OFFICIAL STATEMENT DATED MAY 29, 2025

NEW ISSUE -- BOOK-ENTRY ONLY

Underlying Fitch: "A" (Stable Outlook)
Underlying S&P: "A-" (Stable Outlook)
Insured S&P: "AA" (Stable Outlook)
See "Ratings" herein.

In the opinion of Bond Counsel to the Authority, under existing statutes, regulations and decisions, and assuming compliance with certain covenants described herein, interest on the Series 2025 Bonds is excludable from gross income for federal income tax purposes and is not includable in the alternative minimum taxable income of individuals as an enumerated item of tax preference or other specific adjustment; however, interest on the Series 2025 Bonds will be part of adjusted financial statement income in computing the federal alternative minimum tax on applicable corporations. Additionally, interest on the Series 2025 Bonds will be subject to the branch profits tax imposed on certain foreign corporations engaged in a trade or business in the United States of America. By the terms of the Act, the interest on the Series 2025 Bonds, the transfer of the Series 2025 Bonds and any income derived from the Series 2025 Bonds, including profits made in their sale or transfer, are exempt from all Maryland state and local taxes; no opinion is expressed as to estate or inheritance taxes or any other taxes not levied or assessed directly on the Series 2025 Bonds, their transfer or the income therefrom. See "Tax Matters."

MARYLAND HEALTH AND HIGHER EDUCATIONAL FACILITIES AUTHORITY

$361,030,000
Revenue Bonds
Meritus Health Issue
Series 2025

Dated: Date of initial delivery

Due: July 1, as shown below

The Series 2025 Bonds are issuable only as fully registered bonds in denominations of $5,000 and integral multiples thereof. The Series 2025 Bonds will be maintained under a book-entry system under which The Depository Trust Company, New York, New York ("DTC"), will act as securities depository. Purchases of the Series 2025 Bonds will be in book-entry form only. Interest on the Series 2025 Bonds from the date of delivery is payable on January 1, 2026, and semiannually thereafter on each January 1 and July 1. So long as the Series 2025 Bonds are maintained under a book-entry system, payments of the principal of and premium, if any, and interest on the Series 2025 Bonds will be made when due by The Bank of New York Mellon, as trustee (the "Trustee"), to DTC in accordance with the Resolution, and the Trustee will have no obligation to make any payments to any beneficial owner of any Series 2025 Bonds. See "The Series 2025 Bonds -- Book-Entry Only System."

The Series 2025 Bonds constitute special obligations of the Authority payable solely from payments by Meritus Medical Center, Inc., MSOM, Inc. and Brook Lane Health Services, Inc. (collectively, the "Obligated Group Members") to the Authority or the Trustee pursuant to the Loan Agreement. The performance by the Obligated Group Members of their obligations under the Loan Agreement is secured by a pledge of the Receipts of the Obligated Group Members. See "Security and Sources of Payment for the Series 2025 Bonds."

The scheduled payment of principal of and interest on the Series 2025 Bonds maturing on July 1, 2036, July 1, 2037 and July 1, 2039 through and including July 1, 2046 and the Term Bond maturing July 1, 2055 (collectively, the "2025 Insured Bonds") will be guaranteed under an insurance policy (the "2025 Insurance Policy") to be issued concurrently with the delivery of the 2025 Insured Bonds by Assured Guaranty Inc. ("AG" or the "2025 Insurer"). See "Bond Insurance" herein.

None of the State of Maryland, any political subdivision thereof or the Authority shall be obligated to pay the Series 2025 Bonds or the interest thereon except from the Revenues and other amounts pledged therefor under the Resolution, and neither the faith and credit nor the taxing power of the State of Maryland, of any political subdivision thereof or of the Authority is pledged to the payment of the principal of or the interest on the Series 2025 Bonds. The issuance of the Series 2025 Bonds does not directly, indirectly or contingently obligate, morally or otherwise, the State of Maryland, any political subdivision thereof or the Authority to levy or pledge any form of taxation whatever therefor or to make any appropriation for their payment. The Authority has no taxing power.

The Series 2025 Bonds are subject to redemption prior to maturity as described herein under "The Series 2025 Bonds -- Redemption Provisions."

$212,965,000 Serial Bonds

Due (July 1)	Amount	Interest Rate	Yield	Price	CUSIP	Due (July 1)	Amount	Interest Rate	Yield	Price	CUSIP
2026	$5,765,000	5.00%	3.170%	101.849	57421CJD7	2037**	$10,430,000	5.00%	4.110%	107.257*	57421CJQ8
2027	6,405,000	5.00	3.180	103.559	57421CJE5	2038	10,955,000	5.00	4.330	105.405*	57421CJR6
2028	6,725,000	5.00	3.230	105.078	57421CJF2	2039**	11,505,000	4.25	4.390	98.542	57421CJS4
2029	7,060,000	5.00	3.290	106.412	57421CJG0	2040**	11,990,000	4.25	4.480	97.501	57421CJT2
2030	7,410,000	5.00	3.380	107.442	57421CJH8	2041**	12,500,000	5.00	4.540	103.673*	57421CJU9
2031	7,785,000	5.00	3.470	108.266	57421CJJ4	2042**	13,125,000	5.00	4.660	102.698*	57421CJV7
2032	8,180,000	5.00	3.570	108.826	57421CJK1	2043**	13,780,000	5.00	4.760	101.895*	57421CJW5
2033	8,580,000	5.00	3.660	109.255	57421CJL9	2044**	14,470,000	5.00	4.820	101.417*	57421CJX3
2034	9,010,000	5.00	3.810	109.023	57421CJM7	2045**	15,195,000	5.00	4.870	101.020*	57421CJY1
2035	9,465,000	5.00	3.940	108.715	57421CJN5	2046**	12,695,000	5.00	4.910	100.704*	57421CJZ8
2036**	9,935,000	5.00	4.010	108.112*	57421CJP0						

$57,675,000	**5.25%**	**Term Bonds due July 1, 2050**	**Yield 5.130%**	**Price: 100.929***	**CUSIP: 57421CKA1**
$90,390,000	**5.00%**	**Term Bonds due July 1, 2055****	**Yield 5.090%**	**Price: 98.620***	**CUSIP: 57421CKB9**

***Priced to the first optional redemption date of July 1, 2035.**

****Scheduled payment of principal of and interest guaranteed under the 2025 Insurance Policy by AG.**

The Series 2025 Bonds are offered, subject to prior sale, when, as and if issued by the Authority and accepted by the Underwriters, subject to the approval of McKennon Shelton & Henn LLP, Bond Counsel to the Authority, the approval of certain legal matters by the Chief Legal Officer and Vice President of Legal Services of the Institution, Gallagher Evelius & Jones LLP, counsel to the Obligated Group Members, and Ballard Spahr LLP, counsel to the Underwriters, and certain other conditions. It is expected that the Series 2025 Bonds will be available for delivery on or about June 18, 2025.

Truist Securities **BofA Securities**

No dealer, broker, sales representative or other person has been authorized by Maryland Health and Higher Educational Facilities Authority (the "Authority"), the Obligated Group Members (defined herein) or Truist Securities, Inc. and BofA Securities, Inc. (together, the "Underwriters") to give any information or to make any representation other than as contained in this Official Statement and, if given or made, such other information or representation must not be relied upon as having been authorized by any of the foregoing. This Official Statement does not constitute an offer to sell or the solicitation of an offer to buy, nor shall there be any sale of the Series 2025 Bonds by any person in any jurisdiction in which it is unlawful for such person to make such offer, solicitation or sale. The information set forth herein has been obtained from the Obligated Group Members and other sources that are deemed to be reliable but is not guaranteed as to accuracy or completeness by the Underwriters, and is not to be construed as a representation either by the Underwriters or the Authority. This Official Statement is not to be construed as a contract or agreement between the Authority and the purchasers or holders of any of the Series 2025 Bonds.

The Authority has either provided or reviewed the information under the headings "The Authority," "State Not Liable on Series 2025 Bonds" and "Corporate Existence of the Authority" as it relates to the Authority and will not be responsible for any other statements or information in this Official Statement. The Underwriters have reviewed the information in this Official Statement in accordance with, and as part of, their responsibilities to investors under the federal securities laws as applied to the facts and circumstances of this transaction, but the Underwriters do not guarantee the accuracy or completeness of such information.

CUSIP numbers on the inside cover page of this Official Statement are subject to a copyright by the American Bankers Association ("ABA"). CUSIP numbers herein are provided by CUSIP Global Services, which is managed on behalf of the ABA by FactSet Research Systems Inc. The CUSIP numbers listed on the inside cover page of this Official Statement are being provided solely for convenience of the holders of the Series 2025 Bonds only at the time of issuance of the Series 2025 Bonds, and none of the Authority, the Underwriters or the Obligated Group Members takes any responsibility for the accuracy thereof now or at any time in the future. The CUSIP numbers are subject to being changed after the issuance of the Series 2025 Bonds in certain circumstances. Such CUSIP numbers are not intended to create a database and do not serve in any way as a substitute for the CUSIP Global Services.

Certain statements included or incorporated by reference in this Official Statement constitute "forward looking statements." Such statements are generally identifiable by the terminology used, such as "plan," "expect," "estimate," "budget," "forecast" or other similar words. Such forward-looking statements include, among others, certain of the information in "Certain Bondholders' Risks" herein and in Appendix A. The achievement of certain results or other expectations in such forward looking statements involves known and unknown risks, uncertainties and other factors which may cause actual results, performance or achievements described to be materially different from any future results, performance or achievements expressed or implied by such forward looking statements. The Obligated Group Members do not plan to issue any updates or revisions to those forward looking statements if or when its expectations, or events, conditions or circumstances on which such statements are based, occur or fail to occur.

Assured Guaranty Inc. ("AG" or the "2025 Insurer") makes no representation regarding the Series 2025 Bonds or the advisability of investing in the Series 2025 Bonds. In addition, AG has not independently verified, makes no representation regarding, and does not accept any responsibility for the accuracy or completeness of this Official Statement or any information or disclosure contained herein, or omitted herefrom, other than with respect to the accuracy of the information regarding AG supplied by AG and presented under the heading "Bond Insurance" and "APPENDIX F - Specimen Municipal Bond Insurance Policy."

All quotations from and summaries and explanations of provisions of laws and documents herein do not purport to be complete and reference is made to such laws and documents for full and complete statements of their provisions. Any statements made in this Official Statement involving estimates or matters of opinion, whether or not expressly so stated, are intended merely as estimates or opinions and not as representations of fact. The information and expressions of opinion herein are subject to change without notice, and neither the delivery of this Official Statement nor any sale of the Series 2025 Bonds shall under any circumstances create any implication that there has been no change in the affairs of the Authority or the Obligated Group Members since the date hereof.

TABLE OF CONTENTS

MARYLAND HEALTH AND HIGHER EDUCATIONAL FACILITIES AUTHORITY

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OFFICIAL STATEMENT

relating to

$361,030,000

MARYLAND HEALTH AND HIGHER EDUCATIONAL FACILITIES AUTHORITY

Revenue Bonds
Meritus Health Issue
Series 2025

INTRODUCTORY STATEMENT

This Official Statement, the cover page (exclusive of prices and yields) and appendices set forth certain information for use in connection with the sale by Maryland Health and Higher Educational Facilities Authority (the "Authority") of its $361,030,000 Revenue Bonds, Meritus Health Issue, Series 2025 (the "Series 2025 Bonds") The Series 2025 Bonds are issued pursuant to (i) the Maryland Health and Higher Educational Facilities Authority Act, Sections 10-301 through 10-356 of the Economic Development Article of the Annotated Code of Maryland (the "Act"), (ii) certain proceedings of the Authority and (iii) the Meritus Medical Center Bond Resolution adopted by the Authority (the "Resolution"). Pursuant to the Resolution, The Bank of New York Mellon has been appointed Trustee (the "Trustee"). The Series 2025 Bonds and any Additional Bonds issued under the Resolution are referred to herein collectively as the "Bonds." For the definitions of certain other words and terms used in this Official Statement, see "Definitions of Certain Terms" in Appendix C.

The Series 2025 Bonds are issued at the request of Meritus Medical Center, Inc., a Maryland non-stock corporation (the "Institution") that owns and operates a regional medical center with 259 licensed beds (the "Medical Center") located in Hagerstown, Maryland. Meritus Health, Inc. ("Meritus Health") is the parent of the Institution and certain other affiliates. The Health System provides a broad spectrum of health-related services in Washington County and surrounding areas. As used in this Official Statement, Meritus Health and its affiliates are referred to collectively as the "Health System" and the separate entities that comprise the Health System are referred to as the "System Affiliates." For detailed information concerning the Health System, see Appendix A. Recent audited consolidated financial statements of Meritus Health and its subsidiaries are contained in Appendix B. Such financial statements include affiliates of the Obligated Group Members that are *not* Obligated Group Members.

The Series 2025 Bonds are being issued to (i) refund all of the Authority's Revenue Bonds, Meritus Medical Center Issue, Series 2015 (the "Refunded Bonds"); (ii) finance and refinance the cost of certain capital expenditures related to the construction and equipping of the Meritus School of Osteopathic Medicine (the "Medical School") and the student housing provided at Meritus Commons (collectively, the "2025 Project"); and (iii) pay certain costs of issuance of the Series 2025 Bonds. See "ESTIMATED SOURCES AND USES OF FUNDS" and "PLAN OF FINANCING" and for a description of the 2025 Project, see "THE 2025 PROJECT" in Appendix A. MSOM, Inc. ("MSOM"), the parent of which is Meritus Health, will operate the Medical School.

Currently, the Institution, MSOM and Brook Lane Health Services, Inc. ("Brook Lane") comprise the Obligated Group Members under and as defined in the Master Loan Agreement between the Authority and the Obligated Group Members (as amended and supplemented, the "Loan Agreement"). MSOM was established to operate the Medical School. MSOM has received both a conditional approval from the Maryland Higher Education Commission to operate as an in-state degree-granting institution and pre-accreditation from the Commission on Osteopathic College Accreditation ("COCA"). MSOM is currently seeking final accreditation to offer a Doctor of Osteopathic Medicine degree, which requires full accreditation from COCA. See "ADDITIONAL INFORMATION -- Licenses and Accreditation" in Appendix A and "Certain Bondholders' Risks -- Accreditation of MSOM." Brook Lane owns and operates a psychiatric hospital in Smithsburg, Maryland.

