Equity - large value	3,869,027	-
Equity - growth	1,137,927	-
Fixed income - intermediate	3,912,844	-
Fixed income - multi-sector	960,543	-
Fixed income - short term	2,147,726	3,327,795
Total	13,058,255	13,383,526
Less funds held for current liabilities	1,179,664	1,150,302
Noncurrent portion of professional liability trust fund	$ 11,878,591	$ 12,233,224
Deferred compensation fund:		
Mutual funds,		
Equity - growth	$ 1,403,371	$ 1,466,041

The indenture requirements of certain tax exempt financings provide for the establishment and maintenance of various accounts with a trustee (Note 10). These arrangements require the trustee to control the payment of interest and the ultimate repayment of respective debt to bondholders.

The composition of trustee held and escrow funds at December 31, 2017 and 2016 is as follows:

	2017	2016
Debt service reserve funds	$ 28,224,212	$ 28,118,144
Principal and interest funds	29,448,690	35,363,487
Project fund	188,403,800	207,833,613
Total	$ 246,076,702	$ 271,315,244

Unrestricted investment income and gains and losses for investments, assets whose use is limited, and cash and cash equivalents are comprised of the following in 2017 and 2016:

	2017	2016
Investment income:		
Interest and dividends, net	$ 4,555,234	$ 3,853,355
Interest on trustee held funds	48,913	62,244
Net realized gains (losses) on sale of investments	3,628,355	(710,869)
Total	$ 8,232,502	$ 3,204,730
Other changes in unrestricted net assets,		
Change in net unrealized gains (losses) on investments other than trading securities	$ 2,582,625	$ (1,430,441)

Investment income for HRMC was $75,559 in 2016, which is included in loss from discontinued operations in the consolidated statements of operations. Included in these amounts are net realized losses on sale of investments of $60,700, interest on trustee held funds of $4,030, and interest and dividends, net of $132,229 in 2016.

5. Fair Value Measurements and Financial Instruments

Fair Value Measurements

The Corporation measures its short-term investments, assets whose use is limited, investments, beneficial interest in trusts, and derivative financial instruments at fair value on a recurring basis in accordance with accounting principles generally accepted in the United States of America.

Fair value is defined as the price that would be received to sell an asset or the price that would be paid to transfer a liability in an orderly transaction between market participants at the measurement date. The framework that the authoritative guidance establishes for measuring fair value includes a hierarchy used to classify the inputs used in measuring fair value. The hierarchy prioritizes the inputs used in determining valuations into three levels. The level in the fair value hierarchy within which the fair value measurement falls is determined based on the lowest level input that is significant to the fair value measurement.

The levels of the fair value hierarchy are as follows:

Level 1 - Fair value is based on unadjusted quoted prices in active markets that are accessible to the Corporation for identical assets. These generally provide the most reliable evidence and are used to measure fair value whenever available.

Level 2 - Fair value is based on significant inputs, other than Level 1 inputs, that are observable either directly or indirectly for substantially the full term of the asset through corroboration with observable market data. Level 2 inputs include quoted market prices in active markets for similar assets, quoted market prices in markets that are not active for identical or similar assets, and other observable inputs.

Level 3 - Fair value would be based on significant unobservable inputs. Examples of valuation methodologies that would result in Level 3 classification include option pricing models, discounted cash flows, and other similar techniques.

The fair value of the Corporation's financial instruments was measured using the following inputs at December 31:

	2017				
	Carrying Value	Fair Value	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
Reported at Fair Value					
Assets:					
Cash and cash equivalents	$ 58,471,764	$ 58,471,764	$ 58,471,764	$ -	$ -
Mutual funds:					
Fixed income – intermediate	3,970,702	3,970,702	3,970,702	-	-
Fixed income – multi - sector	960,543	960,543	960,543	-	-
Fixed income – short term	2,147,726	2,147,726	2,147,726	-	-
Equity - growth	12,960,164	12,960,164	12,960,164	-	-
Equity - large value	3,887,685	3,887,685	3,887,685	-	-
Equity - balanced	18,376,788	18,376,788	18,376,788	-	-
U.S. government securities:					
U.S. treasury notes	228,175,227	228,175,227	-	228,175,227	-
U.S. government agency notes	23,234,629	23,234,629	-	23,234,629	-
Asset backed securities	34,501,068	34,501,068		34,501,068	-
Corporate bonds and other debt securities	72,558,705	72,558,705	-	72,558,705	-
Beneficial interest in trusts	1,052,891	1,052,891	-	-	1,052,891
	$ 460,297,892	$ 460,297,892	$ 100,775,372	$ 358,469,629	$ 1,052,891
Liabilities,					
Derivative financial instruments	$ 1,145,303	$ 1,145,303	$ -	$ 1,145,303	$ -

Disclosed at Fair Value					
Cash and cash equivalents	$ 40,714,884	$ 40,714,884	$ 40,714,884	$	$
Pledges receivable	4,333,990	4,181,880	-	-	-
Long-term debt, excluding capital leases (Note 10):					
Fixed rate revenue bonds	526,076,559	578,746,439	-	578,746,439	-
Variable rate revenue bonds	22,985,000	22,985,000	-	22,985,000	-
Note payable	22,861,750	22,861,750	-	-	22,861,750
Secured line of credit	3,500,000	3,500,000	-	-	3,500,000

	2016				
	Carrying Value	**Fair Value**	**Quoted Prices in Active Markets (Level 1)**	**Other Observable Inputs (Level 2)**	**Unobservable Inputs (Level 3)**
Reported at Fair Value					
Assets:					
Cash and cash equivalents	$ 270,610,738	$ 270,610,738	$ 270,610,738	$ -	$ -
Mutual funds:					
Fixed income – short term	3,327,795	3,327,795	3,327,795	-	-
Equity - growth	5,284,502	5,284,502	5,284,502	-	-
Equity - other	716,929	716,929	716,929	-	-
Equity - mid-cap	6,803	6,803	6,803	-	-
Equity - balanced	28,875,405	28,875,405	28,875,405	-	-
U.S. government securities,					
U.S. treasury notes	88,583,869	88,583,869	-	88,583,869	-
Asset backed securities	29,703,673	29,703,673	-	29,703,673	-
Corporate bonds and other debt securities	48,547,456	48,547,456	-	48,547,456	-
Beneficial interest in trusts	1,310,686	1,310,686	-	-	1,310,686
	$ 476,967,856	$ 476,967,856	$ 308,822,172	$ 166,834,998	$ 1,310,686
Liabilities,					
Derivative financial instruments	$ 2,073,079	$ 2,073,079	$ -	$ 2,073,079	$ -

Disclosed at Fair Value					
Cash and cash equivalents	$ 30,198,079	$ 30,198,079	$ 30,198,079	$ -	$ -
Pledges receivable	3,669,290	3,562,332	-	-	-
Long-term debt, excluding capital leases (Note 10):					
Fixed rate revenue bonds	488,299,967	521,087,175	-	521,087,175	-
Variable rate revenue bonds	23,985,000	23,985,000	-	23,985,000	-
Note payable	23,613,911	23,613,911	-	-	23,613,911
Secured lines of credit	7,032,921	7,032,921	-	-	7,032,921

The following table presents the fair value measurements for beneficial interest in trusts that have unobservable inputs at December 31, 2017 and 2016:

