STATE OF MARYLAND

For internal staff use:

MARYLAND HEALTH CARE COMMISSION

_____

MATTER/DOCKET NO.

_____

DATE DOCKETED

Certificate of Need Application

MedStar Health

Greater Chesapeake Surgery Center Expansion

February 5, 2016

Table of Contents

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: **Greater Chesapeake Surgery Center**

Address:

1212 York Road; Suite B101	**Timonium**	**21093**	**Baltimore**
Street	City	Zip	County

2. Name of Owner

If Owner is a Corporation, Partnership, or Limited Liability Company, attach a description of the ownership structure identifying all individuals that have or will have at least a 5% ownership share in the applicant and any related parent entities. Attach a chart that completely delineates this ownership structure.

MedStar Ambulatory Services, Inc. owns 51% interest in GCSC. See also Attachment 1.

3. APPLICANT. *If the application has a co-applicant, provide the following information in an attachment.*

Legal Name of Project Applicant (Licensee or Proposed Licensee):
MedStar Ambulatory Services, Inc., on behalf of Greater Chesapeake Surgery Center, LLC.

Address:

5565 Sterrett Place; 5th Floor	**Columbia**	**21045**	**MD**	**Howard**
Street	City	Zip	State	County
Telephone:	**410-772-6696**			

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

Greater Chesapeake Surgery Center

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 ☐
C.	Partnership		
	General	☐	
	L□mite□	☐	
	Limited Liability Partner□hip	☐	
	Limited Liability Limited Partnership	☐	
	Other (Specify):		
D.	Limited Liabilit□ Company	☒	
E.	Other (Specify):		
	To be formed:	☐	
	□xisting:	☐	

RESPONSE: MedStar Ambulatory Services, Inc. (MAS) is a Maryland not-for-profit corporation and a wholly-owned subsidiary of MedStar Health, Inc. ("MedStar Health"). GCSC is a Maryland for-profit limited liability company.

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

A. Lead or primary contact:

Name and Title: Patricia Cameron, Senior Policy Analyst

Company Name: MedStar Health

Mailing Address: 5565 Sterrett Place; 5th Floor; Columbia, MD 21045

Telephone: 410-772-6689

E-Mail Address: patricia.cameron@medstar.net

FAX: n/a

If company name is different than applicant briefly describe the relationship: MAS is a wholly-owned subsidiary of MedStar Health.

B. Additional or alternate contact:

Name and Title:	Megha Kachalia, Assistant Vice President Physician and Ambulatory Planning
Company Name:	MedStar Health
Mailing Address:	5565 Sterrett Place; 5th Floor; Columbia, MD 21045
Telephone:	410-772-6671
E-Mail Address:	Megha.V.Kachalia@medstar.net
FAX:	n/a

If company name is different than applicant briefly describe the relationship: MAS is a wholly-owned subsidiary of MedStar Health.

7. TYPE OF PROJECT

The following list includes all project categories that require a CON pursuant to COMAR 10.24.01.02(A). Please mark all that apply in the list below.

If approved, this CON would result in (check as many as apply):

(1) A new health care facility built, developed, or established ☒

(2) An existing health care facility moved to another site ☒

(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 ☐

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 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

This project involves expansion of the Greater Chesapeake Surgery Center (GCSC). The GCSC is currently located on York Road in Lutherville, Baltimore County, with two operating rooms and one procedure room. This surgery center has been in existence for over 20 years and is long overdue for modernization. Pursuant to COMAR 10.24.01.03, we are in the process of relocating this surgical capacity to a newly created medical office building in Timonium. The new address is 2118 Greenspring Drive Lutherville, 21092. The plan also involves adding two additional operating rooms, which is the subject of this application. in addition to modernizing the existing surgical capacity, this expansion will also allow MedStar Health to respond to the changing trends in the healthcare market to move procedures out from the hospital setting into the most appropriate outpatient setting in a cost effective manner by creating a lower cost alternative to hospital outpatient surgery. The addition of two operating rooms to the relocated GCSC will cost approximately $1.9 million, which includes construction, equipment, permits, architects/engineering, contingency and other project related costs.

B. Comprehensive Project Description: The description should include details 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
(5) Outline the project schedule.

MedStar Health is developing an Orthopaedic Center at 2118 Greenspring Road in Timonium, Maryland. The building is located near Interstate I-83 north of the Baltimore Beltway (I-695). An opportunity to rent an entire building allows MedStar to develop a state-of-the-art 49,500 square foot medical office building which will include a consolidated, comprehensive Orthopaedic practice, a new Spine/Joint Center, Imaging and Physical Medicine & Rehabilitation services. The building will be renovated for MedStar with occupancy anticipated in August of 2017. The facility will include the Greater Chesapeake Surgery Center, a two-operating room ambulatory surgery center to be relocated from its current location on York Road in Lutherville. Pursuant to COMAR 10.24.01.03D, a certificate of need is not required to relocate this ambulatory surgery center. Notice of the relocation has been filed with MHCC.

The development of an Ambulatory Orthopaedic Center will allow MedStar to achieve the following goals:

- To provide lower cost alternative to hospitals in Baltimore
- To allow program consolidation and multi-disciplinary service line development
- To advance comprehensive programmatic and functional integration of clinical services
- To provide access and convenience to patients in a “one stop shopping” environment
- To provide quality clinical services in the local North Baltimore community
- To provide state of the art equipment and technology

This project involves the addition of two operating rooms to the GCSC as follows:

- The expanded GCSC will have four ORs and the ability to accommodate 23-hour stay; including 14 Pre-op and recovery bays;
- A total 16,114 rentable/ 14,500 usable sq ft on third floor of the building; and

- Total capital cost is approximately $1.9 million for construction and equipment

The new site will allow GCSC to modernize from a 20+ year old 6,121 square foot facility to a state-of-the-art ambulatory surgery center of approximately 14,500 square feet. The existing Greater Chesapeake Surgery Center has outdated facilities including small operating rooms, inadequate space for equipment, staff and storage, inefficient workflow design and outdated design characteristics. For example:

- Electrical & mechanical room location will not allow necessary redesign/expansion of Sterile Core.
- Facility size will not accommodate recent and projected case growth/physician utilization.
- Current procedure room is too small and is no longer in use.
- Facility accommodates only 2 pre-op beds and 3-4 post-op beds/chairs. This prohibits physicians from performing a "full" case load simultaneously.
- Insufficient space for instrument/equipment cleaning and processing.
- Insufficient size to support consolidation, growth in population and movement of cases from the hospital inpatient and outpatient setting to the ambulatory setting.

As demonstrated below, the additional cases for the two operating rooms will come from a) a shift of orthopedic cases from MedStar's four Baltimore area hospitals, b) population growth, c) increasing use rates, and d) market shift as several new specialists come on board.

The case for expansion at Timonium becomes even more compelling as MedStar Health responds to new challenges of population health and the new Medicare waiver. The expansion at Timonium continues a shift to settings where health care can be provided in the most cost effective manner. Providing the right care in the right place at the right cost allows patients the option to access services like radiology and ambulatory surgery in a convenient location under one roof without the additional overhead cost of the hospital-based services. It further allows MedStar Health to continue to execute its ambulatory strategy of creating a distributed care delivery network of services to people in their community, where they live and work. In addition, attention and focus on the quality of care provided and its safety will become drivers in the further development of this ambulatory center for MedStar.

Most of the cases to be done at the relocated and expanded ASC are currently done at Greater Chesapeake Surgery Center, MedStar Union Memorial Hospital, MedStar Good Samaritan Hospital, MedStar Harbor Hospital or MedStar Franklin Square Hospital. The moderate decline in case load at these hospitals will allow much needed renovations.

Because the relocation of GCSC will proceed without delay towards a projected opening date of August 2017, the renovations needed to accommodate the two additional operating rooms will require very little lead time. The two additional operating rooms can be completed at the same time as the two existing operating rooms that are being relocated. If necessary, we will shell space for the additional two operating rooms. Once we obtain CON approval, the construction of the two new ORs is estimated can be completed in approximately 7 months.

9. Current Capacity and Proposed Changes:

Service	Unit Description	Currently Licensed/ Certified	Units to be Added or Reduced	Total Units if Project is Approved
ICF-MR	Beds	____/____		
ICF-C/D	Beds	____/____		
Residential Treatment	Beds	____/____		
Ambulatory Surgery	Operating Rooms	2	+2	4
	Procedure Rooms	1	-1	0
Home Health Agency	Counties	____/____		
Hospice Program	Counties	____/____		
Other (Specify)				
TOTAL				

10. Identify any community based services that are or will be offered at the facility and explain how each one will be affected by the project.

Response: no community based services will be offered by the proposed FASF.

11. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: 2.45 acres (refers to the entire site of the MOB)

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

N/A

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

(1) Owned by: 2118 Greenspring, LLC

(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.

12. PROJECT SCHEDULE

(INSTRUCTION: IN COMPLETING ITEM 12, PLEASE CONSULT THE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

For new construction or renovation projects.

Project Implementation Target Dates

A. Obligation of Capital Expenditure 2 months from approval date.
B. Beginning Construction 3 months from capital obligation (or equipment purchase order).
C. Pre-Licensure/First Use 12 months from capital obligation.
D. Full Utilization 12 months from first use.

For projects not involving construction or renovations.

Project Implementation Target Dates

A. Obligation or expenditure of 51% of Capital Expenditure _____ months from CON approval date.
B. Pre-Licensure/First Use _____ months from capital obligation.
C. Full Utilization _____ months from first use.

For projects not involving capital expenditures.

Project Implementation Target Dates

A. Obligation or expenditure of 51% Project Budget _____ months from CON approval date.
B. Pre-Licensure/First Use _____ months from CON approval.
C. Full Utilization _____ months from first use.

13. PROJECT DRAWINGS

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

These drawings should include the following before (existing) and after (proposed), as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, number of beds, location of bath rooms, 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 projects involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.

C. Specify dimensions and square footage of patient rooms.

RESPONSE: Please see Attachment 2. Full schematic drawings will be submitted as soon as they are available.

14. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete **Tables C and D of the Hospital CON Application Package**

See Attachment 3 for Tables C and D

B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project and identify the provider of each utility. Specify the steps that will be necessary to obtain utilities.

Response: Utilities available on site include water, electricity, sewer, and natural gas. Electricity (power) and natural gas service provider is BGE. Water and sewer are Baltimore County utility services. All utilities at the building are adequate to accommodate this project. Utilities will be extended from the service entrances to the area of renovation.

PART II - PROJECT BUDGET

Complete Table E of the Hospital CON Application Package

Note: Applicant should include a list of all assumptions and specify what is included in each budget line, as well as the source of cost estimates and the manner in which all cost estimates are derived. Explain how the budgeted amount for contingencies was determined and why the amount budgeted is adequate for the project given the nature of the project and the current stage of design (i.e., schematic, working drawings, etc.).

RESPONSE: Please see Attachment 4 for Table E.

Greater Chesapeake Surgery Center Expansion

Statement of Assumptions

- **Capital Cost**
    - Renovation building costs are based on a cost estimate of $250 per square foot for renovation costs and experience of MedStar on other ASC projects.
    - Permit costs of approximately $7,000 are included within the construction management fee and have been broken out for Table E.
    - Inflation costs were calculated using the MHCC methodology and index presented on its website at http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_cap_cost_index_3rd_qtr_2015.pdf
    - Equipment costs include movable equipment of $300,000, systems (such as call system, phones, etc.) of $20,000, operating room equipment of $608,500, pain case equipment of $196,500 and PACU equipment of $75,000 (6 bays at $12,500 each).
- **Source of Funds**
    - Cash of $487,569 (25% of the total project budget) will be funded by MedStar Health.
    - Other (Loan from MedStar Health) of $1,462,706 (75% of the total project budget) will be funded by a loan from MedStar Health. The loan will be amortized over 11 years at interest rate of 3.5% payable in 132 equal monthly installments.

- **Terms of the Lease**
    - The lease is for 11 years. Rent per square foot is $28, CAM, Tax & Insurance per square foot is $2.45, Utilities per square foot is $2.25 and Housekeeping per square foot is $4.60 (Administration $1.60, Janitorial $.20, Repairs/Maintenance $1.00, Property Management $.80 Engineering Payroll $1.00)

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 and its implementation.

   RESPONSE:

2. Are the applicant, owners, or the responsible persons listed in response to Part 1, questions 2, 3, 4, 7, and 9 above now involved, or have they ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of these facilities, including facility name, address, and dates of involvement.

   RESPONSE: MedStar Ambulatory Services is responsible for the development of the Brandywine ambulatory surgery center in Prince George's County, Maryland. It is not, nor has it ever been, involved in the ownership, development, or management of any other health care facilities in Maryland.

3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to Question 2, above, been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, 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.

   RESPONSE: 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) received inquiries in last from 10 years from any federal or state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with any 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.

   RESPONSE: No.

5. Have the applicant, owners or responsible individuals listed in response to Part 1, questions 2, 3, 4, 7, and 9, above, ever pled guilty to 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).

   RESPONSE: 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 proposed or existing facility.

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.

Date

Signature of Owner or Board-designated Official

President, MedStar Ambulatory Services
Position/Title

Robert J. Gilbert
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 to 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>.

Every applicant must address each applicable standard in the chapter of the State Health Plan for Facilities and Services. Commission staff can help guide applicants to the chapter(s) that applies to a particular proposal.

Please provide a direct, concise response explaining the project's consistency with each standard. Some standards require specific documentation (e.g., policies, certifications) which should be included within the application as an exhibit.

10.24.11.05 SURGERY Standards

A. General Standards.

The following general standards encompass Commission expectations for the delivery of surgical services by all health care facilities in Maryland, as defined in Health General §19-114 (d). Each applicant that seeks a Certificate of Need for a project or an exemption from Certificate of Need review for a project covered by this Chapter shall address and document its compliance with each of the following general standards as part of its application.

1. Information Regarding Charges.

Information regarding charges for surgical services shall be available to the public. A hospital or an ambulatory surgical facility shall provide to the public, upon inquiry or as required by applicable regulations or law, information concerning charges for the full range of surgical services provided.

RESPONSE: The Greater Chesapeake Surgery Center will make information regarding charges for the full range of surgical services provided readily available to the public, upon inquiry, or as required by applicable regulations or laws. It should be noted that Medicare and Medicaid fees are fixed based on internal policies, and insurance companies fees are based on their policies or on individual contracts with the ASC. Co-pays and deductibles will vary by payer and by specific insurance plan. The ASC staff will work closely with patients to provide information on charges, and to determine their co-pays.

2a. Charity Care Policy.

a) Each hospital and ambulatory surgical facility 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 ambulatory surgical services on a charitable basis to qualified indigent 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 surgical facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's arrival for surgery, 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. Hospitals shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. ASFs, at a minimum, must include the following eligibility criteria in 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 ASFs described in these regulations.

RESPONSE:

Please see Attachment 5 for the financial assistance policy.

2b. Charity Care Policy.

(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.

RESPONSE:

Not applicable.

2c. Charity Care Policy.

(c) A proposal to establish or expand an ASF for which third party reimbursement is available, shall commit to provide charitable surgical services to indigent patients that are equivalent to at least the average amount of charity care provided by ASFs in the most recent year reported, measured as a percentage of total operating expenses. 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 an existing ASF has not met the expected level of charity care for the two most recent years reported to MHCC, the applicant shall demonstrate that the historic level of charity care was appropriate to the needs of the service area population.

RESPONSE:

Data available from MHCC shows the current average charity care provided by ASFs is 0.46%.

Although GCSC did not record the provision of charity care in CY 13 or CY 14, MedStar's policy that no patient is denied service based on ability to pay applies to this facility since MedStar became a majority owner in January 2015. If any patient presenting to GCSC requests financial assistance, the center staff works with that patient to find the most appropriate solution. Had financial assistance been required with no other solution, it would have been provided. The staff at GCSC in it new and expanded location will work with anyone that requests financial assistance to consider alternatives for the patient, such as eligibility for other coverage. This commitment is not limited to just the state average of 0.46%, but applies to anyone requesting financial assistance.

2. Charity Care Policy.

(d) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a Certificate of Need for a surgical facility project, shall commit to provide charitable services to indigent patients. Charitable services may be surgical or non-surgical and may include charitable programs that subsidize 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 ASFs, measured as a percentage of total ASF 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.

RESPONSE:

Not applicable.

3. Quality of Care.

A facility providing surgical services shall provide high quality care.

(a) An existing hospital or ambulatory surgical facility shall document that it is licensed, in good standing, by the Maryland Department of Health and Mental Hygiene.

(b) A hospital shall document that it is accredited by the Joint Commission.

(c) An existing ambulatory surgical facility shall document that it is:

(i) In compliance with the conditions of participation of the Medicare and Medicaid programs; and

(ii) Accredited by the Joint Commission, the Accreditation Association for Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, or another accreditation agency recognized by the Centers for Medicare and Medicaid as acceptable for obtaining Medicare certification.

(d) A person proposing the development of an ambulatory surgical facility shall demonstrate that the proposed facility will:

(i) Meet or exceed the minimum requirements for licensure in Maryland in the areas of administration, personnel, surgical services provision, anesthesia services provision, emergency services, hospitalization, pharmaceutical services, laboratory and radiologic services, medical records, and physical environment.

(ii) Obtain accreditation by the Joint Commission, the Accreditation Association for Ambulatory Health Care, or the American Association for Accreditation of Ambulatory Surgery Facilities within two years of initiating service at the facility or voluntarily suspend operation of the facility.

RESPONSE:

Quality will be a cornerstone of MedStar health facility at Timonium. The MedStar Quality, Safety, and Patient Affairs Committee, a subcommittee of the MedStar Board, will have ultimate oversight of quality efforts at the Timonium site. The Quality Director, working with each area of service provision at the site, will manage the tracking of quality metrics and improvement efforts. This individual will report to the MedStar Ambulatory Services Medical Director, who will report results to the MedStar Quality, Safety, and Patient Affairs Committee, as well as to the entities that provide physicians for the site. The MedStar Quality and Safety Department will provide

support via the Director of Quality and Assistant Vice President. They will seek the accreditation of the surgery center with AAAHC. The Quality and Safety Department is also managing an ongoing effort to standardize clinical policies and procedures across the consolidated sites in order to ensure consistent care.

Clinical Quality Excellence is one of the core values of the MedStar Health system. Oversight of the proposed facility will benefit from a multi-layered system focused on clinical care excellence. A Physician Leadership Council provides system-wide oversight, support and advocacy for the clinical services provided by physicians in hospital and non-hospital settings throughout MedStar Health, and coordinates engagement of physicians in MedStar's quality and safety initiatives. There is also a Chief Nursing Officer Council, which provides the same support for nursing. In 2013, the two councils began meeting quarterly as a joint Chief Nursing Officer/Chief Medical Officer (CNO/CMO) Council. The Council oversees the following system-based committees:

- Clinical Informatics Council (formerly known as the Clinical Governance Executive Committee)
- Transitions of Care Committee
- Healthcare Epidemiology and Infection Control (HEIC) Task Force
- Council for Ideal Obstetrical Care (CIOC)
- 30-Day Readmissions Committee
- Palliative Care Committee
- Quality & Safety Committees

Continuity and standardization, hallmarks of quality, are addressed with systems in place for Quality and Patient Safety, Performance Improvement and Risk Management. At the system level, The MedStar Vice President of Quality and Safety oversees the MedStar Clinical Care Quality and Safety department, responsible for embedding a culture of safety and clinical quality excellence throughout the system. In 2015, MedStar Health launched the MedStar Institute for Quality and Safety which is now nationally recognized in the areas of quality and safety education, transparency and patient/family partnerships. The Institute also benefits each entity through relevant data reports and standardization of practice related to the latest evidence on cost effective practices. The system-wide leadership structure supports individual entities by:

- Enabling early identification and communication of real and potential safety

concerns across the system

- Implementing system enhancements to drive standardization, evidence-based practice, performance, and outcomes
- Offering supportive consultation and coaching
- Ensuring provider accountability.

Quality and Safety efforts include:

- Participation in the University HealthSystem Consortium (UHC) database, which provides a variety of performance improvement services to over 400 hospitals (includes academic and now their non-academic partners) across the nation, being launched system-wide. This will standardize clinical quality & performance data collection and reporting, provide robust data reports, and "innovative solutions" from other UHC members, and in time, will provide physicians the opportunity to better examine their own practice patterns and benchmarks
- a system-wide High Reliability Organization (HRO) effort, that included high reliability training for all 27,000 MedStar leaders and associates. MedStar has incorporated many of the proven risk-reduction strategies and tools across the system including Safety Moments, Safety/Quality Huddles, Leadership Quality/Safety Walk Rounds, SBAR, and STAR principles to name a few of the many tools being used.
- the MedStar Health Patient and Family Advisory Councils for Quality and Safety (PFACQS) brings the patient's voice into MedStar's quality and safety planning and projects, in ways that directly improve quality and safety throughout the MedStar community. The PFACQS councils include one system level council, 10 hospital based councils and an ambulatory care council. System council membership includes ten nationally recognized leaders in the quality and safety arena.
- a Patient Safety Event (PSE) Management System across all entities, which allows associates to report real or potential safety issues, including patient harm, near misses and unsafe conditions. Over the last two years, close to 80,000 occurrence reports have been submitted allowing MedStar to identify and focus our attention and resources on at risk areas making our care safer and higher quality.

Other system benefits

The Georgetown University School of Medicine is the principal academic partner of MedStar. Most of the hospitals in the MedStar system are teaching hospitals. Each sponsors its own graduate medical education programs and all are fully accredited by the Accreditation Council for Graduate Medical Education (ACGME). In aggregate, the System enrolls just over 1,100 residents and fellows in 75 academic programs of graduate medical education. These programs include virtually all adult specialty training and some pediatric programs; approximately 48 percent of the enrolled residents are in primary care training programs.

MedStar Health Research Institute is the research arm for MedStar, providing scientific, administrative, and regulatory support for research programs that complement the key clinical services and teaching programs in all hospitals in the System. MedStar Health Research Institute supports clinical research performed by private attending medical staff, hospital-employed medical staff and by full-time research investigators. MedStar Health Research Institute and its investigators participate in a wide range of research aimed at advancing health and the quality of delivered care by linking to the major clinical service lines including cardiovascular, diabetes, lipid disorders, orthopedics, cardiac surgery, rehabilitation, renal diseases, anesthesiology, gerontology and women's health and safety. There is also active investigation in diabetes, gerontology and women's health.

The changing healthcare environment highlights the importance of innovation and research as elements for success. For example, the MedStar Institute for Innovation's mission is to catalyze, support and create innovation that advances health. The MedStar Health Research Institute and MedStar's partnership with Georgetown University, are important drivers of success. The MedStar Innovation Institute's role is to foster innovation throughout the MedStar system by offering innovation services that include intellectual property and technology transfer expertise; either in partnership with MedStar associates or with external strategic partners. An Innovation Alliance has been created with the Cleveland Clinic with the first initiative focused on the creation of a comprehensive technology and commercialization infrastructure. MedStar's National Center for Human Factors Engineering, the first of its kind research and applied sciences center, is applying safety science methods to the healthcare environment.

MedStar is implementing an electronic medical record system that will be a feature of the proposed facility. The EMR promotes communication between all providers within the MedStar

system centered on each patient, so that all providers are aware, upon viewing the medical record, all aspects of that patient's care within the system. This system will improve patient care at all MedStar facilities.

Specific Responses

(a)(c)(i-ii) Greater Chesapeake Surgery Center is currently certificated and in good standing with the Maryland Department of Health and Mental Hygiene (MDHMH), American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) and licensed with Centers for Medicare and Medicaid (CMS). See Attachment 6 .

Greater Chesapeake Surgery Center (GCSC) currently has ready access to extended support services via MedStar Union Memorial Hospital for both laboratory and full radiological services. Contract service agreements are in place for on-site anesthesia services and pharmacy management oversight. Emergency transfer agreements are valid with two neighboring acute care hospitals (MedStar Union Memorial Hospital and University of Maryland St. Joseph's Hospital), both within 12 miles of GCSC and the new location in Timonium. All participating physicians are credentialed, approved by both the Medical Executive Committee and Board of Governors and meet the required standards of AAAASF and CMS. Extensive facility operating policies and Quality Process Improvement (QPI) activities are documented and utilized as daily guidance for maintaining environment of care, safety and well-being of patients, staff and medical providers. The facility building will be constructed utilizing all applicable/ required FGI standards/guidelines. See Attachment 6.

(d)(i-ii) It is the intention of MedStar Health to continue to operate the relocated ASC in accordance with the standards and policy as noted above. Upon relocation of the facility and completion of construction, it is the intention of MedStar Health to submit for certification from MDHMH and seek licensure with the Centers for Medicare and Medicaid. At this time, the facility will apply for its accreditation survey with American Association of Ambulatory Health Care (AAAHC). All policies will be reviewed and appropriately modified to meet any unique operating needs and/or physical plant nuances of the new ASC facility.

4. Transfer Agreements.

(a) Each ASF and hospital shall have written transfer and referral agreements with hospitals capable of managing cases that exceed the capabilities of the ASF or hospital.

(b) Written transfer agreements between hospitals shall comply with the Department of Health and Mental Hygiene regulations implementing the requirements of Health-General Article §19-308.2.

(c) Each ASF shall have procedures for emergency transfer to a hospital that meet or exceed the minimum requirements in COMAR 10.05.05.09.

RESPONSE:

Formal transfer agreements are in place with University of Maryland St. Joseph Hospital, as the proximal acute care hospital for all emergency patient transfers, as well as MedStar Union Memorial Hospital. These hospitals are located within 5 and 13 miles respectively, for emergent and non-emergent patient transfers. See Attachment 7

GCSC's current operating policy for *Hospital Transfer* shall be updated as appropriate to meet COMAR and AAAHC requirements. The new facility location, 2118 Greenspring Drive, Timonium, is within 6 and 12 miles respectively of both hospitals listed above. See Attachment 8.

B. Project Review Standards.

The standards in this section govern reviews of Certificate of Need applications and requests for exemption from Certificate of Need review involving surgical facilities and services. An applicant for a Certificate of Need or an exemption from Certificate of Need shall demonstrate consistency with all applicable review standards.

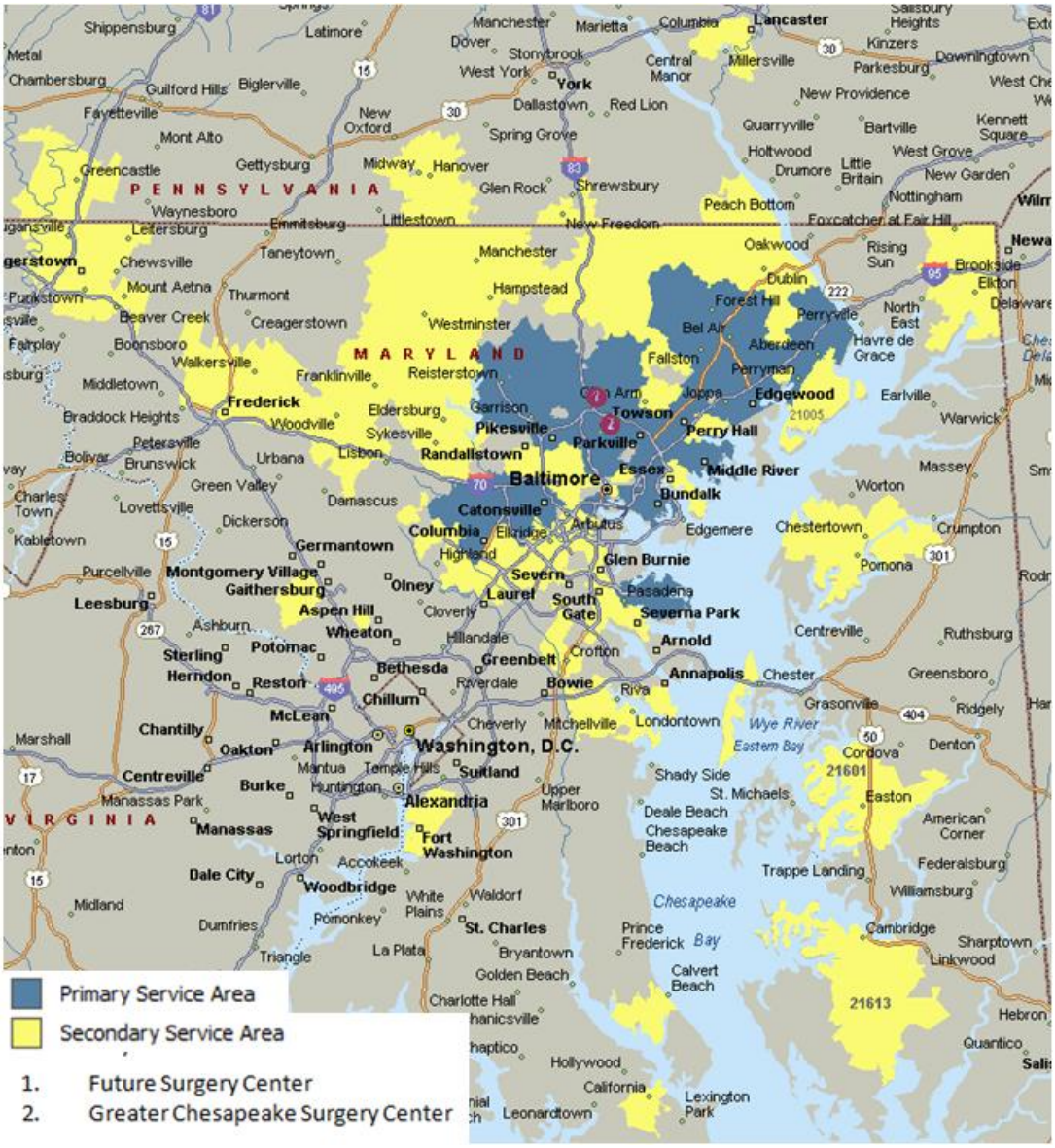
1. Service Area.

An applicant proposing to establish a new hospital providing surgical services or a new ambulatory surgical facility shall identify its projected service area. An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall document its existing service area, based on the origin of patients served.

RESPONSE:

MedStar Health has one freestanding surgery center in the Central Maryland region, the Greater Chesapeake Surgery Center (GCSC) located in Lutherville. The service area for the current GCSC is depicted in the map below using the State Health Plan standard definition of primary and secondary service areas at 60% and 85% patient origin respectively. See Attachment 9 for a list of patients by zip code.

Greater Chesapeake Surgery Center
Primary and Secondary Service Areas, FY 2015



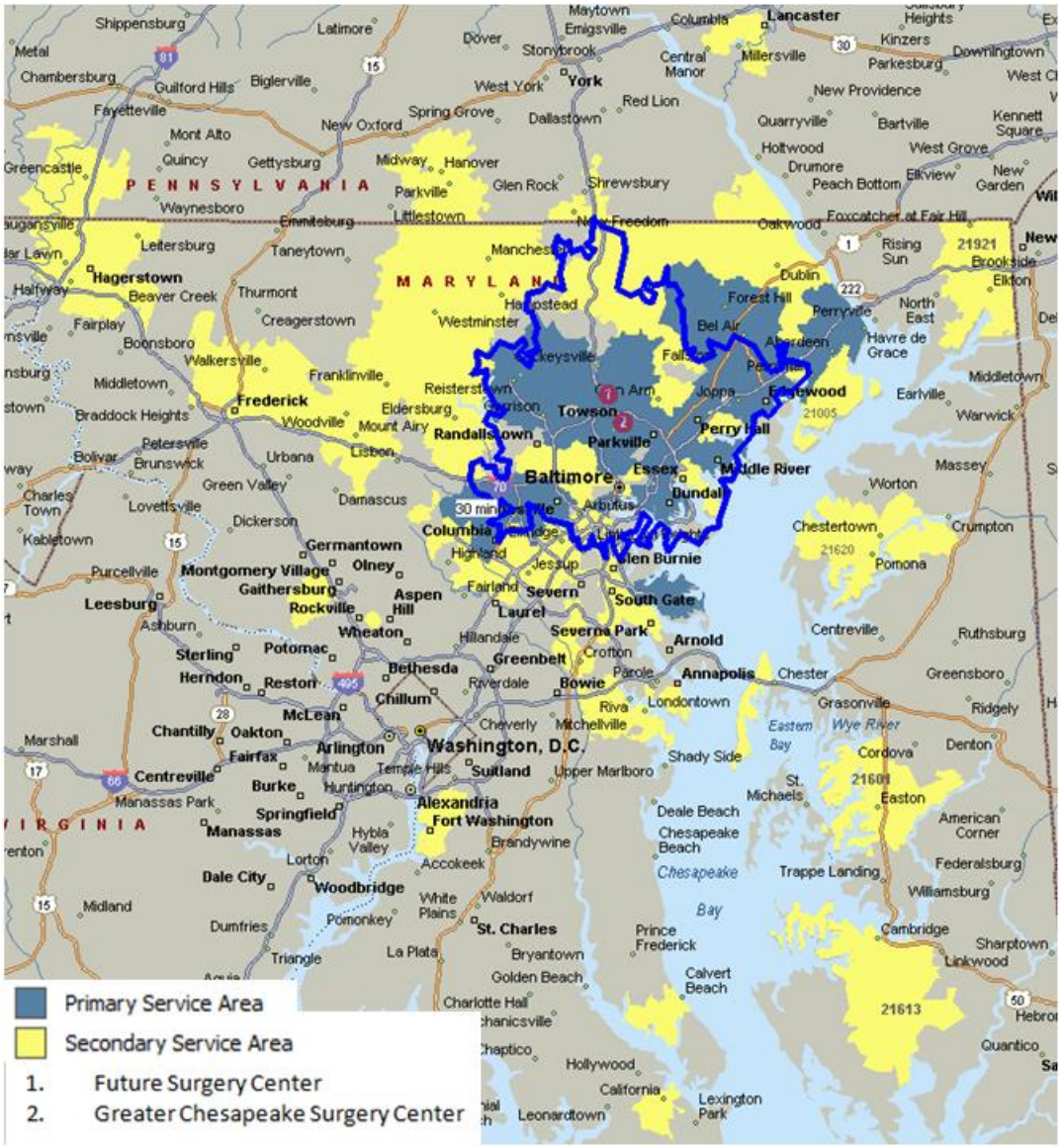
Notes: Primary service area includes zip codes from which 60% of patients originate; secondary service area includes the next 25% of patients

Source: Greater Chesapeake Surgery Center, FY 2015 data

Since the relocated surgery center will be located less than four miles away in Timonium, the service area is projected to remain consistent. Any projected growth plans are focused on the geography surrounding the new ASC within a 30-minute drive time. This is a typical benchmark

for consumers' willingness to travel for ambulatory surgery and includes the MedStar Orthopaedic practices from which ambulatory surgery volumes would be generated.

Map of Greater Chesapeake Surgery Center Primary and Secondary Service Areas with 30-Minute Drive Time Indicated



Notes: Primary service area includes zip codes from which 60% of patients originate; secondary service area includes the next 25% of patients

Source: Greater Chesapeake Surgery Center, FY 2015 data

2. Need - Minimum Utilization for Establishment of a New or Replacement Facility.

An applicant proposing to establish or replace a hospital or ambulatory surgical facility shall demonstrate the need for the number of operating rooms proposed for the facility. This need demonstration shall utilize the operating room capacity assumptions and other guidance included in Regulation .06 of this Chapter. This needs assessment shall demonstrate that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the initiation of surgical services at the proposed facility.

(a) An applicant proposing the establishment or replacement of a hospital shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for inpatient and outpatient surgical procedures by the new or replacement hospital's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed new or replacement hospital by surgical specialty or operating room category; and

(iii) In the case of a replacement hospital project involving relocation to a new site, an analysis of how surgical case volume is likely to change as a result of changes in the surgical practitioners using the hospital.

(b) An applicant proposing the establishment of a new ambulatory surgical facility shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for outpatient surgical procedures by the proposed facility's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed facility by surgical specialty or, if approved by Commission staff, another set of categories; and

(iii) Documentation of the current surgical caseload of each physician likely to perform surgery at the proposed facility.

RESPONSE:

Not applicable, as this project involves the expansion of an existing facility. See Review Standard 3 below.

3. Need - Minimum Utilization for Expansion of An Existing Facility.

An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall:

(a) Demonstrate the need for each proposed additional operating room, utilizing the operating room capacity assumptions and other guidance included at Regulation .06 of this Chapter;

(b) Demonstrate that its existing operating rooms were utilized at optimal capacity in the most recent 12-month period for which data has been reported to the Health Services Cost Review Commission or to the Maryland Health Care Commission; and

(c) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the completion of the additional operating room capacity. The needs assessment shall include the following:

(i) Historic trends in the use of surgical facilities at the existing facility;

(ii) Operating room time required for surgical cases historically provided at the facility by surgical specialty or operating room category; and

(iii) Projected cases to be performed in each proposed additional operating room.

RESPONSE:

MedStar Health's strategic and organizational responses to the changing health care environment requires consolidation of physician offices in convenient locations as well as movement of ambulatory surgical cases from hospital settings to less costly alternatives. The existing ambulatory surgery center at GCSC cannot accommodate this planned growth. In fact, GCSC cannot operate at optimal capacity now. Ambulatory orthopedic cases increasingly require large operating rooms. The outdated facilities at the existing GCSC, such as the location of the electrical and mechanical room, prohibits any necessary redesign or expansion of the sterile core that would allow for operation at optimal capacity. Other issues prohibiting optimal use of the current GCSC include:

- Operating rooms in the current facility are of inadequate size and number to support anticipated growth in procedures such as joint replacement and spine cases.

- The procedure room is small and outdated and does not accommodate current technology.
- The facility accommodates only two pre-op beds and three-four post-op beds/chairs. This is inefficient as it prohibits more than one physician from performing a "full" case load simultaneously.
- The space for instrument and equipment cleaning and processing is insufficient to handle additional caseload.
- The location cannot accommodate the larger scale facility with physician's offices.

The expanded GCSC will serve the population of the Central Maryland region as shown in the patient origin of the existing ASC in Attachment 10. The demographics of this population are described in Attachment 11. Sg2 projections of orthopaedic growth in Central Maryland is 12.5% by 2020. Additional volume is assumed to come from a shift of 35% of outpatient orthopaedic cases currently performed on the MedStar Baltimore hospital campuses to the new ASC. This number is based on patient origin and drive time of 30 minutes to the new ASC. See also Attachment 12. The forecasted growth factor of 12.5% was also applied to this patient population.

In order to determine the optimal number of operating rooms needed to support expected growth, the following information was used:

- Total number of cases per year
- The average number of minutes per case including turnover based on current GCSC experience; and
- MHCC's OR utilization standard.

In FY 2020, Year 3 of implementation of the project, 3.8 ORs will be needed as shown below:

	FY 2018	**FY 2019**	**FY 2020**
Cases	3,334	3,846	4,160
Total Minutes (including turnover**)**	300,051	346,160	374,426
Minutes per Case (including turnover**)**	90	90	90
Capacity per OR	97,920	97,920	97,920
OR Need	3.1	3.5	3.8

The number of cases was derived through detailed analysis by MedStar Health leadership in consultation with physicians who currently practice at the GCSC and physicians who intend to move their cases to the new ASC. Letters of support from some of these physicians are included as Attachment 13. The following methodology supports the number of cases expected to be performed in the new ASC by 2020:

- Baseline volume for FY 2016 was used as the starting point for the analysis.
- Several volume growth assumptions were then layered on to the baseline volume including:
    - A forecasted 12.5% population-based volume growth by FY 2020 (2.4% annually) for orthopaedic surgery in central Maryland with additional impact factors taken into consideration. This methodology is a proprietary calculation by research company Sg2 and includes factors such as:
        - Population (e.g., population growth/decline and aging)
        - Epidemiology (e.g., changes in disease rates and impact of prevention measures)
        - Economics (e.g., unemployment rates)
        - Payment and policy (e.g., coverage expansion, cost sharing)
        - Innovation and Technology (e.g., new technology, shift in care delivery sites)
        - Systems of CARE (e.g., coordination and integration across sites of care)
        - Potentially Avoidable Admissions (e.g., volumes expected to shift to ambulatory settings)
    - An estimated 374 joint replacement and/or spine surgery cases are expected to shift from inpatient to outpatient over the next five years. This assumption is included in the market growth factor above. This shift may accelerate based on physician practice patterns and payor expectations.
    - Additional volume is assumed to come from a shift of 35% of outpatient orthopaedic cases currently performed on the MedStar Baltimore hospital campuses to the new ASC. This number is based on patient origin and drive time of 30 minutes to the new ASC. The forecasted growth factor of 12.5% was also applied to this patient population. See Attachment 12 for a drive time map and patient counts by hospital.
    - The remaining volume growth is projected to come from MedStar regional growth strategies including:
        - Enhanced integration of orthopaedics across the MedStar system;

- Increased enrollment in MedStar insurance products including MedStar Family Choice and MedStar Medicare Advantage;
- Reduced rates of MedStar employed primary care physicians referring patients outside of the MedStar system;
- Improved relationships between MedStar orthopaedic specialists and private referring physicians;
- Increased productivity of MedStar orthopaedic and spine surgeons based on consolidated office locations and less travel between the office, ASC and hospital; and
- Recruitment of new orthopaedic, pain management and spine surgeons to MedStar.