Upon the issuance of the Series 2025 Bonds and the refunding of all of the Refunded Bonds, there will also remain outstanding, in addition to the Series 2025 Bonds, a promissory note in the principal amount of $55,465,000 which constitutes Parity Debt. See "Additional Debt -- Parity Debt."

The outstanding Parity Obligation is, and any Additional Bonds and Parity Obligations issued in the future will be, equally and ratably secured on parity with the Series 2025 Bonds, to the extent provided in the Resolution. See "Plan of Financing" and "Additional Debt -- Parity Debt."

All non-governmental Maryland acute care hospitals, including the Medical Center, charge for hospital services at rates approved by the Maryland Health Services Cost Review Commission (the "HSCRC" or the "Rate Commission"). The ability of the Obligated Group Members to meet the debt service requirements of the Series 2025 Bonds depends, in part, on the ability of the Institution to charge rates for its services commensurate with the related costs to provide these services. See "Regulatory Environment – Maryland Health Services Cost Review Commission."

Certain risk factors that should be considered by prospective investors in the Series 2025 Bonds are set forth under "Certain Bondholders' Risks."

ESTIMATED SOURCES AND USES OF FUNDS

The estimated sources and uses of funds are as follows:

SOURCES OF FUNDS:	
Series 2025 Bonds	$361,030,000.00
Net original issue premium	7,977,350.65
Other sources of funds:	
Equity Contribution	7,604,147.00
Trustee Held Funds for Refunded Bonds	11,336,750.00
Total sources of funds	$387,948,247.65
USES OF FUNDS:	
Amount required to refund the Refunded Bonds	$218,160,400.61
Estimated cost of 2025 Project	166,094,630.95
Estimated financing expenses[(1)]:	3,693,216.09
Total uses of funds	$387,948,247.65

(1) Includes the Underwriters' discount, certain fees and expenses of the financial advisor to the Authority, legal counsel to the Obligated Group Members and the Underwriters and Bond Counsel to the Authority and certain accounting fees, premium for the 2025 Insurance Policy, as well as rating agency fees, printing costs, fees and expenses of the Trustee and other miscellaneous expenses.

PLAN OF FINANCING

The proceeds of the Series 2025 Bonds and other available funds will be used to (i) refund the Refunded Bonds; (ii) finance and refinance a portion of the costs of certain capital expenditures related to the 2025 Project; and (iii) pay the Underwriters' compensation and other administrative, legal, financing and miscellaneous expenses related to the issuance of the Series 2025 Bonds.

Pursuant to the Loan Agreement, the Authority will lend the proceeds of the Series 2025 Bonds to the Institution by depositing such proceeds as provided in the Resolution. As security for the performance of their obligations under the Loan Agreement, each Obligated Group Member has granted to the Authority a security interest in its Receipts. The liens created by the Loan Agreement are subject to certain Permitted Encumbrances and to the right of the Institution, under certain conditions, to dispose of assets. See "Release of Liens and Security Interests" and "Disposition of Assets" under "Summary of Certain Provisions of the Loan Agreement" in Appendix C.

SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2025 BONDS

General

The Series 2025 Bonds are special obligations of the Authority, the principal or Redemption Price of and interest on which are payable solely from the Revenues.

None of the State of Maryland, any political subdivision thereof or the Authority shall be obligated to pay the Series 2025 Bonds or the interest thereon except from Revenues, and neither the faith and credit nor the taxing power of the State of Maryland, of any political subdivision thereof or of the Authority is pledged to the payment of the principal of or the

interest on the Series 2025 Bonds. The issuance of the Series 2025 Bonds does not directly or indirectly or contingently obligate, morally or otherwise, the State of Maryland, any political subdivision thereof or the Authority to levy or to pledge any form of taxation whatever therefor or to make any appropriation for their payment. The Authority has no taxing power. See "State Not Liable on Series 2025 Bonds."

Pledge of Revenues

Pursuant to the Resolution, the Authority pledges and assigns to the Trustee its interest in the Revenues and the Loan Agreement, subject to the rights of the Authority described under "Summary of Certain Provisions of the Resolution -- Enforcement of Loan Agreement" in Appendix C. The Revenues include all payments to the Authority or the Trustee pursuant to the Loan Agreement, other than payments to the Authority of its initial fee, the Annual Administrative Fees, the Administrative Expenditures and any indemnity payments to the Authority.

The pledge made by the Resolution and the covenants and agreements contained in the Resolution to be performed by or on behalf of the Authority are, by their terms, for the equal and ratable benefit, protection and security of the Holders of all Bonds (including any Additional Bonds) and, to the extent provided in the Resolution, any additional Parity Debt outstanding from time to time, all of which, regardless of the time or times of their issuance or maturity, shall be of equal rank without preference, priority or distinction of any Bond or Parity Obligation over any other Bond or Parity Obligation, except as expressly provided in or permitted by the Resolution.

Loan Agreement

General

The Loan Agreement is an unconditional general obligation of the Obligated Group Members, and will remain in full force and effect until all of the Series 2025 Bonds and the interest thereon have been paid or provision for the payment thereof has been made in accordance with the Resolution. The Loan Agreement requires the Obligated Group Members to make payments in such amounts and at such times as shall be sufficient to provide for the payment of the principal of and the premium, if any, and interest on outstanding Series 2025 Bonds when due.

Obligated Group

Currently, the Obligated Group Members consist of the Institution, MSOM and Brook Lane. Other entities may be admitted to the Obligated Group from time to time upon the satisfaction of certain conditions contained in the Loan Agreement. Each Obligated Group Member, as co-obligor and not as guarantor, jointly and severally covenants to pay the principal of and premium, if any, and interest on all outstanding Bonds and Parity Obligations and to perform any and all other agreements and obligations of the Obligated Group Members under the Loan Agreement, subject to the right of any Obligated Group Member other than the Institution to withdraw from the Obligated Group under certain circumstances. See "Summary of Certain Provisions of the Loan Agreement -- Admission to Obligated Group" and "Withdrawal from Obligated Group" in Appendix C. Upon the withdrawal of any entity from the Obligated Group,

any liens on property of such entity securing the obligations of the Obligated Group under the Loan Agreement will be released. The Institution may not withdraw from the Obligated Group.

Security Interest in Receipts

Under the Loan Agreement, as security for the payments due thereunder, the Obligated Group Members have granted to the Authority a security interest in their Receipts, subject to certain Permitted Encumbrances. As defined in the Loan Agreement, the "Receipts" include all tuition, receipts, revenues, rentals, income, insurance proceeds and other money received by or on behalf of any Obligated Group Member, including (without limitation) revenues derived from the ownership, operation or leasing of any Group Facilities and gifts, grants, bequests, donations and contributions heretofore or hereafter made that are legally available to meet any of the obligations of any Obligated Group Member incurred in the financing, operation, maintenance or repair of any of the Group Facilities, and the income therefrom, and all rights to receive the same, whether in the form of accounts, accounts receivable, contract rights, general intangibles, chattel paper, instruments, investment property or other rights, and the proceeds of such rights, whether now existing or hereafter coming into existence or whether now owned or held or hereafter acquired.

Rate Covenant

The Obligated Group Members covenant in the Loan Agreement to fix, charge and collect such fees, rentals, rates and other charges in connection with the operation of the Operating Assets and the products and services provided by the Obligated Group Members as shall be sufficient to produce in each Fiscal Year a Coverage Ratio as of the last day of such Fiscal Year that is not less than 1.10. The Debt Service Requirements of any Long-Term Indebtedness issued to finance Additional Facilities or Capital Improvements shall not be taken into account in calculating the Coverage Ratio until the earlier of (i) the first Fiscal Year in which the principal of any such Long-Term Indebtedness becomes due and payable and (ii) the first Fiscal Year in which any interest on such Long-Term Indebtedness ceases to be paid from amounts deposited in escrow for the payment of interest on such Long-Term Indebtedness. The covenant described in this paragraph is referred to herein as the "Rate Covenant."

If the Obligated Group Members fail to satisfy the Rate Covenant in any Fiscal Year, then the Authority shall immediately employ a Management Consultant unless the Authority waives such requirement as described herein. See "Management Consultant" below.

Under certain circumstances described below under "Management Consultant," the failure of the Obligated Group Members to satisfy the Rate Covenant in such Fiscal Year will not be an Event of Default under the Loan Agreement, but if the Coverage Ratio is less than 1.00 for two consecutive Fiscal Years, an Event of Default shall be deemed to have occurred to the extent provided in the Loan Agreement unless the Obligated Group had Unrestricted Cash and Investments in an amount not less than 150 Days Cash on Hand as of the last day of the second Fiscal Year in which the Coverage Ratio was less than 1.00 (or the Fiscal Year then ended, whichever is later). See "Summary of Certain Provisions of the Loan Agreement -- Events of Default and Remedies" in Appendix C.

Liquidity Covenant

The Obligated Group Members covenant in the Loan Agreement that they will maintain Unrestricted Cash and Investments in an amount not less than 50 Days' Cash on Hand as of June 30 in each year. The covenant described in this paragraph is referred to herein as the "Liquidity Covenant."

If the Obligated Group Members fail to satisfy the Liquidity Covenant as of any June 30, the Authority shall immediately employ a Management Consultant unless the Authority waives such requirement as described below under "Management Consultant."

Under certain circumstances described below under "Management Consultant," the failure of the Obligated Group Members to meet the Liquidity Requirement as of any June 30 shall not constitute an Event of Default under the Loan Agreement.

Management Consultant

If the Obligated Group Members fail to satisfy the Rate Covenant in any Fiscal Year or the Liquidity Requirement as of any June 30, then the Authority shall immediately retain a Management Consultant to submit a written report and recommendations with respect to the fees, rentals, rates and other charges imposed and collected by the Obligated Group Members and with respect to improvements or changes in the operations of or the services rendered by the Obligated Group Members. The Authority shall require any Management Consultant employed under the Loan Agreement to file its Report with the Authority, the Trustee and any holders of outstanding Series 2025 Bonds who shall have filed with the Authority a written request for such Report.

Notwithstanding the provisions of the Loan Agreement described above, unless the requirement that the Authority appoint a Management Consultant in accordance with the Loan Agreement shall have been annulled pursuant to the provisions of the Loan Agreement described below in the immediately preceding Fiscal Year, the Authority may make a determination that under all of the facts and circumstances, the appointment of a Management Consultant in connection with any failure by the Obligated Group Members to satisfy the Rate Covenant or the Liquidity Covenant is not necessary or desirable to protect the interests of the holders of Parity Debt, and the requirement that the Authority appoint a Management Consultant in any Fiscal Year shall be annulled, if:

(i) the fees, rentals, rates and other charges imposed and collected by the Obligated Group Members, together with any unrestricted funds and other moneys available to the Obligated Group Members, shall equal or exceed the amount required by the Rate Covenant in such Fiscal Year; and

(ii) the Authority finds that the failure of the Obligated Group Members to meet the Rate Covenant or the Liquidity Covenant does not evidence a material deterioration in the financial position of the Obligated Group Members or that the appointment of a Management Consultant is not likely to enhance the ability of the Obligated Group Members to meet the Rate Covenant or the Liquidity Covenant.

If the Authority determines that the appointment of a Management Consultant is not necessary or desirable to protect the interests of the holders of Parity Debt as described above, the Authority shall so notify any holders of outstanding Series 2025 Bonds who shall have filed with the Authority a written request for such notification.

Any Management Consultant retained by the Authority may recommend with respect to the fees, rentals, rates or other charges imposed and collected by the Obligated Group Members and with respect to improvements or changes in the operations of or services rendered by the Obligated Group Members that the Obligated Group Members either make no change or make some change, even though such recommendation is not calculated to result in compliance with the Rate Covenant or the Liquidity Covenant, if the Management Consultant includes in its written report a statement to the effect that compliance with such recommendations should result in compliance with the Rate Covenant and the Liquidity Covenant to the maximum extent feasible.

If the requirement that the Authority appoint a Management Consultant is annulled with respect to any Fiscal Year or if the Obligated Group Members revise their fees, rentals, rates and other charges in conformity with the recommendations of the Management Consultant and otherwise follow the recommendations of the Management Consultant, then the failure of the Obligated Group Members to satisfy the Rate Covenant or the Liquidity Requirement in such Fiscal Year will not be an Event of Default under the Loan Agreement, except as described above under "Rate Covenant" and "Liquidity Covenant," respectively.

No Debt Service Reserve Fund

The Series 2025 Bonds will *not* be secured by a Debt Service Reserve Fund.

BOND INSURANCE

Bond Insurance Policy

Concurrently with the issuance of the Series 2025 Bonds, Assured Guaranty Inc. ("AG") will issue its Municipal Bond Insurance Policy (the "2025 Insurance Policy") for the Series 2025 Bonds maturing on July 1, 2036, July 1, 2037 and July 1, 2039 through and including July 1, 2046, inclusive, and the Term Bond maturing July 1, 2055 (collectively, the "2025 Insured Bonds"). The 2025 Insurance Policy guarantees the scheduled payment of principal of and interest on the 2025 Insured Bonds when due as set forth in the form of the 2025 Insurance Policy included as Appendix F to this Official Statement.

The 2025 Insurance Policy is not covered by any insurance security or guaranty fund established under New York, Maryland, California, Connecticut or Florida insurance law.

Assured Guaranty Inc.

AG is a Maryland domiciled financial guaranty insurance company and an indirect subsidiary of Assured Guaranty Ltd. ("AGL" and together with its subsidiaries, "Assured Guaranty"), a Bermuda-based holding company whose shares are publicly traded and are listed on the New York Stock Exchange under the symbol "AGO." AGL, through its subsidiaries, provides credit enhancement products to the U.S. and non-U.S. public finance (including

infrastructure) and structured finance markets and participates in the asset management business through ownership interests in Sound Point Capital Management, LP and certain of its investment management affiliates. Only AG is obligated to pay claims under the insurance policies AG has issued, and not AGL or any of its shareholders or other affiliates.