Balance, January 1, 2016	$ 1,373,458
Decrease in value, included in changes in temporarily restricted net assets	(30,449)
Write-off of HRMC's beneficial interest in trusts	(32,323)
Balance, December 31, 2016	1,310,686
Distributions	(276,192)
Increase in value, included in changes in temporarily restricted net assets	18,397
Balance, December 31, 2017	$ 1,052,891

The following represents a reconciliation of the assets reported at fair value included in the fair value table within the accompanying consolidated balance sheets at December 31:

	2017	2016
Short-term investments (Note 4)	$ 197,803,029	$ 188,594,181
Assets whose use is limited (Note 4):		
Current portion	2,923,796	2,870,341
Under trust indentures and capital lease purchase financing facilities, held by trustees and banks	244,332,570	269,595,205
Professional liability trust fund	11,878,591	12,233,224
Deferred compensation fund	1,403,371	1,466,041
Investments held by foundations	903,644	898,178
Beneficial interest in trusts	1,052,891	1,310,686
	$ 460,297,892	$ 476,967,856

The Corporation did not have any financial assets or financial liabilities measured at fair value.

The following is a description of the valuation methodologies used for assets and liabilities measured at fair value and for financial instruments disclosed at fair value. There have been no changes in methodologies used at December 31, 2017 and 2016.

Cash and cash equivalents: The carrying amounts approximate fair value because of the short maturity of these financial instruments.

Marketable certificates of deposit and mutual funds: Valued based on quoted market prices.

U.S. government securities, corporate bonds and other debt securities: Valued based on estimated quoted market prices of similar securities.

Beneficial interest in trusts: Beneficial interest in trusts are valued based on the fair value of the trusts underlying assets which represents a proxy for discounted present value of future cash flows. Beneficial interest in trusts are included in deposits and other noncurrent assets in the accompanying consolidated balance sheets.

Pledges receivable: Valued based on the original pledge amount, adjusted by a discount rate that a market participant would demand and an evaluation of uncollectible pledges. Pledges receivables are included in prepaid expenses and other current assets and deposits and other noncurrent assets in the accompanying consolidated balance sheets.

Long-term debt: The fair value of the fixed rate debt is estimated based on market data provided by the Corporation's financial consultants. Fair values of the remaining long-term debt are considered to approximate their carrying amounts in the accompanying consolidated balance sheets.

The Corporation measures its derivative financial instruments at fair value based on proprietary models of an independent third-party valuation specialist. The fair value takes into consideration the prevailing interest rate environment and the specific terms and conditions of the derivative financial instrument, and considers the credit risk of the Corporation and counterparty. The method used to determine the fair value calculates the estimated future payments required by the derivative financial instrument and discounts these payments using an appropriate discount rate. The value represents the estimated exit price the Corporation would pay to terminate the agreement.

6. Property and Equipment and Accumulated Depreciation and Amortization

Property and equipment and accumulated depreciation and amortization at December 31, 2017 and 2016 consist of the following:

	2017	2016
Land and improvements	$ 32,566,971	$ 27,532,713
Buildings and improvements	457,474,313	448,226,562
Office furniture and equipment	194,126,065	183,173,853
Computer software and hardware	133,864,945	129,964,265
Equipment under capital leases	24,749,717	24,749,717
Total	842,782,011	813,647,110
Less accumulated depreciation and amortization	(474,343,085)	(440,159,685)
Total	368,438,926	373,487,425
Construction in progress	143,170,869	58,474,476
	$ 511,609,795	$ 431,961,901

Interest incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. During 2017 and 2016, the Corporation incurred interest expense, including amortization expense related to deferred financing costs, of approximately $12,064,000 and $12,012,000, respectively, of which approximately $1,711,000 was capitalized in 2017 and $1,650,000 was capitalized in 2016. HRMC incurred interest expense of approximately $337,000, including amortization expense related to deferred financing costs, in 2016 which is included in loss from discontinued operations in the accompanying consolidated statements of operations of which there were no amounts capitalized. Investment earnings of approximately $12,000 and $16,000 were offset against capitalized interest in 2017 and 2016, respectively.

Depreciation expense, including amortization of equipment under capital leases, was approximately $36,604,000 in 2017 and $37,825,000 in 2016. Depreciation expense, including amortization of equipment under capital leases, for HRMC was approximately $1,247,000 in 2016 and is included in loss from discontinued operations in the accompanying consolidated statements of operations. HRMC did not incur depreciation expense in 2017. Depreciation expense, including amortization of equipment under capital leases, for BH&WS - Eastern Shore was approximately $54,000 in 2016 and is included in loss from discontinued operations in the accompanying consolidated statements of operations. BH&WS - Eastern Shore did not incur any depreciation expense in 2017. Accumulated amortization of equipment under capital lease as of December 31, 2017 and 2016 was approximately $20,314,000 and $19,354,000, respectively.

Construction in progress as of December 31, 2017 consists primarily of major renovation and expansion projects of clinical facilities. Purchase commitments related to these and other miscellaneous projects were approximately $155,237,000 at December 31, 2017. The cost of these projects is expected to be funded through the project fund established through bond proceeds as well as transfers from the Corporation's related foundations and operations.

7. Investments and Investments in Unconsolidated Subsidiaries

The Corporation's investments and investments in unconsolidated subsidiaries include the following at December 31, 2017 and 2016:

	2017	2016
Investment in healthcare entities	$ 6,447,367	$ 5,887,970
Investment in Premier	8,409,290	6,595,929
Investments held by foundations	808,588	799,785
Total	$ 15,665,245	$ 13,283,684

Investment in Healthcare Entities

The Corporation recognized earnings of $258,193 and $509,587 during 2017 and 2016, respectively, related to its ownership interest in the healthcare entities accounted for under the equity method. The Corporation recognized earnings of $98,332 during 2016, which is included in the loss from discontinued operations in the consolidated statement of operations, related to HRMC's ownership interest in healthcare entities accounted for under the equity method. A brief description of these investments is presented below:

Chesapeake Potomac Regional Cancer Center ("CPRCC") - CPRCC provides outpatient radiation oncology services to patients in Maryland. The Corporation has a 20% ownership interest in CPRCC.

Doctors Regional Cancer Center ("DRCC") - DRCC provides outpatient radiation oncology services to patients in Bowie and Lanham, Maryland. The Corporation has a 20% ownership interest in DRCC.

Shady Grove Medical Building, LLC ("SGMB") - SGMB was organized for the purpose of developing and constructing a cancer care center on the campus of Shady Grove Medical Center. The Corporation has a 50% ownership interest in SGMB.

The Corporation has invested $259,100 in Advanced Health Collaborative, LLC for a 25% ownership interest. This organization was formed to share ideas and explore opportunities to enhance quality of healthcare in the state of Maryland.

The Corporation has invested $2,702,672 in Advanced Health Collaborative II, LLC ("AHC II") for a 25% interest. AHC II was formed to hold a 24% interest in Maryland Health Advantage, LLC which is a Medicare preferred provider network providing health services to its members.