The following table details the projected volume methodology:

			Forecasted Volume Growth per Sg2 Impact of Change			
		FY 2016	2.4%	2.4%	2.4%	2.4%
		Outlook	FY 17	FY 18	FY 19	FY 20
GCSC Base Volumes	Total pain cases	441	452	462	474	485
	Total sports cases	741	759	777	796	815
	Total shoulder cases	199	204	209	214	219
	Total foot/ankle cases	368	377	386	395	405
	Total Cases	**1,749**	**1,791**	**1,834**	**1,878**	**1,923**
Shift from Hospital to ASC	Total cases	0	718	1,426	1,457	1,490
	Joints					
	Total cases	**0**	0	51	77	102
	Spine					
	Total cases	**0**	0	23	34	45
	Total Cases		**718**	**1,500**	**1,568**	**1,637**
Growth	**Total Cases**	**0**	**0**	**0**	**0**	**574**
	Grand Total Cases	**1,749**	**2,509**	**3,334**	**3,446**	**4,134**

4. Design Requirements.

Floor plans submitted by an applicant must be consistent with the current FGI Guidelines.

(a) A hospital shall meet the requirements in Section 2.2 of the FGI Guidelines.

(b) An ASF shall meet the requirements in Section 3.7 of the FGI Guidelines.

(c) Design features of a hospital or ASF that are at variance with the current FGI Guidelines shall be justified. The Commission may consider the opinion of staff at the Facility Guidelines Institute, which publishes the FGI Guidelines, to help determine whether the proposed variance is acceptable.

RESPONSE:

This project will be designed in accordance with section 3.7 of the 2006 FGI Guidelines for Outpatient Surgical Facilities and will meet the current Guidelines.

The proposed design for the new ambulatory surgery center at Timonium will employ the latest programming, planning and design elements to maximize adaptability, efficiency, patient safety and convenience, including:

- appropriately sized ORs that can accommodate a wide range of surgical cases, providing necessary space for instrumentation, equipment and maintaining the integrity of sterile fields
- properly zoned facilities that provide necessary dirty to clean to sterile movement for staff, instrument and supplies.
- adequately sized equipment storage areas, located to provide quick access to operatories and eliminating cluttering of hallways
- state-of-the-art mechanical and electrical systems, meeting all current guidelines for air exchanges, temperature and humidity control and emergency power capacity
- private pre and post-operative patient care stations that allow good separation between patient, staff and family areas
- Adequately sized staff areas, both in patient stations and in centralized stations with easy visibility to patient care stations to provide privacy.

5. Support Services.

Each applicant shall agree to provide as needed, either directly or through contractual agreements, laboratory, radiology, and pathology services.

RESPONSE:

Support services, offering comprehensive radiology, pathology and laboratory services, are currently available to GCSC via MedStar Union Memorial Hospital. All support services available at MUMH will likewise be available to augment patient care in the relocated ASC facility. Additionally, limited radiology and physical therapy services (per Health) will be available in MedStar's medical office building housing the new ASC.

6. Patient Safety.

The design of surgical facilities or changes to existing surgical facilities shall include features that enhance and improve patient safety. An applicant shall:

(a) Document the manner in which the planning of the project took patient safety into account; and

(b) Provide an analysis of patient safety features included in the design of proposed new, replacement, or renovated surgical facilities;

RESPONSE:

(a) Document the manner in which the planning of the project took patient safety into account; and

Certification and licensure – Patient safety is a hallmark of this project by replacing old, outdated operating rooms, and replacing them with an expanded state-of-the-art facility. (See also discussion at Review Standard B(3)). The surgery center will be Medicare certified and accredited by the American Association of Ambulatory Health Care (AAAHC). In addition, the proposed design for the new ambulatory surgery center at Timonium will employ the latest programming, planning and design elements to maximize adaptability, efficiency, patient safety and convenience, including:

- appropriately sized ORs that can accommodate a wide range of surgical cases, providing necessary space for instrumentation, equipment and maintaining the integrity of sterile fields
- properly zoned facilities that provide necessary dirty to clean to sterile movement for staff, instrument and supplies
- adequately sized equipment storage areas, located to provide quick access to operatories and eliminating cluttering of hallways
- state-of-the-art mechanical and electrical systems, meeting all current guidelines for air exchanges, temperature and humidity control and emergency power capacity
- private pre and post-operative patient care stations that allow good separation between

patient, staff and family areas

- Adequately sized staff areas, both in patient stations and in centralized stations with easy visibility to patient care stations to provide privacy.

(b) Provide an analysis of patient safety features included in the design of proposed new, replacement, or renovated surgical facilities;

Patient Safety – The new modern state of the art surgical center will be designed to the current codes and designed for best practices and will incorporate the latest technology and equipment for better outcomes. These improvements include larger square footage to accommodate new larger and more equipment that is needed for different procedures, additional power for new equipment, improved lighting, and improved environmental controls for both temperature and humidity. The facility is designed to incorporate Best Practice and progressive surgical planning strategies, including a variety of private and semi-private pre and post-operative patient care stations, responding to the specific needs of patients. Staff, support and sterilization functions are zoned to provide segregated access for patient, supplies and staff, creating efficient “dirty to clean” and “unrestricted to restricted” access and circulation.

7. Construction Costs.

The cost of constructing surgical facilities shall be reasonable and consistent with current industry cost experience.

(a) Hospital projects.

(i) The projected cost per square foot of a hospital construction or renovation project that includes surgical facilities 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.

(ii) 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:

1. The amount of the projected construction cost and associated capitalized construction cost that exceeds the Marshall Valuation Service® benchmark; and

2. Those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

(b) Ambulatory Surgical Facilities.

(i) The projected cost per square foot of an ambulatory surgical facility construction or renovation project shall be compared to the benchmark cost of good quality Class A 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.

(ii) If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost by 15% or more, then the applicant's project shall not be approved unless the applicant demonstrates the reasonableness of the construction costs. Additional independent construction cost estimates or information on the actual cost of recently constructed surgical facilities similar to the proposed facility may be provided to support an applicant's analysis of the reasonableness of the construction costs.

RESPONSE:

This project involves the renovation of leased space. The cost per square foot of this project is lower than the MVS benchmark for Outpatient Surgery Centers, as demonstrated below.

The following compares the project costs to the Marshall Valuation Service ("MVS") benchmark.

I. Marshall Valuation Service Calculation

Type	Outpatient (Surgical) Centers
Construction Quality/Class	A-B/Good
Stories	1
Perimeter	298
Height of Ceiling	14.00
Square Feet	2,380
Average floor Area	2,380
A. Base Costs	
Basic Structure	369.05
Elimination of HVAC cost for adjustment	0
HVAC Add-on for Mild Climate	0
HVAC Add-on for Extreme Climate	0
Total Base Cost	$369.05
B. Additions	
Elevator (If not in base)	$0.00
Other	$0.00
Subtotal	$0.00
Total	$369.05
C. Multipliers	
Perimeter Multiplier	1.1720368
Product	432.540181
Height Multiplier (plus/minus from 12')	1.046
Product	$452.44
Multi-story Multiplier (0.5%/story above 3)	1
Product	$452.44

D. Sprinklers	
Sprinkler Amount	-
Subtotal	$452.44
E. Update/Location Multipliers	
Update Multiplier	1.02
Product	$461.49
Location Multipier	1.01
Product	$466.10
New Construction Square Foot Cost Benchmark	**$466.10**
Adjustment for Renovation Only	68.39%
Final Square Foot Cost Benchmark	**$318.75**

Please note the "Adjustment for Renovation Only." MVS does not have a benchmark for conversion of shell space in a medical office building ("MOB") into an ambulatory surgical center. The 68.39% "Adjustment for Renovation Only" derives from an approach that MedStar's consultant (Andrew L. Solberg) on its MVS comparison did in the matter of Green Spring Station Surgical Center (Matter No. 15-03-2369). In that review, MHCC Staff asked Mr. Solberg to develop an approach for estimating an MVS benchmark for conversion of MOB space into an ASF. He did so, using the benchmarks for generic "Medical Office Buildings" and "Outpatient (Surgical) Centers."

He noted that in Section 87, page 8, MVS shows the "Budget Differential Costs by Department" (to which he refers to as Departmental Cost Differential Factors) for Hospitals (the only type of structure for which MVS supplies these factors). The area of the MOB in which this project will be located would be otherwise considered shell space (or, as MVS terms it on page 8, "Unassigned Space"). MVS estimates that the Departmental Cost Differential Factor for this kind of space is 0.5. Mr. Solberg assumed that the Departmental Cost Differentiation factor of 0.5 should be applied to the MVS benchmark for an MOB, to reflect the portion of the benchmark that reflected only the shell.

In order to calculate a benchmark for only the fitting out of shell space in a generic MOB into a

surgery center, Mr. Solberg subtracted the half the benchmark for Medical Office Building from the benchmark for Outpatient (Surgical) Centers to obtain the benchmark for the fitting out of the generic MOB as a generic surgery center. He then calculated the percentage that this comprised of the full benchmark and calculated that this was 68.39%. He then applied that percentage to the project-specific calculated full benchmark for Outpatient (Surgical) Centers to obtain that project's benchmark for renovation only. He has done the same thing in this project.

II. Cost of Renovation

A. Base Calculations	**Actual**	**Per Sq. Foot**
Building	$663,858	$278.93
Fixed Equipment	In Building	
Site Preparation	$0	$0.00
Architectural Fees	$20,000	$8.40
Capitalized Construction Interest	$0	$0.00
Permits	$7,000	$2.94
Subtotal	$690,858	$290.28

III. Comparison

A. Adjusted Project Cost/Sq. Ft.	$290.28
B. Final Square Foot Cost Benchmark	$318.75

8. Financial Feasibility.

A surgical facility project shall be financially feasible. Financial projections filed as part of an application that includes the establishment or expansion of surgical facilities and services shall be accompanied by a statement containing each assumption used to develop the projections.

(a) An applicant shall document that:

(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the likely service area population of the facility;

(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 facility or, if a new facility, the recent experience of similar facilities;

(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 facility, or, if a new facility, the recent experience of similar facilities; and

(iv) The facility 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 of initiating operations.

(b) A project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project may be approved upon demonstration that overall facility financial performance will be positive and that the services will benefit the facility's primary service area population.

RESPONSE:

GCSC will be financially viable as shown in Table 4 Revenue and Expenses. The calculations are based on fiscal year 2016 actual and projected volumes of the surgeons who will be performing surgery at the center and projected SG2 rate of orthopedic growth in Baltimore County (approximately 2.8% annually and then 2% for out years). Please see response to review standard B(3) above for additional information.

Projected case mix is estimated from the MedStar Ambulatory Services Fiscal Year 2016 Long Range Financial Forecast and is based on current case mix use of the orthopedic, spinal, joint and pain management cases with some additional growth in pain management cases.

Reimbursement rates are inflated based on guidance from MedStar Managed Care contracting experience. Rates used were 3.5% in year one, 3.0% in year 2 and then 2.0% thereafter.

Staffing and overall expenses are inflated based on MedStar Corporate Long Range Financial Forecast Guidelines, with some variability for consideration of the specific types of cases to be performed at this site.

The facility will generate excess revenues over total expenses (including debt service expense s and depreciation), if utilization forecasts are achieved for the specific services affected by the project within four years of initiating operations.

See list of assumptions below that were used in the revenue and expense projections:

- Revenue
    - Volumes are based on current case mix use of the orthopedic, spinal, joint and pain management cases with some additional growth in pain management cases.
    - Reimbursement rates are inflated based on guidance from MedStar Managed Care contracting experience. Rate increases used are 3.5% in year one, 3.0% in year 2 and then 2.0% thereafter.
    - Net Revenue includes contractual allowances, bad debt allowance and charity care estimates.
- Expenses
    - Salary and Wages are based on experience at Greater Chesapeake Surgical Center and on experience as to personnel needed for each staffing area. Rate of salaries is based on current experience and market rates.
    - Benefits are at 20% of salaries and comprise of payroll taxes and health insurance premiums.
    - Contractual Services include laundry and linens and waste removal. These costs are based on current experience and market rates for the purchase of these services in the market place.

- Interest on project debt is based on terms of the loan at 3.5% over 11 years with 132 equal installments.

- Project Depreciation is being depreciated over 11 years for leasehold improvements, over 6 years for equipment, over 5 years for information technology infrastructure and equipment, over 15 years for furniture and fixtures and over 11 years for signage (interior and exterior) and security.

- Supplies are based on project cost of $735 for ortho cases, $133 for pain cases, $1,553 for spine cases, $6,375 for joint cases and $45,673 for fixed office supply cost with inflation each year.

- Billing and Management Fees include Management Fees, Annual Coding Audit Fees, Miscellaneous Claim Fees (estimated at $2 per claim), Accounting Fees from MedStar Central Business Office, Tax Preparations Fees and MedStar Ambulatory Administrative Allocations.

- Risk Management expenses include professional and business fees and are based on current experience and market rates.

- Other expenses include bank fees, software license fees, marketing, license and credentialing fees and are based on MedStar experience.

- Facilities costs include rent of $28.00 per square foot, CAM of $.20 per square foot, real estate of $2.25 per square foot, utilities of $2.25 per square foot and other of $4.60 per square foot. Other includes administration of $1.60, janitorial of $.20, repairs & maintenance of $1.00, property management of $.80 and engineering payroll of $1.00, all based on square foot.

9. Preference in Comparative Reviews.

In the case of a comparative review of CON applications to establish an ambulatory surgical facility or provide surgical services, preference will be given to a project that commits to serve a larger proportion of charity care and Medicaid patients. Applicants' commitment to provide charity care will be evaluated based on their past record of providing such care and their proposed outreach strategies for meeting their projected levels of charity care.

RESPONSE: Not applicable.

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 discuss the need of the population served or to be served by the Project.

Responses should include a quantitative analysis that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. If the relevant chapter of the State Health Plan includes a need standard or need projection methodology, please reference/address it in your response. For applications proposing to address the need of special population groups, please specifically identify those populations that are underserved and describe how this Project will address their needs.

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. 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. List all assumptions made in the need analysis regarding demand for services, utilization rate(s), and the relevant population, and provide information supporting the validity of the assumptions.

Complete Tables 1 and/or 2 below, as applies.

[(INSTRUCTION: Complete Table 1 for the Entire Facility, including the proposed project, and Table 2 for the proposed project only using the space provided on the following pages. Only existing facility applicants should complete Table 1. All Applicants should complete Table 2. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY)]

RESPONSE:

TABLE 1: STATISTICAL PROJECTIONS - ENTIRE FACILITY by Fiscal Year

Table 1	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or **FY** (Circle)	2014	2015	2016*	2017	2018	2019	2020
8. Ambulatory Surgical Facilities							
a. Number of operating rooms (ORs)	2	2	2	2	4	4	4
● Total Procedures in ORs	Not available						
● Total Cases in ORs	1,389	1,412	1,749*	2,509	3,334	3,446	4,134
● Total Surgical Minutes in ORs**	110,895	100,739	99,631***	188,175	250,050	258,450	310,050
b. Number of Procedure Rooms (PRs)	0	0	0	0	0	0	0
● Total Procedures in PRs	0	0	0	0	0	0	0
● Total Cases in PRs	0	0	0	0	0	0	0
● Total Minutes in PRs**	0	0	0	0	0	0	0

Notes: *FY16 projected based on four months actual and eight months budget.
**Per MHCC guidelines, does not include turnover time.
***Annualized based on five months actual.

TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT
(INSTRUCTION: All applicants should complete this table.)

Table 2	Projected Years (Ending with first full year at full utilization)			
CY or **FY** (Circle)	2018	2019	2020	
8. Ambulatory Surgical Facilities				
a. Number of operating rooms (ORs)	4	4	4	
● Total Procedures in ORs	Not available			
● Total Cases in ORs	3,334	3,446	4,134	
● Total Surgical Minutes in ORs**	250,050	258,450	310,050	
b. Number of Procedure Rooms (PRs)	0	0	0	
● Total Procedures in PRs	0	0	0	
● Total Cases in PRs	0	0	0	
● Total Minutes in PRs**	0	0	0	

**Per MHCC guidelines, does not include turnover time.

The need for the additional surgical capacity is described above in response to review standard B(3). Other factors also require the changes described in this application. First, expanded ambulatory surgical capacity improves MedStar's ability to meet changing financial incentives. The requirements of Maryland's Medicare Waiver, and the Affordable Care Act, must be met by moving appropriate cases to a lower cost setting than hospital campuses. The need for this facility can also be described in terms of changing economic incentives, improved efficiency, quality and safety, access, and patient satisfaction.

The operating rooms at the Greater Chesapeake Surgery Center have been in use for over 20 years. The practice has seen significant growth at their Lutherville office and at their Harford County office. This generates further need for modern surgical capacity. The facility is now outdated and needs significant modernization. Moreover, there are several smaller MedStar Orthopaedic providers' offices scattered in the Towson, Lutherville, Timonium and Cockeysville area. Having multiple offices is inefficient for physicians' time as well as staffing. Today, physicians need to drive to multiple locations for office time and surgery days and staff is duplicated in multiple locations. A consolidated office will allow physicians to be more productive and for more efficient operations.

Five MedStar Orthopaedics offices along the York Road corridor will consolidate into one location in Timonium. MedStar currently has only one freestanding surgery center in the Central Maryland region, the Greater Chesapeake Surgery Center (GCSC) located in Lutherville. The current patient base is based on several groups of physicians who are now employed by MedStar Health. The largest proportions of patients are from central Baltimore County and Bel Air in Harford County (see response to review standard (B)1, above). These physicians have well-established MedStar practice sites in both areas and they are growing significantly. Moving to a larger facility is critical for MedStar to continue to support current growth and future growth of orthopaedics in the market in an efficient manner.

Expansion will allow consolidation of several smaller MedStar orthopaedic practices, accommodating system-wide organization and improve efficiency of providers through:

-less travel time between offices for consults and reduced travel between ASC and hospitals;

-consolidated staffing;

-improved workflow and patient convenience by offering relevant services such as physical therapy and imaging in the same facility; and

- use of the latest, state-of-art equipment and technology to provide the highest quality of care in a safe environment.

MedStar Health is investing in this new facility to improve the quality of care and experience for both patients and practicing physicians. The existing GCSC facility is outdated and needs to be replaced. The size and location of the existing facility prohibit that location from being a viable long-term solution. The new and expanded facility will allow MedStar Health to meet patient and physician expectations for quality and safety, and convenient access, including:

- An appropriate number of operating rooms to fit current and future types of procedures;
- Large, state-of-the art operating rooms (~ 450 SF) designed to accommodate modern equipment needs, supplies and storage, while maintaining minimal staff "traffic" within the rooms, thus reducing risk of infection and sterile field contamination;
- Sufficient support space to provide pre and post-operative care in an efficient and safe environment;
- Direct access from staff/physicians locker/lounge area to restricted core reduces potential for extraneous contamination into restricted areas;
- Direct access from pre-op to restricted corridor (OR's) as well as OR's to PACU assures expedited "flow" and maintenance of patient privacy;
- Mirrored Pre-op/PACU patient bay areas adjacent to central support care core- design facilitates operational efficiency and collaboration of patient care staff;
- The consolidated convenient location of ambulatory surgery plus physician's offices and other services immediately off Interstate 83; with a patient drop-off canopy and ample surface parking improves access as well as patient satisfaction.

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 project. It should also identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including the alternative of the services being provided by existing facilities.

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 cost 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 goal and objective achievement or the most effective solution to the identified problem(s) for the level of cost required to implement the project, when compared to the effectiveness and cost of alternatives including the alternative 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.

RESPONSE:

This project involves the expansion of the GCSC. As described above, consolidation of several provider's offices and expansion of the ASC will allow MedStar to manage these services more efficiently. The replacement and expansion are driven by the need to replace the old, outdated ASC, and the need to expand due to:

- improved facilities following replacement
- growth in the MedStar orthopedic services; and
- changing healthcare market needs to shift procedures to lower cost settings.

The following alternatives were considered by MedStar Health -

1. Status Quo
    a. Continuing with the current GCSC is not ideal for many reasons. It does not meet the need of the community in that it does not allow MedStar to provide high-quality care in an efficient and cost effective manner to its patients. MedStar

Health System has been looking for a way to move the kinds of cases that can be safely performed in a freestanding center to a lower cost setting that would satisfy patient preferences for receiving care at sites other than hospital campuses, and physician preferences to operate in a more efficient setting. Doing nothing would not help us achieve that goal and hence is rejected.

2. Shift GCSC cases to hospital outpatient surgery

    a. Closing GCSC or shifting overflow of surgical cases to a MedStar Hospital outpatient setting will shift the cases to higher cost setting and increase the load on already busy hospital outpatient ORs. Hence, this alternative is rejected.

    b. Newly implemented Medicare waiver and Affordable Care Act compel all providers to move the surgeries to lower cost setting such as ambulatory surgery center. MedStar intends to provide lower cost alternatives to continue to comply with reimbursement requirements.

3. Expand at existing GCSC

    a. Current GCSC site is limited from a space perspective and does not allow room for growth and expansion. Additionally, any renovation would be very costly to bring it up to the new codes and standards. Hence this alternative is rejected.

    b.

Project Goals	**Status Quo**	**Shift to Hospital OP**	**Expand at existing site**	**Timonium ASC**
Provide room for current volume and future growth	0	3	0	5
Improve access	0	0	3	5
Shift cases to lower cost setting	0	0	5	5
Provide comprehensive, coordinated Orthopaedic care	0	0	3	5
Create a state-of-art Orthopaedic Center of Excellence	0	3	3	5
Total Scores	0	6	14	25

Based on above criteria, the current project is the most cost effective alternative for meeting the goals.

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 Tables 3 and/or 4 below, as applicable. Attach additional pages as necessary detailing assumptions with respect to each revenue and expense line item.

RESPONSE:

Table 4 is completed below.

TABLE 3: <u>REVENUES AND EXPENSES - ENTIRE FACILITY</u> (including proposed project)

(INSTRUCTION: ALL EXISTING FACILITY APPLICANTS MUST SUBMIT AUDITED FINANCIAL STATEMENTS**)**

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
1. Revenue							
a. Inpatient services							
b. Outpatient services							
c. Gross Patient Service Revenue							
d. Allowance for Bad Debt							
e. Contractual Allowance							
f. Charity Care							
g. Net Patient Services Revenue							
h. Other Operating Revenues (Specify)							
i. Net Operating Revenue							

Table 3 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle	20___	20___	20___	20___	20___	20___	20___
2. Expenses							
a. Salaries, Wages, and Professional Fees, (including fringe benefits)							
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							

i. Supplies							
j. Other Expenses (Specify)							
k. Total Operating Expenses							
3. Income							
a. Income from Operation							
b. Non-Operating Income							
c. Subtotal							
d. Income Taxes							
e. Net Income (Loss)							

Table 3 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
4. Patient Mix: A. Percent of Total Revenue							
1. Medicare							
2. Medicaid							
3. Blue Cross							
4. Commercial Insurance							
5. Self-Pay							
6. Other (Specify)							
7. TOTAL	100%	100%	100%	100%	100%	100%	100%
B. Percent of Patient Days/Visits/Procedures (as applicable)							
1. Medicare							
2. Medicaid							
3. Blue Cross							
4. Commercial Insurance							
5. Self-Pay							
6. Other (Specify)							
7. TOTAL	100%	100%	100%	100%	100%	100%	100%

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

(INSTRUCTION: Each applicant should complete this table for the proposed project only)

	Projected Years (Ending with first full year at full utilization)			
CY or **FY** (Circle)	2018	2019	2020	2021
1. Revenues				
a. Inpatient Services				
b. Outpatient Services				
c. Gross Patient Services Revenue				
d. Allowance for Bad Debt				
e. Contractual Allowance				
f. Charity Care				
g. Net Patient Care Service Revenues				
h. Total Net Operating Revenue	$6,580,998	$7,283,214	$7,981,332	$8,276,273
2. Expenses				
a. Salaries, Wages, and Professional Fees, (including fringe benefits)	$2,010,226	$2,146,382	$2,266,939	$2,360,772
b. Contractual Services	$93,829	$102,059	$110,194	$116,246
c. Interest on Current Debt				
d. Interest on Project Debt	$72,870	$66,321	$59,539	$52,516
e. Current Depreciation				
f. Project Depreciation	$453,513	$907,027	$907,027	$907,027
g. Current Amortization				
h. Project Amortization				
i. Supplies	$2,597,411	$2,916,028	$3,250,369	$3,405,022
j. Other Expenses (Specify)	$987,221	$1,162,722	$1,197,829	$1,215,426
k. Total Operating Expenses	$6,215,070	$7,300,538	$7,791,896	$8,05,007

Under 2. Expenses, J. Other Expenses (Specify) include: Billing and Management Fees, Risk Management Fees (both Professional and Business), Facilities Fees and Other Expenses including Bank Fees, Software License Fees, Marketing, and Licensing & Credentialing.

- Complete Table L (Workforce) from the Hospital CON Application Table Package.

RESPONSE:

Please see Attachment 14 for Table L.

- Audited financial statements for the past two years should be provided by all applicant entities and parent companies to demonstrate the financial condition of the entities involved and the availability of the equity contribution. If audited financial statements are not available for the entity or individuals that will provide the equity contribution, submit documentation of the financial condition of the entities and/or individuals providing the funds and the availability of such funds. Acceptable documentation is a letter signed by an independent Certified Public Accountant. Such letter shall detail the financial information considered by the CPA in reaching the conclusion that adequate funds are available.

RESPONSE:

Please see Attachments 15 and 16 for audited financial statements.

- If debt financing is required and/or grants or fund raising is proposed, detail the experience of the entities and/or individuals involved in obtaining such financing and grants and in raising funds for similar projects. If grant funding is proposed, identify the grant that has been or will be pursued and document the eligibility of the proposed project for the grant.

RESPONSE:

The project budget for the addition of two operating rooms at Greater Chesapeake Surgical Center is $1,930,275. Approximately, $1,462,706 (75% of the total project budget) will be funded by a loan from MedStar Health. The loan will be amortized over 11 years at interest rate of 3.5% payable in 132 equal monthly installments. No grant or fund raising is proposed for this project.

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

RESPONSE:

See Attachment 13 for letters of support from several MedStar physicians involved in the project.

- Identify the performance requirements applicable to the proposed project (see question 12, “Project Schedule”) 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, obtaining State and local land use, environmental, and design approvals, contracting 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(s).

RESPONSE:

Given that the renovations for the GCSC relocation of two operating rooms will be underway when this expansion is approved, assuming prompt approval, there will be no need to stop the renovations and restart. A seamless efficient renovation will mean quick completion of the expansion. Our intent is that this expansion can be approved while the renovations for the relocation of GCSC are underway, saving MedStar Health, and the healthcare system, significant time and expense. The fitting out of two additional operating rooms under this assumption is anticipated to take approximately 7 months.

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 Maryland Certificates of Need that have been issued to the project applicant, its parent, or its affiliates or subsidiaries over the prior 15 years, including their terms and conditions, and any changes to approved Certificates that needed to be obtained. 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.

RESPONSE:

The following certificates of need were issued to MedStar Hospitals over the prior 15 years:

- 05-03-2173 – Franklin Square new addition
- 08-03-2250 – Franklin Square adolescent psych
- 03-24-2117 – Good Samaritan renovations
- 06-15-2186 – Montgomery General new addition
- 09-15-2293 – Montgomery General renovations
- 07-18-2225 – St. Mary's new addition
- 08-18-2248 – St. Mary's expansion and renovation

Copies of these CONs have been requested from MHCC.

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. 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, payer mix, access to service and cost to the health care delivery system including relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions. Provide an analysis of the following impacts:

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;

b) On the payer mix of all other existing health care providers that are likely to experience some impact on payer mix as a result of this project. If an applicant for a new nursing home claims no impact on payer mix, the applicant must identify the likely source of any expected increase in patients by payer.

c) 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);

d) On costs to the health care delivery system.

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

RESPONSE:

Impact to MedStar Hospital Volume - MedStar Health intends to progressively shift appropriate outpatient orthopaedic surgeries from outpatient hospital campuses to the new ambulatory surgery center. The total impact on the Baltimore based MedStar hospitals is 1,637 cases by FY 2020, or 3.2% of hospital surgical volume, averaging about six cases per day over four hospitals. The impact in FY 2020 is projected to be as follows:

- MedStar Franklin Square Medical Center – 396 cases or 2.0% of total cases
- MedStar Good Samaritan Hospital – 186 cases or 1.9% of total cases
- MedStar Harbor Hospital – 215 cases or 3.3% of total cases
- MedStar Union Memorial Hospital – 841 cases or 5.3% of total cases

As part of regional strategic planning, MedStar Health is already well underway with the development of MedStar Orthopaedics – a regional leader in orthopaedic and spine care. As a percentage of cases shifts off the hospital campuses as shown above, there are plans to continue MedStar's orthopaedic and spine inpatient growth through the recruitment of several orthopaedic and spine surgeons whose primary focus will be inpatient care. MedStar also anticipates continued inpatient growth of its cardiovascular program and associated inpatient surgeries.

Impact on Access to Health Care Services for the Service Area Population - The new ASC will provide more convenient access to needed and desired health care services for much of the service area population. Access to the Greenspring Drive location is convenient just off I-83 and there is abundant, free parking. For patients whose insurance companies are restricting use of regulated hospital-based facilities for certain procedures, the new ASC will improve access and reduce costs for patients with high deductibles and/or co pays.

Impact on Other Affected Providers - The additional cases will come from population growth, programmatic growth and some market share shifts. Based on referral data from MedStar employed physician practices, MedStar refers more than 300 patients outside of the system for orthopaedic care annually. The expectation is that many of these patients will be able to receive care within the system once the new orthopaedic center is open. Of the more than 300 referrals leaving the system, more than half are going to various small pain management centers. The remainder are spread among local hospitals including 8% to Johns Hopkins Health System, 8% to GBMC, 7% to LifeBridge, 7% to Mercy, 1% to St. Agnes, and 11% to University of Maryland Medical Center. These hospitals/systems would lose less than 10 referrals each.

Impact on payer mix at other facilities - Because the impact on volume at other facilities will be negligible, as shown above, the expected impact on payer mix is too.

Impact on costs to the health care delivery system - Shifting ambulatory surgery cases from the hospital setting to the freestanding setting responds to reimbursement incentives to reduce costs to the health care system and patients.

Attachment 1

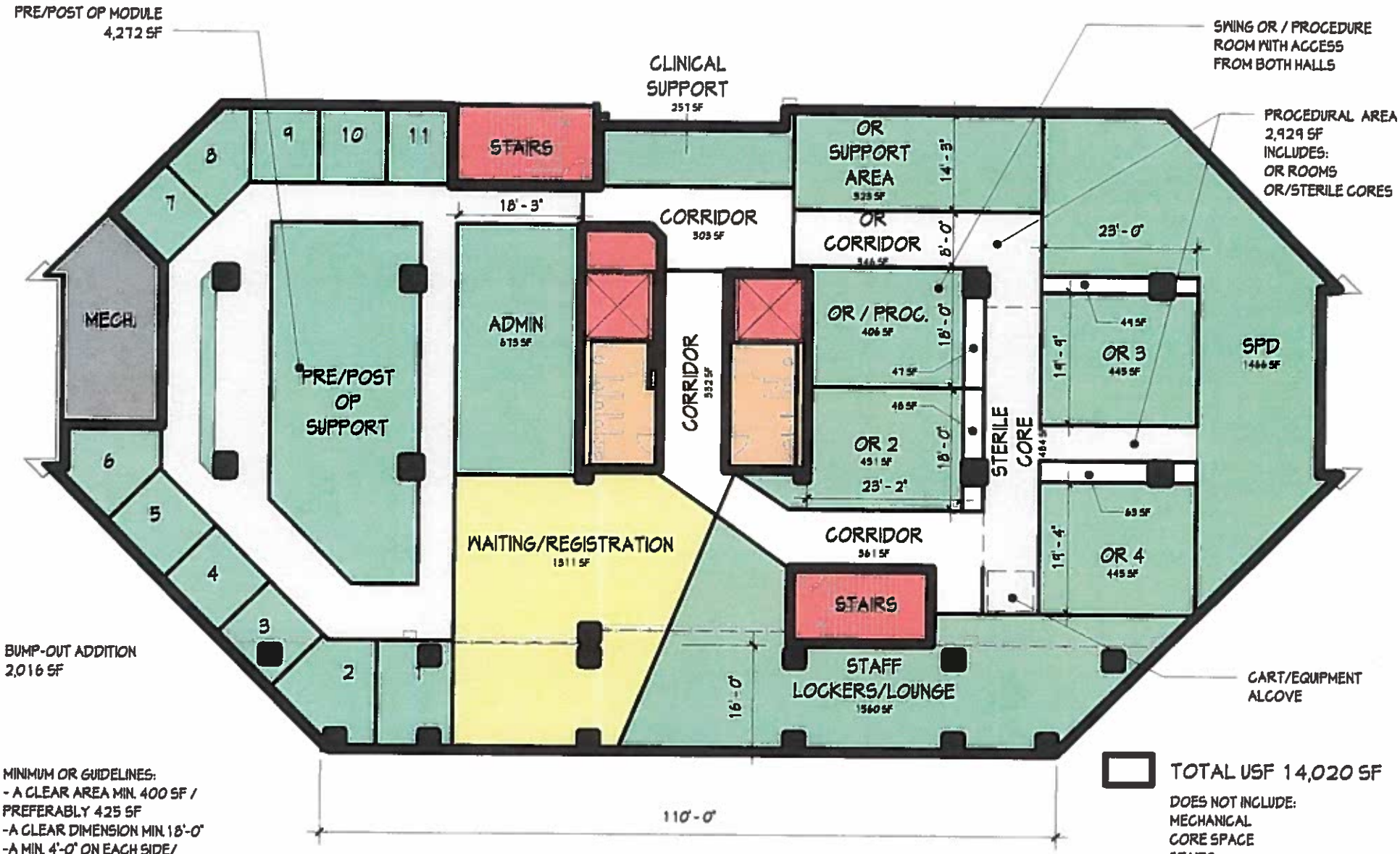
Greater Chesapeake Surgery Center
Current Ownership

Attachment 1 – GCSC Ownership

Member	Percentage Membership Interest
MedStar Ambulatory Services, Inc.	51.00%
Leslie S. Matthews, M.D.	9.924%
John B. O'Donnell, M.D.	9.924%
All other owners <5%	

Attachment 2

Concept Drawings



MedStar Health

MedStar Orthopaedic & Sports Medicine Clinic Center of Excellence

11/23/2015

USF Plan - Option 2 - 4 ORs

1" = 20'-0"

TRINITY

Attachment 3

Tables C & D

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		2,380
Fourth Floor		
Average Square Feet		**2,380**
Perimeter in Linear Feet	**Linear Feet**	
Basement		
First Floor		
Second Floor		
Third Floor		298' 0"
Fourth Floor		
Total Linear Feet		**298'0"**
Average Linear Feet		**298'0"**
Wall Height (floor to eaves)	**Feet**	
Basement		
First Floor		
Second Floor		
Third Floor		14' 0"
Fourth Floor		
Average Wall Height		**14'0"**
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger		2
Freight		
Sprinklers	**Square Feet Covered**	
Wet System		2,380
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project	dedicated air cooled chiller, dedicated outside air hest recovery system, and gas fired humidification system	
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		
Utilities from Structure to Lot Line		$30,000
Subtotal included in Marshall Valuation Costs		
Site Demolition Costs		
Storm Drains		
Rough Grading		
Hillside Foundation		
Paving		
Exterior Signs		$0
Landscaping		
Walls		
Yard Lighting		
Other *(Specify/add rows if needed)*		
Subtotal On-Site excluded from Marshall Valuation Costs		**$0**
OFFSITE COSTS		
Roads		
Utilities		$0
Jurisdictional Hook-up Fees		
Other *(Specify/add rows if needed)*		
Subtotal Off-Site excluded from Marshall Valuation Costs		**$0**
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.

Attachment 4

Table E - Project Budget

TABLE E. PROJECT BUDGET

Greater Chesapeake Surgery Center Expansion

A. USE OF FUNDS	
1. CAPITAL COSTS	
a. Land Purchase	$0
b. New Construction	
(1) Building	$0
(2) Fixed Equipment	$0
(3) Site and Infrastructure	$0
(4) Architect/Engineering Fees	$0
(5) Permits (Building, Utilities, Etc.)	$0
SUBTOTAL	**$0**
c. Renovations	
(1) Building	$663,858
(2) Fixed Equipment (not included in construction)	$0
(3) Architect/Engineering Fees	$20,000
(4) Permits (Building, Utilities, Etc.)	$7,000
SUBTOTAL	**$690,858**
d. Other Capital Costs	
(1) Movable Equipment	$1,200,000
(2) Contingency Allowance	$47,775
(3) Gross interest during construction period	
(4) Other *(Specify/add rows if needed)*	$0
SUBTOTAL	**$1,247,775**
TOTAL CURRENT CAPITAL COSTS	**$1,938,633**
e. Inflation Allowance	$11,642
TOTAL CAPITAL COSTS	**$1,950,275**
2. Financing Cost and Other Cash Requirements	
a. Loan Placement Fees	$0
b. Bond Discount	$0
c. Legal Fees	$0
d. Non-Legal Consultant Fees	$0
e. Liquidation of Existing Debt	$0
f. Debt Service Reserve Fund	$0
g. Other *(Specify/add rows if needed)*	$0
SUBTOTAL	**$0**
3. Working Capital Startup Costs	$0
TOTAL USES OF FUNDS	***$1,950,275***
B. Sources of Funds	
1. Cash	$487,569
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 *(Loan from MedStar Health)*	$1,462,706
Other *(Landlord Tenant Improvement Allowance)*	$0
TOTAL SOURCES OF FUNDS	**$1,950,275**
Annual Lease Costs (if applicable)	
1. Land	$0
2. Building	$601,052
3. Major Movable Equipment	$0
4. Minor Movable Equipment	$0
5. Other *(Specify/add rows if needed)*	$0

Attachment 5

Financial Assistance Policy

GREATER CHESAPEAKE SURGERY CENTER
FINANCIAL ASSISTANCE POLICY AND PROCEDURE

SUBJECT: Financial Assistance

POLICY: Greater Chesapeake Surgery Center is committed to providing quality health care for all patients regardless of their ability to meet the associated financial obligations and without discrimination on the grounds of race, color, national origin or creed. Eligibility for free or reduced fee services will be limited to those persons whose income meets the income guidelines published in the Federal Register. All medically necessary care is covered under the program. Purely elective and/or cosmetic surgery is not covered. Discounts are applied as outlined in the Federal Register and the Greater Chesapeake Surgery Center Income Eligibility Guidelines.

FINANCIAL ELIGIBILITY CRITERIA - Criteria will be based on gross family income of the patient and/or responsible party. Exemption allowance will be deducted for each person living on the gross family income. Annual income criteria used will be 200% of the current poverty guidelines published in the Federal Register. Some persons may exceed established income levels but still qualify for charity services when additional factors are considered. Other financial information such as assets and liabilities will be considered under this policy.

INCOME - Gross income, refers to money wages and salaries from all sources before deductions. Income also refers to social security payments, veteran's benefits, pension plans, unemployment and workmen's compensation, trust payments, child support, alimony, public assistance, strike benefits, union funds, training stipends, income from rent, interest and dividends or other regular support from any person living in the home or outside of the home. Also included as regular income is 100% of all liquid assets (i.e. certificates of deposit, stock, bonds, money market funds, etc.).

ASSETS - Real and chattel property may be evaluated for inclusion as regular income.

COVERAGE - All other resources will first be applied including Medicaid, before the discount adjustment will be given. The individual must apply for available medical assistance funds as appropriate in each individual case.

APPLICATION REQUIREMENTS - Patients requesting a discount must apply prior to treatment. Sliding fee applications will not be considered for accounts final billed and aged in accounts receivable, unless there are extenuating circumstances. Requests for sliding fee discounts ***will not*** be considered for patients who are in bad debt and did not respond to collection activity or statements prior to write-off of account.

> **NOTE:** *During the application process, one or more of the following specific documents must be submitted to gain sufficient information to verify income for each employed family member.*

a. Payroll stub or letter from employer verifying gross income
b. W2
c. Social Service Ward letters, letter from Federal or State agency indicating the amount of assistance received
d. Copy of most recently filed federal income tax return.
e. Proof of other income for all persons living in the household

APPROVAL - Every effort will be made to identify a patient's qualifications at or prior to time of admission and/or service. However, it is recognized that there will be cases in which accurate determinations at time of admission are not possible and that events may occur subsequent to service which may affect a patient's ability to pay.

Patients scheduling surgeries at the Center that have no medical insurance and are requesting special fees, will be referred to the Medical Director and/or Facility Administrator.

PROCEDURE:

1. The Medical Director and/or Facility Administrator will consider alternatives for the patient, (i.e, is the patient eligible for other coverage such as Medical Assistance or other special programs?)

2. The Medical Director and/or Facility Administrator will inform the patient of the sliding fee scale (See Attachment) and will ask the patient about family income to determine eligibility.

3. The Medical Director and/or Facility Administrator will work with the patient to complete the request for sliding fee schedule with supporting documentation attached.

4. The Medical Director and/or Facility Administrator will determine how many family members are dependent on the income covered by patient and if there is additional income in the family.

5. The Medical Director and/or Facility Administrator will submit the application along with the documentation to the Administrator/Patient Accounts manager for approval.

   NOTE: If the patient's request has not been approved prior to the scheduled surgery, the surgery will have to be rescheduled. However, if the patient's medical condition requires immediate attention, they will be seen this visit only at the sliding fee rate. They will be requested to bring any missing information to the Center within seven (7) days. If the information is not received within this time frame, the patient will be billed for the balance of the entire fee.