AG's financial strength is rated "AA" (stable outlook) by S&P Global Ratings, a business unit of Standard & Poor's Financial Services LLC ("S&P"), "AA+" (stable outlook) by Kroll Bond Rating Agency, Inc. ("KBRA") and "A1" (stable outlook) by Moody's Ratings ("Moody's"). Each rating of AG should be evaluated independently. An explanation of the significance of the above ratings may be obtained from the applicable rating agency. The above ratings are not recommendations to buy, sell or hold any security, and such ratings are subject to revision or withdrawal at any time by the rating agencies, including withdrawal initiated at the request of AG in its sole discretion. In addition, the rating agencies may at any time change AG's long-term rating outlooks or place such ratings on a watch list for possible downgrade in the near term. Any downward revision or withdrawal of any of the above ratings, the assignment of a negative outlook to such ratings or the placement of such ratings on a negative watch list may have an adverse effect on the market price of any security guaranteed by AG. AG only guarantees scheduled principal and scheduled interest payments payable by the issuer of bonds insured by AG on the date(s) when such amounts were initially scheduled to become due and payable (subject to and in accordance with the terms of the relevant insurance policy), and does not guarantee the market price or liquidity of the securities it insures, nor does it guarantee that the ratings on such securities will not be revised or withdrawn.

Merger of Assured Guaranty Municipal Corp. Into Assured Guaranty Inc.

On August 1, 2024, Assured Guaranty Municipal Corp., a New York domiciled financial guaranty insurance company and an affiliate of AG ("AGM"), merged with and into AG, with AG as the surviving company (such transaction, the "Merger"). Upon the Merger, all liabilities of AGM, including insurance policies issued or assumed by AGM, became obligations of AG.

Current Financial Strength Ratings

On October 18, 2024, KBRA announced it had affirmed AG's insurance financial strength rating of "AA+" (stable outlook).

On July 10, 2024, Moody's, following Assured Guaranty's announcement of the Merger, announced that it had affirmed AG's insurance financial strength rating of "A1" (stable outlook).

On May 28, 2024, S&P announced it had affirmed AG's financial strength rating of "AA" (stable outlook). On August 1, 2024, S&P stated that following the Merger, there is no change in AG's financial strength rating of "AA" (stable outlook).

AG can give no assurance as to any further ratings action that S&P, Moody's and/or KBRA may take. For more information regarding AG's financial strength ratings and the risks relating thereto, see AGL's Annual Report on Form 10-K for the fiscal year ended December 31, 2024.

Capitalization of AG

At March 31, 2025:

- The policyholders' surplus of AG was approximately $3,522 million.
- The contingency reserve of AG was approximately $1,421 million.
- The net unearned premium reserves and net deferred ceding commission income of AG and its subsidiaries (as described below) were approximately $2,416 million. Such amount includes (i) 100% of the net unearned premium reserve and net deferred ceding commission income of AG, and (ii) the net unearned premium reserves and net deferred ceding commissions of AG's wholly owned subsidiary Assured Guaranty UK Limited ("AGUK"), and its 99.9999% owned subsidiary Assured Guaranty (Europe) SA ("AGE").

The policyholders' surplus, contingency reserve, and net unearned premium reserves and net deferred ceding commission income of AG were determined in accordance with statutory accounting principles. The net unearned premium reserves and net deferred ceding commissions of AGUK and AGE were determined in accordance with accounting principles generally accepted in the United States of America.

Incorporation of Certain Documents by Reference

Portions of the following documents filed by AGL with the Securities and Exchange Commission (the "SEC") that relate to AG are incorporated by reference into this Official Statement and shall be deemed to be a part hereof:

(i) the Annual Report on Form 10-K for the fiscal year ended December 31, 2024 (filed by AGL with the SEC on February 28, 2025); and

(ii) the Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2025 (filed by AGL with the SEC on May 9, 2025).

All information relating to AG included in, or as exhibits to, documents filed by AGL with the SEC pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended, excluding Current Reports or portions thereof "furnished" under Item 2.02 or Item 7.01 of Form 8-K, after the filing of the last document referred to above and before the termination of the offering of the Series 2025 Bonds shall be deemed incorporated by reference into this Official Statement and to be a part hereof from the respective dates of filing such documents. Copies of materials incorporated by reference are available over the internet at the SEC's website at http://www.sec.gov, at AGL's website at http://www.assuredguaranty.com, or will be provided upon request to Assured Guaranty Inc.: 1633 Broadway, New York, New York 10019, Attention: Communications Department (telephone (212) 974-0100). Except for the information referred to above, no information available on or through AGL's website shall be deemed to be part of or incorporated in this Official Statement.

Any information regarding AG included herein under the caption "BOND INSURANCE – Assured Guaranty Inc." or included in a document incorporated by reference herein (collectively, the "AG Information") shall be modified or superseded to the extent that any

subsequently included AG Information (either directly or through incorporation by reference) modifies or supersedes such previously included AG Information. Any AG Information so modified or superseded shall not constitute a part of this Official Statement, except as so modified or superseded.

Miscellaneous Matters

AG makes no representation regarding the Series 2025 Bonds or the advisability of investing in the Series 2025 Bonds. In addition, AG has not independently verified, makes no representation regarding, and does not accept any responsibility for the accuracy or completeness of this Official Statement or any information or disclosure contained herein, or omitted herefrom, other than with respect to the accuracy of the information regarding AG supplied by AG and presented under the heading "BOND INSURANCE".

Certain Provisions Relating to Bond Insurance

For the purposes of this section, capitalized terms shall have the following definitions:

"**2025 Insurance Default**" means any of the following events: (a) the 2025 Insurer shall fail to honor a demand for payment under the 2025 Insurance Policy in accordance with its terms, or (b) the 2025 Insurer shall contest the valid and binding nature of the 2025 Insurance Policy or shall deny any further liability or obligation under the 2025 Insurance Policy, or (c) the 2025 Insurer shall become insolvent or the subject of any insolvency proceeding or shall file a petition or other pleading seeking an "order for relief" within the meaning of the United States Bankruptcy Code or shall file any petition or other pleading seeking any reorganization, composition, readjustment, liquidation or similar relief for itself under any present or future law or regulation, or shall seek or consent to or acquiesce in the appointment of any trustee, receiver or liquidator of the 2025 Insurer, or of substantially all of the assets of the 2025 Insurer, or shall make a general assignment for the benefit of creditors, or shall admit in writing its inability to pay its debts generally as they become due, or (d) a petition or other pleading shall be filed against the 2025 Insurer seeking an "order for relief" within the meaning of the United States Bankruptcy Code or any reorganization, composition, readjustment, liquidation or similar relief under any present or future law or regulation and shall remain undismissed or unstayed for an aggregate period of 90 days (whether or not consecutive), or (e) if, by an order or decree of a court of competent jurisdiction, the 2025 Insurer shall become the subject of an "order for relief" within the meaning of the United States Bankruptcy Code or relief shall be granted under or pursuant to any such petition or other pleading, and such order or decree continues unvacated or unstayed, on appeal or otherwise, and in effect for a period of 90 days, or (f) if, by order or decree of such court, there shall be appointed, without the consent or acquiescence of the 2025 Insurer, a trustee in bankruptcy or reorganization or a receiver or liquidator of the 2025 Insurer or of all or any substantial part of its property and such order of decree continues unvacated or unstayed, on appeal or otherwise, and in effect for a period of 90 days.

"**2025 Insurance Period**" means any period during which any 2025 Insured Bonds remain outstanding and no 2025 Insurance Default with respect to such 2025 Insured Bonds shall have occurred and be continuing, or any amounts are due and payable by the Obligated Group to the 2025 Insurer.

"**2025 Insurance Policy**" means the insurance policy issued by the 2025 Insurer guaranteeing the scheduled payment of principal of and interest on the 2025 Insured Bonds when due.

"**2025 Insured Bonds**" means the Series 2025 Bonds maturing on July 1, 2036, July 1, 2037 and July 1, 2039 through and including July 1, 2046 and the Term Bond maturing July 1, 2055.

"**2025 Insurer**" means Assured Guaranty Inc., a Maryland corporation, or any successor thereto or assignee thereof.

Notwithstanding anything to the contrary set forth in the Resolution and Loan Agreement, the 2025 Insurer retains its rights of subrogation to the extent that it has previously made payment of principal or interest on the 2025 Insured Bonds, and the following provisions apply with respect to the 2025 Insured Bonds during the 2025 Insurance Period:

The 2025 Insurer shall be deemed to be the sole Holder of the 2025 Insured Bonds for the purpose of exercising any voting right or privilege or giving any consent or direction or taking any other action that the Holders of the 2025 Insured Bonds are entitled to take pursuant to the Resolution and the Loan Agreement pertaining to (i) defaults and remedies, (ii) the duties and obligations of the Trustee, and (iii) amendments, consents and waivers. As a term of the Resolution, the Loan Agreement and each 2025 Insured Bond, each Holder of the 2025 Insured Bonds appoints the 2025 Insurer as its agent and attorney-in-fact with respect to the 2025 Insured Bonds and agrees that the 2025 Insurer may at any time during the continuation of any proceeding by or against the Obligated Group under the United States Bankruptcy Code or any other applicable bankruptcy, insolvency, receivership, rehabilitation or similar law (an "Insolvency Proceeding") direct all matters relating to such Insolvency Proceeding, including without limitation, (A) all matters relating to any claim or enforcement proceeding in connection with an Insolvency Proceeding (a "Claim"), (B) the direction of any appeal of any order relating to any Claim, (C) the posting of any surety, supersedeas or performance bond pending any such appeal, and (D) the right to vote to accept or reject any plan of adjustment. In addition, each Holder of the 2025 Insured Bonds delegates and assigns to the 2025 Insurer, to the fullest extent permitted by law, the rights of each Holder of the 2025 Insured Bonds in the conduct of any Insolvency Proceeding, including, without limitation, all rights of any party to an adversary proceeding or action with respect to any court order issued in connection with any such Insolvency Proceeding. Under the Resolution, the Trustee acknowledges such appointment, delegation and assignment by each Holder of the 2025 Insured Bonds for the 2025 Insurer's benefit, and agrees to cooperate with the 2025 Insurer in taking any action reasonably necessary or appropriate in connection with such appointment, delegation and assignment.

Pursuant to the Resolution and Loan Agreement, no grace period for a covenant default shall be extended without the prior written consent of the 2025 Insurer. No grace period shall be permitted for payment defaults with respect to any 2025 Insured Bonds. The 2025 Insurer is a third party beneficiary of the Resolution and Loan Agreement.

Upon the occurrence of an extraordinary optional redemption or extraordinary mandatory redemption in part, if any, the selection of 2025 Insured Bonds to be redeemed shall be subject to the approval of the 2025 Insurer. The exercise of any provision of the Resolution which permits the purchase of 2025 Insured Bonds in lieu of redemption shall require the prior written approval of the 2025 Insurer if any 2025 Insured Bond so purchased is not cancelled upon purchase.

Any amendment, supplement, modification to, or waiver of, the Resolution, the Loan Agreement or any other transaction document, including any underlying security agreement, that requires the consent of Holders of the 2025 Insured Bonds or adversely affects the rights and interests of the 2025 Insurer shall be subject to the prior written consent of the 2025 Insurer.

Unless the 2025 Insurer otherwise directs, upon the occurrence of an Event of Default or an event which with notice or lapse of time would constitute an Event of Default, any amounts on deposit in the Construction Fund for the Series 2025 Bonds shall not be disbursed, but shall instead be applied to the payment of debt service or the Redemption Price of the Series 2025 Bonds.

Beginning on July 1, 2036 and each July 1 thereafter while any 2025 Insured Bonds are outstanding, the Obligated Group shall pay to the 2025 Insurer a non-refundable premium. The failure of the Obligated Group to pay any installment of such annual premium shall constitute an Event of Default under the Loan Agreement.

THE SERIES 2025 BONDS

General

The Series 2025 Bonds are dated the date of their initial delivery, bear interest from their date at the rates set forth on the cover page of this Official Statement, payable on January 1, 2026, and semiannually thereafter on each January 1 and July 1 and, subject to the redemption provisions set forth below, mature on the dates and in the amounts set forth on the cover page of this Official Statement.

The Series 2025 Bonds will be issuable only as fully registered bonds in denominations of $5,000 and integral multiples thereof. The Series 2025 Bonds initially will be maintained under a book-entry system. Beneficial Owners will have no right to receive physical possession of the Series 2025 Bonds and payments of the principal or Redemption Price of and interest on the Series 2025 Bonds will be made as described below under "Book-Entry Only System." If the book-entry system is discontinued, interest on the Series 2025 Bonds will be payable by check mailed by the Trustee to the persons in whose names the Series 2025 Bonds are registered as of the Record Date for the payment of such interest at the address shown on the registration books maintained by the Trustee, which is registrar and paying agent for the Series 2025 Bonds, and the principal or Redemption Price of the Series 2025 Bonds will be payable only upon presentation and surrender of such Series 2025 Bonds at the designated corporate trust office of the Trustee.

Redemption Provisions

Optional Redemption

Series 2025 Bonds maturing on or after July 1, 2036 are subject to redemption prior to maturity beginning on July 1, 2035, at the option of the Authority upon the direction of the Obligated Group, as a whole or in part at any time, at a Redemption Price equal to the principal amount of the Series 2025 Bonds to be redeemed, plus accrued interest thereon to the date set for redemption.