Summarized financial information related to these entities is presented below:

	2017	2016
Net revenue	$ 17,682,566	$ 17,258,901
Revenues in excess of expenses	958,934	1,705,494
Total assets	30,265,624	29,861,576
Total liabilities	15,478,915	15,834,676

Investment in Premier

The Corporation is a partner in Premier, Inc. ("Premier"), a health care system group purchasing organization. In 2013, the Corporation recorded its Premier investment under the cost method of accounting. In October 2013, Premier converted from a privately held company to a public company through the issuance of an Initial Public Offering. At the time of conversion, the Corporation was issued 493,810 Class B common units of which 78,946 units were sold.

The remaining 414,864 Class B common units held by the Corporation are exchangeable for Class A common stock over a 7-year quarterly vesting period. The Corporation recognized a gain of $1,782,147 and $1,727,228 during 2017 and 2016, respectively, based on the market value of the units available for exchange. In addition, the Corporation recognized earnings of $707,426 and $802,812 during 2017 and 2016, respectively, related to distributions. Both the gain and the distributions are included in other revenue in the accompanying consolidated statements of operations.

Investments Held by Foundations

The Foundations also hold marketable debt and equity securities for funds not required to be expended in less than 90 days. These marketable securities are subject to credit and market risks.

8. Land Held for Healthcare Development

From 2002 through 2011, the Corporation acquired various parcels of land in Clarksburg, Maryland totaling approximately 200 acres. Several parcels of the land are fully owned by the Corporation, and the remainder is owned by Cabin Branch Commons, LLC ("Cabin Branch"), of which the Corporation owns 45%.

In May 2013, the Corporation and Cabin Branch entered into a purchase and sale agreement with an unrelated third party to sell 48.8 acres of the land located in Clarksburg. In June 2015, the Corporation and Cabin Branch closed on the sale of the land at a purchase price of $28,250,000. The Corporation's portion of the proceeds was $25,101,980. As of December 31, 2015, the Corporation received $13,225,064 of their portion of the purchase price, with the additional proceeds being held in escrow to be received upon the completion of certain infrastructure improvements to the property, for which the Corporation and Cabin Branch are collectively responsible. Those infrastructure improvements were made during 2016 and 2017, and the Corporation received the remaining proceeds from the escrow of $4,806,542 and $7,070,374 in 2016 and 2017, respectively, as reimbursement for the infrastructure improvements made to the property.

In April 2017, the Corporation entered into a purchase and sale agreement with an unrelated third party to sell 1.6 acres of the land located in Clarksburg. The Corporation closed on the sale of the land in April 2017 at a purchase price of $1,330,000, the entire proceeds of which were received in April 2017.

The total proceeds received related to the parcels of land sold by the Corporation in June 2015 and April 2017 noted above, was $26,431,980. No gain or loss was recognized on the sale of the parcels of land as of December 31, 2017 and 2016. Total remaining land held for healthcare development in Clarksburg as of December 31, 2017 and 2016, was $47,660,070 and $48,706,305, respectively.

9. Short-Term Financing

The Corporation has a $3,000,000 unsecured line of credit with a commercial bank, with interest at LIBOR plus 1.50% (3.06% at December 31, 2017). There were no borrowings outstanding under this line of credit as of December 31, 2017 or 2016.

10. Long Term Obligations

Long term obligations as of December 31, 2017 and 2016 are comprised of the following:

	2017	2016
Fixed rate revenue bonds	$ 526,076,559	$ 488,299,967
Variable rate revenue bonds	22,985,000	23,985,000
Secured lines of credit	3,500,000	7,032,921
Note payable	22,861,750	23,613,911
Other long term liabilities	16,683,010	21,524,170
Total obligations	592,106,319	564,455,969
Plus bond premium	10,507,079	10,869,392
Less:		
Current maturities	(13,019,860)	(12,749,886)
Deferred financing costs	(5,062,797)	(4,839,919)
Noncurrent portion of long term obligations, net	$ 584,530,741	$ 557,735,556

Fixed Rate Revenue Bonds

Fixed rate revenue bonds consist of the Maryland Health and Higher Educational Facilities Authority Refunding Revenue Bonds. Fixed rate revenue bonds consist of the following at December 31:

	Par Amounts	Interest Rates	2017	2016
Adventist Healthcare, Inc.:				
Series 2011A	$ 57,205,000	5-6.25%	$ 57,205,000	$ 57,205,000
Series 2013	15,623,500	3.21%	9,886,559	11,384,967
Series 2014A	24,280,000	3.56%	22,840,000	23,565,000
Series 2016A	269,750,000	5.00%	269,750,000	269,750,000
Series 2016B	126,395,000	3.23%	126,395,000	126,395,000
Series 2017	40,000,000	2.77%	40,000,000	-
Total			$ 526,076,559	$ 488,299,967

The above bond issues are subject to trust indentures which impose various covenants on SGMC, WAH, HRMC, BH&WS, Rehab, Imaging, CIS, Other Health Services and the Support Center (collectively, the "Obligated Group") which include restrictions on the transfer or disposition of property, the incurrence of additional liabilities, and the achievement of certain pre-established financial indicators. Management believes it has complied with these required financial covenants for the years ended December 31, 2017 and 2016. Debt service reserve funds are required on the Series 2011A, Series 2016A and Series 2017 bonds.

Variable Rate Revenue Bonds

The variable rate revenue bonds consist of the Maryland Health and Higher Educational Facilities Authority Revenue Refunding Bonds, Series 2014B, Adventist HealthCare, Inc. which had an outstanding balance of $22,985,000 and $23,985,000 as of December 31, 2017 and 2016, respectively. The Series 2014B Bonds bear interest at a variable rate of one month LIBOR plus 2.3% (3.86% at December 31, 2017). The Series 2014B bonds are subject to an Amended and Restated Master Trust Indenture that imposes various covenants on the Obligated Group which include restrictions on the transfer or disposition of property, the incurrence of additional liabilities, and the achievement of certain pre-established financial indicators. Management believes it has complied with these required financial covenants for the years ended December 31, 2017 and 2016.

The bonds subject to the Amended and Restated Master Trust Indenture are secured by the unrestricted revenues of the Obligated Group as well as a mortgage interest in the facilities of SGMC, WAH, HRMC, BH&WS and Rehab. In conjunction with the closing of the transfer of HRMC to Atlantic Health System as of March 31, 2016, HRMC is no longer a member of the Obligated Group, and as such, the mortgage on HRMC was released.

In December 2016, the variable rate revenue bonds Series 2005A and Series 2011B were refunded with the issuance of the Series 2016B bonds. The Series 2016B bonds were issued as a direct placement with a commercial bank. As a result of this refunding, a loss on extinguishment of debt was recognized in 2016 for $686,357 which is comprised of the remaining unamortized deferred financing costs related to the Series 2005A and Series 2011B bonds.

Secured Lines of Credit

The Corporation has a secured line of credit for $16,000,000 that bears interest at LIBOR plus 2.00% (3.56% at December 31, 2017) and expires on June 30, 2018. The balance on the line of credit was $3,500,000 and $7,032,921 at December 31, 2017 and 2016, respectively.

Note Payable

In December 2014, the corporation entered into a taxable term note for $25,000,000 with a commercial bank, which is secured by a Master Note issued under the Amended and Restated Master Trust Indenture dated as of February 1, 2003. The note bears interest at one month LIBOR plus 2.45% (3.825% as of December 31, 2017). The amortization on the note extends to December 18, 2034, however, the note matures on December 18, 2024. As of December 31, 2017 and 2016, the outstanding balance was $22,861,751 and $23,613,911, respectively.