6. The Medical Director and/or Facility Administrator or designee will make a determination of *probable* eligibility for charity care within two business days following a patient's completed request for assistance.

7. If the application meets the income guidelines, it will be approved and the discount amount will be assigned.

8. Notify the patient with the results of the application review.

9. Advise the patient of the discount amount and remind them that the balance of the charges (if applicable) will be due at the time of surgery.

10. Give the patient a copy of the sliding fee application to present when receiving other services.

11. Enter the discount amount into the computer system and store the approved application and documentation in a discount approval file.

12. The patient's financial status should be assessed at each visit.

13. The Medical Director and/or Facility Administrator or designee will inform the public of the availability of financial assistance through the following means: make a copy of this policy available to all patients, post a notice of this policy in the registration/business office areas of the surgery center; and annually publish a notice in a local newspaper in a format understandable by the service area population.

NOTE: *This information is considered confidential and will only be accessed by authorized personnel.*

Approved by:

_____

Attachment 6

Accreditation and Licensure Documents

AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY SURGERY FACILITIES, INC.
Medicare ASC • Medicare RHC • Medicare RA/OPT • ASF Surgical • ASF Oral Maxillofacial • ASF Procedural
ACCREDITATION OFFICE: 5101 Washington Street, Suite 2F • P.O. Box 9500, Gurnee, Illinois 60031 • Toll Free 1-888-545-5222
Phone 847-775-1970 • Fax 847-775-1985 • E-mail: reception@aaaasf.org • Web Site: www.aaaasf.org

11/30/2015

Final Accreditation Decision Letter

Director: Richard G. Levine M.D.

Thank you for participating in this important quality assurance and patient safety process administered by the American Association for Accreditation of Ambulatory Surgery Facilities. The following report contains information relevant to the conclusion your recent accreditation survey process including your facility accreditation demographic information, accreditation decision, and recent survey history. Please note that AAAASF requires that all standards be met in order to achieve accreditation and that 100% compliance must be maintained at all times. AAAASF reserves the right to conduct additional surveys to validate the findings of previous surveys and to ensure continued compliance with standards.

Attached you will find a report containing all of the deficiencies cited during the accreditation survey along with the corrective action plans submitted to AAAASF. The Final Accreditation Decision based on the findings and corrective action taken in response to your recent survey process is Full.

Survey Details Below

Survey: 13817

Program AAAASF Surgical

DBA:

Mailing: Greater Chesapeake Surgery Center

1212 York Road Suite B101

Lutherville, MD 21093

United States

Accreditation Decision: Full

Facility Number: 3723

Survey Type: Full Accreditation Survey

Request Type: Re-Survey

Survey Begin: 11/23/2015

Survey End: 11/23/2015

Expiration Date: 1/12/2019

Follow-up Method:

Plan of Correction Time Frame:

Recertification Survey Information:

Effective Date of Accreditation: 1/12/2016

11/30/2015

Final Accreditation Decision Letter

Recent Survey History:

Survey	Survey Description	Survey Type	Deficiencies	Corrected	Decision
13817	Full Accreditation Survey	Re-Survey	0		Full

Facility:

Greater Chesapeake Surgery Center 1212 York Road Suite B101 Lutherville, MD 21093 United States

Sincerely,

Thomas S. Terranova, MA
Director of Accreditation

American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

presents this certificate to

Greater Chesapeake Surgery Center

for having met the standards of a CLASS C ambulatory surgery facility in which major surgical procedures are performed under intravenous Propofol or general anesthesia with external support of vital organs.

AAAASF President

Foad Nahai, MD

Foad Nahai

Secretary/Treasurer

Lawrence S. Reed, MD

Lawrence S. Reed

Certified from 1/12/2016 to 1/12/2017

Certification Number 3723

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

July 23, 2014

Barbara Chandler, RN
Greater Chesapeake Surgery Center
1212 York Road
Building B, Suite 101
Lutherville, MD 21093

RE: ACCEPTABLE PLAN OF CORRECTION

Dear Ms. Chandler:

We have reviewed and accepted the Plan of Correction submitted as a result of a recertification survey completed at your facility on June 12, 2014.

Please be advised that an unannounced follow-up visit may occur prior to the standard survey to ensure continual compliance.

If there are any questions concerning this notice, please contact this Office at 410-402-8040.

Sincerely,

Barbara Fagan, Program Manager
Ambulatory Care Programs
Office of Health Care Quality

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

September 23, 2014

Ms. Barbara Chandler, RN
Greater Chesapeake Surgery Center
1212 York Road Bldg B Suite 101
Lutherville, MD 21093

PROVIDER #: 21C0001057
RE: ACCEPTABLE PLAN OF CORRECTION

Dear Ms. Chandler:

We have reviewed and accepted the Plan of Correction submitted as a result of a **LIFE SAFETY CODE SURVEY** completed at your facility on July 29, 2014. We are accepting your plan of correction including the date by which the deficiencies will be corrected as well as the addtional evidence you have submitted to ensure that the deficiencies do not recur, and conclude that you have achieved compliance with the Life Safety Code requirements as of September 22, 2014.

Please be advised that an unannounced follow-up visit may occur prior to the standard survey to ensure continual compliance.

If there are any questions concerning this notice, please contact Debra Munford at (410) 402-8078.

Sincerely,

Debra Munford
Health Facilities Survey Coordinator
Office of Health Care Quality

cc: File

STATE OF 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. A1057

Issued to: Greater Chesapeake Surgery Center, LLC
1212 York Road Bldg B Suite 101
Lutherville, MD 21093

Type of Facility or Community Program: **AMBULATORY SURGICAL CENTER**

Date Issued: June 16, 2015

SPECIALTIES: Orthopedic and Pain Management

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, Title 19 Annotated Code of Maryland, including all applicable rules and regulations promulgated there under. This document is not transferable.

Expiration Date: June 16, 2018

Patricia Tomaskin Gray MD

Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

Attachment 7

Transfer Agreements

Patient Transfer Agreement
By and Between
University of Maryland St. Joseph Medical Center, LLC
and
Greater Chesapeake Surgery Center, LLC

THIS PATIENT TRANSFER AGREEMENT (this "Agreement") is entered into and is effective as of the latest date(s) set forth on the signature lines below (the "Effective Date") and is by and between University of Maryland St. Joseph Medical Center, LLC ("Receiving Facility") and Greater Chesapeake Surgery Center, LLC ("Transferring Facility").

WHEREAS, both Receiving Facility and Transferring Facility desire, by means of this Agreement, to insure continuity of care and treatment appropriate to the needs of patients in Receiving Facility, and at Transferring Facility, utilizing the knowledge and other resources of both in a coordinated and cooperative fashion to improve the care of patients.

NOW THEREFORE, in consideration of the promises, and the mutual covenants and agreements hereinafter contained, the parties hereto agree as follows:

1. AGREEMENTS OF TRANSFER

A. Receiving Facility. Receiving Facility agrees to accept the transfer of patients from Transferring Facility in accordance with the terms of this Agreement.

B. Transferring Facility. Transferring Facility agrees to effect transfers of patients to Receiving Facility in accordance with the terms of this Agreement.

2. CONDITIONS OF TRANSFER

A. Patient Transfers. The decision to transfer a patient will involve the attending physician, the patient (and his/her representatives, as appropriate), Transferring Facility and Receiving Facility in accordance with this Agreement. The need for the transfer of a patient from Transferring Facility to Receiving Facility shall be determined by the patient's treating/attending physician in his/her independent professional judgment. When the determination is made that a transfer is appropriate, Transferring Facility shall immediately inform Receiving Facility of the impending transfer. Receiving Facility agrees to admit the patient as promptly as possible, provided that all conditions of eligibility for admission are met and bed space is available to accommodate the patient. Prior to transferring the patient, Transferring Facility must receive confirmation from Receiving Facility that it can accept the patient.

B. Transfer Consent. Transferring Facility shall have responsibility for obtaining

consent from the patient (or, if applicable, from the patient's authorized representative) to the transfer in accordance with all applicable law. Nothing in this Agreement shall restrict a patient's freedom of choice to choose to be transferred to an institution other than Receiving Facility.

C. Transportation of Patient. Transferring Facility shall have the responsibility for arranging transportation of the patient to Receiving Facility, including the selection of the mode of transportation at the appropriate level of care for the patient. Until the patient is admitted to Receiving Facility, Receiving Facility shall have no responsibility for the patient's care.

D. Provision of Information. The parties agree to provide each other with the names or classifications of persons authorized to initiate, confirm, and accept the transfer of patients on behalf of the other.

E. Patient Records. The parties agree to utilize appropriate and mutually acceptable forms to appropriately document pertinent medical and administrative information, which records shall accompany a patient being transferred from Transferring Facility to Receiving Facility. The information shall include the following patient information:

(i) Patient's name, address, age;

(ii) Name, address, and telephone number of patient's guardian, authorized agent or surrogate decision-maker;

(iii) Any information available to Transferring Facility concerning advance directives of the patient;

(iv) Patient's third party billing data;

(v) History and physical;

(vi) Discharge summary;

(vii) All operative and treatment reports;

(viii) Current care plan;

(ix) Name, address, and phone number of physician referring the patient;

(x) Name of physician in Receiving Facility to whom the patient is to be transferred;

(xi) Name of physician at Receiving Facility who has been contacted about patient; and

(xii) Any other information necessary to continue the patient's treatment without interruption, including the maintenance of the patient during transport and treatment of the patient upon arrival at Receiving Facility.

F. Property of Patient. The parties agree to utilize appropriate and mutually acceptable forms to inventory a patient's personal effects and valuables, which form shall accompany the patient during transfer. Each party also agrees to appropriately safeguard the patient's property in accordance with its policies.

G. Outpatient Diagnostic Services. Receiving Facility agrees to permit the transfer of patients from Transferring Facility for the purpose of receiving diagnostic services ordered by a physician in the outpatient department(s) of Receiving Facility. Transferring Facility will provide patient care personnel to accompany any patient transferred to Receiving Facility under this section.

H. Billing. Receiving Facility and Transferring Facility agree that the party that directly renders services to a patient shall bill and collect for its services from the patient, third party insurance coverage, or other sources typically billed by such party. Neither Receiving Facility nor Transferring Facility shall have any liability to the other party for such charges; provided, however, that Receiving Facility may bill Transferring Facility directly if Transferring Facility assumes responsibility for payment to Receiving Facility, for the reasonable cost of any emergency or outpatient services performed by Receiving Facility for patients of Transferring Facility, if such services are not payable to Receiving Facility under the terms of any third party insurance coverage.

I. Utilization Review. Transferring Facility and its Medical Director shall fully cooperate with the Utilization Review activities of Receiving Facility.

3. TERM

A. The initial term of this Agreement shall be for a period of one year commencing on the Effective Date and terminating on the first anniversary thereof, unless terminated earlier in accordance with the terms hereof.

B. After the initial term, this Agreement shall automatically continue in effect (with the initial term, as thus extended, the "Term"), on the then current terms and conditions of the Agreement until the Agreement is terminated by either party in accordance with the terms hereof.

C. Either party may terminate this Agreement, with or without cause, upon sixty (60) days' advance written notice to the other party. However, if either party shall have its license to operate revoked by the State of Maryland, or lose its certification, this Agreement shall terminate on the date that such revocation becomes effective.

4. INSURANCE AND INDEMNIFICATION

A. Insurance. Each party shall, at its sole cost and expense and at all times during the term of this Agreement, procure and maintain professional liability insurance coverage (including personal injury, property damage, and products liability) applicable to its performance and the performance of its employees and agents hereunder, in a minimum amount of One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate. At the other party's request, a party shall deliver to the other party documentation confirming the required insurance coverages. The foregoing requirement that a party procure insurance shall not be construed as in any manner limiting the extent to which a party has agreed to defend, indemnify, protect, and hold harmless the other party, its officers, directors, affiliates, employees, and agents pursuant to this Agreement.

B. Indemnification. Each party shall indemnify and hold the other party, it officers, employees and agents harmless from and against any and all liabilities, losses, claims, damages, awards, penalties, or injuries, including reasonable attorney's fees, resulting from or arising out of the activities to be carried out pursuant to the obligations of this Agreement, but only in proportion to and to the extent such liability, loss, expense, attorneys fees, or claims for injury or damages are caused by or result from the negligent acts or omissions of the indemnifying party, its officers, agents or employees; provided that the indemnifying party is promptly notified of any such claims. The indemnifying party shall have the sole right to defend such claims at its own expense. The other party shall provide, at the indemnifying party's expense, such assistance in investigating and defending such claims as the indemnifying party may reasonably request. This indemnity shall survive the termination of this Agreement.

5. GENERAL

A. Independent Contractors. In the performance by each party of its obligations pursuant to this Agreement, each party and all of its employees and agents shall be, and will remain at all times, independent contractors, and nothing herein contained shall be construed to create or establish a partnership, joint venture, or any other business relationship between the parties other than that of independent contractors.

B. Compliance with Law. Each party shall comply with, and shall ensure that its employees, agents, representatives and contractors (excluding the other party) comply with, all applicable laws in its/their performance of this Agreement.

C. Advertising and Public Relations. Neither party shall use the name of the other in any promotional or advertising material unless the party whose name is to be used first reviews and approves the intended promotion or advertisement. The parties shall deal with each other in good faith, and each

party shall maintain good public and patient relations and efficiently handle complaints and inquiries with respect to transferred or transferring patients.

D. Non-Exclusive Agreement: No Obligation to Refer. Nothing in this Agreement shall be construed as limiting the rights of either party to affiliate, contract or enter into a transfer agreement with any other facility or entity. In addition, nothing in this Agreement shall require either Receiving Facility or Transferring Facility to refer or transfer any patient to the other for care, items or services.

E. Anti-Fraud and Abuse. Nothing in this Agreement shall be construed as an offer or payment by one party to the other party or any affiliate of the other party of any remuneration, whether directly or indirectly, overtly or covertly, intended to induce or encourage patient referrals or for recommending or arranging the purchase, lease or order of any item or service.

F. Nondiscrimination. The parties agree that the transfer of a patient pursuant to this Agreement shall not be predicated upon discrimination based on race, religion, national origin, age, sex, physical condition or economic status. The parties also agree that the transfer or receipt of patients shall not be based upon a patient's inability to pay for services rendered by the transferring or receiving institution or a patient's source of payment.

G. HIPAA Compliance. Neither Receiving Facility nor Transferring Facility is serving in the capacity of a "business associate" (as defined under 45 C.F.R. Sec. 164.501) of the other party in the performance of services hereunder. Nevertheless, both parties agree to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Sec. 1302d ("HIPAA") and any current and/or future regulations promulgated thereunder including, without limitation, the federal privacy regulations contained in 45 C.F.R., Parts 160 and 164, the federal security standards contained in 45 C.F.R, Part 142, and the federal standards for electronic transactions contained in 45 C.F.R., Parts 160 and 162, all collectively referred to herein as "HIPAA Requirements"). Each party agrees not to use or disclose any protected health information (as defined in 45 C.F.R Sec. 160.103) other than as permitted by HIPAA Requirements.

H. Notices. All notices hereunder shall be in writing, and shall be delivered by hand, sent by a courier service or mailed, postage prepaid, registered, or certified mail receipt requested to the addresses set forth on the signature lines hereto, which may be changed at any time by any party in accordance with this notice provision. Any notice hereunder shall be deemed given five (5) business days after mailing, if given by mailing in the manner provided above, or on the date delivered or transmitted if given by hand or courier service.

I. Assignment. The parties shall not assign or otherwise transfer any responsibilities due under the Agreement without the express written consent

of the other party.

J. Ethical and Religious Directives. Transferring Facility agrees that its performance under this Agreement shall be in accordance with the Ethical and Religious Directives for Catholic Health Care Services, Fifth Edition, as promulgated by the United States Conference of Catholic Bishops, as amended from time to time, and as interpreted by the local bishop (the "Directives"). As of the Effective Date, the Directives are available at the following website: http://www.usccb.org/about/doctrine/ethical-and-religious-directives/. In the event that Receiving Facility determines in good faith that Transferring Facility has failed to comply with its your obligations under this Section, Transferring Facility shall be considered to be in material breach of this Agreement.

K. Waiver. No waiver by either party of any breach or default in performance by the other party, and no failure, refusal or neglect to exercise any right, power or remedy given to either party hereunder or to insist upon strict compliance with or performance of all obligations under this Agreement, shall constitute a waiver of the provisions of this Agreement with respect to any subsequent breach or a waiver by such party of its right at any time thereafter to require exact and strict compliance with the provisions of this Agreement.

L. Severability. The invalidity or unenforceability of any particular provision of this Agreement shall not affect the other provisions hereof, and this Agreement shall be construed in all respects as if such invalid or unenforceable provisions were omitted.

M. Construction; Counterparts. The headings used herein are for convenience only and the parties agree that such headings are not to be construed to be party of this Agreement or to be used to determine the meaning or interpretation of this Agreement. This Agreement may be executed in any number of counterparts, each of which shall be considered an original and all of which taken together shall constitute one and the same instrument.

N. Governing Law; Binding Agreement. This Agreement shall be governed by, and construed in accordance with, the laws of the jurisdiction of Receiving Facility. This Agreement shall inure to the benefit of and shall be binding on Receiving Facility and Transferring Facility and their respective successors and permitted assigns.

O. Legal Costs. In the event of judicial or other legal action(s) to enforce this Agreement, the party prevailing in such action shall be entitled to collect from the other party all of the costs and expenses (including reasonable attorneys' fees) of such action.

P. Entire Agreement; Modifications; Changes in Law. This Agreement constitutes the complete understanding of the parties with respect to the subject matter hereof and supersedes any and all other agreements, either oral or in writing between the parties hereto with respect to the subject matter

hereof, and no other agreement, statement, or promise relating to the subject matter of this Agreement that is not contained herein shall be valid or binding. Any amendments or modifications to this Agreement shall be of no force and effect unless in writing and signed by both Transferring Facility and Receiving Facility.

IN WITNESS WHEREOF, the parties have caused this Agreement to the executed, under seal, by their duly authorized officers as of the day and year first written above.

RECEIVING FACILITY
FACILITY

By: Carl Cunningham

Carl Cunningham
Name

CMO/VPMA
Title

12/22/14
Date

Address:
UM-St. Joseph Medical Center
7601 Osler Drive
Towson, MD 21204

TRANSFERRING

By:

Richard Levine
Name Richard Levine, MD

Medical Director
Title

1-13-15
Date

Address:
GCSC
1212 York Rd
Bldg B-101
Lutherville MD 21093

MedStar Union
Memorial Hospital

201 E. University Parkway
Baltimore, MD 21218
410-554-2260 PHONE
410-554-2652 FAX
unionmemorial.org

Stuart B. Bell, MD
Vice President, Medical Affairs

Administration

February 11, 2015

Barbara Chandler, BSN, RN
1212 York Road, Suite B-101
Lutherville, MD 21093

Dear Barbara,

Attached please find one original fully executed copy of the Patient Transfer Agreement between MedStar Union Memorial Hospital and Greater Chesapeake Surgery Center, LLC.

If you have any questions, please do not hesitate to contact me at 410-554-2260.

Sincerely,

Stuart B. Bell, M.D.
Vice President, Medical Affairs

PATIENT TRANSFER AGREEMENT

THIS PATIENT TRANSFER AGREEMENT ("Agreement"), made and entered into this 19 day of January 2015, by and between the Union Memorial Hospital ("Hospital") and Greater Chesapeake Surgery Center ("Facility").

WITNESS

The Hospital is a nonprofit corporation that operates a hospital to provide access to patient care for the residents of its service area.

The Hospital and Facility have determined that it would be in the best interest of patient care and would promote the optimum use of both facilities to enter into a transfer agreement for the transfer of patients for emergency medical services from the Facility to the Hospital.

Now, therefore, in consideration of the mutual covenants and agreements contained in this Agreement, and for other valuable consideration, the receipt and sufficiency of which is acknowledged, Hospital and Facility agree as follows:

1. Term. This Agreement shall commence on the day and year first above written and shall continue for a period of one year, and after that time it shall be renewed automatically for successive period of one (1) year, unless sooner terminated as provided for in this Agreement.

2. Purpose of Agreement. The Facility agrees to transfer to the Hospital and, within its capability, the Hospital agrees to receive from the Facility, patients in need of emergency hospital care.

3. Patient Transfer. The need for transfer of a patient from the Facility to the Hospital shall be determined by the patient's attending physician. When a transfer determination has been made, the Facility shall immediately notify the Hospital of the impending transfer. Prior to moving the patient, the Facility must receive confirmation from the Hospital that it can accept the patient.

Hospital agrees, within its capability, to admit all emergency patients directed to its emergency room by the State of Maryland's medical emergency system and as otherwise required by State of Maryland and federal laws. The Hospital agrees, within its capability, to provide all necessary and available diagnostic and therapeutic services to the transferred patient.

The Facility agrees to accept the patient as a resident of the Facility after the patient is no longer in need of acute care, as reasonably determined by the patient's attending physician, and in accordance with Facilities reasonable bed-hold policies, an updated copy of which will be provided to the Hospital. The Facility will notify the hospital of any behavioral or payment problems prior to transfer of a patient and the parties will agree on a plan of care for post-acute services. Facility will not refuse to readmit patients unless prior notice and agreement has been arranged.

4. Provision of Information. The Hospital shall provide the Facility with the names or classifications of Hospital persons authorized to initiate, confirm and accept the transfer of patients on behalf of the Hospital. The Hospital shall state specifically where transferring patients are to be delivered at its premises.

5. Patient Records. The Facility agrees to adopt an appropriate and mutually acceptable standard transfer form for medical and administrative information to accompany the patient from the Facility to the Hospital. The transfer form shall include, when appropriate, the following:

A. Patient's name, address, telephone number, if known, and age; and name, address and telephone number of the next of kin;
B. Patient's third party billing data;
C. History of the injury or treatment;
D. Condition on admission;
E. Vital signs pre-hospital and at the time of transfer;
F. Treatment provided to patient, including medications given and route of administration;
G. Laboratory and X-ray findings, including films (if available);
H. Fluids given, by type and volume;
I. Name, address, and phone number of physician referring patient;
J. Name of physician in Hospital to whom patient is to be transferred; and
K. Name of physician of Hospital who has been contacted about patient.

The Facility agrees to supplement this information as necessary for the maintenance of the patient during transport and treatment upon arrival at the Hospital. The records described above shall be placed in the custody of the person in charge of the transporter who shall sign a receipt for the medical records and in turn shall obtain a receipt from the Hospital when it receives the records. It is the Facility's responsibility to assure that the patient's medical records are delivered to the Hospital with the transferred patient.

6. Transfer Consent. The Facility agrees to obtain the patient's informed consent and to make any notification to the next of kin or others regarding the patient's transfer under this Agreement as required by Maryland laws.

7. Payment for Services. The patient is primarily responsible for payment for care received at either the Facility or the Hospital. Each party shall be responsible only for collecting its own payment for services rendered to the patient. This Agreement shall not be interpreted to authorize either party to look to the other party to pay for services rendered to a patient transferred by virtue of this Agreement except for Medicare Part A (PPS) patients receiving wound care treatment. Hospital will be reimbursed an amount equal to the facility fee (at then-current Health Services Cost Review Commission rates) for wound care provided to Medicare Part A (PPS) patients transferred from the Facility. Hospital shall submit to the Facility an itemized invoice for past wound care services rendered. The invoices shall be due and payable not more than thirty (30) days after the date of such itemized invoice.

8. Transportation of Patient. The Facility shall have responsibility for arranging transportation of the patient to the Hospital, including selection of the mode of transportation and providing appropriate health care provider(s) to accompany the patient, if necessary. The Hospital's responsibility for the patient's care shall begin when the patient is admitted to the Hospital.

9. Protection of Patient's Valuables and Personal Effects. The Facility shall develop and follow appropriate policies and procedures to insure the security and accountability of a transferred patient's personal effects. A standard form shall be developed and approved by the parties and used by the Facility to inventory and accompany a patient's personal effects and valuables. The valuables and personal effects along with a completed form shall be placed in the custody of the person in charge of the transporter who shall sign a receipt for the patient's valuables and personal effects and in turn shall obtain a receipt from the Hospital when it receives the patient's valuables and personal effects. The Facility shall be responsible for the personal effects until delivered to the Hospital and receives a receipt from the Hospital acknowledging the delivery of the valuables and personal effects.

10. Independent Contractor Status. Both parties are independent contractors. Neither party is authorized or permitted to act as an agent or employee of the other. Nothing in this Agreement shall in any way alter the freedom enjoyed by either parties, nor shall it in any way alter the control of the management, assets and affairs of the respective institutions. Neither party, by virtue of this Agreement, assumes any liability for any debts or obligations of either a financial or a legal nature incurred by the other party to this Agreement. Both parties acknowledge and agree that this Agreement is not intended to induce referrals between the parties.

11. Liability. Each party shall be responsible for its own acts and omissions and shall not be responsible for the acts and omissions of the other party.

12. Nonexclusivity. Nothing in this Agreement shall be construed as limiting the rights of either party to affiliate or contract with any other hospital or organization while this Agreement is in effect.

13. Termination.

A. Voluntary Termination. This Agreement may be terminated by either party for any reason, by giving sixty (60) calendar days' written notice of its intention to withdraw from this Agreement, and by ensuring the continuity of care to patients who already are involved in the transfer process.

B. Involuntary Termination. This Agreement shall be terminated immediately upon the occurrence of any of the following:

1. Either party loses its license, accreditation or ability to operate in the State of Maryland.

2. Either party no longer is able to provide the service for which the Agreement was sought.

3. Either party is in default under any of the terms of this Agreement.

14. Nonwaiver. No waiver of any term or condition of this Agreement by either party shall be deemed a continuing or further waiver of the same term or condition or a waiver of any other term or a condition of this Agreement.

15. Governing Law. This Agreement is made and entered into in the State of Maryland. This Agreement is subject to all applicable requirements of the State of Maryland and Federal law and regulations, and where this Agreement is in conflict with the provisions of laws or regulations, the laws and regulations shall govern.

16. Assignment. This Agreement shall not be assigned in whole or in part by either party without the express written consent of the other party.

17. Invalid Provision. In the event that any portion of this Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue to be binding upon the parties, in the same manner as if the invalid or unenforceable provision were not a part of this Agreement.

18. Amendment. This Agreement may be amended at any time by a written agreement signed by the parties.

19. Entire Agreement. This Agreement constitutes the entire agreement between the parties and contains all of the agreements between them with respect to the subject matter of this Agreement supersedes any and all other agreements, either oral or in writing between the parties with respect to the subject matter.

20. Binding Agreement. This Agreement shall be binding upon the successors or assigns of the parties.

21. Advertising and Public Relations. Neither party shall use the name of the other party in any promotional or advertising material.

22. Headings. The headings to the various sections of this Agreement have been inserted for convenience only and shall not modify, define, limit or expand express provisions of this Agreement.

23. Counterparts. This Agreement may be executed simultaneously in one or more counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument.

24. Third-Party Beneficiary Rights. This Agreement shall not create any rights, including without limitation, third-party beneficiary rights, in any patient or other person or entity not a party to this Agreement.

25. HIPAA. The parties agree to use protected health information ("PHI") only in accordance with the Health Insurance Portability and Accountability Act (HIPAA), the privacy regulations in 45 CFR Part 160 (the "HIPAA regulations") and applicable state law. In the event that additional steps must be taken to comply with these laws and regulations, the parties agree to negotiate in good faith to amend this Agreement. In the absence of such compromise, either party may terminate this Agreement immediately.

26. Insurance.

a) Facility shall obtain and maintain general liability, personal injury, property damage, motor vehicle liability and workers compensation insurance covering Facility, Facility's Property and Facility personnel performing services under this Agreement. Such insurance's shall be in at least the minimum amounts required by law or as set forth below:

1. Statutory workers' compensation insurance;
2. Contractor or general liability insurance including:
   - Bodily Injury - $1 Million Each Person and $1 Million aggregate;
   - Property Damage - $1 Million Each Occurrence and $1 Million aggregate;
   - Products and Completed Operations - $1 Million aggregate to be maintained for 1 year following payment;
3. Automobile liability including owned, non-owned and hired vehicles covering Bodily Injury - $1 Million Each Person and $1 Million aggregate and Property Damage - $1 Million Each Occurrence and $1 Million aggregate; and
4. Contractual Liability including Bodily Injury - $1 Million Each Person and $1 Million aggregate and Property Damage - $1 Million Each Occurrence and $1 Million aggregate; and

5. Umbrella Excess Liability Insurance in the amount of $3 Million over primary insurance coverage.

b) Facility will have Hospital named as an insured with respect to the above referenced policies, if possible. Facility shall indemnify and hold harmless Hospital and all affiliates thereof against any and all claims, damages, liabilities and expenses (including reasonable attorney's fees) arising or resulting from Facility negligence, fault or wrongdoing.

c) The obligations under this section shall survive the expiration or termination of this Agreement.

IN WITNESS WHEREOF, The Hospital and Facility have caused this Agreement to be executed as by law provided, the day and year first above written.

2/11/16

WITNESS:

_____ (Hospital)
Stuart Bell, MD
MedStar Union Memorial Hospital
201 E. University Parkway
Baltimore, MD 21218

_____ By:
Title:

Greater Chesapeake (Facility)
Surgery Center
1212 York Rd Bldg. B-101
Lutherville, MD 21093

_____ By:
Richard Levine, M.D
Title: Medical Director

G:\Templates\Patient Transfer Agmts\PatientTransferAgmtWithHIPPAAndMedicare5-19-08Blk.doc

Attachment 8

Transfer Policy

SECTION 2
General Clinical

Greater Chesapeake Surgery Center	2 General Clinical 2.13 Hospital Transfer	
Hospital Transfer	Issued: 9/98 Revised: 3/15 Reviewed: 10/15	Number: 2.13

I. Policy

If a patient experiences an unexpected situation that is beyond the scope of care at Greater Chesapeake Surgery Center as defined by the attending surgeon or anesthesiologist, the patient along with his/her medical records, and if applicable, a copy of the patient's Advance Directive, will be transferred to the nearest receiving hospital.

The Center has transfer agreements with St. Joseph Hospital, and Union Memorial Hospital.

Any patient transferred to an acute care facility will be followed with a phone contact from the Center at 24 hours or the next business day.

II. Purpose

See Procedure below.

III. Procedure

A. Responsibility

See Process below.

B. Process

1. Critical Transfer – Any patient who undergoes cardiac arrest, a malignant hyperthermia episode, or anaphylactic shock will be immediately transferred to an acute care facility. Transfer from the surgery center to an acute care facility is accommodated as efficiently as possible.
   a. After initiating CPR, staff will call 911 and request paramedic transport to a nearby acute care facility.
   b. The Surgery Center staff will copy patient's medical record which will be copied to the ER of the facility where the patient will be transported.
   c. Physician will inform family/significant persons attending the patient of the patient's condition and impending transfer.
   d. Physician will inform receiving facility of patient admission.
   e. Physician and nursing staff will give report to paramedics.
   f. Physician and nursing staff will complete the unusual occurrence report form which will be filed in designated file.
2. Non-Critical Transfer – In the event that patient needs exceed resources provided by the Surgery Center, the patient will be transferred to an appropriate medical facility of his/her choice by transport vehicles determined to be appropriate for his/her specific needs.

With physician approval, a stable patient may be transported in a personal vehicle with family or significant others.

Chart will be faxed or copied and sent to receiving facility.

As a designated outpatient facility, the surgery center is unable to provide prolonged nursing care, maximal medical diagnostic regimen and extensive treatment. Patients requiring monitoring for neurological or cardiovascular incidents, prolonged post-anesthesia care, or unanticipated surgical intervention are to be in an acute care facility.

a. Physician orders transfer and arranges admission to acute care facility.
b. Physician informs spouse/family or patient's condition and impending patient transfer.
c. RN remains with the patient until transfer and:
   1) Monitors and records patient's vital signs
   2) Administers medication and treatment as ordered
   3) Requests the surgery center staff to copy medical record
   4) Completes transfer form.
d. RN facilitates transfer by:
   1) Contacting receiving nursing staff and giving verbal telephone report
   2) Contacting appropriate transport agency (e.g. ambulance, medi-van)
   3) Instructing transport agency to enter surgical suite through the side entrance
   4) Assisting transport personnel to transfer the patient to stretcher or wheelchair
   5) Completing patient record and unusual occurrence form
   6) Copies form to center administrator and Q.A. representative.
e. Non-professional staff assist in transfer by:
   1) Assisting RN as directed
   2) Assembling patient belongings in plastic bags, tagging belongings with identification
   3) Directing transport personnel upon their arrival
   4) Assisting transport personnel to transfer the patient to stretcher or wheelchair.

IV. Related Policies/Forms

n/a

V. References

n/a

Reviewed and Approved by:

Board of Managers President — Date 11/16/15

Medical Director — Date 10/20/15

Director of Anesthesiology — Date 11-9-15

Administrator — Date 10.16.15

Director of Clinical Services — Date 10/26/15

Attachment 9

Patients by Zip Code

GCSC Patient Origin by Zip Code, FY 2015

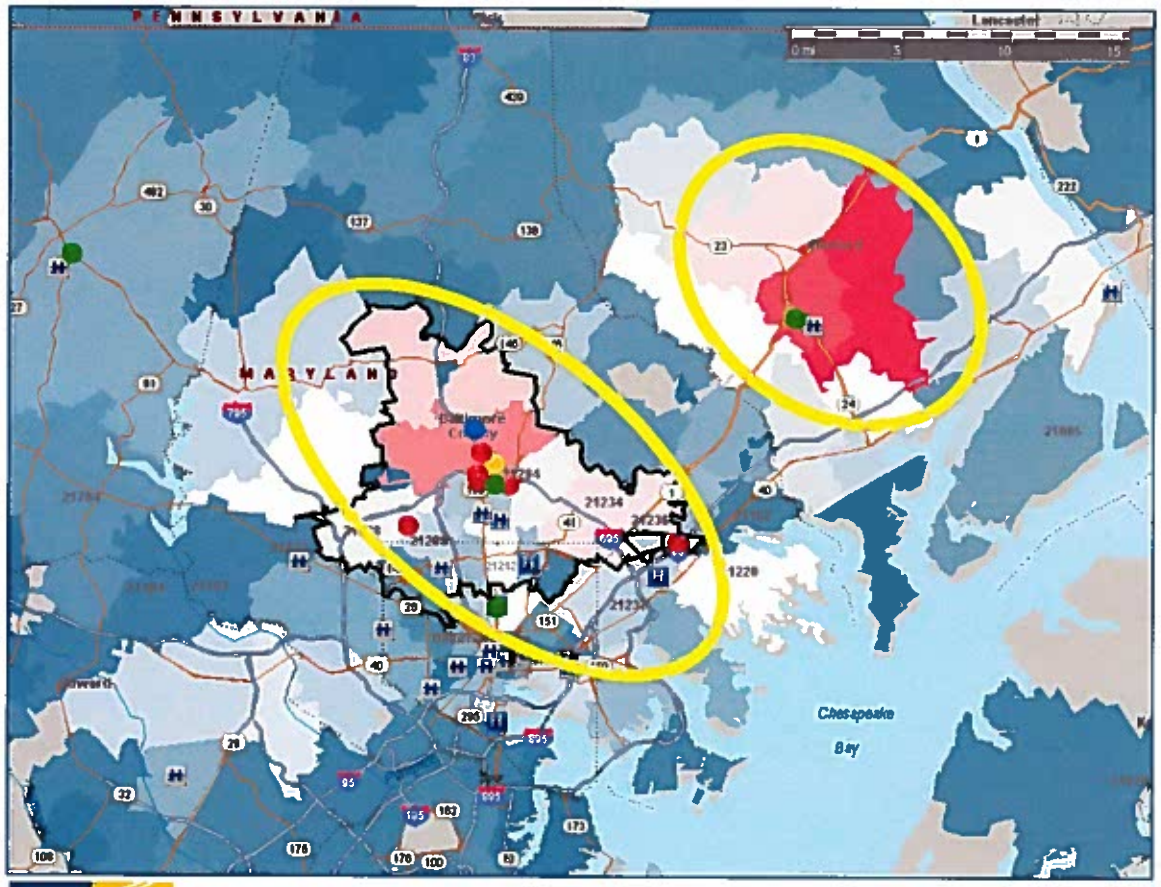
Zip Code	Patients	Cumulative Percentage
21015	48	3.7%
21014	45	7.1%
21093	40	10.2%
21030	32	12.6%
21050	30	14.9%
21234	30	17.2%
21236	30	19.5%
21212	26	21.5%
21218	25	23.4%
21009	23	25.1%
21047	23	26.9%
21117	23	28.6%
21220	23	30.4%
21078	22	32.1%
21208	22	33.7%
21286	21	35.3%
21043	20	36.9%
21084	19	38.3%
21085	19	39.8%
21042	17	41.1%
21206	17	42.4%
21224	17	43.7%
21001	16	44.9%
21209	16	46.1%
21040	15	47.3%
21136	15	48.4%
21228	15	49.5%
21131	14	50.6%
21211	14	51.7%
21237	14	52.7%
21204	13	53.7%
21210	12	54.7%
21239	12	55.6%
21122	11	56.4%
21128	11	57.3%
21222	11	58.1%
21230	11	58.9%
21044	10	59.7%
21087	9	60.4%
21157	9	61.1%
21217	9	61.8%
21229	9	62.4%
21244	9	63.1%
21771	9	63.8%
21048	8	64.4%
21074	8	65.0%
21154	8	65.6%
21207	8	66.3%
21221	8	66.9%
21005	7	67.4%
21213	7	67.9%
21231	7	68.5%
21013	6	68.9%
21017	6	69.4%
21028	6	69.8%
21057	6	70.3%
21114	6	70.8%
21120	6	71.2%
21146	6	71.7%
21215	6	72.1%
21784	6	72.6%
20723	5	73.0%
21061	5	73.4%
21111	5	73.7%
21113	5	74.1%
21132	5	74.5%
21161	5	74.9%
21216	5	75.3%
21601	5	75.6%
21742	5	76.0%
21037	4	76.3%
21045	4	76.6%
21046	4	76.9%
21090	4	77.3%
21158	4	77.6%
21227	4	77.9%
20759	3	78.1%
20878	3	78.3%
21029	3	78.5%
21034	3	78.8%
21075	3	79.0%
21102	3	79.2%
21104	3	79.5%
21160	3	79.7%
21162	3	79.9%
21403	3	80.2%
21613	3	80.4%
21620	3	80.6%
21666	3	80.8%
21701	3	81.1%
21702	3	81.3%
21737	3	81.5%
21740	3	81.8%
21774	3	82.0%
21776	3	82.2%
21793	3	82.4%
21921	3	82.7%
7042	2	82.8%
7305	2	83.0%
17225	2	83.1%
17314	2	83.3%
17331	2	83.4%
17349	2	83.6%
17603	2	83.7%
20619	2	83.9%
20685	2	84.0%
20744	2	84.2%
20794	2	84.4%
20851	2	84.5%
21035	2	84.7%
21076	2	84.8%
21108	2	85.0%
All Other	197	100.0%
TOTAL	**1,310**	**100.0%**

Attachment 10

GCSC Current Population Map

Greater Chesapeake Surgery Center Patient Population

- MedStar currently has one freestanding surgery center in the Central Maryland region, the Greater Chesapeake Surgery Center (GCSC) located in Lutherville. The new center in Timonium will be 3.5 miles from the current center. (The current draw is based on the complement of physicians from the former GCOA practice who are now employed by MedStar Health.)
- Patient draw shows that the largest proportion of patients are from central Baltimore County and Bel Air in Harford County. There are well-established MedStar practice sites in both locations.