In lieu of redeeming any Series 2025 Bonds called for redemption, at the option of the Authority, the Obligated Group Members will have the right to purchase such Series 2025 Bonds or cause such Series 2025 Bonds to be purchased on the date named for redemption at a price equal to the principal amount of such Series 2025 Bonds, plus accrued interest thereon to the date set for redemption, and by their acceptance of the Series 2025 Bonds, the holders thereof will be deemed to have agreed to sell the Series 2025 Bonds to or upon the order of the Obligated Group Members on such date. If there shall have been deposited with the Trustee the purchase price of such Series 2025 Bonds on such date, then such Series 2025 Bonds shall be deemed to have been purchased on such date whether or not the holders thereof surrender such Series 2025 Bonds for purchase and such holders shall not be entitled to interest accruing on such Series 2025 Bonds subsequent to such date and shall have no claims with respect thereto except to receive the purchase price of such Series 2025 Bonds so held by the Trustee.

Mandatory Sinking Fund Redemption

The Series 2025 Bonds maturing on July 1, 2050 will be subject to redemption prior to maturity, at a Redemption Price equal to the principal amount thereof plus accrued interest to the redemption date, from mandatory Sinking Fund Installments becoming due on July 1 of the following years in the following amounts:

Term Bond Due July 1, 2050

Year	Sinking Fund Installment
2047	$13,330,000
2048	14,030,000
2049	14,770,000
2050*	15,545,000

* Final maturity

The average life of the Series 2025 Bonds maturing on July 1, 2050 is approximately 23.600 years.

The Series 2025 Bonds maturing on July 1, 2055 will be subject to redemption prior to maturity, at a Redemption Price equal to the principal amount thereof plus accrued interest to the redemption date, from mandatory Sinking Fund Installments becoming due on July 1 of the following years in the following amounts:

Insured Term Bond Due July 1, 2055

Year	Sinking Fund Installment
2051	$16,360,000
2052	17,175,000
2053	18,035,000
2054	18,935,000
2055*	19,885,000

* Final maturity

The average life of the Series 2025 Bonds maturing on July 1, 2055 is approximately 28.134 years.

Upon any purchase of Series 2025 Bonds subject to redemption from the Sinking Fund Installments by or on behalf of the Obligated Group Members and surrender of such Bonds to the Trustee for cancellation, upon any purchase of any Series 2025 Bonds subject to redemption from the Sinking Fund Installments by application of money set aside under the Resolution and upon any redemption of Series 2025 Bonds subject to redemption from the Sinking Fund Installments, an amount equal to the principal amount thereof shall be credited first against the Sinking Fund Installment due on the immediately succeeding July 1, and then against subsequent Sinking Fund Installments for such Bonds as directed by the Obligated Group.

Extraordinary Redemption

Outstanding Series 2025 Bonds are subject to redemption prior to maturity as a whole or in part at any time, at a Redemption Price equal to 100% of the principal amount thereof plus accrued interest thereon to the date set for redemption, to the extent of (i) proceeds from title insurance with respect to any Operating Assets and related payments, (ii) proceeds from the condemnation of any Operating Assets in whole or in part or from agreements with, or action by, a public authority in the nature of or in lieu of condemnation proceedings and related payments and (iii) proceeds from insurance and related payments received in connection with the loss, damage or destruction of any Operating Assets or any portion thereof, in each case to the extent that such proceeds are not used for any other purpose permitted under the Loan Agreement. See "Summary of Certain Provisions of the Loan Agreement -- Application of Proceeds of Insurance and Condemnation" in Appendix C.

The Series 2025 Bonds are also subject to redemption prior to maturity, as a whole or in part, on the earliest practicable date in the event that (i) the Obligated Group Members determine in good faith that continued operation of all or any portion of the 2025 Project is not financially feasible or is otherwise disadvantageous to the Obligated Group Members, (ii) as a result thereof, the Obligated Group Members sell, lease or otherwise dispose of such portion of the 2025 Project to a person or entity unrelated to the Obligated Group Members and (iii) there is delivered to the Authority a written statement of Bond Counsel to the effect that, unless such Bonds are defeased, redeemed and retired either prior to or concurrently with such sale, lease or other disposition, or on a subsequent date prior to the first date on which the Series 2025 Bonds are subject to redemption at the option of the Authority at the direction of the Obligated Group Representative, Bond Counsel will be unable to render an unqualified opinion that such sale, lease or other disposition of such portion of the 2025 Project will not adversely affect the excludability from gross income, for federal income tax purposes, of the interest on the Series 2025 Bonds. Any such redemption shall be at a Redemption Price equal to the greater of:

(i) one hundred percent (100%) of the Amortized Value (as described below) of such Series 2025 Bonds to be redeemed, plus accrued and unpaid interest to the date of redemption; or

(ii) an amount equal to the sum of the present values of the remaining unpaid payments of principal and interest to be paid on such Series 2025 Bonds to be redeemed from and including the date of redemption to the stated maturity date of such Series 2025 Bonds, discounted to the date of redemption on a semiannual basis at a discount rate equal to the Applicable Tax-Exempt Municipal Bond Rate

(as described below) for such Series 2025 Bonds plus/minus 0.0 basis points (0.000%).

The "Applicable Tax-Exempt Municipal Bond Rate" for such Series 2025 Bonds will be the "Comparable AAA General Obligations" yield curve rate for the stated maturity date of such Series 2025 Bonds as published by Municipal Market Data at least five (5) Business Days, but not more than twenty-five (25) Business Days, prior to the date of redemption. If no such yield curve rate is established for the applicable year, the "Comparable AAA General Obligations" yield curve rate for the two published maturities most closely corresponding to the applicable year will be determined, and the "Applicable Tax-Exempt Municipal Bond Rate" will be interpolated or extrapolated from those yield curve rates on a straight-line basis.

In calculating the Applicable Tax-Exempt Municipal Bond Rate, should Municipal Market Data no longer publish the Comparable AAA General Obligations yield curve rate, then the "Applicable Tax-Exempt Municipal Bond Rate" will equal the Consensus Scale yield curve rate published by Municipal Market Analytics for the applicable year.

In the further event that Municipal Market Analytics no longer publishes the Consensus Scale, the "Applicable Tax-Exempt Municipal Bond Rate" for the Series 2025 Bonds will be determined by Truist Securities, Inc. or a successor determined by the Authority upon consultation with the Obligated Group Representative, as the quotation agent, based upon the rate per annum equal to the semiannual equivalent yield to maturity of those tax-exempt general obligation bonds rated in the highest rating category by Moody's Ratings ("Moody's") and S&P Global Ratings ("S&P") with a maturity date equal to the stated maturity date of such Series 2025 Bonds having characteristics (other than the ratings) most comparable to those of such Series 2025 Bonds in the judgment of the quotation agent. The quotation agent's determination of the Applicable Tax-Exempt Municipal Bond Rate is final and binding in the absence of manifest error.

The "Amortized Value" will equal the principal amount of the Series 2025 Bonds to be redeemed multiplied by the price of such Series 2025 Bonds expressed as a percentage, calculated based on the industry standard method of calculating bond prices, with a delivery date equal to the date of redemption, a maturity date equal to the stated maturity date of such Series 2025 Bonds and a yield equal to such Series 2025 Bonds' original reoffering yield as set forth on the cover of this Official Statement.

The Redemption Price of the Series 2025 Bonds described above will be determined by an independent accounting firm, investment banking firm or financial advisor (which accounting firm or financial advisor shall be selected by the Authority upon consultation with the Obligated Group Representative and retained by the Obligated Group Members at the expense of the Obligated Group Members to calculate such Redemption Price). The Trustee, the Authority and the Obligated Group may conclusively rely on the determination by such accounting firm, investment banking firm, or financial advisor of such Redemption Price, and will bear no liability for any such reliance.

Redemption of Series 2025 Bonds Subject to Deposit of Funds and Other Conditions

Any redemption of the Series 2025 Bonds (other than redemption from the Sinking Fund Installments) shall be subject to the deposit of funds for such redemption by or on behalf of the

Obligated Group Members and may be subject to such other conditions as the Authority shall determine.

Selection of Bonds to Be Redeemed

If fewer than all of the Bonds shall be called for redemption (other than redemption from the Sinking Fund Installments), then the series and maturities of the Bonds to be redeemed shall be selected by the Authority at the direction of the Obligated Group Representative except as otherwise provided in the Resolution.

So long as the Series 2025 Bonds are maintained under a book-entry system, the selection of individual ownership interests in the Series 2025 Bonds of any one maturity to be credited with any partial redemption shall be made as described below under "Book-Entry Only System" except as otherwise directed by the Authority.

At any other time, if fewer than all of the Series 2025 Bonds of any one maturity shall be called for redemption, the Trustee shall select or cause to be selected the particular Series 2025 Bonds or portions of Series 2025 Bonds to be redeemed from such maturity by lot or in such other manner as shall be deemed appropriate by the Trustee except as otherwise directed by the Authority, provided that the portion of any Series 2025 Bond not so redeemed shall be in a principal amount equal to an authorized denomination for such Series 2025 Bond.

Notice of Redemption

So long as the Series 2025 Bonds are maintained under a book-entry system, notice of the call for any redemption of the Series 2025 Bonds shall be given as described below under "Book-Entry Only System." At any other time, the Trustee shall mail notice of the call for any redemption at least 20 days before the redemption date to the registered owners of the Series 2025 Bonds to be redeemed at their addresses as they appear on the registration books maintained by the Trustee, but failure to mail any such notice to any of such registered owners or any defect therein shall not affect the validity of the proceedings for the redemption of any Series 2025 Bonds. The Series 2025 Bonds so called for redemption will cease to bear interest on the specified redemption date and shall no longer be secured by the Resolution, provided that funds for the redemption or purchase thereof shall be on deposit at that time with the Trustee and that all conditions to such redemption shall have been satisfied.

Book-Entry Only System

All of the Series 2025 Bonds initially will be maintained under a book-entry system under which The Depository Trust Company, New York, New York ("DTC" and, together with any successor securities depository for the Series 2025 Bonds, the "Securities Depository"), will act as securities depository. The Series 2025 Bonds will be issued as fully-registered securities registered in the name of Cede & Co., DTC's partnership nominee. Purchases of beneficial ownership interests in the Series 2025 Bonds will be in book-entry form only and purchasers of beneficial ownership interests will not receive certificates representing their interests in the Series 2025 Bonds purchased. So long as the Series 2025 Bonds are in book-entry only form, the principal of and interest on the Series 2025 Bonds will be payable, and redemption and other notices with respect to the Series 2025 Bonds will be given, only to DTC, as the registered owner of the Series 2025 Bonds, and not to the beneficial owners of such Bonds, and neither the Authority nor the Trustee will have any responsibility or obligation with respect to payments or

notices to beneficial owners. Beneficial owners may wish to take certain steps to augment transmission to them of notices of significant events with respect to the Series 2025 Bonds, such as ascertaining whether the nominee holding the Series 2025 Bonds for their benefit has agreed to obtain and transmit notices to beneficial owners or providing their names and addresses to the Trustee and requesting that copies of the notices be provided directly to them. For a further description of the book-entry only system, see Appendix E.

Registration and Exchange of Series 2025 Bonds

So long as the Series 2025 Bonds are maintained under a book-entry system, transfers of ownership interests in the Series 2025 Bonds will be made as described above under "Book-Entry Only System." If the book-entry only system is discontinued, any Series 2025 Bond may be exchanged for an equal aggregate principal amount of Series 2025 Bonds maturing on the same date and bearing interest at the same rate of other authorized denominations, and the transfer of any Series 2025 Bond may be registered, upon presentation and surrender of such Series 2025 Bond at the designated office of the Trustee, together with an assignment duly executed by the registered owner or his attorney or legal representative. The Authority and the Trustee may require the person requesting any such exchange or transfer to reimburse them for any tax or other governmental charge payable in connection therewith. Neither the Authority nor the Trustee shall be required to register the transfer of any Series 2025 Bond or make any such exchange of any Series 2025 Bond (1) during the five days preceding the date of mailing of any notice of redemption of Series 2025 Bonds of the same maturity or (2) after a notice of redemption of such Series 2025 Bond or any portion thereof has been mailed.

Acceleration

Upon the occurrence of certain events, the due date for the payment of the principal amount of the Series 2025 Bonds may be accelerated. See "Summary of Certain Provisions of the Resolution -- Events of Default and Remedies" in Appendix C.

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ANNUAL DEBT SERVICE REQUIREMENTS OF OUTSTANDING PARITY DEBT

The following table sets forth for each 12-month period ending July 1: (i) the principal becoming due on the Series 2025 Bonds (whether at maturity or by mandatory redemption); (ii) interest due on the Series 2025 Bonds; (iii) the total debt service requirements of the Series 2025 Bonds; (iv) the total debt service requirements of other outstanding Parity Debt (excluding the Refunded Bonds); and (v) the total debt service requirements of all outstanding Parity Debt.

	Series 2025 Bonds				
Year	Principal	Interest	Total	Other Parity Debt[3]	Total Debt Service[3]
2026	$5,765,000	$18,670,178	$24,435,178	$3,975,190	$28,410,368
2027	6,405,000	17,731,225	24,136,225	3,967,308	28,103,533
2028	6,725,000	17,410,975	24,135,975	3,956,284	28,092,259
2029	7,060,000	17,074,725	24,134,725	3,951,950	28,086,675
2030	7,410,000	16,721,725	24,131,725	3,939,211	28,070,936
2031	7,785,000	16,351,225	24,136,225	3,924,896	28,061,121
2032	8,180,000	15,961,975	24,141,975	3,911,632	28,053,607
2033	8,580,000	15,552,975	24,132,975	3,906,539	28,039,514
2034	9,010,000	15,123,975	24,133,975	3,897,103	28,031,078
2035	9,465,000	14,673,475	24,138,475	3,885,829	28,024,304
2036	9,935,000	14,200,225	24,135,225	3,879,465	28,014,690
2037	10,430,000	13,703,475	24,133,475	3,867,636	28,001,111
2038	10,955,000	13,181,975	24,136,975	3,850,585	27,987,560
2039	11,505,000	12,634,225	24,139,225	3,841,696	27,980,921
2040	11,990,000	12,145,262	24,135,263	3,831,489	27,966,751
2041	12,500,000	11,635,687	24,135,688	3,817,615	27,953,303
2042	13,125,000	11,010,687	24,135,688	3,807,424	27,943,111
2043	13,780,000	10,354,437	24,134,438		24,134,438
2044	14,470,000	9,665,437	24,135,438		24,135,438
2045	15,195,000	8,941,937	24,136,938		24,136,938
2046	12,695,000	8,182,187	20,877,188		20,877,188
2047	13,330,000[1]	7,547,437	20,877,438		20,877,438
2048	14,030,000[1]	6,847,612	20,877,613		20,877,613
2049	14,770,000[1]	6,111,037	20,881,038		20,881,038
2050	15,545,000[1]	5,335,612	20,880,613		20,880,613
2051	16,360,000[2]	4,519,500	20,879,500		20,879,500
2052	17,175,000[2]	3,701,500	20,876,500		20,876,500
2053	18,035,000[2]	2,842,750	20,877,750		20,877,750
2054	18,935,000[2]	1,941,000	20,876,000		20,876,000
2055	19,885,000[2]	994,250	20,879,250		20,879,250

(1) Sinking Fund Installment for Term Bonds due July 1, 2050.