Other Long Term Liabilities

This category consists of several capital lease obligations and notes payable on various types of medical and IT equipment. The financed equipment serves as security on these leases. Interest rates on these other long term liabilities range from 2.70% - 3.40%.

Scheduled principal repayments of long-term obligations at December 31, 2017 are as follows:

Years ending December 31:	
2018	$ 13,019,860
2019	8,547,724
2020	14,048,645
2021	13,385,399
2022	13,758,949
Thereafter	529,345,742
Total	$ 592,106,319

11. Derivative Financial Instruments

The Corporation has one interest rate swap agreement, which is considered a derivative financial instrument. The agreement is for a notional amount of $50,880,000 and requires the Corporation to pay a fixed interest rate of 3.457% while receiving variable interest rates based upon 67% of LIBOR, maturing January 2021. The agreement was entered into in order to manage interest rate exposure. The principal objective of the swap agreement is to minimize the risks associated with financing activities by reducing the impact of changes in interest rates on its debt portfolio. The notional amount of the swap agreements is used to measure the interest to be paid or received and does not represent the amount of exposure to credit loss. Exposure to credit loss is limited to the receivable, if any, which may be generated as a result of the swap agreement. The interest rate swap agreement is reported at fair value in the consolidated balance sheets. At December 31, 2017 and 2016, the fair value of the Corporation's derivative financial instruments was $1,145,303 and $2,073,079, respectively.

During 2016, the Corporation terminated one of its interest rate swap agreements with a notional amount of $78,000,000 that was designated as a cash flow hedge with the counterparty for $16,875,000. The Corporation borrowed the termination fee, which was included as a component of the proceeds for the 2016B bonds. No gain or loss was recognized on the termination of the swap. As of December 31, 2017 and 2016, $12,288,864 and $12,971,579, respectively, remained in unrestricted net assets. Beginning in January 2017, this amount is being amortized over the remaining term of the hedge, or through January 2035.

The net cash paid or received under the swap agreements is recognized as either an adjustment to interest expense or other income. The net cash paid under the interest rate swap agreements was $928,616 in 2017 and $3,791,973 in 2016. For 2016, $2,548,804 is reported as a component of interest expense in the accompanying consolidated statements of operations which represents the net cash paid related to the swap agreement that was accounted for, prior to the termination, using hedge accounting. The remaining amounts for 2017 and 2016 are reported as a component of other (expense) income in the accompanying consolidated statements of operations, which is related to the swap agreement that does not qualify for hedge accounting.

The fair value of the interest rate swap agreement is estimated to be the amount the Corporation would receive or pay to terminate the swap agreements at the reporting date and was based on information supplied by an independent third party valuation agent (Note 5). Additionally, the fair value reflects a credit risk assessment required under accounting principles generally accepted in the United States of America. Gains or losses resulting from the interest rate swap agreement are entirely recognized as a component of revenues in excess of expenses from continuing operations. The impact on the consolidated statements of operations were gains of $964,909 in 2017 and $1,035,104 in 2016.

On October 3, 2008, the counterparty for the Corporation's fixed pay swap maturing in January 2035, Lehman Brothers, Inc., commenced proceedings under Chapter 11 of the Bankruptcy Code. This action triggered an Event of Default under the ISDA Master Agreement in effect with said party and gave the Corporation the right to terminate the transaction.

On October 16, 2008, the Corporation terminated this agreement and concurrently entered into an agreement with a new counterparty that assumed all existing terms and conditions of the original agreement. The termination of the original swap agreement resulted in a loss of $472,023 which is included in unrestricted net assets in the consolidated balance sheets. This loss is being amortized over the remaining term of the designated period of the hedge, or through January 2035. As of December 31, 2017 and 2016, accumulated amortization of $161,837 and $143,855, respectively, is included in other changes in net assets and interest expense in the consolidated statements of operations and changes in net assets.

12. Leases

The Corporation has entered into various operating leases primarily for office space as well as certain equipment items. Rental expense for operating leases was $20,924,709 in 2017 and $21,263,623 in 2016. Rental expense for operating leases of HRMC was $540,820 in 2016 and is included in loss from discontinued operations in the accompanying consolidated statements of operations. Rental expense for operating leases of BH&WS - Eastern Shore was $692,074 in 2016 and is included in loss from discontinued operations in the accompanying consolidated statements of operations. Future minimum payments under non-cancelable operating leases with initial terms of one year or more consist of the following during the years ending December 31:

Years ending December 31:	
2018	$ 13,368,551
2019	12,665,499
2020	12,554,912
2021	12,649,566
2022	12,537,323
Thereafter	36,643,188
Total	$ 100,419,039

The Corporation has also entered into various sub-lease agreements with tenants that occupy space in the Corporation's buildings. The terms of these sub-leases vary and extend through 2030. Rental income was $3,303,484 in 2017 and $4,506,295 in 2016, which has been reported as a component of other operating revenue in the consolidated statements of operations. Future rent payments expected to be received by the Corporation during the years ending December 31, are as follows:

Years ending December 31:	
2018	$ 4,166,546
2019	3,580,156
2020	3,299,498
2021	2,922,089
2022	2,499,530
Thereafter	3,284,905
Total	$ 19,752,724

13. Retirement, Health Plan and Life Insurance

Defined Contribution Retirement Plan

The Corporation sponsors a 401(a) defined contribution retirement plan, which covers substantially all full-time employees. After twelve months of full-time or regular part-time employment of at least 1,000 base hours, the Corporation will contribute a total of 2% of eligible employees' compensation, plus a matching employer contribution equal to 50% of employee contributions (to the 403(b) plan) up to 6% of base salary. The Corporation also has a 403(b) retirement savings plan for employees. Employee contributions are made to the 403(b) retirement savings plan. Retirement plan expense was $7,983,472 in 2017 and $8,760,252 in 2016. Retirement plan expense for HRMC was $174,378 in 2016 which is included in loss from discontinued operations in the consolidated statements of operations. Retirement plan expense for BH&WS - Eastern Shore was $60,686 in 2016 which is included in loss from discontinued operations in the consolidated statements of operations.

Supplemental Executive Retirement Plan

The Corporation also has a Supplemental Executive Retirement Plan ("SERP") that became effective in 2015 and covers a group of key executives. SERP expense was $404,894 in 2017 and $300,900 in 2016. In addition, a SERP liability adjustment was recorded for $512,305 in 2017 and $521,260 in 2016, which was recognized in other changes in net assets in the consolidated statements of changes in net assets. At December 31, 2017 and 2016, the Corporation's liability for the SERP was $3,811,232 and $2,894,032, respectively, which is included in other liabilities in the consolidated balance sheets.

Executive Retention 457(F) Plan

Effective January 1, 2015, the Corporation established the Executive Retention 457(F) Plan (the "457(F) Plan"). The 457(F) Plan is a tax-deferred plan offered to key executives, whereby annual employer contributions are made to the Plan. Plan participants become vested in the contributions and receive plan payments in the second calendar year after the contribution is made, if the participant is still employed. The final contribution will be made to the Plan for the year in which the plan participant becomes 62. The 457(F) plan expense was $1,451,249 in 2017 and $1,501,925 in 2016. The Corporation's liability for the 457(F) plan at December 31, 2017 and 2016 was $2,792,809 and $2,975,057, respectively, which is included in other liabilities in the consolidated balance sheets.