Patient Origin by County to the Current Lutherville ASC	
County	% of Total
Baltimore, MD	28.2%
Harford, MD	22.8%
Baltimore City, MD	17.7%
Howard, MD	6.1%
Anne Arundel, MD	4.6%
Carroll, MD	3.6%
Other Counties	6.2%
Outside MedStar Region	10.8%
Total	100%

MedStar Health Hospital
MedStar Timonium ASC
ASC Service Area
GCOA Surgery Center
MedStar Orthopaedics Practice
Competitor ASC

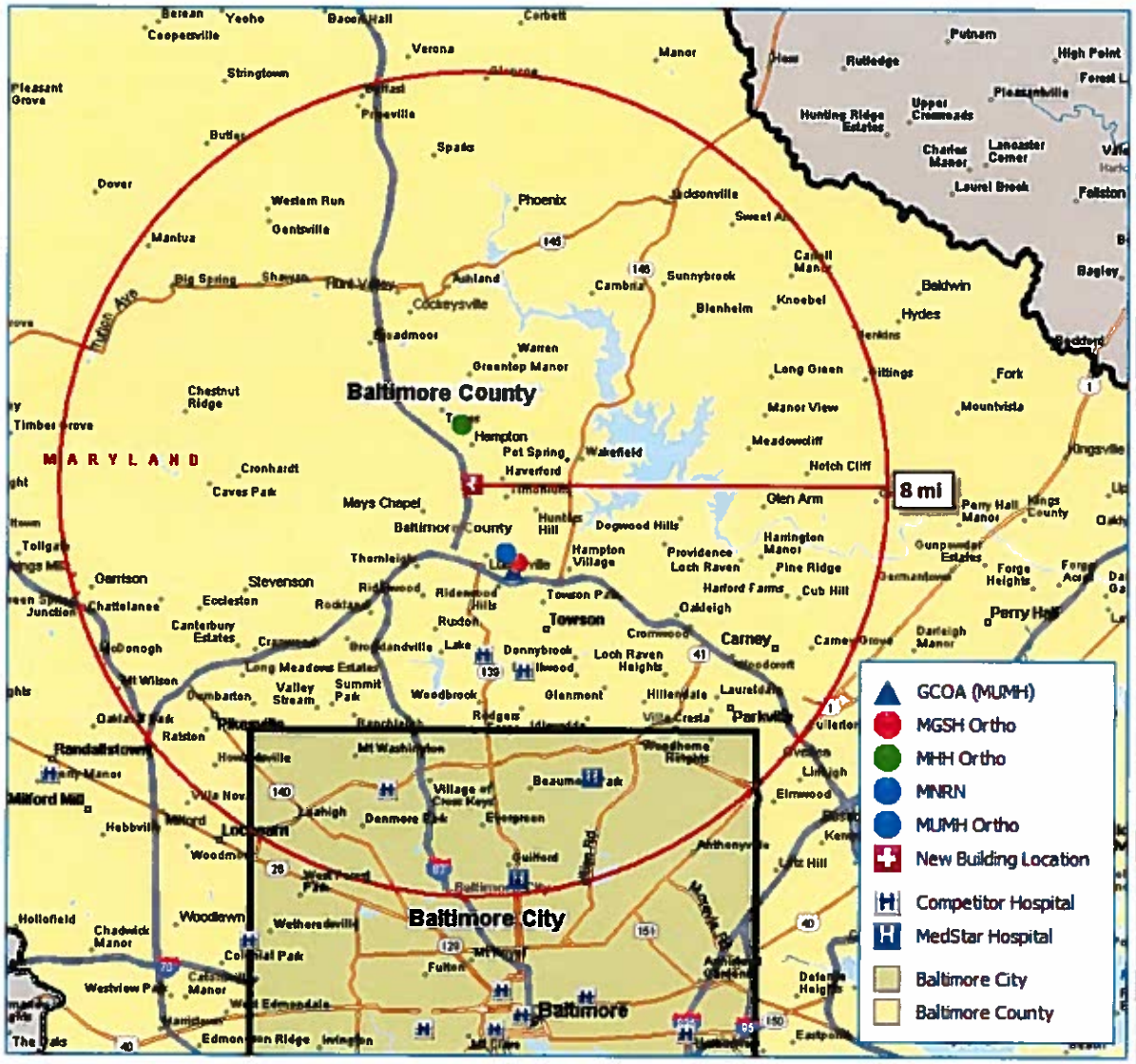
Patient Count by Zip Code
50
25
0

Patient Origin Source: USPI - Michaele Morrison, Crystal Reports data pulled on 7-27-15

Attachment 11

Demographics

2118 Greenspring Drive Market Demographics



- Estimated market size for 2118 Greenspring Dr. is a 15 min drive-time or 8-mile radius

Potential Consolidation Site - 2118 Greenspring Dr.		
Destination	Miles	Mins
MHH ORTHO	1.7	5
MUMH ORTHO	2.1	7
MGSH ORTHO	2.2	7

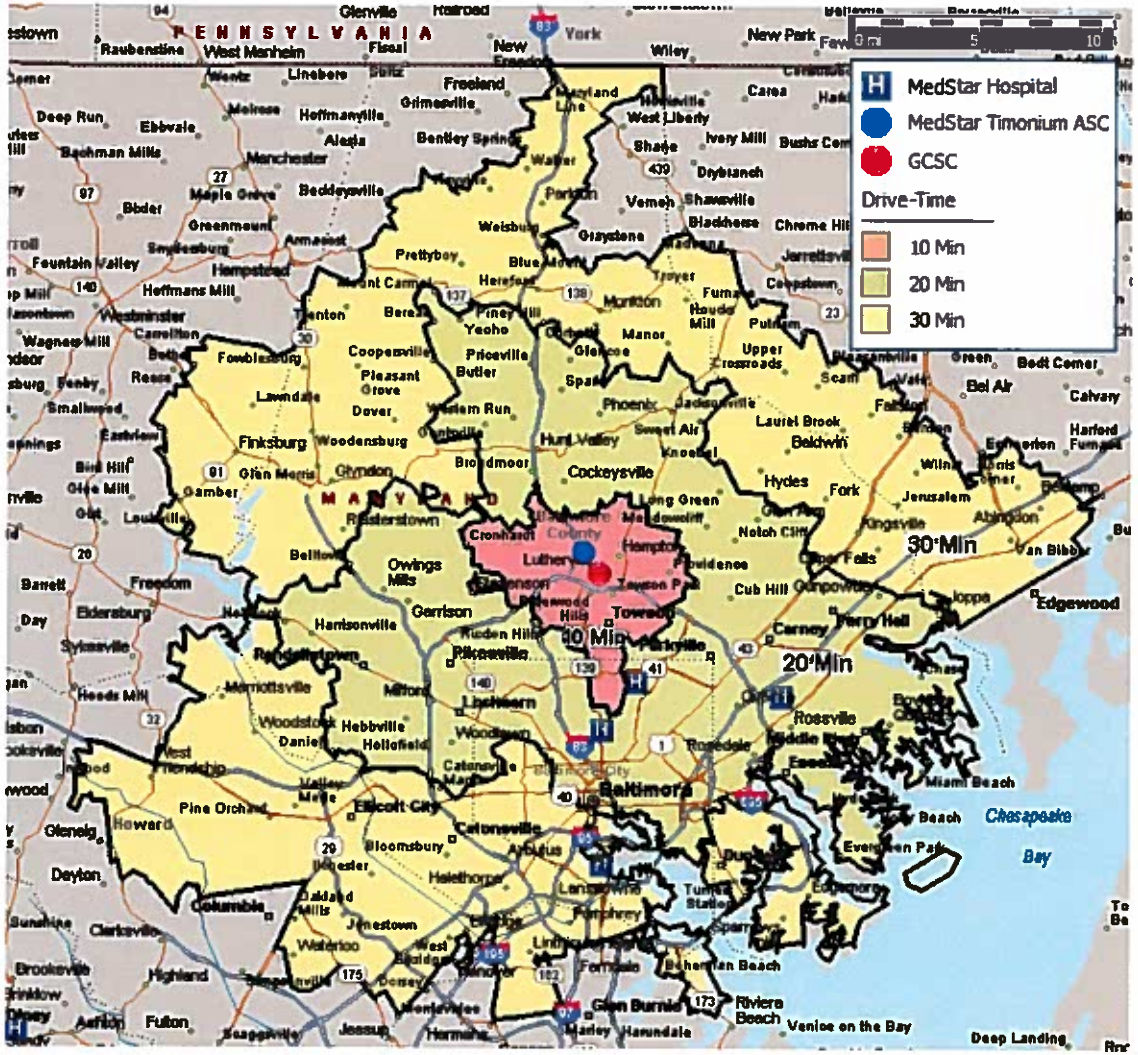
Demographic Comparison	2118 Greenspring	Baltimore County	Central Maryland
Population Characteristics			
Total Population	474,800	811,237	3,497,241
Population Density (Pop/Sq Mi)	2,397	1,357	1,238
Total Households	192,540	318,360	1,346,278
Est. 5yr Pop. Growth	0.5%	1.9%	2.2%
Race/Ethnicity			
White	58.0%	64.3%	62.1%
Black	33.6%	26.1%	28.4%
Asian	4.9%	5.1%	4.8%
Other	3.5%	4.5%	4.7%
Hispanic Ethnicity	3.2%	4.2%	4.6%
Median Age	40	40	39
Household Income			
Average HH Income	$91,510	$91,442	$91,505
Median HH Income	$60,611	$67,751	$66,990
Unemployment Rate	3.7%	3.3%	4.2%
Education Attainment			
Bachelor's Degree	20.9%	20.1%	19.8%
Graduate Degree	20.3%	15.1%	15.2%

Source: SCOUT Buxton (Data Retrieved 2/27/2015)

Attachment 12

Drive Time Map

Analysis of Current MedStar Baltimore Hospital Outpatient Orthopaedic Surgery Patients within 30-min Drive Time of New ASC



- Drive time map from the future Timonium ASC illustrates the potential volume that can be shifted to the ASC based on patient origin.
- Based on physician draw, it is assumed that some portion of patients would be willing to travel where physicians direct based on historical relationships and can be factored into the scenarios.
- Industry benchmarks for patients' willingness to travel for ambulatory surgery is 30 minute drive time.

	Patient Origin Total		
Hospital	10 Mins	20 Mins	30 Mins
MFSMC	10	648	927
MGSH	37	336	424
MHH	10	155	488
MUMH	221	1333	1978
Total	278	2,472	3,817

Source: Planning Mart - OP Hospital Volumes, CPT codes between 20005-29999, FY'15, Data pulled 08-04-15

Attachment 13

Letters of Support

MedStar Orthopaedics

MedStar Union Memorial Hospital
3333 North Calvert Street
Johnston Professional Building
Suite 400
Baltimore, Maryland 21218

(410) 554-2865 PHONE
(410) 554-6423 FAX

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

January 8, 2016

Dear Mr. Steffen,

I am writing in my capacity as Chairman of the Department of Orthopaedic Surgery at Union Memorial Hospital, as well as Regional Medical Director for Orthopaedics for MedStar Health to lend my full and complete support to the certificate of need request to expand the ambulatory surgical facility for MedStar Orthopaedics in the Timonium, Maryland location. We currently operate a two room certificate of need based facility in the Lutherville corridor and have done so for the past fifteen years. Our annualized volumes at the center have approached almost 2,000 cases, all of which have been orthopaedic surgery.

MedStar Health has finalized the plans to obtain a long-term lease in a freestanding building in the Timonium area where all of MedStar Health's orthopaedic services for the area will be consolidated. As part of this integrated effort, we are requesting an expansion to four operating rooms for use for orthopaedic surgery and related specialties. Currently, there are a large number of ambulatory surgery volumes in orthopaedics being performed in higher cost settings at various MedStar regional hospitals, including MedStar Union Memorial, MedStar Good Samaritan, MedStar Franklin Square, and MedStar Harbor Hospital. We anticipate consolidating a significant percentage of the future outpatient volume to an expanded ambulatory surgery footprint in this Timonium facility. This projection includes a combination of relocating existing ambulatory surgery from regulated hospital settings to a lower cost non-regulated ambulatory facility, but also anticipates growth in a number of orthopaedic areas within the next three years.

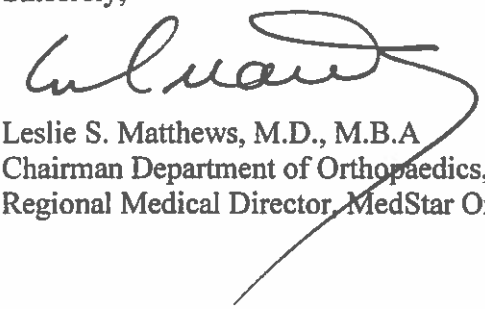
The factors influencing growth in the ambulatory facility will include advances in technology, making historical inpatient surgical procedures more safely amendable to outpatient surgical venues, the patient demand for increasing outpatient surgical treatments, as well as organic growth within our orthopaedic surgical services.

The new Timonium facility will also include a broad spectrum of musculoskeletal services to treat our patients in a more streamlined and consolidated manner. Services such as x-ray and MRI imaging, physical therapy, pain management rehabilitation and intervention, as well as ambulatory clinic space for multiple orthopaedic subspecialties including spine, total joints,

foot & ankle, sports medicine, shoulder & elbow and hand surgery will be included in this facility.

Our physicians and entire care team look forward to a continued focus on high quality and compassionate care within the communities we have proudly served for many decades.

Sincerely,



Leslie S. Matthews, M.D., M.B.A
Chairman Department of Orthopaedics, MedStar Union Memorial Hospital
Regional Medical Director, MedStar Orthopaedics

MedStar Orthopaedics

Leslie S. Matthews, MD, MBA
Chair, Department of Orthopaedic Surgery
Sports Medicine

Disorders of the Spine
Paul L. Asdourian, MD
Michael R. Murray, MD
P. Justin Tortolani, MD

Joint Replacement
Henry R. Boucher, MD
Frank R. Ebert, MD
Robert P. McKinstry, MD

Foot & Ankle
Gregory P. Guyton, MD
Stuart D. Miller, MD
Lew C. Schon, MD
Jacob M. Wisbeck, MD

Sports Medicine
James C. Dreese, MD
Jason W. Hammond, MD
Richard Y. Hinton, MD
Richard G. Levine, MD
John B. O'Donnell, MD
Sean M. Curtin, MD
Kenneth B. Tepper, MD

Shoulder & Elbow
Anand M. Murthi, MD
Jason A. Stein, MD

Trauma
Robert J. Brumback, MD

Physical Medicine & Rehab
Abraham T. Rasul, Jr., MD
Walter J. Roche, MD
Morvarid Yousefi, MD

Pediatric Sports Medicine
Lindsay W. Jones, MD

Family Medicine Sports Medicine
Matthew D. Sedgley, MD
Andrew M. Tucker, MD

Ben Steffen
Executive Director
Maryland Healthcare Commission
4160 Patterson Ave
Baltimore MD, 21215-2299

Dear Mr. Steffen:

I would like to write to you as a member of the MedStar Union Memorial Orthopedic Department and as a frequent user of the Greater Chesapeake Surgery Center to express support for the construction of a new MedStar multispecialty outpatient surgery center in Timonium, Maryland to replace and expand our current facilities in the area.

MedStar Union Memorial Hospital has been a major presence in Baltimore City for well over 150 years. The hospital in general, and our orthopedic group in particular, has made a major commitment to serving patients in the Lutherville-Timonium area with convenient and timely outpatient care. Our current surgery center has been a major presence on the lower York Road corridor for 16 years and our outpatient volumes continue to steadily grow.

In recent years, there has been an increasing shift of emphasis away from inpatient procedures to the outpatient setting. This has placed steady and increasing demand on the outpatient facilities such as the Greater Chesapeake Surgery Center. As part of a strategic vision for the future, MedStar Union Memorial Hospital, in combination with its sister hospitals (MedStar Harbor Hospital, MedStar Franklin Square Hospital, and MedStar Good Samaritan Hospital), project that a very substantial number of cases currently handled at the home institutions would be suitable for a transfer to a new outpatient facility in the Timonium area. The proposed expansion and upgrade of the surgery center would facilitate newer state-of-the-art equipment and a capability of hosting patients for 23-hour overnight stays. This would significantly improve the availability of healthcare in the area both by improving the equipment available to our speciality physicians and allowing a wider range of more complex procedures to be performed in the outpatient setting. This is a major component of our efforts to increase the efficiency of the delivery of healthcare and moves a substantial amount of burden away from the higher-cost inpatient hospital setting.

MedStar Orthopaedics

Leslie S. Matthews, MD, MBA
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Walter J. Roche, MD
Morvarid Yousefi, MD

Pediatric Sports Medicine
Lindsay W. Jones, MD

Family Medicine Sports Medicine
Matthew D. Sedgley, MD
Andrew M. Tucker, MD

I feel strongly that the new proposed surgery center represents a long-term solution to adapt to the changing healthcare environment while increasing patient satisfaction and the responsiveness of our healthcare delivery system.

Thank you for your consideration.

Sincerely,

Gregory Guyton, MD

The Johnston Professional Building at the Union Memorial Hospital 3333 N. Calvert Street, Suite 400 Baltimore, MD 21218
410.554.2270 • Toll Free: 800.571.9820 • Fax: 410.554.2853

MedStar Orthopaedics

1407 York Road
Suite 100A
Lutherville, Maryland 21093

(410) 821-7047 PHONE
(410) 821-7047 FAX

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

January 26, 2016

Dear Mr. Steffen:

I am writing on behalf of the MedStar Union Memorial Orthopaedics department to express our full support for the construction of a new MedStar Multi-Specialty Outpatient Surgery Center in Timonium, Maryland.

MedStar Union Memorial Hospital has been serving the Baltimore area community since 1854. Our commitment remains steadfast, and our patient volume continues to surge. For the past several years, outpatient cases have been consistently on the rise – a trend that is consistent with the latest research supporting improved outcomes and lowered secondary risks that have been attributed to outpatient facilities and procedures.

At the Greater Chesapeake Surgery Center (GCSC) in Lutherville, where I serve as Medical Director, demand for surgical block time continues to increase annually. With the proposed shift of outpatient procedures away from the hospital setting we will be unable to meet patient demand in the current GCSC facility. MedStar Union Memorial Hospital in collaboration with its sister Hospitals (MedStar Harbor Hospital, MedStar Franklin Square Hospital, and MedStar Good Samaritan Hospital) project a substantial increase in surgical procedures annually that would be eligible for transfer to the proposed Timonium MedStar ambulatory surgery center. The creation of the proposed larger and state-of-the-art surgery center would also allow MedStar Specialty Doctors to serve the community with increased efficiency and health benefits while continuing to provide the highest level of quality care.

The creation of the proposed surgery center in Timonium is a future-minded solution. The new, more centrally located center would absorb the current Greater Chesapeake Surgery Center in Lutherville and allow our team of professionals a platform to grow from only two operating rooms to four, which would help facilitate the shift of outpatient surgery from the high-cost hospital environment to the low-cost, efficient ambulatory center setting. Finally, the new center would substantially increase available hours of service and include 23 hour patient stays, which would better meet the needs of our medically low-risk population in undergoing traditional in-patient procedures in an outpatient setting.

In summary, the newly proposed surgery center is good for patient care, good for the community, and good for local business. The new center in Timonium will allow MedStar

Union Memorial Hospital to continue to supply the Greater Baltimore community with high-quality, low-cost healthcare, and to continue to serve a leader in the development and implementation of ambulatory surgical services.

Thank you for your consideration.

Sincerely,

Richard G. Levine, M.D.
Medical Director, Greater Chesapeake Surgery Center
Medical Director, Sports Medicine Clinical Services MedStar Union Memorial Hospital
Department of Orthopaedics, MedStar Union Memorial Hospital

Attachment 14

Table L

TABLE L. WORK FORCE INFORMATION

	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 DOLLARS) *	
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 J)*	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)*											
Management			$0	2.0	$85,100	$170,200			$0	2.0	$170,200
Management Bonus			$0			$6,000			$0	0.0	$6,000
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$176,200			$0	0.0	$176,200
Direct Care Staff *(List general categories, add rows if needed)*											
RN - PreOp/PACU			$0	4.1	$70,104	$285,674			$0	4.1	$285,674
RN			$0	3.5	$68,653	$236,853			$0	3.5	$236,853
OR Tech			$0	4.2	$31,653	$132,943			$0	4.2	$132,943
			$0			$0			$0	0.0	$0
Total Direct Care			$0			$655,469			$0	0.0	$655,469
Support Staff *(List general categories, add rows if needed)*											
Billing Staff			$0	1.0	$55,000	$55,000			$0	1.0	$55,000
Reception			$0	2.2	$29,121	$64,066			$0	2.2	$64,066
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support			$0			$119,066			$0	0.0	$119,066
REGULAR EMPLOYEES TOTAL			$0			$950,735			$0	0.0	$950,735
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)*:						190,147					190,147
20% of Payroll											
TOTAL COST	***0.0***		***$0***	***0.0***		***$1,140,883***	***0.0***		***$0***		***$1,140,883***

Attachment 15

Audited Financials - FY 2014
MedStar Health

MEDSTAR HEALTH, INC.

Consolidated Financial Statements

June 30, 2014 and 2013

(With Independent Auditors' Report Thereon)

MEDSTAR HEALTH, INC.

Table of Contents

KPMG LLP
1 East Pratt Street
Baltimore, MD 21202-1128

Independent Auditors' Report

The Board of Directors
MedStar Health, Inc.:

We have audited the accompanying consolidated financial statements of MedStar Health, Inc. (the Corporation), which comprise the consolidated balance sheets as of June 30, 2014 and 2013, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this responsibility 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 auditors' 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.

KPMG

Opinion

In our opinion, the consolidated financial statements referred to above present fairly in all material respects, the financial position of MedStar Health, Inc. as of June 30, 2014 and 2013, and the results of their operations and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP

October 6, 2014

MEDSTAR HEALTH, INC.

Consolidated Balance Sheets

June 30, 2014 and 2013

(Dollars in millions)

Assets		2014	2013
Current assets:			
Cash and cash equivalents	$	599.9	445.4
Investments		61.4	61.6
Assets whose use is limited or restricted		61.3	64.7
Receivables:			
From patient services (less allowances for uncollectible accounts of $188.8 in 2014 and $204.3 in 2013)		558.0	546.3
Other		69.6	51.2
		627.6	597.5
Inventories		56.3	57.0
Prepaids and other current assets		31.8	38.4
Total current assets		1,438.3	1,264.6
Investments		869.5	733.6
Assets whose use is limited or restricted		548.9	483.9
Property and equipment, net		1,152.9	1,137.1
Interest in net assets of foundation		64.9	54.8
Goodwill and other intangible assets, net		226.5	202.0
Other assets		146.8	135.8
Total assets	$	4,447.8	4,011.8

(Continued)

MEDSTAR HEALTH, INC.

Consolidated Balance Sheets

June 30, 2014 and 2013

(Dollars in millions)

Liabilities and Net Assets		2014	2013
Current liabilities:			
Accounts payable and accrued expenses	$	419.6	357.4
Accrued salaries, benefits, and payroll taxes		304.9	281.5
Amounts due to third-party payors, net		85.7	66.7
Current portion of long-term debt		60.5	61.2
Current portion of self insurance liabilities		86.3	87.5
Other current liabilities		125.3	87.3
Total current liabilities		1,082.3	941.6
Long-term debt, net of current portion		1,192.6	1,207.2
Self insurance liabilities, net of current portion		312.4	253.2
Pension liabilities		234.3	304.9
Other long-term liabilities, net of current portion		137.6	140.0
Total liabilities		2,959.2	2,846.9
Net assets:			
Unrestricted net assets:			
MedStar Health, Inc.		1,322.2	1,017.4
Noncontrolling interests		5.2	9.4
Total unrestricted net assets		1,327.4	1,026.8
Temporarily restricted		121.8	99.0
Permanently restricted		39.4	39.1
Total net assets		1,488.6	1,164.9
Total liabilities and net assets	$	4,447.8	4,011.8

See accompanying notes to consolidated financial statements.

MEDSTAR HEALTH, INC.

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2014 and 2013

(Dollars in millions)

	2014	2013
Operating revenues:		
Net patient service revenue:		
Hospital inpatient services	$ 2,240.1	2,240.8
Hospital outpatient services	1,558.7	1,444.1
Physician services	315.1	290.5
Other patient service revenue	114.8	124.5
Total net patient service revenue	4,228.7	4,099.9
Provision for bad debts	193.2	214.5
Total net patient service revenue, net of provision for bad debts	4,035.5	3,885.4
Premium revenue	357.9	138.2
Other operating revenue	234.7	193.6
Net operating revenues	4,628.1	4,217.2
Operating expenses:		
Personnel	2,455.3	2,310.7
Supplies	696.7	658.9
Purchased services	682.6	562.1
Other operating	426.3	393.9
Interest expense	50.1	45.7
Depreciation and amortization	181.4	167.1
Total operating expenses	4,492.4	4,138.4
Earnings from operations	135.7	78.8
Nonoperating gains (losses):		
Investment income	13.3	15.5
Net realized gains on investments	68.6	24.9
Unrealized gains on derivative instrument	1.4	6.7
Unrealized gains on investments, net	91.6	64.0
Income tax (provision) benefit	(3.9)	1.9
Other nonoperating losses	(2.0)	(6.1)
Total nonoperating gains	169.0	106.9
Excess of revenues over expenses	$ 304.7	185.7

(Continued)

MEDSTAR HEALTH, INC.

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2014 and 2013

(Dollars in millions)

	2014	2013
Unrestricted net assets:		
Excess of revenues over expenses	$ 304.7	185.7
Change in funded status of defined benefit plans	(2.1)	106.9
Distributions to noncontrolling interests	(3.7)	(6.3)
Net assets released from restrictions used for purchase of property and equipment and other	1.7	4.9
Increase in unrestricted net assets	300.6	291.2
Temporarily restricted net assets:		
Contributions	17.1	17.4
Realized net gains on restricted investments	3.1	1.8
Change in unrealized gains on restricted investments	3.4	1.9
Increase in net assets of foundation	10.1	6.3
Net assets released from restrictions	(10.9)	(8.9)
Increase in temporarily restricted net assets	22.8	18.5
Permanently restricted net assets:		
Contributions	—	1.5
Realized net gains on marketable restricted investments	0.1	0.1
Change in unrealized gains on restricted investments	0.2	0.1
Increase in permanently restricted net assets	0.3	1.7
Increase in net assets	323.7	311.4
Net assets, beginning of year	1,164.9	853.5
Net assets, end of year	$ 1,488.6	1,164.9

See accompanying notes to consolidated financial statements.

MEDSTAR HEALTH, INC.

Consolidated Statements of Cash Flows

Years ended June 30, 2014 and 2013

(Dollars in millions)

		2014	2013
Cash flows from operating activities:			
Change in net assets	$	323.7	311.4
Adjustments to reconcile change in net assets to net cash provided by operating activities:			
Depreciation and amortization		181.4	167.1
Amortization of bond financing costs, premiums and discounts		(1.2)	(0.3)
Loss (gain) on sale of property and equipment		0.2	(0.1)
Change in funded status of defined benefit plans		2.1	(106.9)
Realized net gains on marketable investments		(71.8)	(26.8)
Change in unrealized gains of marketable investments		(95.2)	(66.1)
Increase in net assets of foundation		(10.1)	(6.3)
Unrealized gain on derivative instrument		(1.4)	(6.7)
Net settlement payment on derivative instrument		3.7	3.9
Loss on extinguishment of debt		—	2.5
Distributions to noncontrolling interests		3.7	6.3
Deferred income tax provision (benefit)		3.6	(1.8)
Provision for bad debts		193.2	214.5
Temporarily and permanently restricted contributions		(17.1)	(18.9)
Gain on sale of consolidated joint venture, net of noncontrolling interests		(1.2)	—
Changes in operating assets and liabilities:			
Receivables		(224.3)	(188.5)
Inventories and other assets		(28.5)	(44.5)
Accounts payable and accrued expenses		107.0	50.2
Amounts due to third-party payors		19.0	(4.9)
Other liabilities		25.0	(45.5)
Net cash provided by operations		411.8	238.6
Cash flows from investing activities:			
Proceeds (purchases) of investments and assets whose use is limited or restricted, net		81.5	(106.0)
Purchases of alternative investments		(240.7)	(77.0)
Proceeds from sales of alternative investments		128.8	2.8
Proceeds from sale of consolidated joint venture		5.4	—
Net settlement payment on derivative instrument		(3.7)	(3.9)
Purchases of property and equipment, acquisition of Southern Maryland Hospital Center and other		(221.3)	(427.1)
Net cash used in investing activities		(250.0)	(611.2)
Cash flows from financing activities:			
Proceeds from long-term borrowings		—	498.9
Repayments of long-term borrowings		(20.5)	(18.5)
Repayments of refinanced bonds and other borrowings		—	(240.6)
Payment of deferred issuance costs		(0.2)	(3.0)
Temporarily and permanently restricted contributions and other		17.1	18.9
Distributions to noncontrolling interests		(3.7)	(6.3)
Net cash (used in) provided by financing activities		(7.3)	249.4
Increase (decrease) in cash and cash equivalents		154.5	(123.2)
Cash and cash equivalents at beginning of year		445.4	568.6
Cash and cash equivalents at end of year	$	599.9	445.4
Supplemental disclosure of cash flow information:			
Interest paid	$	50.8	44.8
Noncash investing and financing activities:			
Accounts payable for fixed asset purchases	$	17.0	19.2

See accompanying notes to consolidated financial statements.

(1) Description of Organization and Summary of Significant Accounting Policies

(a) Organization

MedStar Health, Inc. (MedStar or the Corporation) is a tax-exempt, Maryland membership corporation which, through its controlled entities and other affiliates, provides and manages healthcare services in the region encompassing Maryland, Washington D.C. and Northern Virginia. The Corporation became operational on June 30, 1998 by the transfer of the membership interests of Helix Health, Inc. (Helix – a not-for-profit Maryland Corporation) and Medlantic Healthcare Group, Inc. (Medlantic – a not-for-profit Delaware Corporation) in exchange for the guarantee of the debt of both Helix and Medlantic by the Corporation. The trade names of the principal tax-exempt and taxable entities of the Corporation are:

Tax-Exempt

- MedStar Ambulatory Services (formerly known as Bay Development Corporation)
- MedStar Franklin Square Medical Center
- MedStar Georgetown University Hospital
- MedStar Good Samaritan Hospital
- MedStar Harbor Hospital
- MedStar Health Research Institute
- MedStar Health Visiting Nurse Association, Inc.
- MedStar Medical Group, LLC
- MedStar Montgomery Medical Center
- MedStar National Rehabilitation Network
- MedStar Southern Maryland Hospital Center
- MedStar St. Mary's Hospital
- MedStar Surgery Center, Inc.
- MedStar Union Memorial Hospital
- MedStar Washington Hospital Center
- Church Home and Hospital of the City of Baltimore, Inc.
- HH MedStar Health, Inc.

Taxable

- Greenspring Financial Insurance, LTD.
- MedStar Enterprises, Inc. and Subsidiaries

(Continued)

- MedStar Family Choice, Inc.
- MedStar Physician Partners, Inc.
- Parkway Ventures, Inc. and Subsidiaries

(b) Acquisition of Southern Maryland Hospital, Inc.

On December 10, 2012, the Corporation and Southern Maryland Hospital, Inc. (the Hospital) closed on an asset purchase agreement, whereby the Corporation purchased substantially all of the assets and assumed certain obligations of the Hospital. The Hospital is a 263-bed acute care hospital located in Clinton, Maryland in Prince George's County. As a result of the transaction, the Corporation recognized approximately $80.0 of property, plant and equipment, approximately $150.0 of goodwill and other intangible assets, and working capital amounts. In December 2012, the Corporation entered into a $180.0 bridge loan, that was replaced by permanent financing in May 2013 (see note 6), and used the proceeds to fund the acquisition. The asset purchase agreement provided for certain adjustments to the purchase price and net working capital calculations, which were settled and recorded during fiscal 2014. The consolidated financial statements include the operations of the Hospital since the closing date.

Due to significant changes in the legal, organizational and reporting structure of the Hospital subsequent to the purchase, the Corporation determined that the presentation of supplemental pro forma results for the year ended June 30, 2013 was impracticable. The net operating revenues and total operating expenses of the Hospital are less than 3% of consolidated operating revenues and expenses for the year ended June 30, 2013, which are not considered significant to the Corporation's operations for the year ended June 30, 2013.

(c) Basis of Presentation

The consolidated financial statements are prepared on the accrual basis of accounting in accordance with U.S. generally accepted accounting principles (U.S. GAAP). All majority owned subsidiaries, direct member entities and controlled affiliates are consolidated. All entities where the Corporation exercises significant influence but for which it does not have control are accounted for under the equity method. All other entities are accounted for under the cost method. All significant intercompany accounts and transactions have been eliminated.

(d) Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant changes to estimates resulting from the above referenced settlement associated with the purchase of the Hospital and amounts related to settled, or tentatively settled, prior year third party cost reports (see note 9) resulted in gains of approximately $20.0 and $16.0 during the years ended June 30, 2014 and 2013, respectively. Future results could differ from those estimates.

(Continued)

(e) Cash Equivalents

All highly liquid investments with a maturity date of three months or less when purchased are considered to be cash equivalents.

(f) Investments and Assets whose use is Limited or Restricted

The Corporation's investment portfolio is considered trading, with the exception of the alternative investments, and is classified as current or noncurrent assets based on management's intention as to use. All securities are reported at fair value principally based on quoted market prices in the consolidated balance sheets. The Corporation has elected to use the fair value option to account for its alternative investments. The fair value of alternative investments is determined based on the Net Asset Value (NAV) of the shares in each investment company or partnership. Purchases and sales of securities are recorded on a trade-date basis.

Investments in unconsolidated affiliates are accounted for under the cost or equity method of accounting, as appropriate, and are included in other assets in the consolidated balance sheets. The Corporation utilizes the equity method of accounting for its investments in entities over which it exercises significant influence. The Corporation's equity income or loss is recognized in other operating revenue on the consolidated statements of operations and changes in net assets.

Assets whose use is limited or restricted include assets held by trustees under bond indenture, self-insurance trust arrangements, assets restricted by donor, and assets designated by the Board of Directors for future capital improvements and other purposes over which it retains control and may, at its discretion, use for other purposes. Amounts from these funds required to meet current liabilities have been classified in the consolidated balance sheets as current assets.

Investment income (interest and dividends) and realized gains and losses on investment sales are reported as nonoperating gains and losses in the excess of revenues over expenses in the accompanying consolidated statements of operations and changes in net assets unless the income or loss is restricted by the donor or law. Investment income and realized gains and losses on funds held in trust for self-insurance purposes is included in other operating revenue. Investment income and net gains and losses that are restricted by the donor are recorded as a component of changes in temporarily or permanently restricted net assets, in accordance with donor imposed restrictions. Realized gains and losses are determined based on the specific security's original purchase price or adjusted cost if the investment was previously determined to be other-than-temporarily impaired. Unrealized gains and losses are included in nonoperating gains and losses within the excess of revenue over expenses.

(g) Inventories

Inventories, which primarily consist of medical supplies and pharmaceuticals at many of the operating entities, are stated at the lower of cost or market, with cost being determined primarily under the average cost or first-in, first-out methods.

(Continued)

(Dollars in millions)

(h) Property and Equipment

Property and equipment acquisitions are recorded at cost and are depreciated or amortized over the estimated useful lives of the assets. Estimated useful lives range from three to forty years. Amortization of assets held under capital leases is computed using the shorter of the lease term or the estimated useful life of the leased asset and is included in depreciation and amortization expense. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. Depreciation is computed on a straight-line basis. Major classes and estimated useful lives of property and equipment are as follows:

Leasehold improvements	Lease term
Buildings and improvements	10–40 years
Equipment	3–20 years

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support, and are excluded from the excess of revenues over expenses, 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.

Management routinely evaluates the carrying value of its long-lived assets for impairment. No impairment charges were recorded against the carrying value of the Corporation's long-lived assets during the years ended June 30, 2014 and 2013.

(i) Interest in Net Assets of Foundation

The Corporation recognizes its rights to assets held by a recipient organization, which accepts cash or other financial assets from a donor and agrees to use those assets on behalf of or transfer those assets, the return on investment of those assets, or both, to the Corporation. Changes in the Corporation's economic interests in the financially interrelated organization are recognized in the consolidated statements of operations and changes in net assets as a component of changes in temporarily restricted net assets.

(j) Goodwill and Other Intangible Assets

Goodwill is an asset representing the future economic benefits arising from other assets acquired in a business combination that are not individually identified and separately recognized. As of June 30, 2014 and 2013, the Corporation had one reporting unit, which included all subsidiaries of the Corporation and held goodwill, net on its balance sheet of $190.2 and $163.8, respectively. Goodwill is evaluated for impairment annually using a qualitative assessment to determine whether there are events or circumstances that indicate it is more likely than not that the reporting unit's fair value is

(Continued)

less than its carrying amount. Based on this qualitative assessment, the Corporation determined that there was no goodwill impairment for the years ended June 30, 2014 and 2013.

Other intangible assets recorded at fair value and amortized over their estimated useful lives. Other intangible assets were $42.4 and $41.9 as of June 30, 2014 and 2013, respectively, and related accumulated amortization was $6.1 and $3.7, respectively. The Corporation recognized amortization expense of $2.4 and $2.0 for the years ended June 30, 2014 and 2013, respectively, related to identifiable intangible assets.

(k) Internal-Use Software

The Corporation capitalizes the direct costs, including internal personnel costs, associated with the implementation of new information systems for internal use. The Corporation capitalized $0.9 and $4.6 during the years ended June 30, 2014 and 2013, respectively. Capitalized amounts are amortized over the estimated lives of the software, which is generally three to five years.

(l) Financing Costs

Financing costs incurred in issuing bonds have been capitalized and are included in other assets on the consolidated balance sheets. These costs are being amortized over the estimated duration of the related debt using the effective interest method. Accumulated amortization totaled $5.6 and $4.7 as of June 30, 2014 and 2013, respectively.

(m) Estimated Professional Liability Costs

The provision for estimated self-insured professional liability claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported. These estimates are based on actuarial analysis of historical trends, claims asserted and reported incidents. The receivables related to such claims are recorded at their net realizable value.

(n) Leases

Lease arrangements, including assets under construction, are capitalized when such leases convey substantially all the risks and benefits incidental to ownership. Capital leases are amortized over either the lease term or the life of the related assets, depending upon available purchase options and lease renewal features. Amortization related to capital leases is included in the consolidated statements of operations and changes in net assets within depreciation and amortization expense.

(o) Derivative

The Corporation utilizes a derivative financial instrument to manage its interest rate risks associated with tax-exempt debt. The Corporation does not hold or issue derivative financial instruments for trading purposes. The derivative instrument is recorded on the consolidated balance sheets at its fair value. The Corporation's current derivative investment does not qualify for hedge accounting; therefore, the changes in fair value have been recognized in the accompanying consolidated statements of operations and changes in net assets as mark-to-market adjustments in nonoperating

gains (losses). The fair market value of the derivative instrument is included in other long-term liabilities in the accompanying consolidated balance sheets.

(p) Net Patient Service Revenue and Net Patient Accounts Receivable

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments due to future audits, reviews and investigations. The differences between the estimated and actual amounts are recorded as part of net patient service revenue in future periods as the amounts become known, or as years are no longer subject to audit, review or investigation. Payment arrangements include prospectively determined rates per discharge, fee-for-service, discounted charges, and per diem payments. Hospital inpatient services, hospital outpatient services, the physician component of physician/managed care networks, and other patient service revenues are recognized when the services are rendered based on billable charges. Other patient service revenue primarily consists of home care, long-term care and other non-hospital patient services.

The Corporation's policy is to write-off all patient receivables which are identified as uncollectible. Patient accounts receivable are reduced by an allowance for uncollectible accounts to reserve for accounts which are expected to become uncollectible in future years. In evaluating the collectability of accounts receivable, the Corporation analyzes historical collections and write-offs and identifies trends for each of its major payor sources of revenue and amounts due from patients to estimate the appropriate allowance for uncollectible accounts and provision for bad debts.

Premium revenue consists of amounts received from the State of Maryland and the District of Columbia by the Corporation's managed care organization for providing medical services to subscribing participants, regardless of services actually performed. The managed care organization provides services primarily to enrolled Medicaid beneficiaries. This revenue is recognized ratably over the contractual period for the provision of services. Medical expenses of the managed care organization include a provision for incurred but unreported claims and are included in purchased services on the consolidated statements of operations.

(q) Charity Care

The Corporation provides care to patients who meet certain criteria under its charity care policies without charge or at amounts less than established rates. Because the Corporation does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

(r) Grants

Federal grants are accounted for as either an exchange transaction or as a contribution based on terms and conditions of the grant. If the grant is accounted for as an exchange transaction, revenue is recognized as other operating revenue when earned. If the grant is accounted for as a contribution, the revenues are recognized as either other operating revenue, or as temporarily restricted contributions depending on the restrictions within the grant.

(Continued)

(s) Contributions

Unconditional promises to give cash and other assets to the Corporation 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. 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 and changes in net assets as net assets released from restrictions in other operating revenue. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted net assets and reported within other operating revenue in the accompanying consolidated financial statements.

(t) Meaningful Use Incentives

Under certain provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), federal incentive payments are available to hospitals, physicians and certain other professionals (Providers) when they adopt, implement or upgrade certified electronic health record (EHR) technology and become "meaningful users," as defined under ARRA, of EHR technology in ways that demonstrate improved quality, safety and effectiveness of care. Incentive payments will be paid out over varying transitional schedules depending on the type of incentive (Medicare and Medicaid) and recipient (hospital or eligible provider). Eligible hospitals can attest for both Medicare and Medicaid incentives, while physicians must select to attest for either Medicare or Medicaid incentives. For Medicare incentives, eligible hospitals receive payments over four years while eligible physicians receive payments over five years. For Medicaid incentives, eligible hospitals receive payments based on the relevant State adopted payment structure and physicians receive payments over six years.

The Corporation recognizes EHR incentives when it is reasonably assured that the Corporation will successfully demonstrate compliance with the meaningful use criteria. During the years ended June 30, 2014 and 2013, certain hospitals and physicians satisfied the meaningful use criteria. As a result, the Corporation recognized $23.4 and $16.6 of EHR incentives during fiscal year 2014 and 2013, respectively, in other operating revenue.

(u) Excess of Revenues over Expenses

The consolidated statements of operations and changes in net assets include a performance indicator, which is the excess of revenues over expenses. Changes in unrestricted net assets that are excluded from excess of revenues over expenses, include contributions of long-lived assets (including assets acquired using contributions that by donor restriction were to be used for the purpose of acquiring such assets), contributions from and distributions to noncontrolling interests, and defined benefit obligations in excess of recognized pension cost, among others.

(v) Income Taxes

Income taxes are accounted for under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the

(Continued)

financial statement carrying amounts of existing assets and liabilities and their respective tax bases and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in the period that includes the enactment date. Any changes to the valuation allowance on the deferred tax asset are reflected in the year of the change. The Corporation accounts for uncertain tax positions in accordance with the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 740, *Income Taxes.*

(w) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Corporation or individual operating units has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation or individual operating units in perpetuity.