(2) Sinking Fund Installment for Term Bonds due July 1, 2055.

(3) Assumes that the interest rate on the Parity Note is not converted to a tax-exempt rate. See "ADDITIONAL DEBT – Parity Debt -- Outstanding Parity Debt."

ADDITIONAL DEBT

Parity Debt

Outstanding Parity Debt

Immediately following the issuance of the Series 2025 Bonds and the refunding of all of the Refunded Bonds, there will remain outstanding a promissory note held by Bank of America, N.A. in the principal amount of $55,465,000, maturing on July 1, 2042 and bearing interest at 2.59% per annum that constitutes Parity Debt (the "Parity Note"). Subject to the satisfaction of certain conditions set forth in the financing agreement under which the Parity Note was issued, the Authority may issue a revenue bond on behalf of the Institution to convert the interest rate on such Parity Note to a tax-exempt rate equal to 2.13% per annum on or before December 31, 2025 which such date may be extended with the consent of the Authority and the holder of the Parity Note. No assurance can be given that such bond will be issued under the financing agreement and the interest rate on the Parity Note be converted to the tax-exempt rate.

For a description of certain terms under the financing agreement under which the Parity Note has been issued, see "Summary of Certain Provisions of Other Credit Agreements Constituting Parity Debt" in Appendix C.

Additional Bonds and Parity Obligations

The Resolution permits the issuance of Additional Bonds for any purpose for which obligations may be issued by the Authority under the Act, including (without limitation) (i) to refund or advance refund Outstanding Long-Term Indebtedness, (ii) to obtain funds necessary to finance or refinance the acquisition or construction of any Additional Facilities or (iii) to obtain funds necessary to finance the reimbursement of the 2025 Project or any Additional Facilities. Parity Obligations may be issued by the Institution or any future Obligated Group Member for any lawful purpose. Additional Bonds and Parity Obligations may be issued to pay the costs incurred in connection with the issuance and sale of any Parity Debt, to capitalize interest and to establish reserves.

Prior to the issuance of Additional Bonds or the certification of any Parity Obligations, the Obligated Group Members must meet the requirements for the issuance of additional debt or secured Hedging Transactions set forth under "Additional Indebtedness" or "Certain Hedging Transactions," respectively, under "Summary of Certain Provisions of the Loan Agreement" in Appendix C.

Parity Debt Equally and Ratably Secured

The Series 2025 Bonds will be secured equally and ratably on parity with any Additional Bonds and Parity Obligations as to the security of the Receipts and the Revenues to the extent provided in the Resolution. Parity Obligations will not be secured by any Debt Service Fund, the Redemption Fund or the Construction Fund created by the Resolution or any amount on deposit in the Additional Facilities Fund created by the Resolution constituting proceeds of Bonds or investment earnings thereon, and the Series 2025 Bonds will not be secured by any debt service fund, debt service reserve fund, redemption fund or other similar fund created for any Parity Obligation or any amount on deposit in any fund or account securing any Parity Obligation

constituting proceeds of such Parity Obligation or investment earnings on such proceeds. Further, separate funds and accounts may be created for any Additional Bonds.

See "Summary of Certain Provisions of the Resolution -- Additional Bonds" and "Summary of Certain Provisions of the Loan Agreement -- Parity Obligations" in Appendix C for a further description of the conditions under which Additional Bonds and Parity Obligations may be issued or certified, respectively.

Other Indebtedness

Immediately following the issuance of the Series 2025 Bonds and the refunding of all of the Refunded Bonds, the Parity Note will be the only other outstanding Long-Term Indebtedness secured as Parity Debt under the Resolution and the Loan Agreement.

The Obligated Group Members may issue or incur other indebtedness on the conditions described in "Summary of Certain Provisions of the Loan Agreement -- Additional Indebtedness" in Appendix C and the Authority may issue or approve the issuance of Subordinate Obligations on the conditions described in "Summary of Certain Provisions of the Resolution -- Subordinate Obligations" in Appendix C.

THE AUTHORITY

The Authority is a body politic and corporate of the State of Maryland, constituting an instrumentality organized and existing under and by virtue of the Act. The purpose of the Authority, as stated in the Act, is to assist certain educational institutions, including institutions of higher education and noncollegiate educational institutions, and health care institutions, including hospitals and certain life care and continuing-care retirement communities, in the construction, financing and refinancing of certain capital projects approved by the Authority.

Membership and Organization

The Act provides that the Authority shall consist of nine members, one of whom shall be the Treasurer of the State of Maryland, *ex officio*, and eight of whom shall be residents of the State appointed by the Governor. All members serve without compensation but are entitled to reimbursement for actual and necessary expenses incurred in the performance of their duties in relation to the Authority. The Governor annually designates one of the members of the Authority to serve as Chairman and one to serve as Vice-Chairman. Subject to the approval of the Governor, the Authority appoints an Executive Director as chief administrative officer to assume responsibility for day-to-day general management of the Authority's affairs. Barlow T. Savidge has served as Executive Director of the Authority since July 1, 2019.

The members of the Authority and some of their past and present affiliations are:

Arnold Williams, *Chairman*; term as member expires July 1, 2029 resident of Baltimore County; Managing Director – Abrams Foster, Nole & Williams, P.A.; Immediate Past Chairman of the Board – Baltimore Development Corporation; Chairman – Neighborhood Impact Investment Fund; Vice Chair – Baltimore City Board of Finance; Qlarant, Inc.; and The Greater Baltimore Committee; Member – Maryland Association of Certified Public Accountants; American Institute of Certified Public Accountants; and National Association of Black

Accountants; former Board Chairman – Bon Secours Health Systems, Inc. and Liberty Medical Center; former Member – Baltimore City Chamber of Commerce; Past Chair and former Member – Maryland State Board of Accountancy; and Emeritus Member – The Presidents' Roundtable.

Granville Templeton, III, Esq., Vice-Chairman; term expires July 1, 2026; resident of Baltimore City; Managing Law Partner - Templeton Firm; Commissioner - Baltimore City Board of Liquor License Commissioners; Vice Chairman of the Board - Beloved Community Services Corporation; former Chairman of the Board - Boys and Girls Clubs Advisory Board of Directors - Baltimore Area Salvation Army; former Chairman of the Board-Project Pneuma Board of Directors; former Chairman of the Board- Monumental City Bar Association; former Member - Monumental City Bar Foundation; former Member - National Academy Foundation; former first Vice Chairman of the Board - Associated Black Charities; former Member - Business Law Section Council Member, Maryland State Bar Association; former Vice Chairman of the Board-International Law Committee, Maryland State Bar Association.

Dereck E. Davis, Ex Officio; resident of Prince George's County; Treasurer of State of Maryland; Chair – Maryland Capital Debt Affordability Committee; Commission on State Debt; and Board of Trustees of the Maryland State Retirement and Pension System; Member – Board of Trustees of the Maryland Teachers and State Employees Supplemental Retirement Plans; Maryland Environmental Service Board of Directors; and Board of Revenue Estimates.

Bisma Beg, M.B.B.S., M.D., MPH, PMP, *Member*, term expires July 1, 2028; resident of Howard County; MPH – Bloomberg School of Public Health – Johns Hopkins University; Member – Board of Health Howard County, Maryland; Associate Medical Director/Administrator – Surgery & Trauma Center; Program Lead (Curriculum & Program Developer & Implementor) Women's Health Education Program for Maryland Department of Public Safety & Corrections; Adjunct Faculty Professor Nursing and Applied Health – Baltimore City Community College, Maryland; Chair Membership Committee – APPNA Maryland – Association of Pakistan Physicians of North American Descent; former OB-GYN – IVF & ICSI; Chief Medical Officer – Tertiary Care Center and teaching hospital (Pakistan).

Frederick W. Meier, Jr., *Member*; term expires July 1, 2025; resident of Baltimore City; Senior Advisor – Lord Baltimore Capital Partners; former Executive Vice President – First Maryland Bancorp; Director – Rodney Trust Company; Attransco; and AMA Capital Partners; Member – Board of Finance of the City of Baltimore; former Vice President and Trustee – The Baltimore Museum of Art; Honorary Trustee and former President of Board of Trustees – The Boys' Latin School of Maryland; former Director and Board Member – Provident Bankshares; former Member of Board of Governors – The Center Club; and former Director – Forestal San Jose (Chile); Jugos delSur (Argentina); Norden A/S (Denmark); and Empresas Navieras, S.A. (Chile).

Mamie J. Perkins, *Member*; term expires July 1, 2027; resident of Howard County; Retired Deputy Superintendent of Howard County Public Schools; former Interim Superintendent of Anne Arundel County Public School System; Chair and former Member – Board of Trustees of Howard County Community College; former Member of Horizon Foundation of Howard County and Grassroots Board of Howard County; former Board Member of numerous educational and non-profit organizations; and Leadership Coach – Anne Arundel County Public School System.

John Phelps, *Member*; term expired July 1, 2024[*]; resident of Baltimore County; President and CEO – Carroll Independent Fuel Company/Highs of Baltimore LLC; former Member and Chairman – Citgo Petroleum National Distributor Council; former member – Mobil Oil National Jobber Council; British Petroleum U.S. Distributor Council; and Sunoco Refining Jobber Council; Chairman Board of Trustees – Saint Frances Academy; Member – M&T Bank Mid Atlantic Advisory Board; and Chairman – Parish Council Chairman Our Lady of Grace Catholic Church.

Arthur S. Varnado, *Member*; term expires July 1, 2028; resident of Howard County; former Vice President of T. Rowe Price Group; Board Member – Stanford University Athletics; National Multiple Sclerosis Society (DC/MD Chapter); former Board Member – St. Ignatius Loyola Academy; Notre Dame Preparatory High School; and Junior Achievement of Central Maryland; Student sponsor – St. Ignatius Loyola Academy and Sisters of Academy of Baltimore; GBMC Leadership Class of 2004.

W. Daniel White, *Member*; term expires July 1, 2025; resident of Baltimore County; retired Executive Vice President, Assistant Secretary, Assistant Treasurer and Member of the Board of Directors – The Whiting-Turner Contracting Company; Board Member – Notre Dame Preparatory High School; and Maryland Family Network; former Board Member of numerous educational, economic development and non-profit organizations.

Powers

The Act authorizes the Authority, among other things, to issue bonds, bond anticipation notes and other obligations and to refund the same; to fix and collect rates, rentals, fees and charges for services and facilities that a project provides or makes available; to directly, or through a participating institution acting as its designated agent, acquire, improve, maintain, operate, lease as lessee or lessor, and regulate a project and enter into contracts for any of these purposes and for the management of a project for certain educational institutions, including institutions of higher education and noncollegiate educational institutions, and health care institutions, including hospitals and life care and continuing-care retirement communities; to directly or, through a participating institution acting as its designated agent, establish rules and regulations for the use of a project; to accept a grant, loan or other assistance in any form from any private source subject to the provisions of the Act; to mortgage, pledge or otherwise encumber a project and its site or hold a mortgage or other encumbrance on a project and its site for the benefit of the holders of bonds issued to finance a project; to make a loan to a participating institution to improve or acquire a project in accordance with an agreement between the Authority and a participating institution; to refinance any part of a project and refund or repay bonds, mortgages, advances, loans or other obligations of a participating institution to the Authority, any person or any unit of federal, state or local government incurred to finance any part of a project; and to do all acts and things necessary or convenient to carry out the powers expressly granted by the Act.

[*] By the terms of the Authority's enabling act, members continue to serve until their successors are appointed.

Bonds and Notes

As of July 1, 2024, the Authority had issued bonds and notes aggregating approximately $31 billion in principal amount, of which approximately $8.4 billion remained outstanding under the applicable bond resolution or trust agreement. Since July 1, 2024, the Authority has issued additional series of bonds aggregating $1.1 billion in principal amount.

The several series of outstanding bonds and notes issued by the Authority are special obligations of the Authority, payable solely from revenues of the Authority received in connection with the respective projects financed or refinanced, and do not constitute general obligations of the Authority, and the full faith and credit of the Authority is not pledged to the payment of the principal or redemption price of and interest on these bonds or notes.

Other than money available from the administrative fees received from participating institutions, it is not anticipated that the Authority will have any assets of its own. Property and funds held by or mortgaged to the Authority for a particular issue of bonds are not available to satisfy claims of holders of other issues of the Authority's bonds. The Authority has no taxing powers.

The Authority expects to enter into separate agreements with other hospitals and related institutions, institutions for higher education and noncollegiate educational institutions to finance and refinance eligible projects. The Authority intends to issue other series of bonds and notes for the purpose of financing and refinancing projects pursuant to such agreements, and each such series will be issued pursuant to a resolution or trust agreement separate and apart from any other resolution or trust agreement, except to the extent a series of bonds may be issued on parity with bonds of another series if permitted by the applicable resolution or trust agreement.