Salary Deferral (457(b)) Plan

Employees who contribute the maximum allowable amount to the 403(b) retirement plan have an opportunity to contribute additional funds on a tax-deferred basis to a 457(b) retirement plan up to the maximum tax-sheltered opportunity. There are no employer contributions to this plan.

Health Plan

The Corporation maintains a self-insurance employee program for its health insurance coverage. The Corporation accrues the estimated costs of incurred and reported and incurred but not reported claims, after consideration of its stop-loss insurance coverage, based upon data provided by the third-party administrator of the program and historical claims experience.

Life Insurance

Full-time and part-time employees are insured, through a third-party carrier, for an amount equal to one times their base salary at time of enrollment up to $450,000 for full-time employees and $10,000 for part-time employees. In addition, if death is caused by accident, the employee is insured for an additional benefit equal to the amount of their life insurance.

14. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for betterments to plant facilities and purchases of equipment or to support operating programs sponsored by the Corporation and its affiliates.

Permanently restricted net assets have been restricted by donor to be maintained by the Corporation in perpetuity.

Net assets were released from donor restriction by satisfying their restricted purposes in the amount of $3,633,418 in 2017 and $3,293,236 in 2016.

15. Commitments and Contingencies

Litigation and Claims

The Corporation is subject to asserted and unasserted claims (in addition to litigation) encountered in the ordinary course of business. In the opinion of management and after consultation with legal counsel, the Corporation has established adequate reserves related to all known matters. The outcome of any potential investigative, regulatory or prosecutorial activity that may occur in the future cannot be predicted with certainty. However, any associated potential future losses resulting from such activity could have a material adverse effect on the Corporation's future financial position, results of operations and liquidity.

Insurance

The Corporation's primary coverage for professional liability is provided through a self-funded insurance retention trust (the "Trust") established on January 1, 1993. The Trust is funded based on actuarial estimates and provides coverage of $4,000,000 per occurrence with no annual aggregate limitation. The Trust also provides general liability coverage up to $1,000,000 per occurrence and $3,000,000 in the aggregate. The Corporation also carries umbrella excess liability insurance on a claims made basis with a commercial carrier, with limits of $20,000,000 per occurrence and in aggregate.

It is the Corporation's policy to accrue for the ultimate cost of uninsured asserted and unasserted malpractice claims, if any, when incidents occur. Based on a review of the Corporation's prior experience and incidents occurring through December 31, 2017, management determined that the fully-funded professional liability reserve reported at December 31, 2017 and 2016 is adequate in light of the program's excess umbrella policy currently in force and historical claims experience. The estimated professional liability for both asserted and unasserted claims was $14,262,545 and $12,865,503 at December 31, 2017 and 2016, respectively. The discount rate used in determining these liabilities was 2.5% at both December 31, 2017 and 2016.

The Corporation is self-insured for unemployment and workers' compensation benefits. The liability for unemployment and worker's compensation claims payable is an estimate based on the Corporation's past experience and is included in the accompanying consolidated balance sheets. It is reasonably possible that the estimates used could change materially in the near term.

Remediation

Certain buildings, which were constructed prior to the passage of the Clean Air Act, contain encapsulated asbestos material. Current law requires that this asbestos be removed in an environmentally safe fashion prior to demolition and renovation of these buildings. At this time, the Corporation has no plans to demolish or renovate these buildings and, as such, cannot reasonably estimate the fair value of the liability for such asbestos removal.

16. Business and Credit Concentrations

The Corporation grants credit to patients, substantially all of whom are local residents. The Corporation generally does not require collateral or other security in extending credit; however, it routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits receivable under their health insurance programs, plans or policies.

At December 31, 2017 and 2016, concentrations of gross receivables from third-party payors and others are as follows:

	2017	2016
Medicare	22 %	22 %
Medicaid	11	12
Other third party payers	39	45
Self-pay and others	28	21
	100 %	100 %

Net patient service revenue, by payor class, consisted of the following for the years ended December 31:

	2017	2016
Medicare	37 %	38 %
Medicaid	11	9
Other third party payers	48	49
Self-pay and others	4	4
	100 %	100 %

The Corporation maintains its cash and cash equivalents with several financial institutions. Cash and cash equivalents on deposit with any one financial institution are insured up to $250,000.

17. Functional Expenses

A summary of the Corporation's operating expenses by function for the years ended December 31, is as follows:

	2017	2016
Hospital acute and ambulatory services	$ 559,232,278	$ 545,995,612
Home care services	26,374,013	19,113,770
Other health care services	196,113,197	184,260,531
Other, including general and administrative	5,702,160	10,751,002
Fundraising	432,501	682,243
Total	$ 787,854,149	$ 760,803,158

The Corporation also incurred hospital acute and other health care services expenses related to HRMC and BH&WS Eastern Shore that were included in loss from discontinued operations in the consolidated statements of operations. HRMC hospital acute services expenses were $22,769,646 in 2016. BH&WS Eastern Shore other healthcare services expenses were $10,001,541 in 2016. No operating expenses were incurred in 2017 for HRMC for BH&WS Eastern Shore.

Adventist HealthCare, Inc. and Controlled Entities
Consolidating Schedule, Balance Sheet
December 31, 2017