(x) Fair Value of Financial Instruments

The following methods and assumptions were used to estimate the fair value of financial instruments:

Cash and cash equivalents, receivables, other current assets, other assets, current liabilities and long-term liabilities: The carrying amount reported in the consolidated balance sheets for each of these assets and liabilities approximates their fair value.

The fair value of investments, assets whose use is limited or restricted and the interest rate swap is discussed in note 3. The fair value of long term debt is discussed in note 6.

(y) New Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued *Accounting Standards update (ASU) 2014-09, Revenue from Contracts with Customers (Topic 606).* This ASU establishes principles for reporting useful information to users of financial statements about the nature, amount, timing, and uncertainty of revenue and cash flows arising from the entity's contracts with customers. Particularly, that an entity recognizes revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. ASU 2014-09 is effective for fiscal year 2018. The Corporation expects to record a decrease in net patient service revenue and a corresponding decrease in bad debt expense upon adoption of the standard.

(z) Reclassifications

Certain prior year amounts have been reclassified to conform with current period presentation, the effect of which is not material.

(Continued)

(Dollars in millions)

(2) Investments and Assets Whose Use is Limited or Restricted

Investments and assets whose use is limited or restricted as of June 30, 2014 and 2013, at fair value consist of the following:

	2014	2013
Cash and cash equivalents	$ 82.8	98.5
Fixed income securities and funds	356.2	393.1
Equity securities	559.3	509.8
Alternative investments:		
Commingled equity funds	194.2	103.3
Inflation hedging equity, commodity, fixed income fund	72.4	62.6
Hedge fund of funds and private equity	276.2	176.5
Total investments and assets whose use is limited or restricted	1,541.1	1,343.8
Less short-term investments and assets whose use is limited or restricted	(122.7)	(126.3)
Long-term investments and assets whose use is limited or restricted	$ 1,418.4	1,217.5

Assets whose use is limited or restricted as of June 30, 2014 and 2013, included in the table above, consist of the following:

	2014	2013
Funds held by trustees	$ 60.5	71.1
Self-insurance funds	256.6	216.8
Funds restricted by donors for specific purposes and endowment	86.1	69.7
Funds designated by board and management	207.0	191.0
Total assets whose use is limited or restricted	610.2	548.6
Less assets required for current obligations	(61.3)	(64.7)
Long-term assets whose use limited or restricted	$ 548.9	483.9

(Continued)

(Dollars in millions)

Investment income and realized and unrealized gains for assets whose use is limited, cash equivalents and investments are comprised of the following for the years ended June 30, 2014 and 2013:

		2014	2013
Other operating revenue:			
Investment income and realized gains	$	8.5	4.9
Nonoperating gains:			
Investment income		13.3	15.5
Net realized gains on investments		68.6	24.9
Unrealized gains on investments		91.6	64.0
		173.5	104.4
Other changes in net assets:			
Realized net gains on temporarily and permanently restricted net assets		3.2	1.9
Change in unrealized gains on temporarily and permanently restricted net assets		3.6	2.0
Total investment return	$	188.8	113.2

(3) Fair Value of Financial Instruments

The Corporation follows the guidance within FASB ASC Topic 820, *Fair Value Measurement (ASC 820)*, which defines fair value and establishes methods used to measure fair value. The fair value hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). A financial instrument's categorization within the valuation hierarchy is based upon the lowest level of input that is significant to the fair value measurement. The three levels of the fair value hierarchy under ASC 820 are described below:

- Level 1 – Quoted prices in active markets for identical assets or liabilities at the measurement date;
- Level 2 – Observable inputs other than quoted prices for the asset, either directly or indirectly observable, that reflect assumptions market participants would use to price the asset based on market data obtained from sources independent of the Corporation.
- Level 3 – Unobservable inputs that reflect the Corporations own assumptions about the assumptions market participants would use to price an asset based on the best information available in the circumstances.

The Corporation has incorporated an Investment Policy Statement (IPS) into the investment program. The IPS, which has been formally adopted by the Corporation's Board of Directors, contains numerous standards designed to ensure adequate diversification by asset class and geography. The IPS also limits all investments by manager and position size, and limits fixed income position size based on credit ratings, which serves to further mitigate the risks associated with the investment program. At June 30, 2014 and 2013, management believes that all investments were being managed in a manner consistent with the IPS.

(Continued)

(Dollars in millions)

The following table illustrates the actual allocations of the investment portfolio as of June 30:

	Actual allocation June 30, 2014	Actual allocation June 30, 2013
Publicly traded equities – domestic	26%	29%
Publicly traded equities – international	14	14
Fixed income securities	16	22
Alternative investments:		
Commingled equity funds	12	9
Inflation hedging equity, commodity, fixed income fund	9	9
Hedge funds	20	13
Private equities	1	2
Cash	2	2
Total	100%	100%

The table below presents the Corporation's investable assets and liabilities as of June 30, 2014, aggregated by the three level valuation hierarchy:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 682.7	—	—	682.7
U.S. Treasury bonds	71.1	—	—	71.1
U.S. agency mortgage backed securities	92.8	—	—	92.8
Corporate bonds	—	82.1	—	82.1
Fixed income mutual funds	0.8	76.9	—	77.7
All other fixed income securities	5.4	27.1	—	32.5
Equity mutual funds & ETF's	121.8	—	—	121.8
Common stocks	437.5	—	—	437.5
Alternative investments:				
Commingled equity funds	—	194.2	—	194.2
Inflation hedging equity, commodity, fixed income fund	—	72.4	—	72.4
Private equity	—	—	17.0	17.0
Hedge funds	—	—	259.2	259.2
Total assets	$ 1,412.1	452.7	276.2	2,141.0
Liabilities:				
Interest rate swap	$ —	15.0	—	15.0
Total liabilities	$ —	15.0	—	15.0

(Continued)

(Dollars in millions)

The table below presents the Corporation's investable assets and liabilities as of June 30, 2013, aggregated by the three level valuation hierarchy:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 543.9	—	—	543.9
U.S. Treasury bonds	60.6	—	—	60.6
U.S. agency mortgage backed securities	124.2	—	—	124.2
Corporate bonds	—	90.7	—	90.7
Fixed income mutual funds	0.7	78.2	—	78.9
All other fixed income securities	4.8	33.9	—	38.7
Equity mutual funds & ETF's	101.8	—	—	101.8
Common stocks	408.0	—	—	408.0
Alternative investments:				
Commingled equity funds	—	103.3	—	103.3
Inflation hedging equity, commodity, fixed income fund	—	62.6	—	62.6
Private equity	—	—	16.4	16.4
Hedge funds	—	—	160.1	160.1
Total assets	$ 1,244.0	368.7	176.5	1,789.2
Liabilities:				
Interest rate swap	$ —	16.4	—	16.4
Total liabilities	$ —	16.4	—	16.4

For the years ended June 30, 2014 and 2013, there were no significant transfers between Levels 1, 2 or 3.

(Continued)

(Dollars in millions)

Changes to the fair values based on the Level 3 inputs are summarized as follows:

	Private equity	Hedge funds	Total
Balance as of June 30, 2012	$ 19.4	117.6	137.0
Additions:			
Contributions/purchases	0.9	26.7	27.6
Disbursements:			
Withdrawals/sales	(2.8)	—	(2.8)
Net change in value	(1.1)	15.8	14.7
Balance as of June 30, 2013	16.4	160.1	176.5
Additions:			
Contributions/purchases	1.4	204.3	205.7
Disbursements:			
Withdrawals/sales	(3.4)	(125.4)	(128.8)
Net change in value	2.6	20.2	22.8
Balance as of June 30, 2014	$ 17.0	259.2	276.2

The following summarizes redemption terms for the hedge fund-of-funds vehicles held as of June 30, 2014:

	Fund 1	Fund 2	Fund 3	Fund 4
Redemption timing:				
Redemption frequency	Quarterly	95% within 1 year [1] 5% in 1 year or longer	Quarterly	Quarterly
Required notice	70 days	up to 90 days	90 days	65 days
Audit reserve:				
Percentage held back for audit reserve	10%	up to 10%	10%	10%
Gates:				
Potential gate holdback	—	up to 7.5%	—	—
Potential gate release timeframe	—	—	—	—

(1) One-third of this fund is redeemable within 90 days and the remainder of the investment is redeemable within one year.

Investments in hedge fund-of-funds are typically carried at estimated fair value. Fair value is based on the Net Asset Value (NAV) of the shares in each investment company or partnership. Such investment companies or partnerships mark-to-market or mark-to-fair value the underlying assets and liabilities in accordance with U.S. GAAP. Realized and unrealized gains and losses of the investment companies and

(Continued)

(Dollars in millions)

partnerships are included in their respective operations in the current year. Changes in unrealized gains or losses on investments, including those for which partial liquidations were effected in the course of the year, are calculated as the difference between the NAV of the investment at year-end less the NAV of the investment at the beginning of the year, as adjusted for contributions and redemptions made during the year and certain lock-up provisions. Generally, no dividends or other distributions are paid.

The following summarizes the status of contributions to the private equity fund-of-funds vehicles held as of June 30, 2014:

		Total commitment	Percentage of commitment contributed	Percentage of commitment remaining
Fund 1	$	11.0	92.7%	7.3%
Fund 2		7.1	95.0	5.0
Fund 3		7.1	81.5	18.5
Fund 4		10.0	6.3	93.7
Total	$	35.2		

Investments in private equity funds, typically structured as limited partnership interests, are carried at fair value using NAV or equivalent as determined by the General Partner in the absence of readily ascertainable market values. Distributions under this investment structure are made to investors through the liquidation of the underlying assets. It is expected to take up to ten years to fully distribute the proceeds of those assets. The fair value of limited partnership interests is generally based on fair value capital balances reported by the underlying partnerships, subject to management review and adjustment. Security values of companies traded on exchanges, or quoted on NASDAQ, are based upon the last reported sales price on the valuation date. Security values of companies traded over the counter, but not quoted on NASDAQ, and securities for which no sale occurred on the valuation date are based upon the last quoted bid price. The value of any security for which a market quotation is not readily available may be its cost, provided however, that the General Partner adjusts such cost value to reflect any bona fide third party transactions in such a security between knowledgeable investors, of which the General Partner has knowledge. In the absence of any such third party transactions, the General Partner may use other information to develop a good faith determination of value. Examples include, but are not limited to, discounted cash flow models, absolute value models, and price multiple models. Inputs for these models may include, but are not limited to, financial statement information, discount rates, and salvage value assumptions.

The valuation of both marketable and nonmarketable securities may include discounts to reflect a lack of liquidity or extraordinary risks, which may be associated with the investment. Determination of fair value is performed on a quarterly basis by the General Partner. Because of the inherent uncertainty of valuation, the determined values may differ significantly from the values that would have been used had a ready market for those investments existed.

(Continued)

(Dollars in millions)

(4) Property and Equipment

Property and equipment as of June 30, 2014 and 2013 is as follows:

	2014	2013
Land	$ 83.8	70.4
Buildings and improvements	1,281.9	1,249.4
Equipment	1,746.4	1,646.3
	3,112.1	2,966.1
Less accumulated depreciation and amortization	(2,025.6)	(1,914.1)
	1,086.5	1,052.0
Construction-in-progress	66.4	85.1
	$ 1,152.9	1,137.1

Construction-in-progress includes a variety of ongoing capital projects at the Corporation as of June 30, 2014 and 2013. Depreciation and amortization expense related to property and equipment amounted to $178.5 and $165.1 for the years ended June 30, 2014 and 2013, respectively.

(5) Other Assets

Other assets as of June 30, 2014 and 2013 consist of the following:

	2014	2013
Deferred financing costs, net	$ 13.1	13.8
Investments in unconsolidated entities	15.2	15.0
Reinsurance receivables	47.3	44.6
Deferred tax asset	26.3	28.4
Other assets	44.9	34.0
	$ 146.8	135.8

The Corporation has investments in other healthcare related organizations that are accounted for under the equity method which total $15.2 and $15.0 at June 30, 2014 and 2013, respectively. Under the equity method, original investments are recorded at cost and adjusted by the Corporation's share of the undistributed earnings or losses of these organizations. The related ownership interest in these organizations ranges from 8% to 50%. The Corporation's share of earnings in these organizations was $3.1 and $4.2 for the years ended June 30, 2014 and 2013, respectively, and are recognized in other operating revenue in the consolidated statements of operations and changes in net assets. Certain other nonconsolidated entities are recorded under the cost method.

(Continued)

(Dollars in millions)

(6) Debt

As of June 30, 2014 and 2013, the Corporation's outstanding borrowings include the following:

	2014	2013
Maryland Health and Higher Educational Facilities:		
Authority revenue bonds:		
5.25% Term bonds (Series 1998A, due 2038)	$ 82.0	82.0
5.25% Term bonds (Series 1998B, due 2038)	57.0	57.0
4.25% – 5.75% Serial bonds (Series 2004, due 2009 – 2025)	21.6	25.8
5.375% Term bonds (Series 2004, due 2024)	49.7	49.7
5.50% Term bonds (Series 2004, due 2033)	80.1	80.1
4.75% Term bonds (Series 2007, due 2042)	56.0	56.0
5.25% Term bonds (Series 2007, due 2046)	89.0	89.0
2.00% – 5.00% Serial bonds (Series 2011, due 2012 – 2023)	44.7	51.8
5.00% Term bonds (Series 2011, due 2031)	5.6	5.6
5.00% Term bonds (Series 2011, due 2041)	35.4	35.4
2.19% Direct Purchase (Series 2012, due 2017 – 2022)	38.6	38.6
3.00% – 5.00% Serial bonds (Series 2013A, due 2016 – 2028)	60.9	60.9
5.00% Term bonds (Series 2013A, due 2038)	17.3	17.3
5.00% Term bonds (Series 2013A, due 2041)	25.0	25.0
4.00% Term bonds (Series 2013A, due 2041)	14.6	14.6
3.00% – 5.00% Serial bonds (Series 2013B, due 2025 – 2033)	60.8	60.8
4.00% Term bonds (Series 2013B, due 2038)	45.0	45.0
5.00% Term bonds (Series 2013B, due 2038)	44.0	44.0
Plus unamortized net premium	28.0	30.0
	855.3	868.6
District of Columbia Hospital Revenue Bonds:		
Multimodal revenue bonds:		
0.03% – 0.08% at June 30, 2014 Serial bonds (Series 1998A due 2008-2038) (and 0.04% – 0.12% at June 30, 2013)	125.9	128.9
2.75% – 5.00% Serial bonds (Series 1998B, due 2008 – 2019)	9.6	11.0
5.00% Term bonds (Series 1998B, due 2028)	20.2	20.2
5.00% Term bonds (Series 1998B, due 2038)	33.9	33.9
2.75% – 5.00% Serial bonds (Series 1998C, due 2008 – 2019)	9.7	11.0

(Continued)

(Dollars in millions)

	2014	2013
5.50% Term bonds (Series 1998C, due 2028)	$ 20.1	20.1
5.00% Term bonds (Series 1998C, due 2038)	34.0	34.0
Less unamortized net discount	(1.3)	(1.2)
	252.1	257.9
Other:		
Notes payable to financial institutions or state agencies under mortgages (floating rates ranging between 0.9% – 6.2%) and other	15.9	12.1
Line of credit due August 2016 (0.18% – 0.80% at June 30, 2014 and 0.25% – 0.90% at June 30, 2013)	129.8	129.8
	145.7	141.9
Total debt	1,253.1	1,268.4
Less current portion of long-term debt	(60.5)	(61.2)
Long-term debt, net	$ 1,192.6	1,207.2

Scheduled maturities on borrowings, for the next five fiscal years and thereafter are as follows:

2015	$ 60.5
2016	19.3
2017	151.1
2018	22.3
2019	23.4
Thereafter	949.8
	$ 1,226.4

The fair value of outstanding tax exempt bonds is estimated to be $1,145.4 and $1,122.4 as of June 30, 2014 and 2013, respectively. The fair value of other long-term debt approximates its carrying value.

In December 1998, the Maryland Health and Higher Education Facilities Authority (MHHEFA) and the District of Columbia (District) issued bonds (Series 1998 Bonds) on behalf of the Corporation. Bond proceeds of approximately $588.6 were loaned to the Corporation under separate loan agreements with MHHEFA and the District upon execution of obligations pursuant to the Master Trust Indenture. The District issued $300.0 of Multimodal Revenue Bonds, including $150.0 Series 1998A ($27.2 repaid through August 2014), $75.0 Series 1998B ($12.7 repaid through August 2014), and $75.0 Series 1998C ($12.7 repaid through August 2014).

The District Series 1998A bonds, which consist of three tranches totaling $122.9 at August 2014, trade as uninsured Variable Rate Demand Obligations backed by bank letters of credit. The Series 1998A Tranche I bonds which remained outstanding in August 2014 consisted of approximately $41.0 bonds trading in a

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daily mode backed by a letter of credit issued by Wells Fargo Bank, National Association (formerly Wachovia Bank, National Association) and remarketed by J.P. Morgan Securities Inc. The letter of credit expires in March 2017. In the event of a failed remarketing, the Tranche I bonds would be tendered to the bank and repaid over a four-year period, beginning 367 days following the date of the failed remarketing. The Series 1998A Tranche II bonds totaled $41.0 in August 2014. These bonds trade in a weekly mode and are remarketed by Citigroup Global Markets Inc. The letter of credit backing these bonds was issued by JPMorgan Chase Bank, N.A. and expires in May 2015 and accordingly is included in the current portion of long-term debt. In the event of a failed remarketing, the Tranche II bonds would be tendered to the bank and repaid over a four-year period, beginning 367 days following the failed remarketing. The Series 1998A Tranche III bonds totaled $41.0 in August 2014. These bonds trade in a weekly mode and are remarketed by Citigroup Global Markets Inc. The letter of credit backing these bonds was issued by PNC Bank, National Association. The term of the letter of credit is five years, and expires in May 2017. In the event of a failed remarketing, the Tranche III bonds would be tendered to the bank and repaid over a four-year period, beginning 367 days following the failed remarketing. No portion of the Series 1998A bonds has been put at June 30, 2014 and 2013, respectively. The $62.3 Series 1998B and $62.3 Series 1998C bonds (as of August 2014) are at a fixed rate, insured by Assured Guaranty, Ltd. (Assured; formerly Financial Security Assurance, Inc.). The reimbursement obligation with respect to the letters of credit are evidenced and secured by obligations issued by the Corporation under the Master Trust Indenture.

MHHEFA issued $283.5 of Revenue Bonds, including the $166.6 Series 1998A ($82.0 outstanding after August 2014) and $116.9 Series 1998B ($57.0 outstanding after August 2014). All Series 1998 MHHEFA bonds were issued at fixed rates. Principal and interest under the Series 1998 MHHEFA bonds are insured under municipal insurance policies with Assured and Ambac. Of the original Series 1998 MHHEFA bonds, $51.7 was refinanced in March 2013 in conjunction with the MHHEFA Series 2013A financing described below.

Related to the District borrowings, the Corporation entered into an interest rate swap with Wells Fargo Bank, National Association in a notional amount totaling $150.0 (reduced to $97.5 at August 2014). The swap agreement expires in fiscal year 2027. The interest rate swap is part of a comprehensive and long-term capital structure strategy. The purpose of the swap is to mitigate the effect of potential interest rate volatility and minimize the variability of the Corporation's average cost of capital. Under the terms of the swap, the Corporation pays a fixed rate and receives a variable rate. Collateral is only required to be posted under the swap in the event that the Corporation's credit ratings are downgraded by two rating agencies below the BBB – or Baa2 – level. To date, no collateral postings have been required. As of June 30, 2014 and 2013, the variable interest rate under these agreements was 0.10% and 0.13%, respectively. The fixed rate was 3.6875% as of June 30, 2014 and 2013. The variable rates are capped at 14.0%. The change in fair value of the swap is reported in nonoperating gains (losses) in the statements of operations and changes in net assets.

In February 2004, MHHEFA issued $170.3 in bonds (Series 2004 Bonds) on behalf of the Corporation. The proceeds of the Series 2004 Bonds were loaned to the Corporation pursuant to a loan agreement with MHHEFA upon execution of an obligation pursuant to the Master Trust Indenture. The Series 2004 Bonds were issued as $40.5 serial bonds maturing 2009 through 2025 ($23.3 repaid through August 2014), $49.7 term bonds maturing 2024, and $80.1 term bonds maturing 2033. Such bonds were issued at fixed rates.

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Series 2004 Bonds maturing on or after August 2015 are subject to redemption or purchase at the option of the Corporation.

In January 2007, MHHEFA issued $145.0 in bonds (Series 2007 Bonds) on behalf of the Corporation. The Series 2007 Bonds were issued at a premium, resulting in total proceeds of $148.6. The proceeds of the Series 2007 Bonds were loaned to the Corporation pursuant to a loan agreement with MHHEFA upon execution of an obligation pursuant to the Master Trust Indenture. The Series 2007 Bonds were issued as $56.0 term bonds maturing 2042 and $89.0 term bonds maturing 2046. Such bonds were issued at fixed rates. Series 2007 Bonds maturing on or after May 2042 are subject to redemption or purchase at the option of the Corporation prior to maturity beginning in 2016.

In November 2011, MHHEFA issued $94.9 in bonds (Series 2011 Bonds) on behalf of the Corporation. The proceeds of the Series 2011 Bonds were loaned to the Corporation pursuant to a loan agreement with MHHEFA upon execution of an obligation pursuant to the Master Trust Indenture. The Series 2011 Bonds were issued as $53.9 serial bonds maturing 2012 through 2023 ($16.5 repaid through August 2014), $5.6 term bonds maturing 2031, and $35.4 term bonds maturing 2041. The Series 2011 Bonds maturing on or after August 2022 are subject to redemption or purchase at the option of the Corporation prior to maturity beginning in 2021. The Series 2011 Bonds were issued at fixed rates. The proceeds from the transaction were used to refund $20.2 of the Series 1998 A&B bonds, to refund debt outstanding on the Corporation's Revolving Credit Facility, and to refund certain debt associated with MedStar St. Mary's Hospital.

In June 2012, the Corporation entered into a $38.6 MHHEFA Direct Purchase financing transaction with JP Morgan Chase Bank, N.A. (the Series 2012 Bond). The proceeds from the transaction were used to redeem certain outstanding MHHEFA Series 1998A bonds that were due to mature in 2018 as well as a portion of the outstanding MHHEFA Series 1998 A&B bonds due to mature in 2028. The repayment of the Series 2012 Bond is evidenced by an obligation issued under the Master Trust Indenture. The term of the Series 2012 Bond is ten years and the repayment terms approximate the previous repayment terms of the Series 1998 bonds that were refunded. Covenants, conditions, and security for the Series 2012 Bond is similar to the revolving credit agreement.

In March 2013, MHHEFA issued $117.8 in bonds (Series 2013A Bonds) on behalf of the Corporation. The Series 2013A Bonds were issued at a premium, resulting in total proceeds of $128.7. The proceeds of the Series 2013A Bonds were loaned to the Corporation pursuant to a loan agreement with MHHEFA upon execution of an obligation pursuant to the Master Trust Indenture. The Series 2013A Bonds were issued as $60.9 serial bonds maturing 2016 through 2028, $17.3 term bonds maturing 2038, $25.0 term bonds due 2041, and $14.6 term bonds maturing 2041. The Series 2013A Bonds maturing on or after August 2024 are subject to redemption or purchase at the option of the Corporation prior to maturity beginning in 2023. The Series 2013A Bonds were issued at fixed rates. The proceeds from the transaction were used to refund $51.7 of the Series 1998 A&B bonds, to fund various capital projects and capitalized interest on those projects.

In May 2013, MHHEFA issued $149.8 in bonds (Series 2013B Bonds) on behalf of the Corporation. The Series 2013B Bonds were issued at a premium, resulting in total proceeds of $159.4. The proceeds of the Series 2013B Bonds were loaned to the Corporation pursuant to a loan agreement with MHHEFA upon execution of an obligation pursuant to the Master Trust Indenture. The Series 2013B Bonds were issued as

(Continued)

$60.8 serial bonds maturing 2025 through 2033, $45.0 term bonds maturing 2038, and $44.0 term bonds maturing 2038. The Series 2013B Bonds maturing on or after August 2024 are subject to redemption or purchase at the option of the Corporation prior to maturity beginning in 2023. The Series 2013B Bonds were issued at fixed rates. The proceeds from the transaction were used to refinance a portion of the bridge loan put in place when MedStar acquired the assets of Southern Maryland Hospital Center in December 2012.

The Corporation, which is currently the sole member of an "obligated group" as defined in the Master Trust Indenture, is bound by the provisions of the Master Trust Indenture for payment of any outstanding obligations under existing loan agreements. All of the hospitals and certain other affiliates (the guarantors) of the Corporation are parties to a guaranty agreement pursuant to which they jointly and severally guaranty the payment and performance of the obligations under the Master Trust Indenture. The obligations of the guarantors under the Guaranty Agreement are collateralized by deeds of trust granted by the hospitals. Under the Master Trust Indenture and the deeds of trust, as collateral for the payments due thereunder, the Corporation and its hospital affiliates, have granted a security interest in their revenues subject to permitted encumbrances.

Under the Master Trust Indenture, the Corporation is required to maintain, among other covenants, a maximum annual debt service coverage ratio of not less than 1.10. Under the loan agreements relating to the Series 1998 Bonds, the Corporation is required to maintain a historical debt service coverage ratio of not less than 2.0 and to maintain at least 65 days cash on hand. In the event the Corporation does not meet either of these requirements, it is required to fund a trustee-held debt service reserve fund securing the Series 1998 Bonds. The amount to be deposited shall equal the lesser of: 10% of the principal amount of such outstanding bonds, or the largest annual debt service with respect to such bonds in any future year, or 125% of the average annual debt service of future years. As of June 30, 2014 and 2013, there were no funds required to be held in the debt service reserve fund for the Series 1998 Bonds.

The Corporation maintains a $250.0 revolving credit agreement provided by a group of banks. The facility has a three-year term expiring in August 2016. The facility is evidenced by an obligation issued under the Master Trust Indenture. The outstanding balance on the facility was $129.8 at June 30, 2014 and 2013. The facility includes certain covenants, including a requirement to maintain Days Cash on Hand of 70 days, measured semi-annually at each June 30 and December 31, and a Debt Service Coverage ratio of 1.25, measured quarterly on a rolling four quarters basis. In addition, the Corporation is required to maintain a minimum credit rating of Baa2 from Moody's Investor's Service, and BBB from Standard & Poor's and Fitch Ratings. In addition, the Corporation maintains a $30.0 letter of credit facility, provided by a single lender, which is also evidenced by an obligation issued under the Master Trust Indenture. This facility is principally used to securitize certain regulatory obligations under various insurance programs, and has terms and conditions similar to the revolving credit agreement. The facility has a three-year term expiring in August 2016. However, the standby letters of credit issued under the facility can be canceled at the bank's option each year. As of June 30, 2014 and 2013, standby letters of credit issued pursuant to the facility were $18.2. No amounts have been drawn by the beneficiaries under the standby letters of credit.

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(7) Retirement Plans

The Corporation has two qualified defined benefit pension plans (MedStar Health, Inc. Pension Equity Plan (PEP) and MedStar Health, Inc. Cash Balance Retirement Plan (CBRP)) covering substantially all full-time employees hired before 2005. MedStar St. Mary's Hospital also has a defined benefit plan that substantially covers all employees of MedStar St. Mary's Hospital. Participation in all plans has been closed to new entrants and all plans are frozen to future benefit accruals.

Benefits under the plans are substantially based on years of service and the employees' career earnings. The Corporation contributes to the plans based on actuarially determined amounts necessary to provide assets sufficient to meet benefits to be paid to plan participants and to meet the minimum funding requirements of the Employee Retirement Income Security Act of 1974, as amended by the Pension Protection Act of 2006, and Internal Revenue Service regulations. Effective July 1, 2000, employees of the Transferred Businesses (note 17) became participants in one of the Corporation's pension plans and are reflected in the pension information provided below.

The Corporation's investment policies are established by the MedStar Health, Inc.'s Investment Committee, which is comprised of members of the Board of Directors, other community leaders, and management. Among its responsibilities, the Investment Committee is charged with establishing and reviewing asset allocation strategies, monitoring investment manager performance, and making decisions to retain and terminate investment managers. Assets of each of the Corporation's pension plans are managed in a similar fashion by the same group of investment managers. The Corporation has incorporated an Investment Policy Statement (IPS) into the investment program. The IPS, which has been formally adopted by the Corporation's Board of Directors, contains numerous standards designed to ensure adequate diversification by asset class and geography. The IPS also limits all investments by manager and position size, and limits fixed income position size based on credit ratings, which serves to further mitigate the risks associated with the investment program. As of June 30, 2014 and 2013, management believes that all investments were being managed in a manner consistent with the IPS.

(Continued)

(Dollars in millions)

The following table illustrates the actual allocations as of June 30:

	Actual allocation June 30, 2014	Actual allocation June 30, 2013
Publicly traded equities – domestic	30%	34%
Publicly traded equities – international	10	12
Fixed income securities	16	21
Alternative investments:		
Commingled equity funds	14	9
Inflation hedging equity, commodity, fixed income fund	5	5
Hedge funds	18	13
Private equities	2	2
Cash	5	4
Total	100%	100%

The table below presents the Corporation's pension plans' investable assets as of June 30, 2014 aggregated by the three level valuation hierarchy:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 50.1	—	—	50.1
U.S. Treasury bonds	42.8	—	—	42.8
U.S. agency mortgage backed securities	24.0	—	—	24.0
Corporate bonds	—	37.2	—	37.2
Fixed income mutual funds	—	47.2	—	47.2
All other fixed income securities	1.2	13.2	—	14.4
Equity mutual funds and ETF's	74.5	—	—	74.5
Common stocks	346.1	—	—	346.1
Alternative investments:				
Commingled equity funds	—	145.2	—	145.2
Inflation hedging equity, commodity, fixed income fund	—	55.4	—	55.4
Private equity	—	—	17.0	17.0
Hedge funds	—	—	193.0	193.0
Total assets	$ 538.7	298.2	210.0	1,046.9

(Continued)

(Dollars in millions)

The table below presents the Corporation's pension plans' investable assets as of June 30, 2013 aggregated by the three level valuation hierarchy:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 36.2	—	—	36.2
U.S. Treasury bonds	34.3	—	—	34.3
U.S. agency mortgage backed securities	31.5	—	—	31.5
Corporate bonds	—	43.8	—	43.8
Fixed income mutual funds	—	60.1	—	60.1
All other fixed income securities	0.6	16.4	—	17.0
Equity mutual funds and ETF's	80.5	—	—	80.5
Common stocks	326.1	—	—	326.1
Alternative investments:				
Commingled equity funds	—	75.2	—	75.2
Inflation hedging equity, commodity, fixed income fund	—	47.9	—	47.9
Private equity	—	—	17.0	17.0
Hedge funds	—	—	111.4	111.4
Total assets	$ 509.2	243.4	128.4	881.0

For the years ended June 30, 2014 and 2013, there were no significant transfers between Levels 1, 2 or 3.

(Continued)

(Dollars in millions)

Changes to the fair values based on the Level 3 inputs are summarized as follows:

	Private equity	Hedge funds	Total
Balance as of June 30, 2012	$ 17.1	82.4	99.5
Additions:			
Contributions/purchases	0.9	20.2	21.1
Disbursements:			
Withdrawals/sales	(2.6)	(0.3)	(2.9)
Net change in value	1.6	9.1	10.7
Balance as of June 30, 2013	17.0	111.4	128.4
Additions:			
Contributions/purchases	1.3	149.3	150.6
Disbursements:			
Withdrawals/sales	(3.4)	(83.2)	(86.6)
Net change in value	2.1	15.5	17.6
Balance as of June 30, 2014	$ 17.0	193.0	210.0

The following summarizes redemption terms for the hedge fund-of-funds vehicles held as of June 30, 2014:

	Fund 1	Fund 2	Fund 3	Fund 4
Redemption timing:				
Redemption frequency	Quarterly	95% within 1 year [1] 5% in 1 year or longer	Quarterly	Quarterly
Required notice	70 days	up to 90 days	90 days	65 days
Audit reserve:				
Percentage held back for audit reserve	10%	up to 10%	10%	10%
Gates:				
Potential gate holdback	—	up to 7.5%	—	—
Potential gate release timeframe	—	—	—	—

(1) One-third of this fund is redeemable within 90 days and the remainder of the investment is redeemable within one year.

Investments in hedge fund-of-funds are typically carried at estimated fair value. Fair value is based on the Net Asset Value (NAV) of the shares in each investment company or partnership. Such investment companies or partnerships mark-to-market or mark-to-fair value the underlying assets and liabilities in accordance with U.S. GAAP. Realized and unrealized gains and losses of the investment companies and

(Continued)

(Dollars in millions)

partnerships are included in their respective operations in the current year. Changes in unrealized gains or losses on investments, including those for which partial liquidations were effected in the course of the year, are calculated as the difference between the NAV of the investment at year-end less the NAV of the investment at the beginning of the year, as adjusted for contributions and redemptions made during the year and certain lock-up provisions. Generally, no dividends or other distributions are paid.

The following summarizes the status of contributions to the private equity fund-of-funds vehicles held as of June 30, 2014:

	Total commitment	Percentage of commitment contributed	Percentage of commitment remaining
Fund 1	$ 9.0	92.9%	7.1%
Fund 2	8.5	95.0	5.0
Fund 3	8.5	81.5	18.5
Fund 4	5.0	8.0	92.0
Fund 5	5.0	—	100.0
Total	$ 36.0		

Investments in private equity funds, typically structured as limited partnership interests are carried at fair value using NAV or equivalent as determined by the General Partner in the absence of readily ascertainable market values. Distributions under this investment structure are made to investors through the liquidation of the underlying assets. It is expected to take up to ten years to fully distribute the proceeds of those assets. The fair value of limited partnership interests is generally based on fair value capital balances reported by the underlying partnerships, subject to management review and adjustment. Security values of companies traded on exchanges, or quoted on NASDAQ, are based upon the last reported sales price on the valuation date. Security values of companies traded over the counter, but not quoted on NASDAQ, and securities for which no sale occurred on the valuation date are based upon the last quoted bid price. The value of any security for which a market quotation is not readily available may be its cost, provided however, that the General Partner adjusts such cost value to reflect any bona fide third party transactions in such a security between knowledgeable investors, of which the General Partner has knowledge. In the absence of any such third party transactions, the General Partner may use other information to develop a good faith determination of value. Examples include, but are not limited to, discounted cash flow models, absolute value models, and price multiple models. Inputs for these models may include, but are not limited to, financial statement information, discount rates, and salvage value assumptions.

The valuation of both marketable and nonmarketable securities may include discounts to reflect a lack of liquidity or extraordinary risks, which may be associated with the investment. Determination of fair value is performed on a quarterly basis by the General Partner. Because of the inherent uncertainty of valuation, the determined values may differ significantly from the values that would have been used had a ready market for those investments existed.

(Continued)

(Dollars in millions)

The Corporation has established a long-term investment return target of 7.75% and 8.00% for both PEP and CBRP in 2014 and 2013, respectively. These assumptions are based on historical returns achieved in the investment portfolios over the last ten years and represent the return that can reasonably be expected to be generated on a similarly structured portfolio in the future.

The Corporation recognizes the funded status of defined benefit pension plans in the consolidated balance sheets and the recognition in unrestricted net assets of unrecognized gains or losses, prior service costs or credits and transition assets or obligations. The funded status is measured as the difference between the fair value of the plan's assets and the projected benefit obligation of the plan. The measurement date for the plans is June 30.

By letter dated March 12, 2012, the Internal Revenue Service (IRS) notified the plan administrator that it had selected the plans for a routine examination. The examination initially covered the plan year ended December 31, 2010. During the examination, the IRS extended the examination to include additional years for some of the plans. By letter dated October 31, 2013, the IRS notified the plan administrator that it had completed the examination and had found that the plans were in compliance and that it had accepted all of its returns as filed.

The following are deferred pension costs which have not yet been recognized in periodic pension expense but instead are accrued in unrestricted net assets, as of June 30, 2014 and 2013. Unrecognized actuarial losses represent unexpected changes in the projected benefit obligation and plan assets over time, primarily due to changes in assumed discount rates and investment experience. Unrecognized prior service cost is the impact of changes in plan benefits applied retrospectively to employee service previously rendered. Deferred pension costs are amortized into annual pension expense over the expected future lifetime for active employees with frozen benefits.

	Amounts in unrestricted net assets to be recognized during the next fiscal year	Amounts recognized in unrestricted net assets as of June 30, 2014	Amounts recognized in unrestricted net assets as of June 30, 2013
Net actuarial loss	$ 16.4	549.4	547.2

(Continued)

(Dollars in millions)

The following table sets forth the plans' funded status and amounts recognized in the accompanying consolidated financial statements as of June 30, 2014 and 2013:

		2014	2013
Change in benefit obligation:			
Benefit obligation at beginning of year	$	1,183.0	1,244.1
Interest cost		59.1	55.9
Actuarial loss (gain)		89.9	(74.2)
Benefits paid		(53.2)	(42.8)
Benefit obligation at end of year		1,278.8	1,183.0
Change in plan assets:			
Plan assets at fair value at beginning of year		881.0	773.8
Actual return on plan assets		143.2	81.4
Company contributions		75.9	68.6
Benefits paid		(53.2)	(42.8)
Plan assets at fair value at end of year		1,046.9	881.0
Funded status/net amount recognized	$	(231.9)	(302.0)

The amounts recognized in the consolidated financial statements consist of the following as of June 30:

		2014	2013
Pension assets (included in other assets)	$	2.4	2.9
Pension liabilities		(234.3)	(304.9)

The Corporation has estimated $55.7 for its defined benefit contributions for the fiscal year ending June 30, 2015. The accumulated benefit obligation is $1,278.8 and $1,183.0 at June 30, 2014 and 2013, respectively.

Expected fiscal year benefit payments for all defined benefit plans is as follows:

2015	$	59.5
2016		58.0
2017		61.7
2018		65.9
2019		68.6
2020–2024		392.5
Total	$	706.2

(Continued)

(Dollars in millions)

Net periodic pension expense for the years ended June 30, 2014 and 2013 is as follows:

	2014	2013
Interest cost on projected benefit obligation	$ 59.1	55.9
Return on plan assets	(69.6)	(65.3)
Recognized actuarial loss	14.2	16.7
Net periodic pension expense	$ 3.7	7.3

The assumptions used in determining net periodic pension expense and accrued pension costs shown above are as follows:

	2014	2013
Discount rates for obligations at year end:		
MedStar Health, Inc. Pension Equity Plan	4.65%	5.20%
MedStar Health, Inc. Cash Balance Retirement Plan	4.50	5.05
MedStar St. Mary's Hospital Pension Plan	4.25	5.00
Discount rates for pension cost:		
MedStar Health, Inc. Pension Equity Plan – July 1 – June 30	5.20%	4.60%
MedStar Health, Inc. Cash Balance Retirement Plan – July 1 – June 30	5.05	4.55
MedStar St. Mary's Hospital Pension Plan – July 1 – June 30	5.00	4.35
Expected long-term rate of return on plan assets – PEP and CBRP	7.75%	8.00%
Expected long-term rate of return on plan assets – MedStar St. Mary's Hospital	7.50	7.50

The Corporation also has various contributory, tax deferred annuity and savings plans with participation available to certain employees. The Corporation matches employee contributions up to 3.0% of compensation in certain plans. The Corporation contributed approximately $27.3 and $26.1 during the years ended June 30, 2014 and 2013, respectively.

(8) Business and Credit Concentrations

The Corporation provides healthcare services through its inpatient and outpatient care facilities located in the State of Maryland, the District of Columbia and Northern Virginia. 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 (e.g., Medicare, Medicaid, Blue Cross, Workers' Compensation, health maintenance organizations (HMOs) and commercial insurance policies).

(Continued)

(Dollars in millions)

The Corporation estimates the allowance for uncollectible accounts based on the aging of accounts receivable, historical collection experience, payor mix and other relevant factors. A significant portion of the allowance for uncollectible accounts relates to self-pay patients, as well as co-payments and deductibles owed by patients with insurance. There are various factors that can impact collection trends, such as changes in the economy, which in turn have an impact on unemployment rates and the number of uninsured and underinsured patients. Other factors include the volume of patients through the emergency departments and the increased level of co-payments and deductibles due from patients with insurance. These factors continuously change and can have an impact on collection trends and the estimation process.

The activity in the allowance for uncollectible accounts is summarized as follows for the years ended June 30, 2014 and 2013:

		2014	2013
Beginning balance	$	204.3	189.7
Provision for bad debts		193.2	214.5
Write-offs, net of recoveries		(208.7)	(199.9)
Ending balance	$	188.8	204.3

As of June 30, 2014 and 2013, the Corporation's allowance for uncollectible accounts was approximately 25.3% and 27.2%, respectively, as a percentage of patient service receivables. The Corporation's provision for bad debts represents 4.6% and 5.2% of net patient service revenue for the years ended June 30, 2014 and 2013, respectively.