REGULATORY ENVIRONMENT

Maryland Health Care Commission

Under current law, a non-federal healthcare facility in the State of Maryland may not develop, operate or participate in a covered healthcare project unless the Maryland Health Care Commission (the "Health Care Commission") has issued a certificate of need ("CON") for such project. The Health Care Commission is an independent commission functioning within the Maryland Department of Health. Covered healthcare projects include, among other things, the construction, development or other establishment of a new healthcare facility, certain relocations of healthcare facilities, certain changes in the type or scope of healthcare services offered by a healthcare facility, certain changes in bed capacity, certain changes in operating room capacity, certain health service-related obligations or capital expenditures and the offering of certain new health services.

A CON is not required under existing law for certain projects, including, among others: (i) certain transfers or acquisitions of existing healthcare facilities not involving changes in services or bed capacity, (ii) capital expenditures by a healthcare facility for the acquisition and installation of major medical equipment, (iii) patient care related capital expenditures made by or on behalf of a hospital that do not exceed the lesser of 25% of the hospital's gross regulated charges for the immediately preceding year or $50 million as further adjusted for inflation (the "hospital capital threshold"), if the expenditures do not involve the addition of new beds or

certain healthcare services, (iv) patient care related capital expenditures for construction or renovation in excess of the hospital capital threshold, so long as the project does not require a total cumulative increase in patient charges or hospital rates of more than $1.5 million for the capital costs associated with the project over the entire period or schedule of debt service as determined by the Health Care Commission, (v) capital expenditures made by hospitals that are not related to patient care and do not increase patient charges or other rates, and (vi) the closure of a hospital provided certain conditions are met. In addition, qualified mergers and consolidations between or among healthcare facilities are exempt from CON review if certain findings are made by the Health Care Commission. In 2019, the Maryland General Assembly enacted legislation, which increased the hospital capital threshold and eliminated the CON capital threshold that previously applied to other healthcare facilities. Although the capital threshold has been eliminated for other healthcare facilities, a CON is still required to establish, relocate, change the bed capacity, or engage in other CON regulated actions (as described above) pertaining to such facilities. The Health Care Commission annually adjusts the hospital capital expenditure threshold based on the Consumer Price Index-Urban for the Mid-Atlantic Area published by the U.S. Department of Labor, Bureau of Labor Statistics, rounded to the nearest $50,000.

The Obligated Group has determined that no CON is required in connection with the 2025 Project and that no review and determination by the Health Care Commission with respect to the need for a CON for the 2025 Project is required.

According to the Health Care Commission, the CON program is intended to ensure that new healthcare facilities and services are developed in the State of Maryland only as needed and if determined to be needed, that they are the most cost-effective approach to meeting identified needs, of high quality, geographically and financially accessible, and financially viable. If the Health Care Commission determines that the new healthcare facilities or services are needed, the Health Care Commission seeks to ensure that such facilities or services will not have a significant negative impact on the cost, quality, or viability of existing healthcare facilities or services.

Maryland Health Services Cost Review Commission

General

Hospital rate regulation was established by an act of the Maryland legislature in 1971, which created the Maryland Health Services Cost Review Commission (the "Rate Commission" or the "HSCRC"). The Rate Commission was given broad authority to establish hospital rates and regulate cost containment, quality and financial stability. Under current law, the rates charged for most hospital services by non-governmental Maryland hospitals are subject to review and approval by the Rate Commission pursuant to Sections 19-201 through 19-227 of the Health-General Article of the Annotated Code of Maryland, as amended (the "Rate Commission Act"). By the terms of the Rate Commission Act, no hospital subject to the Rate Commission Act is permitted to charge for covered hospital services (inpatient services, emergency services and outpatient services provided at the hospital) at rates other than those established by the Rate Commission in accordance with the procedures established under the Rate Commission Act. The Rate Commission is empowered by statute to initiate hospital rate reviews and to review hospital rate applications on an individual basis to assure that (i) the total costs of all hospital services offered by or through a hospital are reasonable, (ii) the hospital's aggregate rates are

reasonably related to the hospital's aggregate costs, and (iii) rates are charged equitably among all purchasers or classes of purchasers without undue discrimination or preference.

The Rate Commission Act provides in part that the Rate Commission, in discharging its duties, shall permit any nonprofit institution subject to its jurisdiction to charge reasonable rates which will permit the institution to provide, on a solvent basis, effective and efficient service in the public interest. The Rate Commission Act states that, in considering a request for change in or initiating a review of rate schedules or other charges, the Rate Commission shall permit any institution subject to the Rate Commission Act to charge rates which will in the aggregate produce sufficient total revenue to enable the institution reasonably to meet all of the obligations and requirements specified in the Rate Commission Act. The Rate Commission Act also provides that, in the determination of reasonable rates, the Rate Commission shall take into account all of the costs of complying with the determinations made by the Health Care Commission.

The Rate Commission Act requires all payors to pay Rate Commission-approved rates for appropriately billed, covered hospital services. Differentials up to 7.7% are allowed if the payor meets certain conditions. These differentials apply to Medicare and Medicaid as discussed in the next section.

Maryland Medicare Waiver

In 1977, Medicare signed a contract with the Rate Commission agreeing to pay Maryland acute care general hospitals, as an experimental program and subject to certain limitations, on the basis of Rate Commission-approved rates, less a 6% differential. This contract, commonly referred to as the "Medicare Waiver," was in effect from 1977 through 2013, with several renewals. Under the Medicare Waiver, Maryland hospitals were exempted from reimbursement under the Medicare Inpatient Prospective Payment System and Outpatient Prospective Payment System pursuant to Section 1814(b)(3) of the Social Security Act.

Continuation of the Medicare Waiver was contingent on Maryland's performance on certain factors, including Maryland's aggregate rate of increase in Medicare cost per hospital admission as compared to the national rate of increase (the "Waiver Test"). Since the Waiver Test was primarily focused on inpatient services and factors such as cost-per-discharge and length of stay, the system did not provide regulated hospitals with incentives with respect to population health management and coordinated care and Maryland's performance on the Waiver Test deteriorated over time.

Following the enactment of the Affordable Care Act (hereinafter defined), on February 11, 2014, the Centers for Medicare and Medicaid Services ("CMS"), the Governor of Maryland, the Maryland Department of Health (formerly Department of Health and Mental Hygiene) and the Rate Commission (collectively, the "State") signed the Maryland All-Payer Model Agreement (the "Agreement") pursuant to Section 1115A(b) of the Social Security Act. Pursuant to the Agreement, at the election of the State, reimbursement under Section 1814(b)(3) of the Social Security Act was terminated and the State elected instead for regulated hospitals to be reimbursed under the terms of the All-Payer Model (the "Model" or the "Waiver Model") described below. The Agreement replaced the Waiver Test and provided that CMS would waive certain requirements of the Social Security Act as applied to regulated hospitals subject to the

conditions of the Agreement. The Agreement obligated Maryland to continue its all-payor rate-setting system. The Model did not cover physician services and other non-hospital services.

The Agreement covered a performance period of five calendar years (each, a "Performance Year") which commenced January 1, 2014 and ended December 31, 2018 (collectively, the "Performance Period"). The Agreement provided that, during the Performance Period, Medicare would continue to pay for services provided by Maryland hospitals regulated by the Rate Commission at rates established by the Rate Commission.

Performance under the Agreement was measured using the following five metrics: total inpatient and outpatient hospital revenue growth per capita; Medicare per beneficiary total hospital cost growth; transition to population-based payment reimbursement; hospital acquired conditions rate; and reductions in hospital Medicare readmission rates.

All Total Inpatient and Outpatient Hospital Cost Growth Per Capita

During the first, second and third Performance Years, the State was to limit the cumulative annual all-payer per capita total hospital revenue growth for Maryland residents to an amount less than or equal to the per capita growth ceiling. For the first, second and third Performance Years, the growth ceiling was fixed at 3.58% per capita per year, which represented the State's per capita gross state product ("GSP") compound annual growth rate from 2002 through 2012. In the third quarter of the third Performance Year, the State could, subject to prior approval by CMS, update the annual all-payer per capita total hospital revenue growth limit for the fourth and fifth Performance Years to the State of Maryland's most recent 10-year per capita GSP growth rate. The State did not request an update of the annual all-payer per capita total hospital revenue growth limit for the fourth and fifth Performance Years.

Following the execution of the Agreement, a majority of regulated Maryland hospitals and health systems entered into rate-setting agreements with the Rate Commission under which the hospitals' total revenue for services regulated by the Rate Commission is capped at a predetermined amount (the "Global Budget Revenue" or "GBR"). Each hospital is required to adjust its rates from time to time so as not to exceed its GBR. If a hospital's volume declines, it may increase its rates by up to five percent to maintain its revenues at the specified GBR level. Rates may be increased by up to 10 percent to offset volume declines with the approval of Rate Commission staff.

Each hospital's Global Budget Revenue is updated annually with positive or negative adjustments for inflation, population changes and changes in market share. A hospital's GBR may also be increased or decreased based on the hospital's performance (or in the case of a health system, the health system's performance) under the Maryland Readmission Reduction Program, the Maryland Hospital-Acquired Conditions Program and other measurements adopted by the Rate Commission to measure hospital quality. The Rate Commission may also adjust a hospital's GBR to provide funding for specific projects or objectives, such as population health management and infrastructure development. In addition, the Rate Commission may adjust hospitals' GBRs based on the State's performance on the metrics reflected in the Agreement with CMS.

In 2016, the Maryland General Assembly enacted legislation allowing an acute general hospital in Maryland to convert to a freestanding medical facility upon: (1) issuance of CON

exemption from the Health Care Commission; and (2) authorization from the Rate Commission to regulate rates for outpatient services provided in the freestanding medical facility, including observation services and ancillary services needed to support emergency and observation services. In Maryland, freestanding medical facilities operate as freestanding emergency departments and must be physically separate from but operated as part of an acute general hospital. Accordingly, services provided at the freestanding medical facility are billed as part of the main hospital provider and are subject to the parent hospital's GBR. When an acute care hospital in Maryland converts to a freestanding medical facility, the Rate Commission evaluates the expected volume shifts and determines the consolidated GBR that will apply to the parent hospital and newly converted freestanding medical facility.

Total Cost of Care Model

In early 2017, the State and federal government negotiated an extension and revision to the State's Medicare Model, which was approved by CMS in 2018. The new program is called the "Total Cost of Care Model" ("TCOC Model"). The TCOC Model went into effect beginning January 1, 2019, for a term of ten years, requiring Maryland to meet model performance requirements for the term to remain in effect. The currently negotiated performance period will end on December 31, 2025. On November 1, 2024, CMS and the State of Maryland agreed that Maryland will participate in the States Advancing All-Payer Equity Approaches and Development Model ("AHEAD Model") as the next framework for the reimbursement of covered providers in Maryland.

The TCOC Model is the first CMS Innovation model to hold a state fully at risk for the total cost of care for Medicare beneficiaries. The TCOC Model extends the use of the GBR model. The new model builds upon the previous All-Payer Model by including spending for non-hospital healthcare providers in the program. Under the TCOC Model, State growth in Medicare spending per beneficiary must not exceed the national growth rate by more than 1% any year and must not exceed the national growth rate by any amount for two or more consecutive years. Hospital cost growth per capita is not to exceed 3.58% per year for all payers under the model. The State may adjust the growth limit, subject to federal approval. Under the model, all Maryland Medicare fee-for-service beneficiaries are prospectively attributed to a Maryland hospital, and hospitals are accountable for the Medicare total cost of care of these beneficiaries by placing a maximum of 1% of a hospital's Medicare revenue at-risk for its performance against a total cost of care benchmark amount. The model includes a commitment from Maryland to save $300 million in annual total Medicare spending for Medicare Part A and Part B by the end of 2023, which the State achieved, and $408 million by the end of 2026; voluntary programs to assist physicians and other providers in leveraging voluntary initiatives, federal programs, and incentive programs to align participation in care coordination and improvement efforts; aggressive quality of care goals; and a range of population health goals. The model allows for hospitals to participate in the Maryland Primary Care Program and the Care Redesign Programs such as the Episode Care Improvement Program, which provides financial incentives when the total cost of care for a service bundle, e.g., joint replacement, can be provided lower than a defined target. Further, Maryland has chosen its own measures and targets in six high-priority areas in which it desires to improve population health, including diabetes, hypertension, and obesity. It selects its own measures and targets within each area for CMS approval, and can earn credit for its performance on these measures and targets.

Under the TCOC Model, Maryland's waivers under the All-Payer Model pursuant to the Agreement continue. Maryland has been waived from the CMS Value-Based Purchasing, Hospital Acquired Conditions, and Hospital Readmissions Reduction programs, but will continue to operate comparable programs applied on an all-payer basis. Maryland's waivers remain in effect during the term of the TCOC Model to the extent Maryland remains in compliance with the TCOC Model. The TCOC Model includes three programs: (1) Hospital Payment Program, (2) Care Redesign Program and (3) Maryland Primary Care Program.

Hospital Payment Program. This program tests population-based payments for Maryland hospitals, by providing each hospital a population-based payment amount to cover all hospital services provided during the course of the year. This creates a financial incentive for hospitals to provide value-based care and to reduce the number of unnecessary hospitalizations, including readmissions.

Care Redesign Program. This program allows hospitals to make incentive payments to nonhospital healthcare providers who partner and collaborate with the hospital and perform care redesign activities aimed at improving quality of care. To be eligible to make these payments, a participating hospital must attain certain savings under its GBR and the total amount of incentive payments made cannot exceed such savings. Further, a participating hospital must enter into a Care Redesign Program participation agreement with CMS and the State.

Maryland Primary Care Program. The Maryland Primary Care Program is structured to provide an incentive for primary care providers in Maryland to offer advanced primary care services to their patients, including care management services. Participating practices will receive additional per beneficiary per month payments directly from CMS to cover care management services, and may receive performance-based incentive payments or negative adjustments based on certain cost and quality metrics. These practices may contract with Care Transformation Organizations to provide certain of the advanced primary care services and administrative services required under the program.