	Shady Grove Medical Center	Washington Adventist Hospital	Hackettstown Regional Medical Center	Behavioral Health & Wellness Services	Rehabilitation	Imaging Services	Clinical Integration Services	Other Health Services	Support Center	Eliminating Entries	Total Combined Obligated Group	Lourie Center	Adventist Home Care Services	Urgent Care Centers	One Health Quality Alliance	Mid-Atlantic Primary Care	Adventist HealthCare, Inc. Foundations	Eliminating Entries	Consolidated Adventist HealthCare, Inc.
Assets																			
Cash and cash equivalents	$ 169,434,502	$ (48,120,660)	$ 76,562,848	$ (21,307,114)	$ 15,664,304	$ (24,043,730)	$ (22,721,885)	$ 976,421	$ (102,774,082)	$ -	$ 43,670,604	$ (683,588)	$ 6,073,433	$ (10,347,048)	$ (2,292,572)	$ 1,184,117	$ 3,109,938	$ -	$ 40,714,884
Short-term investments	-	-	-	-	-	-	-	-	197,803,029	-	197,803,029	-	-	-	-	-	-	-	197,803,029
Assets whose use is limited	-	-	-	-	-	-	-	-	2,923,796	-	2,923,796	-	-	-	-	-	-	-	2,923,796
Patient accounts receivable, net of estimated allowance for doubtful collections of $22,487,000	48,088,584	26,969,168	-	4,934,224	4,822,816	3,033,771	642,956	(519)	-	-	88,491,000	-	4,276,085	442,861	-	-	-	-	93,209,946
Other receivables, net of estimated allowance for doubtful collections of $628,000	1,841,050	2,499,566	-	2,117,139	156,162	3,330,207	56,869	652,062	2,171,520	(597,738)	12,226,837	2,751,224	31,141	-	-	-	1,061,779	-	16,070,981
Due from third party payors	-	-	-	115,974	254,469	-	-	-	-	(370,443)	-	-	-	-	-	-	-	-	-
Inventories	5,118,233	3,982,471	-	90,779	93,906	-	-	125,388	-	-	9,410,777	-	-	-	-	-	-	-	9,410,777
Prepaid expenses and other current assets	676,417	861,007	-	56,871	65,765	58,059	19,950	148,175	5,658,068	-	7,544,312	-	52,908	55,828	-	-	-	-	7,653,048
Total current assets	225,158,786	(13,808,448)	76,562,848	(13,992,127)	21,057,422	(17,621,693)	(22,002,110)	1,901,527	105,782,331	(968,181)	362,070,355	2,067,636	10,433,567	(9,848,359)	(2,292,572)	1,184,117	4,171,717	-	367,786,461
Property and Equipment, Net	178,100,768	185,644,026	-	13,145,193	10,299,587	8,494,432	1,203,692	201,174	104,539,932	-	501,628,804	1,617,534	1,667,237	6,696,220	-	-	-	-	511,609,795
Assets Whose Use is Limited																			
Under trust indentures and capital lease purchase financing facilities, held by trustees and banks	841,316	239,237,934	-	490,768	444,028	-	-	-	3,318,524	-	244,332,570	-	-	-	-	-	-	-	244,332,570
Professional liability trust fund	-	-	-	-	-	-	-	-	11,878,591	-	11,878,591	-	-	-	-	-	-	-	11,878,591
Deferred compensation fund	-	-	-	-	-	-	-	-	1,403,371	-	1,403,371	-	-	-	-	-	-	-	1,403,371
Cash and Cash Equivalents Temporarily Restricted for Capital Acquisitions	331,900	-	-	-	96,436	-	-	-	-	-	428,336	694,688	-	-	-	-	1,199,729	-	2,322,753
Investments and Investments in Unconsolidated Subsidiaries	843,836	-	-	-	-	-	-	-	14,012,821	-	14,856,657	-	-	-	-	-	808,588	-	15,665,245
Land Held for Healthcare Development	-	-	-	-	-	-	-	-	47,660,070	-	47,660,070	-	-	-	-	-	-	-	47,660,070
Intangible Assets, Net	1,018,809	-	-	841,587	845,496	5,435,091	-	36,236	7,736	-	8,184,955	-	158,175	-	-	-	-	-	8,343,130
Deposits and Other Noncurrent Assets	1,887,263	31,350	-	26,674	43,000	15,687	46,716	32,754	858,754	-	2,942,198	5,054	30,828	200,582	-	-	2,432,031	-	5,610,693
Total assets	$ 408,182,678	$ 411,104,862	$ 76,562,848	$ 512,095	$ 32,785,969	$ (3,676,483)	$ (20,751,702)	$ 2,171,691	$ 289,462,130	$ (968,181)	$ 1,195,385,907	$ 4,384,912	$ 12,289,807	$ (2,951,557)	$ (2,292,572)	$ 1,184,117	$ 8,612,065	$ -	$ 1,216,612,679

Adventist HealthCare, Inc. and Controlled Entities

Consolidating Schedule, Balance Sheet
December 31, 2017

	Shady Grove Medical Center	Washington Adventist Hospital	Hackettstown Regional Medical Center	Behavioral Health & Wellness Services	Rehabilitation	Imaging Services	Clinical Integration Services	Other Health Services	Support Center	Eliminating Entries	Total Combined Obligated Group	Lourie Center	Adventist Home Care Services	Urgent Care Centers	One Health Quality Alliance	Mid-Atlantic Primary Care	Adventist HealthCare, Inc. Foundations	Eliminating Entries	Consolidated Adventist HealthCare, Inc.
Liabilities and Net Assets																			
Current Liabilities																			
Accounts payable and accrued expenses	$ 26,268,407	$ 18,582,280	$ 673,330	$ 2,828,158	$ 1,041,179	$ 1,454,804	$ 1,669,173	$ 526,843	$ 29,413,814	$ -	$ 82,457,988	$ 1,047,774	$ 1,005,852	$ 618,064	$ 128,774	$ 1,408,826	$ 150,906	$ -	$ 86,818,184
Accrued compensation and related items	13,433,344	9,658,349	-	2,523,983	2,764,208	211,138	214,677	236,808	6,595,689	(597,738)	35,040,458	607,017	1,317,213	295,758	-	-	-	-	37,260,446
Interest payable	-	-	-	-	-	-	-	-	9,747,294	-	9,747,294	-	-	-	-	-	-	-	9,747,294
Due to third party payors	10,850,189	7,169,320	67,547	101,789	-	-	-	-	-	(370,443)	17,818,402	-	-	-	-	-	-	-	17,818,402
Estimated self-insured professional liability	-	-	-	-	-	-	-	-	1,179,664	-	1,179,664	-	-	-	-	-	-	-	1,179,664
Current maturities of long-term obligations	5,044,073	2,770,640	-	165,859	-	775,089	-	-	4,109,705	-	12,865,366	-	-	154,494	-	-	-	-	13,019,860
Total current liabilities	55,596,013	38,180,589	740,877	5,619,789	3,805,387	2,441,031	1,883,850	763,651	51,046,166	(968,181)	159,109,172	1,654,791	2,323,065	1,068,316	128,774	1,408,826	150,906	-	165,843,850
Construction Payable	1,786,159	12,402,322	-	92,500	94,556	14,286	-	-	282,306	-	14,672,129	-	152,030	4,380	-	-	-	-	14,828,539
Long-Term Obligations, Net																			
Bonds payable	123,749,836	379,651,523	-	5,954,585	4,293,277	-	-	-	37,577,507	-	551,226,728	-	-	(15,239)	-	-	-	-	551,211,489
Notes payable	-	-	-	-	-	-	-	-	17,688,481	-	17,688,481	-	-	4,400,801	-	-	-	-	22,089,282
Capital lease obligations	2,661,743	1,191,231	-	776,029	-	1,401,975	-	-	5,198,992	-	11,229,970	-	-	-	-	-	-	-	11,229,970
Derivative Financial Instruments	-	-	-	-	-	-	-	-	1,145,303	-	1,145,303	-	-	-	-	-	-	-	1,145,303
Other Liabilities	1,544,428	-	-	-	-	-	549,178	-	9,816,737	-	11,910,343	-	-	-	-	-	53,422	-	11,963,765
Estimated Self-Insured Professional Liability	-	-	-	-	-	-	-	-	13,082,881	-	13,082,881	-	-	-	-	-	-	-	13,082,881
Total liabilities	185,338,179	431,425,665	740,877	12,442,903	8,193,220	3,857,292	2,433,028	763,651	135,838,373	(968,181)	780,065,007	1,654,791	2,475,095	5,458,258	128,774	1,408,826	204,328	-	791,395,079
Net Assets (Deficit)																			
Unrestricted	222,945,080	(21,043,903)	75,821,971	(11,930,808)	24,590,615	(7,533,775)	(23,184,730)	1,408,040	152,816,329	-	413,888,819	2,095,431	9,814,712	(8,409,815)	(2,421,346)	(224,709)	2,585,883	-	417,328,975
Temporarily restricted	(100,581)	723,100	-	-	2,134	-	-	-	807,428	-	1,432,081	293,269	-	-	-	-	5,821,854	-	7,547,204
Permanently restricted	-	-	-	-	-	-	-	-	-	-	-	341,421	-	-	-	-	-	-	341,421
Total net assets (deficit)	222,844,499	(20,320,803)	75,821,971	(11,930,808)	24,592,749	(7,533,775)	(23,184,730)	1,408,040	153,623,757	-	415,320,900	2,730,121	9,814,712	(8,409,815)	(2,421,346)	(224,709)	8,407,737	-	425,217,600
Total liabilities and net assets	$ 408,182,678	$ 411,104,862	$ 76,562,848	$ 512,095	$ 32,785,969	$ (3,676,483)	$ (20,751,702)	$ 2,171,691	$ 289,462,130	$ (968,181)	$ 1,195,385,907	$ 4,384,912	$ 12,289,807	$ (2,951,557)	$ (2,292,572)	$ 1,184,117	$ 8,612,065	$ -	$ 1,216,612,679