A summary of net patient service revenue by major category of payor for the years ended June 30, 2014 and 2013 is as follows:

	2014	2013
Medicare and Medicare HMO	37%	36%
Medicaid and Medicaid HMO	11	10
Carefirst Blue Cross Blue Shield	19	19
Other commercial and managed care payors	24	26
Self-pay	9	9
	100%	100%

(Continued)

(Dollars in millions)

A summary of net patient receivables by major category of payor as of June 30, 2014 and 2013 is as follows:

	2014	2013
Medicare and Medicare HMO	28%	27%
Medicaid and Medicaid HMO	20	19
Carefirst Blue Cross Blue Shield	13	13
Other commercial and managed care payors	30	29
Self-pay	9	12
	100%	100%

Certain Maryland-based hospital charges are subject to review and approval by the 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.

Under the Maryland HSCRC rate methodology, amounts payable for services in 2014 and 2013 to Maryland hospital patients under the Medicare and Medicaid insurance programs are computed at 94% of regulated charges. This discount amount does not include MCO granted discounts for medical education. Hospital patients under the Blue Cross and approved health maintenance organization insurance programs are computed at 98% of regulated charges. Maryland accounts receivable from these third-party payors have been adjusted to reflect the difference between charges and the payable amounts.

In January 2014, CMS approved Maryland's new waiver for a five-year period beginning January 1, 2014 for inpatient and outpatient hospital services. The new waiver ties hospital per capita revenue growth to the state's economic growth of 3.58% and requires Medicare spending in Maryland to be 0.5% below the national average. CMS can require the State to submit a corrective action plan if targets for a given performance year are not met. The new waiver also imposes quality measures and encourages population health management.

In connection with the new waiver, the HSCRC introduced new revenue arrangements, including the Global Budget Revenue (GBR) model. This new model for Maryland Hospitals moves payment to hospitals from each individual service to a total revenue for each hospital or a combination of hospitals to provide hospitals flexibility in the objectives of better care for individuals, higher levels of overall population health, and improved health care affordability. It removes the financial incentive from increasing volume and provides incentive to work with partners to provide care in the appropriate setting. The Company entered into a GBR arrangement covering five of its seven Maryland hospitals during the year ended June 30, 2014. In August 2014, the Company also entered into GBR arrangements for its remaining two Maryland hospitals. The GBR arrangement is expected to be in place at least three years, but will be renewed annually unless terminated by either party with 180 days prior notice. The Company recognized hospital inpatient and outpatient revenue under the new arrangement for the year ended June 30, 2014. For the fiscal year ended June 30, 2013, the Company recognized hospital inpatient and

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outpatient revenue under its previous agreements with the HSCRC. These agreements included reimbursement on a charge per episode target, defining episode as inpatient care provided within 30 days.

The Budget Control Act of 2011 (the Budget Control Act) mandated significant reductions and spending caps on the federal budget for fiscal years 2012 through 2021. As part of this legislation, a 2% reduction in Medicare spending, known as Sequestration, was implemented beginning April 1, 2013 and the Corporation's Medicare payments subsequent to that date were reduced by the mandatory 2%. It is not possible to determine how future congressional actions to reduce the federal deficit in order to end Sequestration will impact the Corporation's revenues.

Through its MedStar Family Choice, Inc. subsidiary, the Corporation enters into fee-for-service and capitation agreements with independent health professionals and organizations to provide covered services to eligible enrollees where such services cannot be provided by its employed physicians or controlled entities. Medical and clinical expenses from these agreements include claim payments, capitation payments, and estimates of outstanding claims liabilities for services provided prior to the balance sheet date. The estimates of outstanding claims liabilities ($52.2 and $17.0 as of June 30, 2014 and 2013, respectively), are based on management's analysis of historical claims paid reports and as well as review of health services utilization during the period and are included in accounts payable and accrued expenses on the consolidated balance sheets. Changes in these estimates are recorded in the period of change. Claims payments and capitation payments are expensed in the period services are provided to eligible enrollees.

(9) Certain Significant Risks and Uncertainties

The Corporation provides general healthcare services in the State of Maryland, the District of Columbia and Northern Virginia. As a healthcare provider, the Corporation is subject to certain significant inherent risks, including the following:

- Dependence on revenues derived from reimbursement by the federal Medicare and state Medicaid programs;
- Regulation of hospital rates by the State of Maryland HSCRC;
- Government regulation, government budgetary constraints and proposed legislative and regulatory changes, and;
- Lawsuits alleging malpractice or other claims.

Such inherent risks require the use of certain management estimates in the preparation of the Corporation's consolidated financial statements and it is reasonably possible that a change in such estimates may occur.

The Medicare and state Medicaid reimbursement programs represent a substantial portion of the Corporation's revenues and the Corporation's operations are subject to a variety of other federal, state and local regulatory requirements. In addition, changes in federal and state reimbursement funding mechanisms and related government budgetary constraints could have a significant adverse effect on the Corporation. Similarly, failure by the Corporation to maintain required regulatory approvals and licenses and/or changes in related regulatory requirements could have a significant adverse effect.

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Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount. Management periodically reviews recorded amounts receivable from or payable to third-party payors and may adjust these balances as new information becomes available. In addition, revenue received under certain third-party agreements is subject to audit. During 2014 and 2013, certain of the Corporation's prior year third-party cost reports were audited and settled, or tentatively settled, by third-party payors. Adjustments resulting from such audits and management reviews of unaudited years and open claims are reflected as adjustments to revenue in the year that the adjustment becomes known. Although certain other prior year cost reports submitted to third-party payors remain subject to audit and retroactive adjustment, management does not expect any material adverse settlements.

The healthcare industry is subject to numerous laws and regulations from federal, state and local governments, and the government has increased enforcement of Medicare and Medicaid anti-fraud and abuse laws, as well as physician self referral laws (STARK laws and regulation). The Corporation's compliance with these laws and regulations is subject to periodic governmental review, which could result in enforcement actions unknown or unasserted at this time. The Corporation is aware of certain asserted and unasserted legal claims by the government, and has provided requested information. The final outcomes of these government investigations cannot be determined at this time.

Recent federal initiatives have prompted a national review of federally funded healthcare programs. To this end, the federal government, and many states, implemented programs to audit and recover potential overpayments to providers from the Medicare and Medicaid programs. Since June 2010, the Corporation's hospitals have received audit requests from the Medicare Recovery Audit Contractor (RAC) program. These RAC audit requests have focused on medical necessity of inpatient admissions and hospital coding practices. In addition, the hospitals have continued to receive routine audit requests from other Medicare contractors and the Office of Inspector General. The Corporation's hospitals have cooperated with each of these audit requests and implemented a program to track and manage their effect.

As a result of recently enacted and pending federal healthcare reform legislation, rules and regulations, substantial changes are occurring in the United States healthcare system. These include numerous provisions affecting the delivery of healthcare services, the financing of healthcare costs, reimbursement to healthcare providers and the legal obligations of health insurers, providers and employers. These provisions are currently slated to take effect at specified times over the next decade. This federal healthcare reform legislation did not significantly affect the 2014 or 2013 consolidated financial statements.

The Corporation, in the normal course of business, is a party to legal and regulatory proceedings. These include a lawsuit filed in June 2011 by several MedStar Washington Hospital Center (MWHC) employees alleging violations by the Corporation of wage-hour laws. The plaintiffs in this action are seeking certification of a class that would include hourly employees at all of the Corporation's hospitals. The Corporation is opposing class certification and taking other steps to defend itself and the hospitals in this litigation. The final outcome of this litigation cannot be determined at this time. In April 2014, another lawsuit was filed in federal court alleging similar wage-hour violations as the 2011 action. This lawsuit seeks to certify a class to include hourly employees at six of the Company's hospitals. The Company will oppose class certification and otherwise defend itself and the hospitals in this matter.

(Dollars in millions)

In June 2014, MWHC agreed on a new collective bargaining agreement with the union that represents its service employees, SEIU, Local 722. In September 2014, MWHC began negotiations with National Nurses United, the union that represents the hospital's nurses. The existing collective bargaining agreement will expire on November 15, 2014.

The Corporation, in the normal course of business, is a party to a number of legal and regulatory proceedings. Management does not expect that the results of these proceedings will have a material adverse effect on the consolidated financial position or results of operations of the Corporation.

(10) Self-Insurance Programs

The Corporation maintains self-insurance programs for professional and general liability risks, employee health and workers' compensation. Estimated liabilities have been recorded based on actuarial estimation of reported and incurred but not reported claims. The combined accrued liabilities for these programs at June 30, 2014 and 2013 were as follows:

	2014	2013
Professional and general liability	$ 345.4	285.9
Employee health	18.9	21.9
Workers' compensation	34.4	32.9
Total liabilities	398.7	340.7
Less current portion	(86.3)	(87.5)
	$ 312.4	253.2

The Corporation's self insurance program for professional and general liability is responsible for the following exposures as of June 30, 2014:

(a) For professional liability during the periods of July 1, 2012 to June 30, 2013 and July 1, 2013 to June 30, 2014, for all MedStar entities except MedStar Montgomery Medical Center (MMMC) and MedStar St. Mary's Hospital (MSMH), the Corporation is responsible for the first $5.0 exposure for each and every claim plus an additional exposure above the $5.0 self-insured retention referred to as an "inner aggregate."

For the period July 1, 2011 to December 31, 2012, the applicable inner aggregate was an inner aggregate that was in effect for the 24 month period January 1, 2010 through December 31, 2012. This inner aggregate exposes the Corporation to up to $2.5 per claim with an aggregate for the 24 month period of $5.0 above the $5.0 per claim self-insured retention for all claims incurred during the period January 1, 2011 through December 31, 2012.

For the period January 1, 2013 to June 30, 2013, the applicable inner aggregate was the inner aggregate in effect for the 12 month period January 1, 2013 through December 31, 2013. This inner aggregate exposes the Corporation to up to $3.0 per claim with an annual aggregate of $6.0 above

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the Corporation's $5.0 per claim self-insured retention for all claims incurred during the period January 1, 2013 through December 31, 2013.

For the period January 1, 2014 to June 30, 2014, the applicable inner aggregate was in effect for the 12 month period of January 1, 2014 to December 31, 2014. This inner aggregate exposes the Corporation to up to $3.0 per claim with a $6.0 annual aggregate above the Corporation's $5.0 per claim self-insured retention for all claims incurred during the period January 1, 2014 to December 31, 2014.

Effective December 10, 2012, Southern Maryland Hospital joined the Corporation as MedStar Southern Maryland Hospital Center (MSMHC). MSMHC is covered for all professional liability exposure for activities on or after December 10, 2012 under the same program of coverage described above. The Corporation did not assume responsibility for MSMHC exposure or any tail claims that might arise in future years related to activities that occurred prior to the acquisition by the Corporation.

For MMMC and MSMH, the Corporation is responsible for the first $2.0 exposure for each claim (not subject to the inner aggregate structures noted above).

(b) For general liability, the Corporation is responsible for the first $3.0 exposure for each claim (for MMMC and MSMH, the first $2.0 exposure for each claim). General liability claims are not subject to the inner aggregate excess retention as described above. MSMHC is covered for general liability exposure for activities on or after December 10, 2012 under the Corporation's general liability program.

(c) Commercial excess re-insurance has been purchased above the self-insured retentions described above in multiple layers and in twin towers; one for professional and one for general liability. During the period of July 1, 2011 to December 31, 2012, each tower has seven layers of excess re-insurance coverage which provides coverage of up to $100.0 per claim and $100.0 in the annual aggregate. Effective January 1, 2013, the Corporation purchased an additional layer of commercial excess re-insurance. During the period of January 1, 2013 through June 30, 2014, each tower has eight layers of excess re-insurance which provides coverage of up to $125.0 per claim and $125.0 in the annual aggregate. The Corporation maintains reinsurance contracts with various "A" rated commercial insurance companies.

The professional and general liabilities as of June 30, 2014 and 2013 have been discounted at a rate of 1.75%. The workers' compensation liabilities as of June 30, 2014 and 2013 have been discounted at a rate of 1.50%.

Assets available to fund these liabilities are held in separate accounts (see note 2). Contributions required to fund professional and general liability, employee health benefits and workers' compensation programs are determined by the plans' administrators based on appropriate actuarial assumptions. The professional and general liability programs are administered through an offshore wholly owned captive insurance company, Greenspring Financial Insurance Limited (GFIL), which is domiciled in the Grand Cayman Islands.

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(Dollars in millions)

(11) Unrestricted Net Assets

The Corporation accounts for and presents noncontrolling interests in a consolidated subsidiary as a separate component of the appropriate class of consolidated net assets. The income attributable to noncontrolling interests is included within operating income on the consolidated statements of operations and changes in net assets. The following table presents a reconciliation of the changes in consolidated unrestricted net assets attributable to the Corporation's controlling interest and noncontrolling interest, including amounts such as the performance indicator and other changes in unrestricted net assets as of and for the years ended June 30, 2014 and 2013:

	MedStar Health, Inc.	Noncontrolling interests	Total unrestricted net assets
Balance as of June 30, 2012	$ 726.9	8.7	735.6
Excess of revenues over expenses	180.6	5.1	185.7
Change in funded status of defined benefit plans	106.9	—	106.9
Net assets released for property and equipment and other	3.0	1.9	4.9
Distributions to noncontrolling interests	—	(6.3)	(6.3)
Increase in unrestricted net assets	290.5	0.7	291.2
Balance as of June 30, 2013	1,017.4	9.4	1,026.8
Excess of revenues over expenses	302.4	2.3	304.7
Change in funded status of defined benefit plans	(2.1)	—	(2.1)
Net assets released for property and equipment and other	4.5	(2.8)	1.7
Distributions to noncontrolling interests	—	(3.7)	(3.7)
Increase (decrease) in unrestricted net assets	304.8	(4.2)	300.6
Balance as of June 30, 2014	$ 1,322.2	5.2	1,327.4

(Continued)

(Dollars in millions)

(12) Temporarily and Permanently Restricted Net Assets

Temporarily and permanently restricted net assets as of June 30, 2014 and 2013 are available for the following purposes:

		2014	2013
Temporary restrictions:			
Interest in net assets of foundation	$	64.9	54.8
Other		56.9	44.2
	$	121.8	99.0
Permanent restrictions:			
Investments to be held in perpetuity, the income from which is available to support healthcare services	$	39.4	39.1

Temporarily restricted net assets are available for the purposes of purchasing property and equipment, providing health education, research and other healthcare services.

(13) Endowment Net Assets

The Corporation's endowments consist of individual donor-restricted funds established for a variety of purposes. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

(a) Interpretation of Relevant Law

The Corporation has interpreted the State Prudent Management of Institutional Funds Act (SPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Corporation classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the organization in a manner consistent with the standard of prudence prescribed by SPMIFA. In accordance with SPMIFA, the Corporation considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

(1) The duration and preservation of the fund

(2) The purposes of the Corporation and the donor-restricted endowment fund

(3) General economic conditions

(Continued)

(Dollars in millions)

(4) The possible effect of inflation and deflation

(5) The expected total return from income and the appreciation of investments

(6) Other resources of the Corporation

(7) The investment policies of the Corporation

(b) Endowment Net Assets Consist of the Following as of June 30, 2014

	Unrestricted	Temporarily restricted	Permanently restricted	Total
Donor-restricted endowment funds	$ —	6.6	39.4	46.0
Total endowed net assets	$ —	6.6	39.4	46.0

(c) Endowment Net Assets Consist of the Following as of June 30, 2013

	Unrestricted	Temporarily restricted	Permanently restricted	Total
Donor-restricted endowment funds	$ —	3.6	39.1	42.7
Total endowed net assets	$ —	3.6	39.1	42.7

(d) Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or SPMIFA requires the Corporation to retain as a fund of perpetual duration. In accordance with U.S. GAAP, there were no deficiencies of this nature that are reported in unrestricted net assets as of June 30, 2014 and 2013.

(e) Investment Strategies

The Corporation has adopted policies for corporate investments, including endowment assets, that seek to maximize risk-adjusted returns with preservation of principal. Endowment assets include those assets of donor-restricted funds that the Corporation must hold in perpetuity or for a donor-specified period(s). The endowment assets are invested in a manner that is intended to hold a mix of investment assets designed to meet the objectives of the account. The Corporation expects its endowment funds, over time, to provide an average rate of return that generates earnings to achieve the endowment purpose.

(Continued)

To satisfy its long-term rate-of-return objectives, the Corporation relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Corporation employs a diversified asset allocation structure to achieve its long-term return objectives within prudent risk constraints.

The Corporation monitors the endowment funds returns and appropriates average returns for use. In establishing this practice, the Corporation considered the long-term expected return on its endowment. This is consistent with the Corporation's objective to maintain the purchasing power of the endowment assets held in perpetuity or for a specified term as well as to provide additional real growth through new gifts and investment return.

(14) Income Taxes

The Corporation and the majority of its subsidiaries are not-for-profit corporations as defined in Section 501(c)(3) of the Internal Revenue Code (the Code) and are exempt from federal income taxes under Section 501(a) of the Code. The Corporation's tax-exempt businesses generate nominal amounts of unrelated business income subject to income tax. For corporate income tax purposes, the Corporation has two consolidated groups of for-profit, taxable entities. The parent companies of these groups are Parkway Ventures, Inc. and MedStar Enterprises, Inc.

The Corporation's taxable subsidiaries have approximately $221.5 of net operating loss (NOL) carryforwards as of June 30, 2014, which expire in varying periods through 2034, available to offset future taxable income. This NOL carryforward represents $84.2 of gross deferred tax assets. In assessing the realizability of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences become deductible. Management considers the scheduled reversal of deferred tax liabilities, projected future taxable income, and tax planning strategies in making this assessment. During the years ended June 30, 2014 and 2013, the Corporation decreased and increased its net deferred tax asset by $3.6 and $1.8 respectively, which was recorded in nonoperating income. The remaining amount of the deferred tax asset considered realizable, $27.9 as of June 30, 2014, could be reduced if estimates of future taxable income during the carry forward period are reduced. The current tax provisions for the years ended June 30, 2014 and 2013 were immaterial.

(15) Charity Care

The Corporation's hospitals utilize a cost to charge ratio methodology to convert charity care to cost. The estimated cost of services provided is determined based on the relationship of total operating costs to gross charges. Total operating costs for purposes of this ratio exclude bad debt expense as well as costs associated with community benefit activities. Total gross patient charges are then offset with any related reimbursements. The Corporation provided $45.5 and $51.5 of charity care at cost during the years ended June 30, 2014 and 2013, respectively, based on the cost to charge ratio.

In addition to charity care, the Corporation funds numerous programs designed to benefit the healthcare interests of the communities it serves, examples of which are: health education programs and services,

(Continued)

(Dollars in millions)

health information and referral services, school-based clinics, public health screenings and home care. The costs associated with these programs are recorded in the appropriate operating expense categories.

(16) Leases

The Corporation is obligated under various operating leases with initial terms of one year or more. Aggregate future minimum payments as of June 30, 2014 are as follows:

2015	$	53.2
2016		44.9
2017		36.6
2018		28.2
2019		22.4
2020 and Thereafter		41.8
Total minimum lease payments	$	227.1

Certain leases include provisions allowing the minimum rental payments to be adjusted annually for increases in operating costs and, in some cases, real estate taxes attributable to leased property. Total rental expense for all operating leases amounted to approximately $65.9 and $56.0 during the years ended June 30, 2014 and 2013, respectively.

(17) Commitments and Contingencies

In February 2000 and on June 30, 2000, the Corporation and Georgetown University (the University) signed certain definitive agreements whereby the Corporation would receive through purchase or capital lease substantially all of the assets (including working capital) owned by the University that constitutes the MedStar Georgetown University Hospital, the Community Practice Network, the Faculty Practice Group and certain office buildings and a parking lot on the campus (collectively referred to as the Transferred Businesses). These agreements became effective July 1, 2000 and transferred control of the identified physical plant and other real property assets of the Transferred Businesses to the Corporation for use as an academic medical center for a minimum of ninety-eight years. At the end of the one hundred and fifty year lease term (including a fifty-two year renewal), the University shall convey all leased assets, excluding the underlying land, to the Corporation for a nominal amount and enter into a rent-free ground lease for the Corporation's use. This transaction was accounted for under the purchase method of accounting effective July 1, 2000.

In recognition of the value of the transaction, the Corporation shall annually pay the University 50% of the amount by which the combined operating earnings before interest, taxes, depreciation and amortization (EBITDA), as defined in the asset purchase agreement, of certain entities of the Corporation in the Washington D.C. area (collectively referred to as the Washington Clinical Enterprises) exceeds $60.0, subject to certain adjustments. These additional payments expire when cumulative payments reach $70.0. The Corporation has paid $36.7 to the University as of June 30, 2014.

(Continued)

The Corporation also entered into an Academic Affiliation and Operations Agreement (Affiliation Agreement) with the University. The purpose of this agreement is to make available to the University the facilities of the Transferred Businesses and provide the Corporation with a first-class University medical center. The University shall make payments to the Corporation determined by multiplying the University School of Medicine's total undergraduate tuition revenue by 36% for providing teaching services. The Corporation recognized $12.3 and $12.8 of tuition revenue during the years ended June 30, 2014 and 2013, respectively. In support of academic programs at the University, for each fiscal year following the termination of the additional payment terms in the asset purchase agreement described above, the Corporation shall pay to the University 17.5% of the operating EBITDA of the Washington Clinical Enterprises in excess of $60.0, subject to certain adjustments. No amounts have been paid under this Affiliation Agreement through June 30, 2014.

The Corporation and the University also entered into a Research Agreement to sustain and advance a program of health-related University research at the Transferred Business facilities. Under this agreement the University is required to reimburse the Corporation for certain costs incurred by the Corporation in support of University sponsored research. Amounts reimbursed to the Corporation were $2.7 and $3.1 for the years ended June 30, 2014 and 2013, respectively.

MedStar Georgetown University Hospital and the University are parties to a fixed fee shared services agreement. Georgetown University provided to MedStar Georgetown University Hospital the following services: utilities, telephone/IT services, transportation services and library services. Expenses charged for such services were $13.6 and $12.2 for the years ended June 30, 2014 and 2013, respectively.

The MedStar Washington Hospital Center campus is subject to the lien of a Permitted Encumbrance in the amount of $21.5 to the United States government. This encumbrance was created in the deed of the hospital property from the United States government to MedStar Washington Hospital Center in February 1960. There is no repayment date for this lien stated in the deed. Under enabling legislation, repayment could be required after a determination that the property is no longer required for hospital services or the property is disposed of, in which event all or a portion of the lien may be payable to the government. This lien is subordinated to the Deed of Trust on the MedStar Washington Hospital Center campus.

(Continued)

(Dollars in millions)

(18) Functional Expenses

The Corporation considers integrated health services, research and management and general to be its primary functional categories for purposes of expense classification. Management and general include information systems, general corporate management, advertising and marketing. Functional categories of expenses for the years ended June 30, 2014 and 2013 are as follows:

	2014	2013
Integrated health services	$ 3,532.4	3,319.9
Management and general	924.7	782.9
Research	30.4	31.0
Fundraising	4.9	4.6
	$ 4,492.4	4,138.4

(19) Subsequent Events

Management evaluated all events and transactions that occurred after June 30, 2014 and through October 6, 2014. The Corporation did not have any events that were required to be recognized or disclosed.

Attachment 16

Audited Financials - FY 2015
MedStar Health

MEDSTAR HEALTH, INC.

Consolidated Financial Statements

June 30, 2015 and 2014

(With Independent Auditors' Report Thereon)

MEDSTAR HEALTH, INC.

Table of Contents

KPMG LLP
1 East Pratt Street
Baltimore, MD 21202-1128

Independent Auditors' Report

The Board of Directors
MedStar Health, Inc.:

We have audited the accompanying consolidated financial statements of MedStar Health, Inc. (the Corporation), which comprise the consolidated balance sheets as of June 30, 2015 and 2014, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; 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 auditors' 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 MedStar Health, Inc. as of June 30, 2015 and 2014, and the results of their operations and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP

October 2, 2015

MEDSTAR HEALTH, INC.

Consolidated Balance Sheets

June 30, 2015 and 2014

(Dollars in millions)

Assets		2015	2014
Current assets:			
Cash and cash equivalents	$	572.3	599.9
Investments		74.9	61.4
Assets whose use is limited or restricted		61.3	61.3
Receivables:			
From patient services (less allowances for uncollectible accounts of $207.0 in 2015 and $188.8 in 2014)		584.1	558.0
Other		93.0	69.6
		677.1	627.6
Inventories		60.4	56.3
Prepaids and other current assets		33.1	31.8
Total current assets		1,479.1	1,438.3
Investments		1,002.2	869.5
Assets whose use is limited or restricted		554.7	548.9
Property and equipment, net		1,197.4	1,152.9
Interest in net assets of foundation		63.0	64.9
Goodwill and other intangible assets, net		258.2	226.5
Other assets		136.3	146.8
Total assets	$	4,690.9	4,447.8

(Continued)

MEDSTAR HEALTH, INC.

Consolidated Balance Sheets

June 30, 2015 and 2014

(Dollars in millions)

Liabilities and Net Assets		2015	2014
Current liabilities:			
Accounts payable and accrued expenses	$	433.8	419.6
Accrued salaries, benefits, and payroll taxes		348.2	304.9
Amounts due to third-party payors, net		83.5	85.7
Current portion of long-term debt		19.5	60.5
Current portion of self insurance liabilities		88.4	86.3
Other current liabilities		147.9	125.3
Total current liabilities		1,121.3	1,082.3
Long-term debt, net of current portion		1,323.0	1,192.6
Self insurance liabilities, net of current portion		310.6	312.4
Pension liabilities		293.0	234.3
Other long-term liabilities, net of current portion		137.3	137.6
Total liabilities		3,185.2	2,959.2
Net assets:			
Unrestricted net assets:			
MedStar Health, Inc.		1,319.0	1,322.2
Noncontrolling interests		15.3	5.2
Total unrestricted net assets		1,334.3	1,327.4
Temporarily restricted		131.9	121.8
Permanently restricted		39.5	39.4
Total net assets		1,505.7	1,488.6
Total liabilities and net assets	$	4,690.9	4,447.8

See accompanying notes to consolidated financial statements.

MEDSTAR HEALTH, INC.

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2015 and 2014

(Dollars in millions)

	2015	2014
Operating revenues:		
Net patient service revenue:		
Hospital inpatient services	$ 2,130.3	2,088.8
Hospital outpatient services	1,427.9	1,362.9
Physician services	756.1	662.2
Other patient service revenue	123.3	114.8
Total net patient service revenue	4,437.6	4,228.7
Provision for bad debts	206.7	193.2
Total net patient service revenue, net of provision for bad debts	4,230.9	4,035.5
Premium revenue	561.3	357.9
Other operating revenue	235.0	234.7
Net operating revenues	5,027.2	4,628.1
Operating expenses:		
Personnel	2,591.5	2,455.3
Supplies	741.5	696.7
Purchased services	844.0	682.6
Other operating	452.6	426.3
Interest expense	47.9	50.1
Depreciation and amortization	188.9	181.4
Total operating expenses	4,866.4	4,492.4
Earnings from operations	160.8	135.7
Nonoperating gains (losses):		
Investment income	16.1	13.3
Net realized gains on investments	43.2	68.6
Unrealized gains on derivative instrument	1.1	1.4
Unrealized (losses) gains on investments, net	(75.9)	91.6
Loss on extinguishment of debt	(25.2)	—
Income tax provision	(8.2)	(3.9)
Other nonoperating losses	(0.6)	(2.0)
Total nonoperating (losses) gains	(49.5)	169.0
Excess of revenues over expenses	$ 111.3	304.7

(Continued)

MEDSTAR HEALTH, INC.

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2015 and 2014

(Dollars in millions)

	2015	2014
Unrestricted net assets:		
Excess of revenues over expenses	$ 111.3	304.7
Acquired noncontrolling interests	10.8	—
Change in funded status of defined benefit plans	(118.5)	(2.1)
Distributions to noncontrolling interests	(2.9)	(3.7)
Net assets released from restrictions used for purchase of property and equipment and other	6.2	1.7
Increase in unrestricted net assets	6.9	300.6
Temporarily restricted net assets:		
Contributions	25.6	17.1
Realized net gains on restricted investments	2.0	3.1
Change in unrealized (losses) gains on restricted investments	(2.4)	3.4
(Decrease) increase in net assets of foundation	(1.9)	10.1
Net assets released from restrictions	(13.2)	(10.9)
Increase in temporarily restricted net assets	10.1	22.8
Permanently restricted net assets:		
Realized net gains on marketable restricted investments	0.3	0.1
Change in unrealized (losses) gains on restricted investments	(0.2)	0.2
Increase in permanently restricted net assets	0.1	0.3
Increase in net assets	17.1	323.7
Net assets, beginning of year	1,488.6	1,164.9
Net assets, end of year	$ 1,505.7	1,488.6

See accompanying notes to consolidated financial statements.

MEDSTAR HEALTH, INC.

Consolidated Statements of Cash Flows

Years ended June 30, 2015 and 2014

(Dollars in millions)

	2015	2014
Cash flows from operating activities:		
Change in net assets	$ 17.1	323.7
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	188.9	181.4
Amortization of bond financing costs, premiums and discounts	(2.5)	(1.2)
(Gain) loss on sale of property and equipment	(0.1)	0.2
Change in funded status of defined benefit plans	118.5	2.1
Realized net gains on marketable investments	(45.5)	(71.8)
Change in unrealized losses (gains) of marketable investments	78.5	(95.2)
Decrease (increase) in net assets of foundation	1.9	(10.1)
Unrealized gain on derivative instrument	(1.1)	(1.4)
Net settlement payment on derivative instrument	3.6	3.7
Loss on extinguishment of debt	25.2	—
Distributions to noncontrolling interests	2.9	3.7
Deferred income tax provision	6.1	3.6
Provision for bad debts	206.7	193.2
Temporarily and permanently restricted contributions	(25.6)	(17.1)
Acquired noncontrolling interests	(10.8)	—
Gain on sale of consolidated joint venture, net of noncontrolling interests	—	(1.2)
Changes in operating assets and liabilities:		
Receivables	(255.9)	(224.3)
Inventories and other assets	(7.8)	(28.5)
Accounts payable and accrued expenses	71.8	107.0
Amounts due to third-party payors	(2.2)	19.0
Other liabilities	(44.8)	25.0
Net cash provided by operations	324.9	411.8
Cash flows from investing activities:		
(Purchases) proceeds of investments and assets whose use is limited or restricted, net	(111.2)	81.5
Purchases of alternative investments	(109.6)	(240.7)
Proceeds from sales of alternative investments	35.9	128.8
Proceeds from sale of consolidated joint venture	—	5.4
Net settlement payment on derivative instrument	(3.6)	(3.7)
Purchases of property and equipment, and other	(252.4)	(221.3)
Net cash used in investing activities	(440.9)	(250.0)
Cash flows from financing activities:		
Proceeds from long-term borrowings	511.6	—
Repayments of long-term borrowings	(21.9)	(20.5)
Repayments of refinanced bonds and other borrowings	(420.2)	—
Payment of deferred issuance costs	(3.8)	(0.2)
Temporarily and permanently restricted contributions	25.6	17.1
Distributions to noncontrolling interests	(2.9)	(3.7)
Net cash provided by (used in) financing activities	88.4	(7.3)
(Decrease) increase in cash and cash equivalents	(27.6)	154.5
Cash and cash equivalents at beginning of year	599.9	445.4
Cash and cash equivalents at end of year	$ 572.3	599.9
Supplemental disclosure of cash flow information:		
Interest paid	$ 50.8	50.8
Noncash investing and financing activities:		
Accounts payable for fixed asset purchases	$ 19.5	17.0

See accompanying notes to consolidated financial statements.

(1) Description of Organization and Summary of Significant Accounting Policies

(a) Organization

MedStar Health, Inc. (MedStar or the Corporation) is a tax-exempt, Maryland membership corporation which, through its controlled entities and other affiliates, provides and manages healthcare services in the region encompassing Maryland, Washington D.C. and Northern Virginia. The Corporation became operational on June 30, 1998 by the transfer of the membership interests of Helix Health, Inc. (Helix – a not-for-profit Maryland Corporation) and Medlantic Healthcare Group, Inc. (Medlantic – a not-for-profit Delaware Corporation) in exchange for the guarantee of the debt of both Helix and Medlantic by the Corporation. The trade names of the principal tax-exempt and taxable entities of the Corporation are:

Tax-Exempt

- MedStar Ambulatory Services (formerly known as Bay Development Corporation)
- MedStar Franklin Square Medical Center
- MedStar Georgetown University Hospital
- MedStar Good Samaritan Hospital
- MedStar Harbor Hospital
- MedStar Health Research Institute
- MedStar Health Visiting Nurse Association, Inc.
- MedStar Medical Group, LLC
- MedStar Montgomery Medical Center
- MedStar National Rehabilitation Network
- MedStar Southern Maryland Hospital Center
- MedStar St. Mary's Hospital
- MedStar Surgery Center, Inc.
- MedStar Union Memorial Hospital
- MedStar Washington Hospital Center
- Church Home and Hospital of the City of Baltimore, Inc.
- HH MedStar Health, Inc.

Taxable

- Greenspring Financial Insurance, LTD.
- MedStar Enterprises, Inc. and Subsidiaries

(Continued)

- MedStar Family Choice, Inc.
- MedStar Physician Partners, Inc.
- Parkway Ventures, Inc. and Subsidiaries
- RadAmerica II, LLC

(b) Basis of Presentation

The consolidated financial statements are prepared on the accrual basis of accounting in accordance with U.S. generally accepted accounting principles (U.S. GAAP). All majority owned subsidiaries, direct member entities and controlled affiliates are consolidated. All entities where the Corporation exercises significant influence but for which it does not have control are accounted for under the equity method. All other entities are accounted for under the cost method. All significant intercompany accounts and transactions have been eliminated.

(c) Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant changes to estimates resulting from amounts settled, or tentatively settled, related to prior year third party cost reports (see note 9) resulted in gains of approximately $22.1 during the year ended June 30, 2015. Significant changes to estimates resulting from amounts settled, or tentatively settled, related to prior year third party cost reports and amounts settled associated with the purchase of MedStar Southern Maryland Hospital Center resulted in gains of approximately $20.0 during the year ended June 30, 2014. Future results could differ from current estimates.

(d) Cash Equivalents

All highly liquid investments with a maturity date of three months or less when purchased are considered to be cash equivalents.

(e) Investments and Assets Whose Use is Limited or Restricted

The Corporation's investment portfolio is considered trading, with the exception of the alternative investments, and is classified as current or noncurrent assets based on management's intention as to use. All securities are reported at fair value principally based on quoted market prices in the consolidated balance sheets. The Corporation has elected to use the fair value option to account for its alternative investments. The fair value of alternative investments is determined based on the Net Asset Value (NAV) of the shares in each investment company or partnership. Purchases and sales of securities are recorded on a trade-date basis.

Investments in unconsolidated affiliates are accounted for under the cost or equity method of accounting, as appropriate, and are included in other assets in the consolidated balance sheets. The Corporation utilizes the equity method of accounting for its investments in entities over which it

exercises significant influence. The Corporation's equity income or loss is recognized in other operating revenue on the consolidated statements of operations and changes in net assets.

Assets whose use is limited or restricted include assets held by trustees under bond indenture, self-insurance trust arrangements, assets restricted by donor, and assets designated by the Board of Directors for future capital improvements and other purposes over which it retains control and may, at its discretion, use for other purposes. Amounts from these funds required to meet current liabilities have been classified in the consolidated balance sheets as current assets.

Investment income (interest and dividends), realized gains and losses on investment sales, and unrealized gains and losses are reported as nonoperating gains and losses in the excess of revenues over expenses in the accompanying consolidated statements of operations and changes in net assets unless the income or loss is restricted by the donor or law. Investment income and realized gains and losses on funds held in trust for self-insurance purposes is included in other operating revenue. Investment income and net gains and losses that are restricted by the donor are recorded as a component of changes in temporarily or permanently restricted net assets, in accordance with donor imposed restrictions. Realized gains and losses are determined based on the specific security's original purchase price or adjusted cost if the investment was previously determined to be other-than-temporarily impaired.

(f) Inventories

Inventories, which primarily consist of medical supplies and pharmaceuticals at many of the operating entities, are stated at the lower of cost or market, with cost being determined primarily under the average cost or first-in, first-out methods.

(g) Property and Equipment

Property and equipment acquisitions are recorded at cost and are depreciated or amortized over the estimated useful lives of the assets. Estimated useful lives range from three to forty years. Amortization of assets held under capital leases is computed using the shorter of the lease term or the estimated useful life of the leased asset and is included in depreciation and amortization expense. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. Depreciation is computed on a straight-line basis. Major classes and estimated useful lives of property and equipment are as follows:

Leasehold improvements	Lease term
Buildings and improvements	10–40 years
Equipment	3–20 years

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support, and are excluded from the excess of revenues over expenses, 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.

Management routinely evaluates the carrying value of its long-lived assets for impairment. No significant impairment charges were recorded against the carrying value of the Corporation's long-lived assets during the years ended June 30, 2015 and 2014.

(h) Interest in Net Assets of Foundation

The Corporation recognizes its rights to assets held by a recipient organization, which accepts cash or other financial assets from a donor and agrees to use those assets on behalf of or transfer those assets, the return on investment of those assets, or both, to the Corporation. Changes in the Corporation's economic interests in the financially interrelated organization are recognized in the consolidated statements of operations and changes in net assets as a component of changes in temporarily restricted net assets.

(i) Goodwill and Other Intangible Assets

Goodwill is an asset representing the future economic benefits arising from other assets acquired in a business combination that are not individually identified and separately recognized. As of June 30, 2015 and 2014, the Corporation had one reporting unit, which included all subsidiaries of the Corporation and held goodwill, net on its balance sheet of $219.2 and $190.2, respectively. Goodwill is evaluated for impairment annually using a qualitative assessment to determine whether there are events or circumstances that indicate it is more likely than not that the reporting unit's fair value is less than its carrying amount. Based on this qualitative assessment, the Corporation determined that there was no goodwill impairment for the years ended June 30, 2015 and 2014.

Other intangible assets are recorded at fair value and amortized over their estimated useful lives. Other intangible assets were $48.2 and $42.4 as of June 30, 2015 and 2014, respectively, and related accumulated amortization was $9.2 and $6.1, respectively. The Corporation recognized amortization expense of $3.1 and $2.4 for the years ended June 30, 2015 and 2014, respectively, related to identifiable intangible assets.

(j) Internal-Use Software

The Corporation capitalizes the direct costs, including internal personnel costs, associated with the implementation of new information systems for internal use. The Corporation capitalized internal costs of $3.4 and $0.9 during the years ended June 30, 2015 and 2014, respectively. Capitalized amounts are amortized over the estimated lives of the software, which is generally three to five years.

(k) Financing Costs

Financing costs incurred in issuing bonds have been capitalized and are included in other assets on the consolidated balance sheets. These costs are being amortized over the estimated duration of the

related debt using the effective interest method. Accumulated amortization totaled $4.0 and $5.6 as of June 30, 2015 and 2014, respectively.

(l) Estimated Professional Liability Costs

The provision for estimated self-insured professional liability claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported. These estimates are based on actuarial analysis of historical trends, claims asserted and reported incidents. The receivables related to such claims are recorded at their net realizable value.

(m) Leases

Lease arrangements, including assets under construction, are capitalized when such leases convey substantially all the risks and benefits incidental to ownership. Capital leases are amortized over either the lease term or the life of the related assets, depending upon available purchase options and lease renewal features. Amortization related to capital leases is included in the consolidated statements of operations and changes in net assets within depreciation and amortization expense.

(n) Derivative

The Corporation utilizes a derivative financial instrument to manage its interest rate risks associated with tax-exempt debt. The Corporation does not hold or issue derivative financial instruments for trading purposes. The derivative instrument is recorded on the consolidated balance sheets at its fair value. The Corporation's current derivative investment does not qualify for hedge accounting; therefore, the changes in fair value have been recognized in the accompanying consolidated statements of operations and changes in net assets as mark-to-market adjustments in nonoperating gains (losses). The fair market value of the derivative instrument is included in other long-term liabilities in the accompanying consolidated balance sheets.

(o) Net Patient Service Revenue and Net Patient Accounts Receivable

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments due to future audits, reviews and investigations. The differences between the estimated and actual amounts are recorded as part of net patient service revenue in future periods as the amounts become known, or as years are no longer subject to audit, review or investigation. Payment arrangements include prospectively determined rates per discharge, fee-for-service, discounted charges, and per diem payments. Hospital inpatient services, hospital outpatient services, physician services, and other patient service revenues are recognized when the services are rendered based on billable charges. Other patient service revenue primarily consists of home care, long-term care and other non-hospital patient services.

The Corporation's policy is to write-off all patient receivables which are identified as uncollectible. Patient accounts receivable are reduced by an allowance for uncollectible accounts to reserve for accounts which are expected to become uncollectible in future years. In evaluating the collectability of accounts receivable, the Corporation analyzes historical collections and write-offs and identifies

trends for each of its major payor sources of revenue and amounts due from patients to estimate the appropriate allowance for uncollectible accounts and provision for bad debts.

(p) Charity Care

The Corporation provides care to patients who meet certain criteria under its charity care policies without charge or at amounts less than established rates. Because the Corporation does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

(q) Premium Revenue

Premium revenue consists of amounts received from the State of Maryland, the District of Columbia and the Centers for Medicare and Medicaid Services (CMS) by the Corporation's managed care organization for providing medical services to subscribing participants, regardless of services actually performed. The managed care organization provides services primarily to enrolled Medicaid and Medicare beneficiaries. This revenue is recognized ratably over the contractual period for the provision of services. Medical expenses of the managed care organization include actuarially determined estimates of the ultimate costs for both reported claims and claims incurred but unreported and are included in purchased services on the consolidated statements of operations and changes in net assets.