The State's All-Payer Health Equity Approaches and Development Model

As noted above, on November 1, 2024, CMS and the State of Maryland entered an agreement for the State to participate in the new AHEAD Model, which enables Maryland to continue its all-payer rate setting system. The AHEAD Model is a new voluntary state total cost of care model. CMS's stated goals in the AHEAD Model are to collaborate with states to curb health care cost growth; improve population health; and advance health equity by reducing disparities in health outcomes. Through AHEAD, CMS will support participating states through various AHEAD Model components that aim to increase investment in primary care, provide financial stability for hospitals, and support beneficiary connection to community resources.

Under the agreement to enter the AHEAD Model, Maryland will continue state-wide efforts to improve healthcare quality and control costs started under the current TCOC Model. The AHEAD Model agreement includes three defined time periods. The Pre-Implementation Period commenced on July 1, 2024 and expires on December 31, 2025; the Implementation Period begins on January 1, 2026 and expires on December 31, 2034; and a Transition Period, following expiration of the implementation period or earlier termination, may last up to five years.

Like the TCOC Model, the AHEAD Model includes requirements to meet certain health care cost savings targets, among other goals, such as health quality and equity and population health. During the Implementation Period, the State will be accountable for meeting targets in the following seven categories: (1) Medicare fee-for-service total cost of care; (2) all-payer total cost of care growth; (3) Medicare fee-for-service primary care investment; (4) all-payer primary care investment; (5) statewide quality and equity; (6) statewide population health; and (7) all-payer revenue limit. Maryland's targets for Medicare fee-for-service total cost of care savings under the AHEAD Model are more modest than those required under the current TCOC Model.

Maryland Hospital Bond Program

In 1985, the Maryland General Assembly enacted comprehensive health care legislation for the purpose of encouraging the reduction of excess capacity in the Maryland health care system. Pursuant to this legislation, the Maryland Hospital Bond Program (the "Bond Indemnification Program" or the "Program") was created to preserve the access of Maryland health care facilities to adequate financing by establishing a program to facilitate the refinancing and payment of certain public obligations of a closed or delicensed hospital. The terms of the Program are set forth in Part IV of the Act consisting of Sections 10-340 through 10-353 of the Economic Development Article of the Annotated Code of Maryland.

As defined in the Act, "public obligations" include all bonds, notes or other obligations for the payment of borrowed money issued by the Authority, the State of Maryland, any political subdivision thereof or any of their instrumentalities, except any obligation or portion of an obligation (a) insured by an effective municipal bond insurance policy, if a hospital voluntarily closes, or (b) issued to finance a facility that is used primarily (i) to provide outpatient services at a location other than the hospital, or (ii) by physicians who are not employees of the hospital to provide services to nonhospital patients. All of the Series 2025 Bonds constitute public obligations under the provisions of the Act as currently in effect.

The Act provides that the Bond Indemnification Program shall provide for the payment and refinancing of public obligations of a hospital if:

(a) the hospital is (i) closed in accordance with Section 19-120(l) of the Health-General Article of the Annotated Code of Maryland, as amended, or (ii) delicensed in accordance with Section 19-325 of the Health-General Article of the Annotated Code of Maryland, as amended, upon the petition of the Health Care Commission and the Rate Commission after efforts to encourage the hospital to reduce its excess capacity have failed;

(b) a public obligation issued on behalf of the hospital is outstanding;

(c) the hospital plan for closure or delicensure and the related financing plan is acceptable to the Secretary of the Maryland Department of Health and the Authority; and

(d) in the case of the Series 2025 Bonds and any other public obligations issued after October 1, 2008 (i) the Rate Commission determines that implementation of the Program is in the public interest, taking into account the amount of system-wide savings to the health care system in the State of Maryland that might be expected as a result of the closure, and (ii) the hospital provides to the Health Care Commission a closure plan including the hospital's plan for the provision of care to its patients and the population in its service area.

The Bond Indemnification Program may also be used to provide for the payment of certain closure costs of a closed or delicensed hospital if the Rate Commission determines, after consideration of the system-wide savings to the Maryland health care system expected to result from the closure or delicensure of the hospital, that the payment of such costs is necessary or appropriate to encourage and assist the hospital to close or to implement the Program.

The Act authorizes the Authority to issue bonds or notes to refund any eligible public obligations and to pay closure costs approved by the Rate Commission in accordance with the Act.

Under the Program, the Rate Commission must assess a fee on all Maryland hospitals whose rates have been approved by the Rate Commission in an amount sufficient to pay any eligible public obligations or any bonds that the Authority issues to refund such public obligations and to pay any eligible closure costs. The fee assessed each hospital is proportionate to that hospital's gross patient revenues compared with the total gross patient revenues of all Maryland hospitals. In the event that the Rate Commission is terminated by law, the Secretary of the Maryland Department of Health shall impose the fee.

The Bond Indemnification Program has paid for the public obligations of several Maryland hospitals closed in accordance with the Program.

The Bond Indemnification Program does *not* provide for the payment of any hospital obligations unless the hospital closes or is delicensed as described above. Accordingly, default in the payment of bonds or other default, including the initiation of bankruptcy proceedings by or against a hospital, would not, in and of itself, require or permit the implementation of the Program. Further, there can be no assurance that the Program will not be modified or eliminated by future legislation amending or repealing the Act. The initiation of bankruptcy or similar proceedings by or against a closed or delicensed hospital could preclude or substantially delay the implementation of the Program with regard to the public obligations of such hospital.

Other Laws and Regulations Affecting Nonprofit Health Care Institutions

Meritus Health and its System Affiliates are subject to federal, state and local laws, regulations, rulings and court decisions relating to their organization and operation, including, in the case of the nonprofit System Affiliates, their operation for charitable purposes. At the same time, the System Affiliates conduct significant business transactions. As a result, the System Affiliates must ensure consistency between the rules designed to regulate a wide range of charitable organizations and the day-to-day operations of complex health care organizations.

The operations and practices of nonprofit, tax-exempt hospitals are routinely challenged for inconsistent or inadequate compliance with the regulatory requirements for, and societal expectations of, nonprofit charitable tax-exempt organizations. An overarching concern is that nonprofit hospitals may not be providing community benefits that equal or exceed the benefit received from their tax-exempt status. In addition to required compliance with federal and state statutes and regulations, such as those related to the Medicare and Medicaid programs, the core business practices of health care organizations are routinely examined. Areas which have come under examination have included pricing practices, billing and collection practices, charitable care, methods of providing and reporting community benefit, executive compensation and

private use of facilities financed with tax-exempt obligations. Questions regarding the business practices of nonprofit hospitals have come from a variety of sources, including state attorneys general, the Internal Revenue Service (the "Internal Revenue Service" or "IRS"), labor unions, the United States Congress, state legislatures, the press and patients, and in a variety of forums, including hearings, audits and litigation.

For more than a decade, the IRS has been concerned with excessive compensation of and benefits to officers and other insiders of tax-exempt organizations. In 2009, the IRS issued its Hospital Compliance Project Final Report, which indicated that the IRS would continue to heavily scrutinize executive compensation arrangements, practices and procedures of tax-exempt hospitals and other tax-exempt organizations and, in certain circumstances, may conduct further investigations or impose fines on such organizations. The IRS, pursuant to the intermediate sanctions excise taxes set forth in Code Section 4958), may impose taxes on certain excess benefit transactions, whereby an exempt organization's insiders unduly benefit from a transaction with the organization. Excessive compensation is a form of excess benefit transaction subject to these taxes. The Tax Cuts and Jobs Act imposes on most tax-exempt organizations a 21% excise tax on compensation exceeding $1 million paid to an organization's five highest-paid employees. This excise tax does not apply to compensation for the direct provision of medical services by licensed medical professionals.

In 2010, the IRS revised the Form 990 return required to be filed annually by tax-exempt organizations to include a new schedule, Schedule H, which hospitals must use to report their community benefit activities, including the cost of providing charitable care and other information pertinent to their tax-exempt status.

The IRS initiative to ensure that an organization's tax-exempt status is used for charitable purposes and not for any private benefit includes a schedule to Form 990, Schedule K, which is intended to address what the IRS believes is significant noncompliance with recordkeeping and record retention requirements. Schedule K also requires tax-exempt organizations to report on the investment and use of tax-exempt bond proceeds to address IRS concerns regarding compliance with arbitrage rebate requirements and the private use of tax-exempt bond-financed facilities.

The Affordable Care Act expanded these initiatives and imposed additional requirements for tax-exemption and reporting obligations, including obligations to adopt and publicize financial assistance and emergency medical care policies; limit charges to patients who qualify for financial assistance to the lowest amount charged to insured patients; and control billing and collection processes. Additionally, tax-exempt hospitals must conduct community health needs assessments and adopt an implementation strategy to meet the health needs identified in the assessment at least once every three years. Failure to satisfy these conditions may result in the imposition of excise taxes and the loss of tax-exempt status. See "CERTAIN BONDHOLDERS' RISKS – Affordable Care Act" herein.

The foregoing are some examples of certain challenges facing nonprofit health care organizations. These challenges, and any resulting examinations, legislation, regulations, judgments or penalties could have a material adverse effect on the Obligated Group's ability to make payments with respect to the Series 2025 Bonds and other outstanding Parity Debt.

CERTAIN BONDHOLDERS' RISKS

Payment of the Series 2025 Bonds is dependent primarily upon the ability of the Obligated Group to generate revenues sufficient to provide for their payment while meeting their operating expenses, debt service on other indebtedness and other cash requirements. Future revenues and expenses of the Obligated Group are subject to future events and conditions that cannot be determined at this time.

The paragraphs below discuss certain Bondholders' risks, but are not intended to be a complete statement of all risks associated with the purchase or holding of the Series 2025 Bonds. The order in which such risks are presented does not necessarily reflect the relative importance of such risks or the likelihood that any of the events or circumstances described below will occur or exist.

General

No representation can be made or assurance given that revenues will be realized by the Obligated Group Members in amounts sufficient to make the payments necessary to meet the obligations of the Obligated Group. Future revenues and expenses of the Obligated Group are subject to, among other things, the capabilities of the management of the Obligated Group and future economic conditions and other conditions which are unpredictable, and which may affect the revenues of the Obligated Group and, therefore, may affect the ability of the Obligated Group Members to make payments of principal of and interest on the Series 2025 Bonds as well as other obligations of the Obligated Group.

Future economic and other conditions that may adversely affect the future financial condition of the Obligated Group and, consequently, its ability to make payments of the principal of and premium, if any, and interest on the Series 2025 Bonds include (without limitation) decreases in the demand for healthcare services, technological developments and demographic changes, loss of confidence of physicians and patients in the healthcare facilities operated by the Obligated Group, malpractice claims and other litigation, competition, changes in regulations and procedures of the Rate Commission or other governmental bodies exercising jurisdiction over the Institution and the System Affiliates that operate hospitals, changes in the methods and rates of payment for healthcare services, increases in costs, the availability and affordability of insurance, including without limitation malpractice and casualty insurance, availability of nursing and other professional personnel and failure to obtain gifts and contributions from donors and with respect to MSOM, demand for medical degrees; the ability of prospective students to afford the costs of medical school; the ability to compete for students; the ability to maintain or increase in the future funds from other sources, including gifts and contributions from donors and grants or appropriations from governmental bodies; reductions in the sources of funds available to pay tuition, such as student loans and grants; increasing costs of compliance with federal or state regulatory laws and regulations, including (without limitation) laws and regulations concerning environmental quality, work safety, accommodating the handicapped and changes in federal government policy relating to the reimbursement of overhead costs on government grants and contracts; and any unionization of the work force with consequent impact on wage scales and operating costs; inflation and increasing operating and maintenance costs; and changes in the structure of faculty compensation.

There can be no assurance given that the financial condition of the Obligated Group and utilization of the facilities of the Obligated Group will not be adversely affected by future events.

ADVERSE CONSEQUENCES ARISING FROM ONE OR MORE OF THE FOLLOWING RISKS, OR THE OCCURRENCE OF OTHER UNANTICIPATED EVENTS, COULD ADVERSELY AFFECT THE OPERATIONS OR FINANCIAL PERFORMANCE OF THE OBLIGATED GROUP. THIS DISCUSSION IS NOT, AND IS NOT INTENDED TO BE, EXHAUSTIVE. THE RISKS DISCUSSED BELOW SHOULD BE READ IN CONJUNCTION WITH THE DISCUSSION SET FORTH IN APPENDIX A, THE DISCUSSION APPEARING UNDER THE CAPTION "REGULATORY ENVIRONMENT" ABOVE AND THE INFORMATION APPEARING ELSEWHERE IN THIS OFFICIAL STATEMENT.

Obligated Group

At the time of issuance of the Series 2025 Bonds, the Obligated Group will be composed of the Institution, Brooke Lane and MSOM. The Loan Agreement provides that other entities may be admitted to the Obligated Group from time to time and that Obligated Group Members other than the Institution may withdraw from the Obligated Group upon the satisfaction of certain conditions. See "SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2025 BONDS -- Loan Agreement -- Obligated Group." Thus, there is no assurance that any entity other than the Institution will remain a part of the Obligated Group. The covenants included in the Loan Agreement apply only to Obligated Group Members.

Inflation, Tariffs and Supply Chain Issues

Currently the United States is experiencing high levels of inflation and increased tariffs which are having an impact on the costs of goods and services needed by the Obligated Group to operate its facilities. Additionally, supply chain crises may also negatively impact the Obligated Group's ability to maintain its facilities and construct new facilities. As a result, the Obligated Group may experience delays and increased costs associated with inflation, increased tariffs and supply chain issues.

Security for the Series 2025 Bonds

Security Interest in Receipts

While the Series 2025 Bonds are secured by a pledge of the Receipts of the Obligated Group Members, the Series 2025 Bonds will *not* be secured by a mortgage or any other lien on or security interest in any other real or personal property of the Obligated Group Members.