Adventist Healthcare, Inc. and Controlled Entities
Consolidating Schedule, Statement of Operations
Year Ended December 31, 2017

	Shady Grove Medical Center	Washington Adventist Hospital	Hackettstown Regional Medical Center	Behavioral Health & Wellness Services	Rehabilitation	Imaging Services	Clinical Integration Services	Other Health Services	Support Center	Eliminating Entries	Total Combined Obligated Group	Lourie Center	Adventist Home Care Services	Urgent Care Centers	One Health Quality Alliance	Mid-Atlantic Primary Care	Adventist HealthCare, Inc. Foundations	Eliminating Entries	Consolidated Adventist HealthCare, Inc.
Unrestricted Revenues																			
Net patient service revenue	$ 375,793,489	$ 261,758,259	$ -	$ 42,080,118	$ 48,151,057	$ 30,871,761	$ 11,078,330	$ 38,286	$ -	$ (100,874)	$ 769,670,426	$ 818,945	$ 27,207,082	$ 4,156,714	$ -	$ -	$ -	$ (16,500)	$ 801,836,667
Provision for doubtful collections	(13,378,429)	(12,611,472)	-	(1,828,140)	(655,338)	(2,097,280)	(650,236)	(131,895)	-	-	(31,352,790)	(112,355)	(42,553)	(274,843)	-	-	-	-	(31,782,541)
Net patient service revenue less provision for doubtful collections	362,415,060	249,146,787	-	40,251,978	47,495,719	28,774,481	10,428,094	(93,609)	-	(100,874)	738,317,636	706,590	27,164,529	3,881,871	-	-	-	(16,500)	770,054,126
Other revenue	7,490,548	3,755,767	-	6,313,442	3,070,951	1,788,034	220,297	6,866,110	6,113,830	(10,653,269)	24,965,710	10,903,927	260,955	150	-	1,356,468	1,946,154	(1,369,042)	38,064,322
Total unrestricted revenues	369,905,608	252,902,554	-	46,565,420	50,566,670	30,562,515	10,648,391	6,772,501	6,113,830	(10,754,143)	763,283,346	11,610,517	27,425,484	3,882,021	-	1,356,468	1,946,154	(1,385,542)	808,118,448
Expenses																			
Salaries and wages	122,047,800	97,092,286	-	26,452,333	28,307,040	15,571,770	9,608,695	2,333,144	34,239,094	(2,060,361)	333,591,801	5,956,279	17,868,478	2,914,752	340,586	48,850	-	-	360,720,746
Employee benefits	25,662,739	16,874,104	-	5,161,671	5,142,120	2,952,109	351,085	422,926	7,185,299	(351,542)	63,400,511	1,280,600	3,432,002	445,078	63,799	8,262	-	-	68,630,252
Contract labor	18,763,758	13,844,823	-	2,538,947	312,986	531,457	-	747,671	259,318	(64,709)	36,934,251	1,437,866	402,529	418,974	-	-	-	(153,937)	39,039,683
Medical supplies	55,251,030	41,406,956	-	1,360,408	1,566,646	1,142,348	746,210	849,253	49,752	(64,820)	102,307,783	85,141	406,590	213,849	-	-	-	-	103,013,363
General and administrative	33,256,315	27,437,502	-	3,789,842	3,296,744	5,001,846	3,486,150	1,158,968	45,660,458	(5,867,109)	117,220,716	1,725,367	1,158,556	1,232,698	153,593	459,063	1,294,806	(1,208,579)	122,036,220
Building and maintenance	22,580,781	7,805,978	-	2,384,851	1,499,134	5,045,272	376,233	514,655	1,967,342	(2,345,603)	39,828,643	307,054	731,810	1,077,236	300	300	-	(23,026)	41,922,317
Insurance	2,101,469	1,988,032	-	344,492	140,095	630,688	164,407	4,213	43,309	-	5,416,705	28,892	75,738	153,428	-	-	-	-	5,674,763
Interest	5,632,231	1,330,250	-	263,249	158,289	84,581	-	-	2,719,498	-	10,188,098	-	-	165,354	-	-	-	-	10,353,452
Depreciation and amortization	15,188,646	5,205,877	-	1,285,983	906,729	1,312,531	253,095	75,768	11,505,885	-	35,734,514	160,196	251,761	316,882	-	-	-	-	36,463,353
IT depreciation	5,663,083	3,835,214	-	742,097	509,355	94,123	-	30,213	(10,956,906)	-	(82,821)	-	82,821	-	-	-	-	-	-
IT services	19,972,695	12,812,683	-	1,903,545	2,133,066	260,713	-	139,555	(37,940,639)	-	(718,382)	-	718,382	-	-	-	-	-	-
Shared Services	15,063,059	9,385,490	-	1,718,548	1,468,869	442,566	557,721	66,039	(29,398,034)		(695,742)	278,867	368,827	48,048			-	-	-
Management fees	8,656,970	5,857,705	-	1,615,414	1,417,193	20,923	492,538	145,592	(19,571,019)	-	(1,364,684)	338,708	875,479	150,497	-	-	-	-	-
Total expenses	349,840,576	244,876,900	-	49,561,380	46,858,266	33,090,927	16,036,134	6,487,997	5,763,357	(10,754,144)	741,761,393	11,598,970	26,372,973	7,136,796	558,278	516,475	1,294,806	(1,385,542)	787,854,149
Income (loss) from operations	20,065,032	8,025,654	-	(2,995,960)	3,708,404	(2,528,412)	(5,387,743)	284,504	350,473	1	21,521,953	11,547	1,052,511	(3,254,775)	(558,278)	839,993	651,348	-	20,264,299
Other Income (Expense)																			
Investment income (loss)	4,046,655	4,018	-	3,492	349,920	-	-	13,674	3,636,073	-	8,053,832	14,074	135,858	-	-	-	28,738	-	8,232,502
Other (expense) income	(504,187)	(2,209,514)	249,985	(2,838,286)	(16,509)	-	-	-	662,392	2,661,722	(1,994,397)	-	-	-	-	-	-	-	(1,994,397)
Total other income (expense)	3,542,468	(2,205,496)	249,985	(2,834,794)	333,411	-	-	13,674	4,298,465	2,661,722	6,059,435	14,074	135,858	-	-	-	28,738	-	6,238,105
Revenues in excess of (less than) expenses from continuing operations	23,607,500	5,820,158	249,985	(5,830,754)	4,041,815	(2,528,412)	(5,387,743)	298,178	4,648,938	2,661,723	27,581,388	25,621	1,188,369	(3,254,775)	(558,278)	839,993	680,086	-	26,502,404
Change in net unrealized gains (losses) on investments other than trading securities	770,559	(674,580)	-	548	58,735	-	-	(2,025)	2,434,283	-	2,587,520	(9,815)	24,570	-	-	-	(19,650)	-	2,582,625
Change in net unrealized gain on derivative financial instruments	-	-	-	-	-	-	-	-	700,697	-	700,697	-	-	-	-	-	-	-	700,697
Transfer from (to) subsidiaries	648,577	423,286	2,272,747	1,611,358	50,255	-	-	-	(5,065,250)	-	(59,027)	-	-	-	-	-	-	59,027	-
Net assets released from restriction for purchase of property and equipment	30,957	1,078,789	-	-	42,844	-	-	-	-	-	1,152,590	-	-	-	-	-	-	-	1,152,590
Deferred compensation plan liability adjustment	-	-	-	-	-	-	-	-	(512,305)	-	(512,305)	-	-	-	-	-	-	-	(512,305)
Other unrestricted net asset activity	(1)	6	-	2	(185,835)	8	797	-	(1,518,108)	(1)	(1,703,132)	(1)	(4)	(6)	-	(801)	-	(59,027)	(1,762,971)
Increase (decrease) in unrestricted net assets from continuing operations	25,057,592	6,647,659	2,522,732	(4,218,846)	4,007,814	(2,528,404)	(5,386,946)	296,153	688,255	2,661,722	29,747,731	15,805	1,212,935	(3,254,781)	(558,278)	839,192	660,436	-	28,663,040
Loss from discontinued operations	-	-	-	-	-	-	-	-	-	(2,661,722)	(2,661,722)	-	-	-	-	-	-	-	(2,661,722)
Increase (decrease) in unrestricted net assets	$ 25,057,592	$ 6,647,659	$ 2,522,732	$ (4,218,846)	$ 4,007,814	$ (2,528,404)	$ (5,386,946)	$ 296,153	$ 688,255	$ -	$ 27,086,009	$ 15,805	$ 1,212,935	$ (3,254,781)	$ (558,278)	$ 839,192	$ 660,436	$ -	$ 26,001,318