(r) Grants

Federal grants are accounted for as either an exchange transaction or as a contribution based on terms and conditions of the grant. If the grant is accounted for as an exchange transaction, revenue is recognized as other operating revenue when earned. If the grant is accounted for as a contribution, the revenues are recognized as either other operating revenue, or as temporarily restricted contributions depending on the restrictions within the grant.

(s) Contributions

Unconditional promises to give cash and other assets to the Corporation are reported at fair value at the date the promise is received. Conditional promises to give are reported at fair value at the date the condition is 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 and changes in net assets as net assets released from restrictions in other operating revenue. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted net assets and reported within other operating revenue in the accompanying consolidated financial statements.

(t) Meaningful Use Incentives

Under certain provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), federal incentive payments are available to hospitals, physicians and certain other professionals (Providers) when they adopt, implement or upgrade certified electronic health record (EHR) technology and

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.

Management routinely evaluates the carrying value of its long-lived assets for impairment. No significant impairment charges were recorded against the carrying value of the Corporation's long-lived assets during the years ended June 30, 2015 and 2014.

(h) Interest in Net Assets of Foundation

The Corporation recognizes its rights to assets held by a recipient organization, which accepts cash or other financial assets from a donor and agrees to use those assets on behalf of or transfer those assets, the return on investment of those assets, or both, to the Corporation. Changes in the Corporation's economic interests in the financially interrelated organization are recognized in the consolidated statements of operations and changes in net assets as a component of changes in temporarily restricted net assets.

(i) Goodwill and Other Intangible Assets

Goodwill is an asset representing the future economic benefits arising from other assets acquired in a business combination that are not individually identified and separately recognized. As of June 30, 2015 and 2014, the Corporation had one reporting unit, which included all subsidiaries of the Corporation and held goodwill, net on its balance sheet of $219.2 and $190.2, respectively. Goodwill is evaluated for impairment annually using a qualitative assessment to determine whether there are events or circumstances that indicate it is more likely than not that the reporting unit's fair value is less than its carrying amount. Based on this qualitative assessment, the Corporation determined that there was no goodwill impairment for the years ended June 30, 2015 and 2014.

Other intangible assets are recorded at fair value and amortized over their estimated useful lives. Other intangible assets were $48.2 and $42.4 as of June 30, 2015 and 2014, respectively, and related accumulated amortization was $9.2 and $6.1, respectively. The Corporation recognized amortization expense of $3.1 and $2.4 for the years ended June 30, 2015 and 2014, respectively, related to identifiable intangible assets.

(j) Internal-Use Software

The Corporation capitalizes the direct costs, including internal personnel costs, associated with the implementation of new information systems for internal use. The Corporation capitalized internal costs of $3.4 and $0.9 during the years ended June 30, 2015 and 2014, respectively. Capitalized amounts are amortized over the estimated lives of the software, which is generally three to five years.

(k) Financing Costs

Financing costs incurred in issuing bonds have been capitalized and are included in other assets on the consolidated balance sheets. These costs are being amortized over the estimated duration of the

related debt using the effective interest method. Accumulated amortization totaled $4.0 and $5.6 as of June 30, 2015 and 2014, respectively.

(l) Estimated Professional Liability Costs

The provision for estimated self-insured professional liability claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported. These estimates are based on actuarial analysis of historical trends, claims asserted and reported incidents. The receivables related to such claims are recorded at their net realizable value.

(m) Leases

Lease arrangements, including assets under construction, are capitalized when such leases convey substantially all the risks and benefits incidental to ownership. Capital leases are amortized over either the lease term or the life of the related assets, depending upon available purchase options and lease renewal features. Amortization related to capital leases is included in the consolidated statements of operations and changes in net assets within depreciation and amortization expense.

(n) Derivative

The Corporation utilizes a derivative financial instrument to manage its interest rate risks associated with tax-exempt debt. The Corporation does not hold or issue derivative financial instruments for trading purposes. The derivative instrument is recorded on the consolidated balance sheets at its fair value. The Corporation's current derivative investment does not qualify for hedge accounting; therefore, the changes in fair value have been recognized in the accompanying consolidated statements of operations and changes in net assets as mark-to-market adjustments in nonoperating gains (losses). The fair market value of the derivative instrument is included in other long-term liabilities in the accompanying consolidated balance sheets.

(o) Net Patient Service Revenue and Net Patient Accounts Receivable

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments due to future audits, reviews and investigations. The differences between the estimated and actual amounts are recorded as part of net patient service revenue in future periods as the amounts become known, or as years are no longer subject to audit, review or investigation. Payment arrangements include prospectively determined rates per discharge, fee-for-service, discounted charges, and per diem payments. Hospital inpatient services, hospital outpatient services, physician services, and other patient service revenues are recognized when the services are rendered based on billable charges. Other patient service revenue primarily consists of home care, long-term care and other non-hospital patient services.

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trends for each of its major payor sources of revenue and amounts due from patients to estimate the appropriate allowance for uncollectible accounts and provision for bad debts.

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The Corporation provides care to patients who meet certain criteria under its charity care policies without charge or at amounts less than established rates. Because the Corporation does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

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Premium revenue consists of amounts received from the State of Maryland, the District of Columbia and the Centers for Medicare and Medicaid Services (CMS) by the Corporation's managed care organization for providing medical services to subscribing participants, regardless of services actually performed. The managed care organization provides services primarily to enrolled Medicaid and Medicare beneficiaries. This revenue is recognized ratably over the contractual period for the provision of services. Medical expenses of the managed care organization include actuarially determined estimates of the ultimate costs for both reported claims and claims incurred but unreported and are included in purchased services on the consolidated statements of operations and changes in net assets.

(r) Grants

Federal grants are accounted for as either an exchange transaction or as a contribution based on terms and conditions of the grant. If the grant is accounted for as an exchange transaction, revenue is recognized as other operating revenue when earned. If the grant is accounted for as a contribution, the revenues are recognized as either other operating revenue, or as temporarily restricted contributions depending on the restrictions within the grant.

(s) Contributions

Unconditional promises to give cash and other assets to the Corporation are reported at fair value at the date the promise is received. Conditional promises to give are reported at fair value at the date the condition is 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 and changes in net assets as net assets released from restrictions in other operating revenue. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted net assets and reported within other operating revenue in the accompanying consolidated financial statements.

(t) Meaningful Use Incentives

Under certain provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), federal incentive payments are available to hospitals, physicians and certain other professionals (Providers) when they adopt, implement or upgrade certified electronic health record (EHR) technology and

become "meaningful users," as defined under ARRA, of EHR technology in ways that demonstrate improved quality, safety and effectiveness of care. Incentive payments are paid out over varying transitional schedules depending on the type of incentive (Medicare and Medicaid) and recipient (hospital or eligible provider). Eligible hospitals can attest for both Medicare and Medicaid incentives, while physicians must select to attest for either Medicare or Medicaid incentives. For Medicare incentives, eligible hospitals receive payments over four years while eligible physicians receive payments over five years. For Medicaid incentives, eligible hospitals receive payments based on the relevant State adopted payment structure and physicians receive payments over six years.

The Corporation recognizes EHR incentives when it is reasonably assured that the Corporation will successfully demonstrate compliance with the meaningful use criteria. During the years ended June 30, 2015 and 2014, certain hospitals and physicians satisfied the meaningful use criteria. As a result, the Corporation recognized $28.1 and $23.4 of EHR incentives during the years ended June 30, 2015 and 2014, respectively, in other operating revenue.

(u) Excess of Revenues over Expenses

The consolidated statements of operations and changes in net assets include a performance indicator, which is the excess of revenues over expenses. Changes in unrestricted net assets that are excluded from excess of revenues over expenses, include contributions of long-lived assets (including assets acquired using contributions that by donor restriction were to be used for the purpose of acquiring such assets), contributions from and acquisitions of and distributions to noncontrolling interests, and defined benefit obligations in excess of recognized pension cost, among others.

(v) Income Taxes

Income taxes are accounted for under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in the period that includes the enactment date. Any changes to the valuation allowance on the deferred tax asset are reflected in the year of the change. The Corporation accounts for uncertain tax positions in accordance with the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 740, *Income Taxes*.

(w) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Corporation or individual operating units has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation or individual operating units in perpetuity.

(Continued)

(x) Fair Value of Financial Instruments

The following methods and assumptions were used to estimate the fair value of financial instruments:

Cash and cash equivalents, receivables, other current assets, other assets, current liabilities and long-term liabilities: The carrying amount reported in the consolidated balance sheets for each of these assets and liabilities approximates their fair value.

The fair value of investments, assets whose use is limited or restricted and the interest rate swap is discussed in note 3. The fair value of long term debt is discussed in note 6.

(y) New Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued *Accounting Standards update (ASU) 2014-09, Revenue from Contracts with Customers (Topic 606)*. This ASU establishes principles for reporting useful information to users of financial statements about the nature, amount, timing, and uncertainty of revenue and cash flows arising from the entity's contracts with customers. Particularly, that an entity recognizes revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. ASU 2014-09 is effective for fiscal year 2019. The Corporation expects to record a decrease in net patient service revenue and a corresponding decrease in bad debt expense upon adoption of the standard.

(z) Reclassifications

Certain prior year amounts have been reclassified to conform with current period presentation, the effect of which is not material.

(Continued)

(Dollars in millions)

(2) Investments and Assets Whose Use is Limited or Restricted

Investments and assets whose use is limited or restricted as of June 30, 2015 and 2014, at fair value consist of the following:

	2015	2014
Cash and cash equivalents	$ 87.6	82.8
Fixed income securities and funds	393.1	356.2
Equity securities	604.1	559.3
Alternative investments:		
Commingled equity funds	243.6	194.2
Inflation hedging equity, commodity, fixed income fund	58.8	72.4
Hedge fund of funds and private equity	305.9	276.2
Total investments and assets whose use is limited or restricted	1,693.1	1,541.1
Less short-term investments and assets whose use is limited or restricted	(136.2)	(122.7)
Long-term investments and assets whose use is limited or restricted	$ 1,556.9	1,418.4

Assets whose use is limited or restricted as of June 30, 2015 and 2014, included in the table above, consist of the following:

	2015	2014
Funds held by trustees	$ 30.7	60.5
Self-insurance funds	293.4	256.6
Funds restricted by donors for specific purposes and endowment	80.5	86.1
Funds designated by board	211.4	207.0
Total assets whose use is limited or restricted	616.0	610.2
Less assets required for current obligations	(61.3)	(61.3)
Long-term assets whose use limited or restricted	$ 554.7	548.9

(Continued)

(Dollars in millions)

Investment income and realized and unrealized gains (losses) for assets whose use is limited, cash equivalents and investments are comprised of the following for the years ended June 30, 2015 and 2014:

	2015	2014
Other operating revenue:		
Investment income and realized gains	$ 18.5	8.5
Nonoperating gains:		
Investment income	16.1	13.3
Net realized gains on investments	43.2	68.6
Unrealized (losses) gains on investments	(75.9)	91.6
	(16.6)	173.5
Other changes in net assets:		
Realized net gains on temporarily and permanently restricted net assets	2.3	3.2
Change in unrealized (losses) gains on temporarily and permanently restricted net assets	(2.6)	3.6
Total investment return	$ 1.6	188.8

(3) Fair Value of Financial Instruments

The Corporation follows the guidance within FASB ASC Topic 820, *Fair Value Measurement (ASC 820)*, which defines fair value and establishes methods used to measure fair value. The fair value hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). A financial instrument's categorization within the valuation hierarchy is based upon the lowest level of input that is significant to the fair value measurement. The three levels of the fair value hierarchy under ASC 820 are described below:

- Level 1 – Quoted prices in active markets for identical assets or liabilities at the measurement date;
- Level 2 – Observable inputs other than quoted prices for the asset, either directly or indirectly observable, that reflect assumptions market participants would use to price the asset based on market data obtained from sources independent of the Corporation.
- Level 3 – Unobservable inputs that reflect the Corporations own assumptions about the assumptions market participants would use to price an asset based on the best information available in the circumstances.

The Corporation has incorporated an Investment Policy Statement (IPS) into the investment program. The IPS, which has been formally adopted by the Corporation's Board of Directors, contains numerous standards designed to ensure adequate diversification by asset class and geography. The IPS also limits all investments by manager and position size, and limits fixed income position size based on credit ratings, which serves to further mitigate the risks associated with the investment program. As of June 30, 2015 and 2014, management believes that all investments were being managed in a manner consistent with the IPS.

(Continued)

(Dollars in millions)

The following table illustrates the actual allocations of the Corporation's primary long-term investment portfolio as of June 30:

	Actual allocation June 30, 2015	Actual allocation June 30, 2014
Publicly traded equities – domestic	29%	26%
Publicly traded equities – international	14	14
Fixed income securities	14	16
Alternative investments:		
Commingled equity funds	13	12
Inflation hedging equity, commodity, fixed income fund	5	9
Hedge funds	21	20
Private equities	1	1
Cash	3	2
Total	100%	100%

The table below presents the Corporation's investable assets and liabilities as of June 30, 2015, aggregated by the three level valuation hierarchy:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 659.9	—	—	659.9
U.S. Treasury bonds	75.6	—	—	75.6
U.S. agency mortgage backed securities	151.8	—	—	151.8
Corporate bonds	—	132.8	—	132.8
Fixed income mutual funds	0.4	—	—	0.4
All other fixed income securities	3.2	29.3	—	32.5
Equity mutual funds & ETF's	147.4	—	—	147.4
Common stocks	456.7	—	—	456.7
Alternative investments:				
Commingled funds	—	243.6	—	243.6
Inflation hedging equity, commodity, fixed income fund	—	58.8	—	58.8
Private equity	—	—	16.6	16.6
Hedge funds:				
Custom hedge fund	—	—	59.7	59.7
Other hedge funds	—	—	229.6	229.6
Total assets	$ 1,495.0	464.5	305.9	2,265.4

(Continued)

(Dollars in millions)

	Level 1	Level 2	Level 3	Total
Liabilities:				
Interest rate swap	$ —	13.9	—	13.9
Total liabilities	$ —	13.9	—	13.9

The table below presents the Corporation's investable assets and liabilities as of June 30, 2014, aggregated by the three level valuation hierarchy:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 682.7	—	—	682.7
U.S. Treasury bonds	71.1	—	—	71.1
U.S. agency mortgage backed securities	92.8	—	—	92.8
Corporate bonds	—	82.1	—	82.1
Fixed income mutual funds	0.8	76.9	—	77.7
All other fixed income securities	5.4	27.1	—	32.5
Equity mutual funds & ETF's	121.8	—	—	121.8
Common stocks	437.5	—	—	437.5
Alternative investments:				
Commingled equity funds	—	194.2	—	194.2
Inflation hedging equity, commodity, fixed income fund	—	72.4	—	72.4
Private equity	—	—	17.0	17.0
Hedge funds:				
Custom hedge fund	—	—	58.8	58.8
Other hedge funds	—	—	200.4	200.4
Total assets	$ 1,412.1	452.7	276.2	2,141.0
Liabilities:				
Interest rate swap	$ —	15.0	—	15.0
Total liabilities	$ —	15.0	—	15.0

For the years ended June 30, 2015 and 2014, there were no significant transfers between Levels 1, 2 or 3.

(Continued)

(Dollars in millions)

Changes to the fair values based on the Level 3 inputs are summarized as follows:

	Private equity	Hedge funds	Total
Balance as of June 30, 2013	$ 16.4	160.1	176.5
Additions:			
Contributions/purchases	1.4	204.3	205.7
Disbursements:			
Withdrawals/sales	(3.4)	(125.4)	(128.8)
Net change in value	2.6	20.2	22.8
Balance as of June 30, 2014	17.0	259.2	276.2
Additions:			
Contributions/purchases	2.9	21.6	24.5
Disbursements:			
Withdrawals/sales	(4.8)	—	(4.8)
Net change in value	1.5	8.5	10.0
Balance as of June 30, 2015	$ 16.6	289.3	305.9

The following summarizes redemption terms for the hedge fund-of-funds vehicles held as of June 30, 2015:

	Custom Hedge Fund			
	Fund 1	Fund 2	Fund 3	Fund 4
Redemption timing:				
Redemption frequency	Quarterly	68% monthly – quarterly 32% quarterly – annually	Quarterly	Quarterly
Required notice	70 days	within 90 days	90 days	65 days
Audit reserve:				
Percentage held back for audit reserve	10%	up to 10%	10%	10%
Gates:				
Potential gate holdback	—	—	—	—
Potential gate release timeframe	—	—	—	—

(Continued)

The hedge funds include three hedge funds-of-funds and one custom hedge fund. The custom fund is structured as a multi-strategy hedge fund with the Corporation as the sole investor. The investment objective and strategies used by the hedge funds-of-funds and custom hedge fund are similar. The investment objective is to achieve positive absolute returns with low volatility, achieved through investments with multiple underlying managers who are investing across various strategies. Strategies utilized within these hedge funds include, but are not limited to:

- *Credit/Distressed* includes investment companies that focus mainly on opportunities in corporate fixed income securities of companies that are in financial distress, or perceived financial distress, or going through a restructuring or re-organization.

- *Event Driven* includes investment companies that focus on identifying securities that would benefit from the occurrence of a major corporate event.

- *Global Macro* includes investment companies that employ broad mandates to invest globally across all asset classes, including interest rates, currencies, commodities, and equities, in order to benefit from market movements within various countries.

- *Equity Long/Short* includes investment companies that maintain long and short positions in publicly traded equities in order to capture opportunities driven by their perception of securities or industries being overvalued or undervalued.

- *Relative Value* includes investment companies that seek to identify valuation discrepancies between related securities, utilizing fundamental and quantitative techniques to establish equities, fixed income, and derivative positions.

Investments in hedge funds are typically carried at estimated fair value. Fair value is based on the Net Asset Value (NAV) of the shares in each investment company or partnership. Such investment companies or partnerships mark-to-market or mark-to-fair value the underlying assets and liabilities in accordance with U.S. GAAP. Realized and unrealized gains and losses of the investment companies and partnerships are included in their respective operations in the current year. Changes in unrealized gains or losses on investments, including those for which partial liquidations were effected in the course of the year, are calculated as the difference between the NAV of the investment at year-end less the NAV of the investment at the beginning of the year, as adjusted for contributions and redemptions made during the year and certain lock-up provisions. Generally, no dividends or other distributions are paid.

(Continued)

(Dollars in millions)

The following summarizes the status of contributions to the private equity fund-of-funds vehicles held as of June 30, 2015:

		Total commitment	Percentage of commitment contributed	Percentage of commitment remaining
Fund 1	$	11.0	95.0%	5.0%
Fund 2		7.1	95.3	4.7
Fund 3		7.1	90.0	10.0
Fund 4		10.0	14.3	85.7
Fund 5		5.0	23.5	76.5
Total	$	40.2		

Investments in private equity funds, typically structured as limited partnership interests, are carried at fair value using NAV or equivalent as determined by the General Partner in the absence of readily ascertainable market values. Distributions under this investment structure are made to investors through the liquidation of the underlying assets. It is expected to take up to ten years to fully distribute the proceeds of those assets. The fair value of limited partnership interests is generally based on fair value capital balances reported by the underlying partnerships, subject to management review and adjustment. Security values of companies traded on exchanges, or quoted on NASDAQ, are based upon the last reported sales price on the valuation date. Security values of companies traded over the counter, but not quoted on NASDAQ, and securities for which no sale occurred on the valuation date are based upon the last quoted bid price. The value of any security for which a market quotation is not readily available may be its cost, provided however, that the General Partner adjusts such cost value to reflect any bona fide third-party transactions in such a security between knowledgeable investors, of which the General Partner has knowledge. In the absence of any such third-party transactions, the General Partner may use other information to develop a good faith determination of value. Examples include, but are not limited to, discounted cash flow models, absolute value models, and price multiple models. Inputs for these models may include, but are not limited to, financial statement information, discount rates, and salvage value assumptions.

The valuation of both marketable and nonmarketable securities may include discounts to reflect a lack of liquidity or extraordinary risks, which may be associated with the investment. Determination of fair value is performed on a quarterly basis by the General Partner. Because of the inherent uncertainty of valuation, the determined values may differ significantly from the values that would have been used had a ready market for those investments existed.

(Continued)

(Dollars in millions)

(4) Property and Equipment

Property and equipment as of June 30, 2015 and 2014 is as follows:

	2015	2014
Land	$ 84.1	83.8
Buildings and improvements	1,346.9	1,281.9
Equipment	1,801.2	1,746.4
	3,232.2	3,112.1
Less accumulated depreciation and amortization	(2,139.2)	(2,025.6)
	1,093.0	1,086.5
Construction-in-progress	104.4	66.4
	$ 1,197.4	1,152.9

Construction-in-progress includes a variety of ongoing capital projects at the Corporation as of June 30, 2015 and 2014. Depreciation and amortization expense related to property and equipment amounted to $185.7 and $178.5 for the years ended June 30, 2015 and 2014, respectively.

On April 1, 2015, the Corporation and Shah Associates, M.D, P.A. (Shah Associates or the Practice) closed on an asset purchase agreement, whereby the Corporation purchased substantially all of the assets and assumed certain obligations of the Practice and invested in certain real estate and management services joint ventures with Shah Associates. The Practice is a multispecialty medical group serving Southern Maryland and has joined the Corporation under the name MedStar Shah Medical Group (included within MedStar Medical Group, LLC). Through this agreement, the Corporation added more than 85 providers in 17 medical specialties with offices throughout Southern Maryland. As a result of the transaction, the Corporation recognized approximately $28.0 of goodwill and other intangible assets, approximately $25.0 of property, plant and equipment and approximately $8.0 of other liabilities. The consolidated financial statements include the operations of the Practice since the closing date.

(Continued)

(Dollars in millions)

(5) Other Assets

Other assets as of June 30, 2015 and 2014 consist of the following:

	2015	2014
Deferred financing costs, net	$ 10.8	13.1
Investments in unconsolidated entities	14.9	15.2
Reinsurance receivables	33.1	47.3
Deferred tax asset	21.7	26.3
Other assets	55.8	44.9
	$ 136.3	146.8

The Corporation has investments in other healthcare related organizations that are accounted for under the equity method which total $14.9 and $15.2 at June 30, 2015 and 2014, respectively. Under the equity method, original investments are recorded at cost and adjusted by the Corporation's share of the undistributed earnings or losses of these organizations. The related ownership interest in these organizations ranges from 8% to 50%. The Corporation's share of earnings in these organizations was $2.6 and $3.1 for the years ended June 30, 2015 and 2014, respectively, and are recognized in other operating revenue in the consolidated statements of operations and changes in net assets. Certain other nonconsolidated entities are recorded under the cost method.

(Continued)

(Dollars in millions)

(6) Debt

As of June 30, 2015 and 2014, the Corporation's outstanding borrowings include the following:

	2015	2014
Maryland Health and Higher Educational Facilities:		
Authority revenue bonds:		
5.25% Term bonds (Series 1998A, due 2038)	$ 82.0	82.0
5.25% Term bonds (Series 1998B, due 2038)	57.0	57.0
4.25%–5.75% Serial bonds (Series 2004, due 2009–2025)	4.6	21.6
5.375% Term bonds (Series 2004, due 2024)	—	49.7
5.50% Term bonds (Series 2004, due 2033)	—	80.1
4.75% Term bonds (Series 2007, due 2042)	—	56.0
5.25% Term bonds (Series 2007, due 2046)	—	89.0
2.00%–5.00% Serial bonds (Series 2011, due 2012–2023)	37.4	44.7
5.00% Term bonds (Series 2011, due 2031)	5.6	5.6
5.00% Term bonds (Series 2011, due 2041)	35.4	35.4
2.19% Direct Purchase (Series 2012, due 2017–2022)	38.6	38.6
3.00%–5.00% Serial bonds (Series 2013A, due 2016–2028)	60.9	60.9
5.00% Term bonds (Series 2013A, due 2038)	17.3	17.3
5.00% Term bonds (Series 2013A, due 2041)	25.0	25.0
4.00% Term bonds (Series 2013A, due 2041)	14.6	14.6
3.00%–5.00% Serial bonds (Series 2013B, due 2025–2033)	60.8	60.8
4.00% Term bonds (Series 2013B, due 2038)	45.0	45.0
5.00% Term bonds (Series 2013B, due 2038)	44.0	44.0
2.00%-5.00% Serial bonds (Series 2015, due 2016-2033)	180.4	—
5.00% Term bonds (Series 2015, due 2038)	35.2	—
5.00% Term bonds (Series 2015, due 2042)	75.2	—
4.00% Term bonds (Series 2015, due 2045)	66.4	—
Plus unamortized net premium	75.8	28.0
	961.2	855.3

(Continued)

(Dollars in millions)

		2015	2014
District of Columbia Hospital Revenue Bonds:			
Multimodal revenue bonds:			
0.02%–0.11% at June 30, 2015 Serial bonds (Series 1998A due 2008-2038) (0.03%–0.08% at June 30, 2014	$	122.9	125.9
2.75%–5.00% Serial bonds (Series 1998B, due 2008–2019)		6.4	9.6
5.00% Term bonds (Series 1998B, due 2028)		—	20.2
5.00% Term bonds (Series 1998B, due 2038)		—	33.9
2.75%–5.00% Serial bonds (Series 1998C, due 2008–2019)		6.4	9.7
5.50% Term bonds (Series 1998C, due 2028)		—	20.1
5.00% Term bonds (Series 1998C, due 2038)		—	34.0
Less unamortized net discount		—	(1.3)
		135.7	252.1
MedStar Health, Inc. Taxable Revenue Bonds:			
0.80%-3.70% Serial bonds (Series 2015, due 2016-2031)		100.9	—
Other:			
Notes payable to financial institutions or state agencies under mortgages (floating rates ranging between 1.1%–6.2%) and other		14.9	15.9
Line of credit due August 2016 (0.18%–0.84% at June 30, 2015 and 0.18%–0.80% at June 30, 2014)		129.8	129.8
		144.7	145.7
Total debt		1,342.5	1,253.1
Less current portion of long-term debt		(19.5)	(60.5)
Long-term debt, net	$	1,323.0	1,192.6

Scheduled maturities on borrowings, for the next five fiscal years and thereafter are as follows:

2016	$	19.5
2017		155.6
2018		26.7
2019		27.5
2020		28.4
Thereafter		1,009.0
	$	1,266.7

(Continued)

The fair value of outstanding tax exempt bonds is estimated to be $1,109.3 and $1,145.4 as of June 30, 2015 and 2014, respectively. The fair value of other long-term debt approximates its carrying value.

In December 1998, the Maryland Health and Higher Education Facilities Authority (MHHEFA) and the District of Columbia (District) issued bonds (Series 1998 Bonds) on behalf of the Corporation. Bond proceeds of approximately $588.6 were loaned to the Corporation under separate loan agreements with MHHEFA and the District upon execution of obligations pursuant to the Master Trust Indenture. The District issued $300.0 of Multimodal Revenue Bonds, including $150.0 Series 1998A ($30.3 repaid through August 2015), $75.0 Series 1998B ($14.2 repaid through August 2015 and $55.9 advance refunded in conjunction with the MHHEFA Series 2015 financing described below), and $75.0 Series 1998C ($14.2 repaid through August 2015 and $55.9 advance refunded in conjunction with the MHHEFA Series 2015 financing described below).

The District Series 1998A bonds, which consist of three tranches totaling $119.7 at August 2015, trade as uninsured Variable Rate Demand Obligations backed by bank letters of credit. The Series 1998A Tranche I bonds which remained outstanding in August 2015 consisted of approximately $39.9 bonds trading in a daily mode backed by a letter of credit issued by Wells Fargo Bank, National Association (formerly Wachovia Bank, National Association) and remarketed by J.P. Morgan Securities Inc. The letter of credit expires in March 2017. In the event of a failed remarketing, the Tranche I bonds would be tendered to the bank and repaid over a four-year period, beginning 367 days following the date of the failed remarketing. The Series 1998A Tranche II bonds totaled $39.9 in August 2015. These bonds trade in a weekly mode and are remarketed by TD Securities. The letter of credit backing these bonds was issued by TD Bank, National Association and expires in April 2018. In the event of a failed remarketing, the Tranche II bonds would be tendered to the bank and repaid over a five-year period, beginning 367 days following the failed remarketing. The Series 1998A Tranche III bonds totaled $39.9 in August 2015. These bonds trade in a weekly mode and are remarketed by Citigroup Global Markets Inc. The letter of credit backing these bonds was issued by PNC Bank, National Association. The term of the letter of credit is five years, and expires in May 2017. In the event of a failed remarketing, the Tranche III bonds would be tendered to the bank and repaid over a four-year period, beginning 367 days following the failed remarketing. No portion of the Series 1998A bonds has been put at June 30, 2015 and 2014, respectively. The $4.9 Series 1998B and $4.9 Series 1998C bonds (as of August 2015) are at a fixed rate, insured by Assured Guaranty, Ltd. (Assured; formerly Financial Security Assurance, Inc.). The reimbursement obligation with respect to the letters of credit are evidenced and secured by obligations issued by the Corporation under the Master Trust Indenture.

MHHEFA issued $283.5 of Revenue Bonds, including the $166.6 Series 1998A ($82.0 outstanding after August 2015) and $116.9 Series 1998B ($57.0 outstanding after August 2015). All Series 1998 MHHEFA bonds were issued at fixed rates. Principal and interest under the Series 1998 MHHEFA bonds are insured under municipal insurance policies with Assured and Ambac. Of the original Series 1998 MHHEFA bonds, $51.7 was refinanced in March 2013 in conjunction with the MHHEFA Series 2013A financing described below.

Related to the District borrowings, the Corporation entered into an interest rate swap with Wells Fargo Bank, National Association in a notional amount totaling $150.0 (reduced to $91.3 at August 2015). The

swap agreement expires in fiscal year 2027. The interest rate swap is part of a comprehensive and long-term capital structure strategy. The purpose of the swap is to mitigate the effect of potential interest rate volatility and minimize the variability of the Corporation's average cost of capital. Under the terms of the swap, the Corporation pays a fixed rate and receives a variable rate. Collateral is only required to be posted under the swap in the event that the Corporation's credit ratings are downgraded by two rating agencies below the BBB – or Baa2 – level. To date, no collateral postings have been required. As of June 30, 2015 and 2014, the variable interest rate under these agreements was 0.12% and 0.10%, respectively. The fixed rate was 3.6875% as of June 30, 2015 and 2014. The variable rates are capped at 14.0%. The change in fair value of the swap is reported in nonoperating gains (losses) in the statements of operations and changes in net assets.

In February 2004, MHHEFA issued $170.3 in fixed rate bonds (Series 2004 Bonds) on behalf of the Corporation. The proceeds of the Series 2004 Bonds were loaned to the Corporation pursuant to a loan agreement with MHHEFA upon execution of an obligation pursuant to the Master Trust Indenture. $142.5 of the Series 2004 Bonds were refunded in conjunction with the MHHEFA Series 2015 financing described below, and the remaining bonds were fully repaid as of August 2015.

In January 2007, MHHEFA issued $145.0 in fixed rate bonds (Series 2007 Bonds) on behalf of the Corporation. The Series 2007 Bonds were issued at a premium, resulting in total proceeds of $148.6. The proceeds of the Series 2007 Bonds were loaned to the Corporation pursuant to a loan agreement with MHHEFA upon execution of an obligation pursuant to the Master Trust Indenture. The Series 2007 bonds were advance refunded in conjunction with the MHHEFA Series 2015 financing described below.

In November 2011, MHHEFA issued $94.9 in bonds (Series 2011 Bonds) on behalf of the Corporation. The proceeds of the Series 2011 Bonds were loaned to the Corporation pursuant to a loan agreement with MHHEFA upon execution of an obligation pursuant to the Master Trust Indenture. The Series 2011 Bonds were issued as $53.9 serial bonds maturing 2012 through 2023 ($24.0 repaid through August 2015), $5.6 term bonds maturing 2031, and $35.4 term bonds maturing 2041. The Series 2011 Bonds maturing on or after August 2022 are subject to redemption or purchase at the option of the Corporation prior to maturity beginning in 2021. The Series 2011 Bonds were issued at fixed rates. The proceeds from this transaction were used to refund $20.2 of the MHHEFA Series 1998 A&B bonds, to refund debt outstanding on the Corporation's Revolving Credit Facility, and to refund certain debt associated with MedStar St. Mary's Hospital.

In June 2012, the Corporation entered into a $38.6 MHHEFA Direct Purchase financing transaction with JP Morgan Chase Bank, N.A. (the Series 2012 Bond). The proceeds from the transaction were used to redeem certain outstanding MHHEFA Series 1998A bonds that were due to mature in 2018 as well as a portion of the outstanding MHHEFA Series 1998 A&B bonds due to mature in 2028. The repayment of the Series 2012 Bond is evidenced by an obligation issued under the Master Trust Indenture. The term of the Series 2012 Bond is ten years and the repayment terms approximate the previous repayment terms of the Series 1998 bonds that were refunded. Covenants, conditions, and security for the Series 2012 Bond is similar to the revolving credit agreement.

In March 2013, MHHEFA issued $117.8 in bonds (Series 2013A Bonds) on behalf of the Corporation. The Series 2013A Bonds were issued at a premium, resulting in total proceeds of $128.7. The proceeds of the

(Continued)

Series 2013A Bonds were loaned to the Corporation pursuant to a loan agreement with MHHEFA upon execution of an obligation pursuant to the Master Trust Indenture. The Series 2013A Bonds were issued as $60.9 serial bonds maturing 2016 through 2028, $17.3 term bonds maturing 2038, $25.0 term bonds due 2041, and $14.6 term bonds maturing 2041. The Series 2013A Bonds maturing on or after August 2024 are subject to redemption or purchase at the option of the Corporation prior to maturity beginning in 2023. The Series 2013A Bonds were issued at fixed rates. The proceeds from the transaction were used to refund $51.7 of the MHHEFA Series 1998 A&B bonds, to fund various capital projects and capitalized interest on those projects.

In May 2013, MHHEFA issued $149.8 in bonds (Series 2013B Bonds) on behalf of the Corporation. The Series 2013B Bonds were issued at a premium, resulting in total proceeds of $159.4. The proceeds of the Series 2013B Bonds were loaned to the Corporation pursuant to a loan agreement with MHHEFA upon execution of an obligation pursuant to the Master Trust Indenture. The Series 2013B Bonds were issued as $60.8 serial bonds maturing 2025 through 2033, $45.0 term bonds maturing 2038, and $44.0 term bonds maturing 2038. The Series 2013B Bonds maturing on or after August 2024 are subject to redemption or purchase at the option of the Corporation prior to maturity beginning in 2023. The Series 2013B Bonds were issued at fixed rates. The proceeds from the transaction were used to refinance a portion of the bridge loan put in place when MedStar acquired the assets of Southern Maryland Hospital Center in December 2012.

In February 2015, MHHEFA issued $357.2 in bonds (Series 2015 MHHEFA Bonds) on behalf of the Corporation. The Series 2015 MHHEFA Bonds were issued at a premium, resulting in total proceeds of $410.8. The proceeds of the Series 2015 MHHEFA Bonds were loaned to the Corporation pursuant to a loan agreement with MHHEFA upon execution of an obligation pursuant to the Master Trust Indenture. The Series 2015 MHHEFA Bonds were issued as $180.4 serial bonds maturing 2016 through 2033, $35.2 term bonds maturing 2038, $75.2 term bonds maturing 2042, and $66.4 term bonds maturing 2045. The Series 2015 MHHEFA Bonds maturing on or after August 2025 are subject to redemption or purchase at the option of the Corporation prior to maturity beginning in 2025. The Series 2015 MHHEFA Bonds were issued at fixed rates. The proceeds from the transaction were used to advance refund the MHHEFA Series 2007 bonds, refund a portion of the MHHEFA Series 2004 bonds, and advance refund a portion of the District 1998B and 1998C bonds.

In February 2015, MedStar Health, Inc. issued $100.9 in fixed rate bonds, issued at par, in the taxable market (Series 2015 Taxable Bonds) on behalf of the Corporation. The Series 2015 Taxable Bonds were issued as parity bonds under the Master Trust Indenture. The Series 2015 Taxable Bonds were issued as serial bonds maturing 2016 through 2031, and are subject to optional redemption prior to their respective maturities at a make-whole redemption price, together with accrued interest thereon to the redemption date. The proceeds from the transaction were used to finance and refinance the acquisition and renovation of ambulatory care facilities.

The Corporation, which is currently the sole member of an "obligated group" as defined in the Master Trust Indenture, is bound by the provisions of the Master Trust Indenture for payment of any outstanding obligations under existing loan agreements. All of the hospitals and certain other affiliates (the guarantors) of the Corporation are parties to a guaranty agreement pursuant to which they jointly and severally

guaranty the payment and performance of the obligations under the Master Trust Indenture. The obligations of the guarantors under the Guaranty Agreement are collateralized by deeds of trust granted by the hospitals. Under the Master Trust Indenture and the deeds of trust, as collateral for the payments due thereunder, the Corporation and its hospital affiliates, have granted a security interest in their revenues subject to permitted encumbrances.

Under the Master Trust Indenture, the Corporation is required to maintain, among other covenants, a maximum annual debt service coverage ratio of not less than 1.10. Under the loan agreements relating to the Series 1998 Bonds, the Corporation is required to maintain a historical debt service coverage ratio of not less than 2.0 and to maintain at least 65 days cash on hand. In the event the Corporation does not meet either of these requirements, it is required to fund a trustee-held debt service reserve fund securing the Series 1998 Bonds. The amount to be deposited shall equal the lesser of: 10% of the principal amount of such outstanding bonds, or the largest annual debt service with respect to such bonds in any future year, or 125% of the average annual debt service of future years. As of June 30, 2015 and 2014, there were no funds required to be held in the debt service reserve fund for the Series 1998 Bonds.

The Corporation maintains a $250.0 revolving credit agreement provided by a group of banks. The facility has a three-year term expiring in August 2016. The facility is evidenced by an obligation issued under the Master Trust Indenture. The outstanding balance on the facility was $129.8 at June 30, 2015 and 2014. The facility includes certain covenants, including a requirement to maintain Days Cash on Hand of 70 days, measured semi-annually at each June 30 and December 31, and a Debt Service Coverage ratio of 1.25, measured quarterly on a rolling four quarters basis. In addition, the Corporation is required to maintain a minimum credit rating of Baa2 or its equivalent from at least two of Moody's Investor's Service, Standard & Poor's, and Fitch Ratings. In addition, the Corporation maintains a $30.0 letter of credit facility, provided by a single lender, which is also evidenced by an obligation issued under the Master Trust Indenture. This facility is principally used to securitize certain regulatory obligations under various insurance programs, and has terms and conditions similar to the revolving credit agreement. The facility has a three-year term expiring in August 2016. However, the standby letters of credit issued under the facility can be canceled at the bank's option each year. As of June 30, 2015 and 2014, standby letters of credit issued pursuant to the facility were $21.2 and $18.2, respectively. No amounts have been drawn by the beneficiaries under the standby letters of credit.

(7) Retirement Plans

The Corporation has two qualified defined benefit pension plans (MedStar Health, Inc. Pension Equity Plan (PEP) and MedStar Health, Inc. Cash Balance Retirement Plan (CBRP)) covering substantially all full-time employees hired before 2005. MedStar St. Mary's Hospital also has a defined benefit plan that substantially covers all employees of MedStar St. Mary's Hospital. Participation in all plans has been closed to new entrants and all plans are frozen to future benefit accruals.

Benefits under the plans are substantially based on years of service and the employees' career earnings. The Corporation contributes to the plans based on actuarially determined amounts necessary to provide assets sufficient to meet benefits to be paid to plan participants and to meet the minimum funding requirements of the Employee Retirement Income Security Act of 1974, as amended by the Pension Protection Act of 2006, and Internal Revenue Service regulations. Effective July 1, 2000, employees of the

(Dollars in millions)

Transferred Businesses (note 17) became participants in one of the Corporation's pension plans and are reflected in the pension information provided below.

The Corporation's investment policies are established by the MedStar Health, Inc.'s Investment Committee, which is comprised of members of the Board of Directors, other community leaders, and management. Among its responsibilities, the Investment Committee is charged with establishing and reviewing asset allocation strategies, monitoring investment manager performance, and making decisions to retain and terminate investment managers. Assets of each of the Corporation's pension plans are managed in a similar fashion by the same group of investment managers. The Corporation has incorporated an Investment Policy Statement (IPS) into the investment program. The IPS, which has been formally adopted by the Corporation's Board of Directors, contains numerous standards designed to ensure adequate diversification by asset class and geography. The IPS also limits all investments by manager and position size, and limits fixed income position size based on credit ratings, which serves to further mitigate the risks associated with the investment program. As of June 30, 2015 and 2014, management believes that all investments were being managed in a manner consistent with the IPS.

The following table illustrates the actual allocations of the Corporation's pension plans' investment portfolio as of June 30:

	Actual allocation June 30, 2015	Actual allocation June 30, 2014
Publicly traded equities – domestic	29%	30%
Publicly traded equities – international	11	10
Fixed income securities	15	16
Alternative investments:		
Commingled equity funds	15	14
Inflation hedging equity, commodity, fixed income fund	4	5
Hedge funds	20	18
Private equities	2	2
Cash	4	5
Total	100%	100%

(Continued)

(Dollars in millions)

The table below presents the Corporation's pension plans' investable assets as of June 30, 2015 aggregated by the three level valuation hierarchy:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 47.1	—	—	47.1
U.S. Treasury bonds	50.5	—	—	50.5
U.S. agency mortgage backed securities	24.7	—	—	24.7
Corporate bonds	—	67.0	—	67.0
All other fixed income securities	1.0	14.2	—	15.2
Equity mutual funds and ETF's	73.8	—	—	73.8
Common stocks	344.5	—	—	344.5
Alternative investments:				
Commingled funds	—	155.2	—	155.2
Inflation hedging equity, commodity, fixed income fund	—	43.3	—	43.3
Private equity	—	—	18.5	18.5
Hedge funds:				
Custom hedge fund	—	—	47.6	47.6
Other hedge funds	—	—	156.4	156.4
Total assets	$ 541.6	279.7	222.5	1,043.8

(Continued)

(Dollars in millions)

The table below presents the Corporation's pension plans' investable assets as of June 30, 2014 aggregated by the three level valuation hierarchy:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 50.1	—	—	50.1
U.S. Treasury bonds	42.8	—	—	42.8
U.S. agency mortgage backed securities	24.0	—	—	24.0
Corporate bonds	—	37.2	—	37.2
Fixed income mutual funds	—	47.2	—	47.2
All other fixed income securities	1.2	13.2	—	14.4
Equity mutual funds and ETF's	74.5	—	—	74.5
Common stocks	346.1	—	—	346.1
Alternative investments:				
Commingled equity funds	—	145.2	—	145.2
Inflation hedging equity, commodity, fixed income fund	—	55.4	—	55.4
Private equity	—	—	17.0	17.0
Hedge funds:				
Custom hedge fund	—	—	48.1	48.1
Other hedge funds	—	—	144.9	144.9
Total assets	$ 538.7	298.2	210.0	1,046.9

For the years ended June 30, 2015 and 2014, there were no significant transfers between Levels 1, 2 or 3.

(Continued)

(Dollars in millions)

Changes to the fair values based on the Level 3 inputs are summarized as follows:

	Private equity	Hedge funds	Total
Balance as of June 30, 2013	$ 17.0	111.4	128.4
Additions:			
Contributions/purchases	1.3	149.3	150.6
Disbursements:			
Withdrawals/sales	(3.4)	(83.2)	(86.6)
Net change in value	2.1	15.5	17.6
Balance as of June 30, 2014	17.0	193.0	210.0
Additions:			
Contributions/purchases	4.2	6.0	10.2
Disbursements:			
Withdrawals/sales	(4.9)	—	(4.9)
Net change in value	2.2	5.0	7.2
Balance as of June 30, 2015	$ 18.5	204.0	222.5

The following summarizes redemption terms for the hedge fund-of-funds vehicles held as of June 30, 2015:

	Custom Hedge Fund			
	Fund 1	Fund 2	Fund 3	Fund 4
Redemption timing:				
Redemption frequency	Quarterly	68% monthly – quarterly 32% quarterly – annually	Quarterly	Quarterly
Required notice	70 days	within 90 days	90 days	65 days
Audit reserve:				
Percentage held back for audit reserve	10%	up to 10%	10%	10%
Gates:				
Potential gate holdback	—	—	—	—
Potential gate release timeframe	—	—	—	—

(Continued)

The hedge funds include three hedge funds-of-funds and one custom hedge fund. The custom fund is structured as a multi-strategy hedge fund with the Corporation as the sole investor. The investment objective and strategies used by the hedge funds-of-funds and custom hedge fund are similar. The investment objective is to achieve positive absolute returns with low volatility, achieved through investments with multiple underlying managers who are investing across various strategies. Strategies utilized within these hedge funds include, but are not limited to:

- *Credit/Distressed* includes investment companies that focus mainly on opportunities in corporate fixed income securities of companies that are in financial distress, or perceived financial distress, or going through a restructuring or re-organization.
- *Event Driven* includes investment companies that focus on identifying securities that would benefit from the occurrence of a major corporate event.
- *Global Macro* includes investment companies that employ broad mandates to invest globally across all asset classes, including interest rates, currencies, commodities, and equities, in order to benefit from market movements within various countries.
- *Equity Long/Short* includes investment companies that maintain long and short positions in publicly traded equities in order to capture opportunities driven by their perception of securities or industries being overvalued or undervalued.
- *Relative Value* includes investment companies that seek to identify valuation discrepancies between related securities, utilizing fundamental and quantitative techniques to establish equities, fixed income, and derivative positions.

Investments in hedge funds are typically carried at estimated fair value. Fair value is based on the Net Asset Value (NAV) of the shares in each investment company or partnership. Such investment companies or partnerships mark-to-market or mark-to-fair value the underlying assets and liabilities in accordance with U.S. GAAP. Realized and unrealized gains and losses of the investment companies and partnerships are included in their respective operations in the current year. Changes in unrealized gains or losses on investments, including those for which partial liquidations were effected in the course of the year, are calculated as the difference between the NAV of the investment at year-end less the NAV of the investment at the beginning of the year, as adjusted for contributions and redemptions made during the year and certain lock-up provisions. Generally, no dividends or other distributions are paid.

(Continued)

(Dollars in millions)

The following summarizes the status of contributions to the private equity fund-of-funds vehicles held as of June 30, 2015:

		Total commitment	Percentage of commitment contributed	Percentage of commitment remaining
Fund 1	$	9.0	95.0%	5.0%
Fund 2		8.5	95.3	4.7
Fund 3		8.5	90.0	10.0
Fund 4		5.0	11.5	88.6
Fund 5		5.0	23.5	76.5
Fund 6		5.0	38.0	62.0
Total	$	41.0		

Investments in private equity funds, typically structured as limited partnership interests are carried at fair value using NAV or equivalent as determined by the General Partner in the absence of readily ascertainable market values. Distributions under this investment structure are made to investors through the liquidation of the underlying assets. It is expected to take up to ten years to fully distribute the proceeds of those assets. The fair value of limited partnership interests is generally based on fair value capital balances reported by the underlying partnerships, subject to management review and adjustment. Security values of companies traded on exchanges, or quoted on NASDAQ, are based upon the last reported sales price on the valuation date. Security values of companies traded over the counter, but not quoted on NASDAQ, and securities for which no sale occurred on the valuation date are based upon the last quoted bid price. The value of any security for which a market quotation is not readily available may be its cost, provided however, that the General Partner adjusts such cost value to reflect any bona fide third party transactions in such a security between knowledgeable investors, of which the General Partner has knowledge. In the absence of any such third party transactions, the General Partner may use other information to develop a good faith determination of value. Examples include, but are not limited to, discounted cash flow models, absolute value models, and price multiple models. Inputs for these models may include, but are not limited to, financial statement information, discount rates, and salvage value assumptions.

The valuation of both marketable and nonmarketable securities may include discounts to reflect a lack of liquidity or extraordinary risks, which may be associated with the investment. Determination of fair value is performed on a quarterly basis by the General Partner. Because of the inherent uncertainty of valuation, the determined values may differ significantly from the values that would have been used had a ready market for those investments existed.

The Corporation has established a long-term investment return target of 7.75% for both the PEP and CBRP in 2015 and 2014, respectively. These assumptions are based on historical returns achieved in the investment portfolios and represent the return that can reasonably be expected to be generated on a similarly structured portfolio in the future.

(Continued)

(Dollars in millions)

The Corporation recognizes the funded status of defined benefit pension plans in the consolidated balance sheets and the recognition in unrestricted net assets of unrecognized gains or losses, prior service costs or credits and transition assets or obligations. The funded status is measured as the difference between the fair value of the plan's assets and the projected benefit obligation of the plan. The measurement date for the plans is June 30.

The following are deferred pension costs which have not yet been recognized in periodic pension expense but instead are accrued in unrestricted net assets, as of June 30, 2015 and 2014. Unrecognized actuarial losses represent unexpected changes in the projected benefit obligation and plan assets over time, primarily due to changes in assumed discount rates and investment experience. Unrecognized prior service cost is the impact of changes in plan benefits applied retrospectively to employee service previously rendered. Deferred pension costs are amortized into annual pension expense over the expected future lifetime for active employees with frozen benefits.

	Amounts in unrestricted net assets to be recognized during the next fiscal year	Amounts recognized in unrestricted net assets as of June 30, 2015	Amounts recognized in unrestricted net assets as of June 30, 2014
Net actuarial loss	$ 17.4	667.9	549.4

The following table sets forth the plans' funded status and amounts recognized in the accompanying consolidated financial statements as of June 30, 2015 and 2014:

	2015	2014
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 1,278.8	1,183.0
Interest cost	57.0	59.1
Actuarial loss	53.7	89.9
Benefits paid	(55.1)	(53.2)
Benefit obligation at end of year	1,334.4	1,278.8
Change in plan assets:		
Plan assets at fair value at beginning of year	1,046.9	881.0
Actual return on plan assets	(3.7)	143.2
Company contributions	55.7	75.9
Benefits paid	(55.1)	(53.2)
Plan assets at fair value at end of year	1,043.8	1,046.9
Funded status/net amount recognized	$ (290.6)	(231.9)

(Continued)

(Dollars in millions)

The amounts recognized in the consolidated financial statements consist of the following as of June 30:

	2015	2014
Pension assets (included in other assets)	$ 2.4	2.4
Pension liabilities	(293.0)	(234.3)

The Corporation has estimated $77.0 for its defined benefit contributions for the fiscal year ending June 30, 2015. The accumulated benefit obligation is $1,334.4 and $1,278.8 at June 30, 2015 and 2014, respectively.

Expected fiscal year benefit payments for all defined benefit plans is as follows:

2016	$ 60.5
2017	62.6
2018	66.7
2019	69.7
2020	74.6
2021–2025	409.0
	$ 743.1

Net periodic pension (income) expense for the years ended June 30, 2015 and 2014 is as follows:

	2015	2014
Interest cost on projected benefit obligation	$ 57.0	59.1
Return on plan assets	(77.7)	(69.6)
Recognized actuarial loss	16.4	14.2
Net periodic pension (income) expense	$ (4.3)	3.7

(Continued)

(Dollars in millions)

The assumptions used in determining net periodic pension expense and accrued pension costs shown above are as follows:

	2015	2014
Discount rates for obligations at year end:		
MedStar Health, Inc. Pension Equity Plan	4.70%	4.65%
MedStar Health, Inc. Cash Balance Retirement Plan	4.50	4.50
MedStar St. Mary's Hospital Pension Plan	4.35	4.25
Discount rates for pension cost:		
MedStar Health, Inc. Pension Equity Plan – July 1 – June 30	4.65%	5.20%
MedStar Health, Inc. Cash Balance Retirement Plan – July 1 – June 30	4.50	5.05
MedStar St. Mary's Hospital Pension Plan – July 1 – June 30	4.25	5.00
Expected long-term rate of return on plan assets – PEP and CBRP	7.75%	7.75%
Expected long-term rate of return on plan assets – MedStar St. Mary's Hospital	7.50	7.50

In 2015, the mortality assumption for the plans was updated to reflect recently published general industry mortality tables. Those tables were adjusted to reflect a slightly lower level of long-term improvement in life expectancy.

The Corporation also has various contributory, tax deferred annuity and savings plans with participation available to certain employees. The Corporation matches employee contributions up to 3.0% of compensation in certain plans. The Corporation contributed approximately $29.1 and $27.3 during the years ended June 30, 2015 and 2014, respectively.

(8) Business and Credit Concentrations

The Corporation provides healthcare services through its inpatient and outpatient care facilities located in the State of Maryland, the District of Columbia and Northern Virginia. 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 (e.g., Medicare, Medicaid, Blue Cross, Workers' Compensation, health maintenance organizations (HMOs) and commercial insurance policies).

(Continued)

(Dollars in millions)

The Corporation estimates the allowance for uncollectible accounts based on the aging of accounts receivable, historical collection experience, payor mix and other relevant factors. A significant portion of the allowance for uncollectible accounts relates to self-pay patients, as well as co-payments and deductibles owed by patients with insurance. There are various factors that can impact collection trends, such as changes in the economy, which in turn have an impact on unemployment rates and the number of uninsured and underinsured patients. Other factors include the volume of patients through the emergency departments and the increased level of co-payments and deductibles due from patients with insurance. These factors continuously change and can have an impact on collection trends and the estimation process.

The activity in the allowance for uncollectible accounts is summarized as follows for the years ended June 30, 2015 and 2014:

		2015	2014
Beginning balance	$	188.8	204.3
Provision for bad debts		206.7	193.2
Write-offs, net of recoveries		(188.5)	(208.7)
Ending balance	$	207.0	188.8

As of June 30, 2015 and 2014, the Corporation's allowance for uncollectible accounts was approximately 26.2% and 25.3%, respectively, as a percentage of patient service receivables. The Corporation's provision for bad debts represents 4.7% and 4.6% of net patient service revenue for the years ended June 30, 2015 and 2014, respectively.

A summary of net patient service revenue by major category of payor for the years ended June 30, 2015 and 2014 is as follows:

		2015	2014
Medicare and Medicare HMO	$	34%	37%
Medicaid and Medicaid HMO		13	11
Carefirst Blue Cross Blue Shield		23	19
Other commercial and managed care payors		23	24
Self-pay		7	9
	$	100%	100%

(Continued)

(Dollars in millions)

A summary of net patient receivables by major category of payor as of June 30, 2015 and 2014 is as follows:

	2015	2014
Medicare and Medicare HMO	27%	27%
Medicaid and Medicaid HMO	19	18
Carefirst Blue Cross Blue Shield	15	14
Other commercial and managed care payors	33	33
Self-pay	6	8
	100%	100%

Certain Maryland-based hospital charges are subject to review and approval by the 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.

Under the Maryland HSCRC rate methodology, amounts payable for services in 2015 and 2014 to Maryland hospital patients under the Medicare and Medicaid insurance programs are computed at 94% of regulated charges. This discount amount does not include MCO granted discounts for medical education. Hospital patients under the Blue Cross and approved health maintenance organization insurance programs are computed at 98% of regulated charges. Maryland accounts receivable from these third-party payors have been adjusted to reflect the difference between charges and the payable amounts.

In January 2014, CMS approved Maryland's new waiver for a five-year period beginning January 1, 2014 for inpatient and outpatient hospital services. The new waiver ties hospital per capita revenue growth to the state's economic growth of 3.58% and will require growth in Medicare spending per beneficiary in Maryland to be 0.5% below the national average. CMS can require the State to submit a corrective action plan if targets for a given performance year are not met. The new waiver also imposes quality measures and encourages population health management.

In connection with the new waiver, the HSCRC introduced new revenue arrangements, including the Global Budget Revenue (GBR) model. This new model for Maryland Hospitals moves payment to hospitals from each individual service to a total revenue for each hospital or a combination of hospitals to provide hospitals flexibility in the objectives of better care for individuals, higher levels of overall population health, and improved health care affordability. It removes the financial incentive from increasing volume and provides incentive to work with partners to provide care in the appropriate setting. The Corporation entered into a GBR arrangement covering five of its seven Maryland hospitals during the year ended June 30, 2014. In August 2014, the Corporation also entered into GBR arrangements for its remaining two Maryland hospitals. The GBR arrangement is expected to be in place at least three years, but will be renewed annually unless terminated by either party with 180 days prior notice. The Corporation recognized hospital inpatient and outpatient regulated revenue under the new arrangement for the hospitals covered under the arrangement for the years ended June 30, 2015 and 2014.

(Continued)

(Dollars in millions)

The Budget Control Act of 2011 (the Budget Control Act) mandated significant reductions and spending caps on the federal budget for fiscal years 2012 through 2021. As part of this legislation, a 2% reduction in Medicare spending, known as Sequestration, was implemented beginning April 1, 2013 and the Corporation's Medicare payments subsequent to that date were reduced by the mandatory 2%. It is not possible to determine how future congressional actions to reduce the federal deficit in order to end Sequestration will impact the Corporation's revenues.

Through its MedStar Family Choice, Inc. subsidiary, the Corporation enters into fee-for-service and capitation agreements with independent health professionals and organizations to provide covered services to eligible enrollees where such services cannot be provided by its employed physicians or controlled entities. This subsidiary has contracts to provide Medicare and Medicaid services to those within Maryland and the District of Columbia. Premium revenue primarily consists of the following:

		2015	2014
Maryland Medicaid	$	309.5	204.2
District of Columbia Medicaid		212.4	152.1
Total Medicaid	$	521.9	356.3
Maryland Medicare	$	36.4	0.0
District of Columbia Medicare		2.6	1.2
Total Medicare	$	39.0	1.2

Medical and clinical expenses from these agreements include claim payments, capitation payments, and estimates of outstanding claims liabilities for services provided prior to the balance sheet date. The estimates of outstanding claims liabilities of $62.3 and $52.2 as of June 30, 2015 and 2014, respectively, are based on management's analysis of historical claims paid reports and review of health services utilization during the period and are included in accounts payable and accrued expenses on the consolidated balance sheets. Changes in these estimates are recorded in the period of change. Claims payments and capitation payments are expensed in the period services are provided to eligible enrollees.

(9) Certain Significant Risks and Uncertainties

The Corporation provides general healthcare services in the State of Maryland, the District of Columbia and Northern Virginia. As a healthcare provider, the Corporation is subject to certain significant inherent risks, including the following:

- Dependence on revenues derived from reimbursement by the federal Medicare and state Medicaid programs;
- Regulation of hospital rates by the State of Maryland HSCRC;
- Government regulation, government budgetary constraints and proposed legislative and regulatory changes, and;
- Lawsuits alleging malpractice or other claims.

(Continued)

Such inherent risks require the use of certain management estimates in the preparation of the Corporation's consolidated financial statements and it is reasonably possible that a change in such estimates may occur.

The Medicare and state Medicaid reimbursement programs represent a substantial portion of the Corporation's revenues and the Corporation's operations are subject to a variety of other federal, state and local regulatory requirements. In addition, changes in federal and state reimbursement funding mechanisms and related government budgetary constraints could have a significant adverse effect on the Corporation. Similarly, failure by the Corporation to maintain required regulatory approvals and licenses and/or changes in related regulatory requirements could have a significant adverse effect.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount. Management periodically reviews recorded amounts receivable from or payable to third-party payors and may adjust these balances as new information becomes available. In addition, revenue received under certain third-party agreements is subject to audit. During 2015 and 2014, certain of the Corporation's prior year third-party cost reports were audited and settled, or tentatively settled, by third-party payors. Adjustments resulting from such audits and management reviews of unaudited years and open claims are reflected as adjustments to revenue in the year that the adjustment becomes known. Although certain other prior year cost reports submitted to third-party payors remain subject to audit and retroactive adjustment, management does not expect any material adverse settlements.

The healthcare industry is subject to numerous laws and regulations from federal, state and local governments, and the government has increased enforcement of Medicare and Medicaid anti-fraud and abuse laws, as well as physician self referral laws (Stark laws and regulation). The Corporation's compliance with these laws and regulations is subject to periodic governmental inquiries, and the Corporation has responded appropriately to any such inquiries. The Corporation is aware of certain asserted and unasserted legal claims by the government, and from time to time, the Corporation may agree to resolve certain legal claims asserted by the government. The Corporation will continue to monitor all government inquiries and respond appropriately. The final outcomes of these government investigations cannot be determined at this time.

Recent federal initiatives have prompted a national review of federally funded healthcare programs. To this end, the federal government, and many states, implemented programs to audit and recover potential overpayments to providers from the Medicare and Medicaid programs. Since June 2010, the Corporation's hospitals have received audit requests from the Medicare Recovery Audit Contractor (RAC) program. These RAC audit requests have focused on medical necessity of inpatient admissions and hospital coding practices. In addition, the hospitals have continued to receive routine audit requests from other Medicare and Medicaid contractors and the Office of Inspector General. The Corporation's hospitals have cooperated with each of these audit requests and implemented a program to track and manage their effect. In October 2014, in response to a global settlement offer made by the Centers of Medicare and Medicaid Services (CMS), the Corporation's hospitals submitted requests to settle certain outstanding appeals of claims denied by the RAC and other Medicare contractors on the basis of patient status. The hospitals entered into settlements with CMS and have received initial settlement payments of approximately $11.0, which have been reflected as adjustments to revenue in the current period.

(Continued)

(Dollars in millions)

As a result of recently enacted and pending federal healthcare reform legislation, rules and regulations, substantial changes are occurring in the United States healthcare system. These include numerous provisions affecting the delivery of healthcare services, the financing of healthcare costs, reimbursement to healthcare providers and the legal obligations of health insurers, providers and employers. These provisions are currently slated to take effect at specified times over the next decade. This federal healthcare reform legislation did not significantly affect the 2015 or 2014 consolidated financial statements.

The Corporation, in the normal course of business, is a party to legal and regulatory proceedings. These include a lawsuit filed in June 2011 by several MedStar Washington Hospital Center (MWHC) employees alleging violations by the Corporation of wage-hour laws. The plaintiffs in this action are seeking certification of a class that would include hourly employees at all of the Corporation's hospitals. The Corporation is opposing class certification and taking other steps to defend itself and the hospitals in this litigation. The final outcome of litigation cannot be determined at this time. In April 2014, another lawsuit was filed in federal court alleging similar wage-hour violations as the 2011 action. This lawsuit seeks to certify a class to include hourly employees at six of the Company's hospitals; and in August 2015, plaintiffs added a seventh MedStar hospital to this litigation. The Corporation will oppose class certification and otherwise defend itself and the hospitals in this matter.

In June 2015, MWHC agreed on a new collective bargaining agreement with the union that represents its nurses, National Nurses United. That agreement provides for a four-year term through May 31, 2019.

The Corporation, in the normal course of business, is a party to a number of legal and regulatory proceedings. Management does not expect that the results of these proceedings will have a material adverse effect on the consolidated financial position or results of operations of the Corporation.

(10) Self-Insurance Programs

The Corporation maintains self-insurance programs for professional and general liability risks, employee health and workers' compensation. Estimated liabilities have been recorded based on actuarial estimation of reported and incurred but not reported claims. The combined accrued liabilities for these programs at June 30, 2015 and 2014 were as follows:

		2015	2014
Professional and general liability	$	344.6	345.4
Employee health		20.2	18.9
Workers' compensation		34.2	34.4
Total liabilities		399.0	398.7
Less current portion		(88.4)	(86.3)
	$	310.6	312.4

(Continued)

The Corporation's self insurance program for professional and general liability is responsible for the following exposures as of June 30, 2015:

(a) For professional liability during the periods of July 1, 2013 to June 30, 2014 and July 1, 2014 to June 30, 2015, for all MedStar entities except MedStar Montgomery Medical Center (MMMC) and MedStar St. Mary's Hospital (MSMH), the Corporation is responsible for the first $5.0 exposure for each and every claim plus an additional exposure above the first $5.0 self-insured retention referred to as an "inner aggregate."

For the period July 1, 2013 to December 31, 2013, the applicable inner aggregate was an inner aggregate that was in effect for the 12 month period January 1, 2013 through December 31, 2013. This inner aggregate exposes the Corporation to up to $3.0 per claim with an aggregate for the 12 month period of $6.0 above the $5.0 per claim self-insured retention for all claims incurred during the period January 1, 2013 through December 31, 2013.

For the period January 1, 2014 to June 30, 2014, the applicable inner aggregate was in effect for the 12 month period of January 1, 2014 to December 31, 2014. This inner aggregate exposes the Corporation to up to $3.0 per claim with a $6.0 annual aggregate above the Corporation's $5.0 per claim self-insured retention for all claims incurred during the period January 1, 2014 to December 31, 2014.

For the period January 1, 2015 to June 30, 2015, the applicable inner aggregate was in effect for the 12 month period of January 1, 2015 to December 31, 2015. This inner aggregate exposes the Corporation to up to $3.0 per claim with a $6.0 annual aggregate above the Corporation's $5.0 per claim self-insured retention for all claims incurred during the period January 1, 2015 to December 31, 2015.

Effective December 10, 2012, Southern Maryland Hospital joined the Corporation as MedStar Southern Maryland Hospital Center (MSMHC). MSMHC is covered for all professional liability exposure for activities on or after December 10, 2012 under the same program of coverage described above. The Corporation did not assume responsibility for MSMHC exposure or any tail claims that might arise in future years related to activities that occurred prior to the acquisition by the Corporation.

For MMMC and MSMH, the Corporation is responsible for the first $2.0 exposure for each claim (not subject to the inner aggregate structures noted above).

(b) For general liability, the Corporation is responsible for the first $3.0 exposure for each claim (for MMMC and MSMH, the first $2.0 exposure for each claim). General liability claims are not subject to the inner aggregate excess retention as described above. MSMHC is covered for general liability exposure for activities on or after December 10, 2012 under the Corporation's general liability program.

(c) Commercial excess re-insurance has been purchased above the self-insured retentions described above in multiple layers and in twin towers; one for professional and one for general liability.

(Continued)

(Dollars in millions)

Effective January 1, 2013, the Corporation purchased an additional layer of commercial excess re-insurance. During the period of January 1, 2013 through June 30, 2015, each tower has eight layers of excess re-insurance which provides coverage of up to $125.0 per claim and $125.0 in the annual aggregate. The Corporation maintains reinsurance contracts with various "A" rated commercial insurance companies.

The professional and general liabilities as of June 30, 2015 and 2014 have been discounted at a rate of 1.75%. The workers' compensation liabilities as of June 30, 2015 and 2014 have been discounted at a rate of 1.50%.

Assets available to fund these liabilities are held in separate accounts (see note 2). Contributions required to fund professional and general liability, employee health benefits and workers' compensation programs are determined by the plans' administrators based on appropriate actuarial assumptions. The professional and general liability programs are administered through an offshore wholly owned captive insurance company, Greenspring Financial Insurance Limited (GFIL), which is domiciled in the Grand Cayman Islands.

(11) Unrestricted Net Assets

The Corporation accounts for and presents noncontrolling interests in a consolidated subsidiary as a separate component of the appropriate class of consolidated net assets. The income attributable to noncontrolling interests is included within operating income on the consolidated statements of operations and changes in net assets. The following table presents a reconciliation of the changes in consolidated unrestricted net assets attributable to the Corporation's controlling interest and noncontrolling interest, including amounts such as the performance indicator and other changes in unrestricted net assets as of and for the years ended June 30, 2015 and 2014:

	MedStar Health, Inc.	Noncontrolling interests	Total unrestricted net assets
Balance as of June 30, 2013	$ 1,017.4	9.4	1,026.8
Excess of revenues over expenses	302.4	2.3	304.7
Change in funded status of defined benefit plans	(2.1)	—	(2.1)
Net assets released for property and equipment and other	4.5	(2.8)	1.7
Distributions to noncontrolling interests	—	(3.7)	(3.7)
Increase (decrease) in unrestricted net assets	304.8	(4.2)	300.6
Balance as of June 30, 2014	1,322.2	5.2	1,327.4

(Continued)

(Dollars in millions)

	MedStar Health, Inc.	Noncontrolling interests	Total unrestricted net assets
Excess of revenues over expenses	$ 109.1	2.2	111.3
Change in funded status of defined benefit plans	(118.5)	—	(118.5)
Net assets released for property and equipment	6.2	—	6.2
Acquired noncontrolling interests	—	10.8	10.8
Distributions to noncontrolling interests	—	(2.9)	(2.9)
(Decrease) increase in unrestricted net assets	(3.2)	10.1	6.9
Balance as of June 30, 2015	$ 1,319.0	15.3	1,334.3

(12) Temporarily and Permanently Restricted Net Assets

Temporarily and permanently restricted net assets as of June 30, 2015 and 2014 are available for the following purposes:

	2015	2014
Temporary restrictions:		
Interest in net assets of foundation	$ 63.0	64.9
Other	68.9	56.9
	$ 131.9	121.8
Permanent restrictions:		
Investments to be held in perpetuity, the income from which is available to support healthcare services	$ 39.5	39.4

Temporarily restricted net assets are available for the purposes of purchasing property and equipment, providing health education, research and other healthcare services.

(13) Endowment Net Assets

The Corporation's endowments consist of individual donor-restricted funds established for a variety of purposes. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

(a) Interpretation of Relevant Law

The Corporation has interpreted the State Prudent Management of Institutional Funds Act (SPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of

(Continued)

(Dollars in millions)

this interpretation, the Corporation classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the organization in a manner consistent with the standard of prudence prescribed by SPMIFA. In accordance with SPMIFA, the Corporation considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

(1) The duration and preservation of the fund

(2) The purposes of the Corporation and the donor-restricted endowment fund

(3) General economic conditions

(4) The possible effect of inflation and deflation

(5) The expected total return from income and the appreciation of investments

(6) Other resources of the Corporation

(7) The investment policies of the Corporation

(b) Endowment Net Assets Consist of the Following as of June 30, 2015

	Unrestricted	Temporarily restricted	Permanently restricted	Total
Donor-restricted endowment funds	$ —	5.2	39.5	44.7
Total endowed net assets	$ —	5.2	39.5	44.7

(c) Endowment Net Assets Consist of the Following as of June 30, 2014

	Unrestricted	Temporarily restricted	Permanently restricted	Total
Donor-restricted endowment funds	$ —	6.6	39.4	46.0
Total endowed net assets	$ —	6.6	39.4	46.0

(Continued)

(d) Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or SPMIFA requires the Corporation to retain as a fund of perpetual duration. In accordance with U.S. GAAP, there were no deficiencies of this nature that are reported in unrestricted net assets as of June 30, 2015 and 2014.

(e) Investment Strategies

The Corporation has adopted policies for corporate investments, including endowment assets, that seek to maximize risk-adjusted returns with preservation of principal. Endowment assets include those assets of donor-restricted funds that the Corporation must hold in perpetuity or for a donor-specified period(s). The endowment assets are invested in a manner that is intended to hold a mix of investment assets designed to meet the objectives of the account. The Corporation expects its endowment funds, over time, to provide an average rate of return that generates earnings to achieve the endowment purpose.

To satisfy its long-term rate-of-return objectives, the Corporation relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Corporation employs a diversified asset allocation structure to achieve its long-term return objectives within prudent risk constraints.

The Corporation monitors the endowment funds returns and appropriates average returns for use. In establishing this practice, the Corporation considered the long-term expected return on its endowment. This is consistent with the Corporation's objective to maintain the purchasing power of the endowment assets held in perpetuity or for a specified term as well as to provide additional real growth through new gifts and investment return.

(14) Income Taxes

The Corporation and the majority of its subsidiaries are not-for-profit corporations as defined in Section 501(c)(3) of the Internal Revenue Code (the Code) and are exempt from federal income taxes under Section 501(a) of the Code. The Corporation's tax-exempt businesses generate nominal amounts of unrelated business income subject to income tax. For corporate income tax purposes, the Corporation has two consolidated groups of for-profit, taxable entities. The parent companies of these groups are Parkway Ventures, Inc. and MedStar Enterprises, Inc.

The Corporation's taxable subsidiaries have approximately $218.5 of net operating loss (NOL) carryforwards as of June 30, 2015, which expire in varying periods through 2035, available to offset future taxable income. This NOL carryforward represents $83.0 of gross deferred tax assets. In assessing the realizability of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences become deductible. Management considers the scheduled reversal of deferred tax liabilities, projected future taxable income, and tax planning strategies in making this assessment. During the years ended June 30, 2015 and 2014, the Corporation decreased its net deferred tax asset by $6.1 and $3.6,

respectively, which was recorded in nonoperating income. The remaining amount of the deferred tax asset considered realizable, $21.7 as of June 30, 2015, could be reduced if estimates of future taxable income during the carry forward period are reduced. The current tax provisions for the years ended June 30, 2015 and 2014 were immaterial.

(15) Charity Care and Other Community Benefits

MedStar Health is committed to ensuring that patients within the communities it serves who lack financial resources have access to necessary hospital services. MedStar Health and its healthcare facilities serve the emergency health care needs of everyone who visits the facilities regardless of a patient's ability to pay for care; and assist those patients who are admitted through the admissions process for non-urgent and urgent, medically necessary care who cannot pay for the care they receive.

In meeting this commitment, MedStar Health's facilities work with uninsured patients to gain an understanding of each patient's financial resources prior to admission (for scheduled services) or prior to billing (for emergency services). Based on this information and patient eligibility, the Corporation's facilities assist uninsured and certain underinsured patients that meet medical hardship criteria who reside within the communities served. This assistance is provided in one or more of the following ways:

- Assist with enrollment in publicly-funded entitlement programs (e.g. Medicaid and Medicare programs).
- Assist with consideration of funding that may be available from other charitable organizations.
- Provide charity care and financial assistance according to applicable guidelines, including considerations for patients that may be underinsured and for those that may be suffering from a medical hardship.
- Provide financial assistance for payment of facility charges using a sliding scale based on patient family income and financial resources.
- Offer periodic payment plans to assist patients with financing their healthcare services.

Eligibility criteria for financial assistance consider patient's household income in relation to the federal poverty guidelines and the equity value of real property and/or other assets. By definition, free care is available to uninsured patients in households between 0% and 200% of the federal poverty line. Reduced cost-care is based on a sliding-scaled and is available to uninsured patients in households between 200% and 400% of the federal poverty line.

In addition to charity care, the Corporation also funds unpaid costs of services provided to persons covered by publicly-funded programs and numerous programs designed to benefit the healthcare interests of the communities it serves. Examples of these programs are health education programs and services, health information and referral services, school-based clinics, public health screenings and home care. The costs associated with these programs are recorded in the appropriate operating expense categories.

The Corporation's hospitals utilize a cost to charge ratio methodology to convert charity care to cost. The estimated cost of services provided is determined based on the relationship of total operating costs to gross

(Dollars in millions)

charges. Total operating costs for purposes of this ratio exclude bad debt expense as well as costs associated with community benefit activities. Total gross patient charges are then offset with any related reimbursements. The Corporation provided $26.1 and $45.5 of charity care at cost during the years ended June 30, 2015 and 2014, respectively, based on the cost to charge ratio. The reduction in charity care is a result of expanded coverage under the Affordable Care Act (ACA), contributing to a shift from self-pay to Medicaid and Medicaid managed care. In addition, the ACA contains a number of provisions intended to improve quality and reduce spending related to the Medicare program. The reduction in spending on the Medicare program, which includes readmission penalties, a reduction in disproportionate share payments, and reduction in payment rates, is intended to offset the cost of expanding coverage under the ACA.

(16) Leases

The Corporation is obligated under various operating leases with initial terms of one year or more. Aggregate future minimum payments as of June 30, 2015 are as follows:

2016	$ 64.5
2017	57.1
2018	49.9
2019	45.1
2020	36.8
2021 and Thereafter	182.7
	$ 436.1

Certain leases include provisions allowing the minimum rental payments to be adjusted annually for increases in operating costs and, in some cases, real estate taxes attributable to leased property. Total rental expense for all operating leases amounted to approximately $72.7 and $65.9 during the years ended June 30, 2015 and 2014, respectively.

(17) Commitments and Contingencies

In February 2000 and on June 30, 2000, the Corporation and Georgetown University (the University) signed certain definitive agreements whereby the Corporation would receive through purchase or capital lease substantially all of the assets (including working capital) owned by the University that constitutes the MedStar Georgetown University Hospital, the Community Practice Network, the Faculty Practice Group and certain office buildings and a parking lot on the campus (collectively referred to as the Transferred Businesses). These agreements became effective July 1, 2000 and transferred control of the identified physical plant and other real property assets of the Transferred Businesses to the Corporation for use as an academic medical center for a minimum of ninety-eight years. At the end of the one hundred and fifty year lease term (including a fifty-two year renewal), the University shall convey all leased assets, excluding the underlying land, to the Corporation for a nominal amount and enter into a rent-free ground lease for the Corporation's use. This transaction was accounted for under the purchase method of accounting effective July 1, 2000.

(Continued)

In recognition of the value of the transaction, the Corporation shall annually pay the University 50% of the amount by which the combined operating earnings before interest, taxes, depreciation and amortization (EBITDA), as defined in the asset purchase agreement, of certain entities of the Corporation in the Washington D.C. area (collectively referred to as the Washington Clinical Enterprises) exceeds $60.0, subject to certain adjustments. These additional payments expire when cumulative payments reach $70.0. The Corporation has paid $52.7 to the University as of June 30, 2015 and is expected to pay the remaining $17.3 by June 30, 2016.

The Corporation also entered into an Academic Affiliation and Operations Agreement (Affiliation Agreement) with the University. The purpose of this agreement is to make available to the University the facilities of the Transferred Businesses and provide the Corporation with a first-class University medical center. The University shall make payments to the Corporation determined by multiplying the University School of Medicine's total undergraduate tuition revenue by 36% for providing teaching services. The Corporation recognized $12.9 and $12.3 of tuition revenue during the years ended June 30, 2015 and 2014, respectively. In support of academic programs at the University, for each fiscal year following the termination of the additional payment terms in the asset purchase agreement described above, the Corporation shall pay to the University 17.5% of the operating EBITDA of the Washington Clinical Enterprises in excess of $60.0, subject to certain adjustments. No amounts have been paid under this Affiliation Agreement through June 30, 2015.

The Corporation and the University also entered into a Research Agreement to sustain and advance a program of health-related University research at the Transferred Business facilities. Under this agreement the University is required to reimburse the Corporation for certain costs incurred by the Corporation in support of University sponsored research. Amounts reimbursed to the Corporation were $2.8 and $2.7 for the years ended June 30, 2015 and 2014, respectively.

MedStar Georgetown University Hospital and the University are parties to a fixed fee shared services agreement. Georgetown University provided to MedStar Georgetown University Hospital the following services: utilities, telephone/IT services, transportation services and library services. Expenses charged for such services were $14.3 and $13.6 for the years ended June 30, 2015 and 2014, respectively.

The MedStar Washington Hospital Center campus is subject to the lien of a Permitted Encumbrance in the amount of $21.5 to the United States government. This encumbrance was created in the deed of the hospital property from the United States government to MedStar Washington Hospital Center in February 1960. There is no repayment date for this lien stated in the deed. Under enabling legislation, repayment could be required after a determination that the property is no longer required for hospital services or the property is disposed of, in which event all or a portion of the lien may be payable to the government. This lien is subordinated to the Deed of Trust on the MedStar Washington Hospital Center campus.

(Continued)

(Dollars in millions)

(18) Functional Expenses

The Corporation considers integrated health services, research and management and general to be its primary functional categories for purposes of expense classification. Management and general include information systems, general corporate management, advertising and marketing. Functional categories of expenses for the years ended June 30, 2015 and 2014 are as follows:

	2015	2014
Integrated health services	$ 3,885.9	3,532.4
Management and general	946.2	924.7
Research	30.0	30.4
Fundraising	4.3	4.9
	$ 4,866.4	4,492.4

(19) Subsequent Events

Management evaluated all events and transactions that occurred after June 30, 2015 and through October 2, 2015. The Corporation did not have any events that were required to be recognized or disclosed.

Attachment 17

Affirmation Statements

Affirmation Statement

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.

(signature)

MEGHA KACHALIA, AVP PHYSICIAN & AMBULATORY PLANNING
(print name and affiliation)

02/08/16
(date)

Affirmation Statement

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.

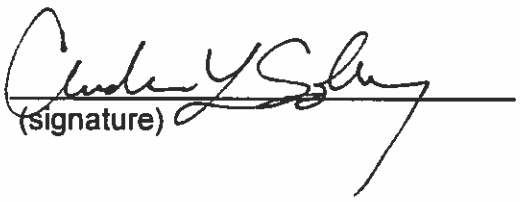
Ulana Bilynsky
(signature)

ULANA BILYNSKY, AVP Ambulatory Dev
MedStar Health
(print name and affiliation)

2/2/16
(date)

Affirmation Statement

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.



(signature)

Andrew L. Solberg, A.L.S. Healthcare Consultant Services
(print name and affiliation)

2/3/16
(date)

Affirmation Statement

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.

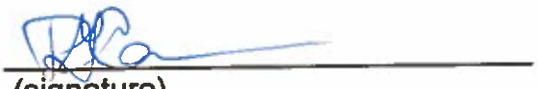
(signature)

John St. Leger, Counsel, MedStar Health, Inc.
(print name and affiliation)

2/3/16
(date)

Affirmation Statement

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.



(signature)

Patricia Cameron, Senior Policy Analyst, MedStar Health

Feb 3, 2016

(date)

Affirmation Statement

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.

(signature)

Jason Mueller

(print name and affiliation)

02/03/2016

(date)

Affirmation Statement

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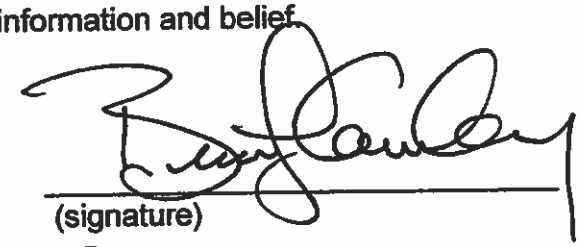

(signature)

Brian J. Cawley, VP MedStore Orthopaedics

(print name and affiliation)

February 3, 2016

(date)

Affirmation Statement

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.

Maria Mitchell
(signature)

MARIA MITCHELL, VP UNITED SURGICAL PARTNERS
(print name and affiliation)

2/3/16
(date)

Affirmation Statement

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.

Mark Meginnis

(signature)

MARK MEGINNIS TREASURER

(print name and affiliation)

2/3/16

(date)

Affirmation Statement

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.

Jennifer Wilkerson
(signature)

Jennifer Wilkerson, MedStar Health
(print name and affiliation)

2/4/16
(date)