Adventist HealthCare, Inc. - Foundations

Combining Schedule, Balance Sheet
December 31, 2017

	Shady Grove Medical Center Foundation, Inc.	Washington Adventist Hospital Foundation, Inc.	Behavioral Health & Wellness Services Foundation, Inc.	Eliminating Entries	Combined Adventist HealthCare, Inc. Foundations
Assets					
Current Assets					
Cash and cash equivalents	$ 2,116,816	$ 755,937	$ 237,185	$ -	$ 3,109,938
Current portion pledges receivable, less allowance for doubtful pledges of $65,000	457,156	551,283	53,340	-	1,061,779
Total current assets	2,573,972	1,307,220	290,525	-	4,171,717
Cash and Cash Equivalents Temporarily Restricted for Capital Acquisitions	-	1,160,963	38,766	-	1,199,729
Investments	802,871	5,717	-	-	808,588
Beneficial Interest in Trusts	95,055	431,162	-	-	526,217
Noncurrent Portion of Pledges Receivable	659,364	1,246,450	-	-	1,905,814
Total assets	$ 4,131,262	$ 4,151,512	$ 329,291	$ -	$ 8,612,065
Liabilities and Net Assets					
Current Liabilities					
Accounts payable and accrued expenses	$ 19,866	$ 131,040	$ -	$ -	$ 150,906
Liability to Charitable Gift Annuitants	53,422	-	-	-	53,422
Total liabilities	73,288	131,040	-	-	204,328
Net Assets					
Unrestricted	2,162,088	276,285	147,510	-	2,585,883
Temporarily restricted	1,895,886	3,744,187	181,781	-	5,821,854
Total net assets	4,057,974	4,020,472	329,291	-	8,407,737
Total liabilities and net assets	$ 4,131,262	$ 4,151,512	$ 329,291	$ -	$ 8,612,065

Adventist HealthCare, Inc. - Foundations

Combining Schedule, Statement of Operations and Changes in Net Assets
Year Ended December 31, 2017

	Shady Grove Medical Center Foundation, Inc.	Washington Adventist Hospital Foundation, Inc.	Behavioral Health & Wellness Services Foundation, Inc.	Eliminating Entries	Combined Adventist HealthCare, Inc. Foundations
Changes in Unrestricted Net Assets					
Unrestricted Revenues, Gains, And Other Support					
Contributions, net	$ 630,669	$ 111,425	$ 31,376	$ -	$ 773,470
Investment income	28,500	-	238	-	28,738
Net assets released from restrictions	(219,861)	1,304,552	87,993	-	1,172,684
Total unrestricted revenues, gains, and other support	439,308	1,415,977	119,607	-	1,974,892
Expenses					
General and administrative expenses	90,104	120,306	43,746	-	254,156
In-kind gifts expended	161,164	17,181	-	-	178,345
Total expenses before transfers to the hospitals	251,268	137,487	43,746	-	432,501
Transfers to the hospitals	(314,189)	1,131,494	45,000	-	862,305
Total expenses	(62,921)	1,268,981	88,746	-	1,294,806
Revenues in excess of expenses	502,229	146,996	30,861	-	680,086
Change in net unrealized losses on investments other than trading securities	(19,650)	-	-	-	(19,650)
Increase in unrestricted net assets	482,579	146,996	30,861	-	660,436
Unrestricted net assets, beginning	1,679,509	129,289	116,649	-	1,925,447
Unrestricted net assets, ending	$ 2,162,088	$ 276,285	$ 147,510	$ -	$ 2,585,883
Changes in Temporarily Restricted Net Assets					
Contributions, net	$ 310,736	$ 1,486,275	$ 107,077	$ -	$ 1,904,088
Net assets released from restrictions	219,861	(1,304,552)	(87,993)	-	(1,172,684)
Change in discount of pledges receivable and provision for doubtful pledges	50,057	(38,581)	(167)	-	11,309
Investment income and unrealized gain on investments	10,234	-	-	-	10,234
Increase in temporarily restricted net assets	590,888	143,142	18,917	-	752,947
Temporarily restricted net assets, beginning	1,304,998	3,601,045	162,864	-	5,068,907
Temporarily restricted net assets, ending	$ 1,895,886	$ 3,744,187	$ 181,781	$ -	$ 5,821,854

EXHIBIT 21

AFFIRMATION

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

Printed Name: Brent Reitz Date: 7/9/18

Title: President . Adventist HealthCare Rehabilitation

AFFIRMATION

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

Elizabeth Kotroba

Printed Name: Elizabeth Kotroba Date: 7/8/18

Title: Assoc. VP of Operations

AFFIRMATION

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

Printed Name: Martha Velez Date: 7/9/2018

Title: Associate Vice President of Finance

AFFIRMATION

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

Printed Name: Robert E. Jepson Date: 7/6/18

Title: Vice President / Business Development

AFFIRMATION

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

Linda Beth Berman 7/6/18

Linda Beth Berman
Manager, Grants Management Department
Adventist HealthCare, Inc.

Date