The Authority's security interest in the Receipts is subject to, among other things, Permitted Encumbrances and the following:

(i) statutory liens or rights arising in favor of the Authority and the Trustee by virtue of the operation of the Act;

(ii) other statutory liens;

(iii) rights arising in favor of the United States of America or any agency thereof;

(iv) prohibitions against assignment contained in state or federal statutes, including those governing Medicare and Medicaid and the absence of an express provision permitting assignment of receivables due under contracts with other third-party payors;

(v) constructive trusts, equitable liens or other rights impressed or conferred by any state or federal court in the exercise of its equitable jurisdiction;

(vi) state and federal insolvency or bankruptcy laws affecting Receipts earned by any current or future Obligated Group Member within the statutorily prescribed preference period prior to any effectual institution of bankruptcy proceedings by or against such Obligated Group Member and thereafter;

(vii) rights of third parties in any Receipts, including Receipts converted to cash, not in the possession of the Trustee; and

(viii) the requirement that appropriate financing and continuation statements be filed in accordance with the Uniform Commercial Code as in effect from time to time.

The Authority's security interest in the Receipts may not extend to any revenues generated from the use and operation of any Group Facilities after any person who is not an Obligated Group Member obtains possession of such property, whether by voluntary transfer, foreclosure under a mortgage or other security agreement or enforcement of a statutory or judicially created lien.

Priority of the Liens

The Obligated Group covenants in the Loan Agreement not to create or permit to exist any mortgage or other lien on its property, except Permitted Encumbrances. However, the Loan Agreement permits the Obligated Group to dispose of assets, including (without limitation) accounts receivable, and to pledge, mortgage or grant a security interest in revenues, property and other assets of the Obligated Group to secure other obligations of the Obligated Group, subject to certain limitations stated therein. Any such liens and security interests may under certain circumstances be prior to the lien of the Loan Agreement. See "Summary of Certain Provisions of the Loan Agreement -- Liens and Encumbrances" in Appendix C. Any lien on accounts receivable or other property of the Obligated Group created by the Loan Agreement and the proceeds thereof would terminate and be immediately extinguished upon the sale of such property or the enforcement by the holder of any lien on such property that is prior to the lien of the Loan Agreement, whether such lien is permitted by the Loan Agreement or constitutes a statutory lien (such as liens for enforcement of tax and environmental laws) or is created in violation of the Loan Agreement. Further, the existence of any such liens could have an adverse effect on the treatment of holders of the Series 2025 Bonds in any bankruptcy proceeding involving the Obligated Group. See "Bankruptcy" below.

Infectious Disease Outbreak, Pandemics, or Other Public Health Emergencies or Crisis

The business and financial results of the Obligated Group may be harmed by an international, national or localized outbreak of a highly contagious or epidemic disease, including but not limited to, COVID-19 or similar corona-type viruses, Ebola, Zika, or avian influenza may put stress on the capacity of all or a part of the Obligated Group's health care facilities, could result in an abnormally high demand for health care services, require that resources be diverted from one part of operations to another part, disrupt the supply chain for equipment and supplies necessary for the operations of the Obligated Group's health care facilities. In addition, unaffected individuals may decide to defer elective procedures or otherwise avoid medical treatment, resulting in reduced patient volumes and operating revenues at facilities of the Obligated Group's health care facilities. The effect of any future public health emergency or crisis on the Obligated Group's operations and finances could be material and cannot be predicted at this time.

Health care providers are also disproportionately likely to be exposed to and become ill from a highly contagious disease or pandemic, which may limit the ability of the Obligated Group's health care facilities to have staff on duty at all times sufficient to provide care. Business disruptions could also include temporary closures of the Obligated Group's health care facilities or the facilities of suppliers and their contract manufacturers, and a reduction in the business hours of healthcare facilities. Changes in operations at the Obligated Group Members' health care facilities may result in additional costs being incurred related to adjustments to the use of various facilities and to staffing during an outbreak, including overtime wages, wages paid to employees who are unable to work due to quarantine, and utilization of more expensive contract staff to provide care. In addition, health care providers may be required to provide significant amounts of uncompensated care. The Obligated Group cannot predict any costs associated with the potential treatment of an infection disease or pandemic or preparation for such treatment.

In the future, pandemic or other highly contagious disease at the Obligated Group's health care facilities may adversely affect the Obligated Group's operations and financial performance in various ways, including but not limited to (1) an overburdening of facilities, (2) a quarantine, temporary shutdown or diversion of patients, (3) a disruption in the production or supply of pharmaceuticals, medical supplies and protective equipment and increases in the costs of such products, (4) professional or non-professional staff shortages or illnesses, (5) an increase in overhead costs due to additional costs incurred related to adjustments to the use of various health care facilities and to staffing during the outbreak, including overtime wages, mandated sick pay, and the use of more expensive contract staff to provide care, (6) significantly delayed payments from third-party payors, (7) increased numbers of professional liability lawsuits, (8) a larger number of uninsured patients due to increased unemployment rates, and (9) reduced patient volumes and operating revenues due to unaffected individuals deferring elective procedures or otherwise avoiding medical treatment.

Bankruptcy

Enforcement of the Resolution, the Loan Agreement and the Series 2025 Bonds is subject to bankruptcy, insolvency, moratorium, reorganization and other state and federal laws affecting the enforcement of creditors' rights and to general principles of equity. A claim for payment of the principal of or interest on the Series 2025 Bonds could be made subject to any statutes that

may be constitutionally enacted by the United States Congress or the Maryland General Assembly affecting the time and manner of payment or imposing other constraints upon enforcement. The obligation of an Obligated Group Member to make payments of debt service on the Series 2025 Bonds may not be enforceable under applicable state insolvency, fraudulent conveyance, bankruptcy, trust and other laws affecting the Obligated Group. Further, the obligations of any future Obligated Group Member to make payments of debt service on any Parity Debt, the proceeds of which were not loaned or otherwise made available to such Obligated Group Member, may not be enforceable under applicable state insolvency, fraudulent conveyance, bankruptcy, trust and other laws affecting such Obligated Group Member.

If an Obligated Group Member were to file a petition for relief under the United States Bankruptcy Code (the "Bankruptcy Code"), the filing could operate as an automatic stay of the commencement or continuation of any judicial or other proceeding against the Obligated Group and its property. If the bankruptcy court so ordered, the property of the Obligated Group, including its accounts receivable and proceeds thereof, could be used for the benefit of the Obligated Group despite the claims of its creditors.

In a case under the Bankruptcy Code, an Obligated Group Member could file a plan of reorganization. The plan is the vehicle for satisfying, and provides for the comprehensive treatment of, all claims against the debtor, and could result in the modification of rights of creditors generally, or the rights of any class of creditors, secured or unsecured. Under certain circumstances, those voting against the plan or not voting at all are nonetheless bound by the terms thereof. Other than as provided in the confirmed plan, all claims and interests are discharged and extinguished. Even if less than all the impaired classes accept the plan, the plan may nevertheless be confirmed by the bankruptcy court, and the dissenting claims and interests bound thereby.

The Bankruptcy Code permits a bankruptcy court to modify the rights of a secured creditor. In the event of a bankruptcy proceeding involving an Obligated Group Member, the Authority or the Trustee (as the case may be) could be treated under the Bankruptcy Code as one holding a secured claim, to the extent provided in the Resolution and the Loan Agreement. The potential effects of the bankruptcy of any Obligated Group Member could be to delay substantially the enforcement of remedies otherwise available to the Authority and the Trustee and to allow the bankruptcy court, under certain circumstances (i) to substitute other assets of the Obligated Group for collateral under the Loan Agreement, (ii) to sell all or part of the collateral under the Loan Agreement without application of the proceeds to the payment of Parity Debt, (iii) to subordinate the Loan Agreement to liens securing borrowings approved by the bankruptcy court, (iv) to permit the Obligated Group Members to cure defaults and reinstate the Loan Agreement, (v) to compel termination of the Loan Agreement as to one or more of the Obligated Group Members by payment of an amount determined by the bankruptcy court to be the value of the collateral pledged by the Obligated Group thereunder (even though less than the total amount of Parity Debt outstanding), or (vi) to modify the terms of or payments due under the Loan Agreement. For additional detail, reference is made to the Bankruptcy Code, 11 U.S.C. §101 *et seq.*

In determining whether various covenants and tests contained in the Loan Agreement are met, the Obligated Group Members will be combined, notwithstanding any uncertainties as to the enforceability of certain obligations of the Obligated Group Members contained in the Loan Agreement which bear on the availability of the revenues of the Obligated Group Members for

payment of debt service on Parity Debt, including the Series 2025 Bonds. In the event of bankruptcy of any Obligated Group Member, there is no assurance that certain covenants, including tax covenants, contained in the Loan Agreement and certain other documents would survive. Accordingly, a bankruptcy trustee could take action which would adversely affect the exclusion of interest on the Series 2025 Bonds from gross income of the Bondholders for federal income tax purposes.

In addition, the bankruptcy of a health plan or physician group that is a party to a significant managed care arrangement with the Obligated Group Members could have material adverse effects on the Obligated Group Members.

Additional Limitations on Enforceability

In addition to the limitations described above under "Bankruptcy," the joint and several obligation of any Obligated Group Member to make payments of debt service with respect to any Parity Debt, the proceeds of which were not loaned or otherwise made available to such Obligated Group Member, is subject to the application of charitable trust principles which may vary from jurisdiction to jurisdiction and may not be enforceable to the extent that such payments (i) will be made on Parity Debt issued for a purpose that is not consistent with the charitable purposes of the entity from which such payment is requested; (ii) will be made from any property that is donor restricted or that is subject to a direct or express trust that does not permit the use of such property for such payments; (iii) would result in the cessation or discontinuation of any material portion of the services previously provided by the entity from which such payment is requested; or (iv) will be made pursuant to any loan violating applicable usury laws. Due to the absence of clear legal precedent in this area, the extent to which the property of any Obligated Group Member may be described above cannot be determined and could be substantial.

There exists, in addition to the foregoing, common law authority and authority under various state statutes pursuant to which courts may terminate the existence of a not-for-profit corporation or undertake supervision of its affairs on various grounds, including a finding that such corporation has insufficient assets to carry out its stated charitable purposes or has taken some action which renders it unable to carry out such purposes. Such court action may arise on the court's own motion or pursuant to a petition of a state attorney general or other person who has interests different from those of the general public, pursuant to the common law and statutory power to enforce charitable trusts and to see to the application of their funds to their intended charitable uses.

As described above under "Bankruptcy," in determining whether various covenants and tests contained in the Loan Agreement are met, the Obligated Group Members will be combined, notwithstanding uncertainties as to the enforceability of certain obligations of the Obligated Group Members contained in the Loan Agreement.

In addition to the limitations on enforceability described above, the realization of rights under the Resolution and the Loan Agreement upon a default by an Obligated Group Member depends upon the exercise of various remedies specified in the Resolution and the Loan Agreement, respectively. These remedies may require judicial action which is often subject to discretion and delay. Under existing law, certain of the remedies specified in the Resolution and the Loan Agreement may not be readily available or may be limited. For example, a court may

decide not to order the specific performance of the covenants contained in the Resolution or the Loan Agreement. Accordingly, the ability of the Authority or the Trustee to exercise remedies under the Resolution and the Loan Agreement upon an Event of Default could be impaired by the need for judicial or regulatory approval.

Facility Damage

Health care and educational facilities are highly dependent on the condition and functionality of their physical facilities. Damage from natural causes, severe weather, fire, deliberate acts of destruction, terrorism or various facility system failures may have a material adverse impact on the business or financial condition of the Obligated Group, especially if insurance is inadequate to cover resulting property and business losses. Climate change may increase the frequency or severity of natural disasters.

Hedging Transactions

The Obligated Group Members from time to time in the future may enter into hedging arrangements to hedge the interest payable or manage interest cost on Indebtedness, assets or any other derivative arrangements. Changes in the market value of any such agreements could have a negative impact upon the operating results and financial condition of the Obligated Group, and such impact could be material. Any hedging arrangement entered into by any Obligated Group Member in the future may be subject to early termination upon the occurrence of certain events. If either an Obligated Group Member or the counterparty under a swap agreement or other hedging agreement terminates such agreement under market conditions that are unfavorable to the Obligated Group, the Obligated Group could be obligated to make a substantial termination payment, which could materially adversely affect the financial condition of the Obligated Group.

Covenants Related to Other Indebtedness

Certain agreements entered into by the Obligated Group Members in connection with the issuance of Parity Debt contain, and future credit arrangements entered into by the Obligated Group Members (collectively, "Other Credit Agreements") may contain, certain covenants or terms that have been required by the financial institutions purchasing Parity Debt or providing credit enhancement for outstanding Parity Debt that are more restrictive than those described herein. Certain defaults under the Other Credit Agreements, including a default under any Other Credit Agreement that constitutes a Parity Obligation or pursuant to which a Parity Obligation was issued which is not remedied within any applicable cure period or waived by the holder under such agreement would constitute an Event of Default under the Loan Agreement, whether or not the holder chooses to accelerate the due date for the payment of amounts due under such Other Credit Agreement. Any such Event of Default could cause an Event of Default under the Resolution and the Loan Agreement, which could result in a decline in the market value of the Series 2025 Bonds and an acceleration of the Series 2025 Bonds.

For a description of certain covenants and events of default in Other Credit Agreements that are in addition to, different from or more stringent than those in the Loan Agreement, see "Summary of Certain Provisions of Other Credit Agreements Constituting Parity Debt" in Appendix C.

Discretion of Board and Management

The Obligated Group Members may enter into transactions that could materially affect the business, organizational structure and control of the Obligated Group Members and other System Affiliates, subject to certain limitations contained in the Loan Agreement. Such transactions could include, among others, divestitures of affiliates, substantial new joint ventures and mergers, consolidations or other forms of affiliation in which control of the Obligated Group Members and other System Affiliates could be materially changed. Given the pace of change in the health care industry, it is likely that the Institution will be presented with opportunities to enter into transactions of considerable magnitude or significance. The ability of the Obligated Group Members to generate revenues sufficient to pay debt service on the Series 2025 Bonds and other Parity Debt is dependent in large measure on the decisions of the board and management of the Institution with respect to any such opportunities. In addition, any such initiative may involve significant capital commitments and/or capital or operating risk (including, potentially, insurance risk) in a business in which the Institution may have less expertise than in hospital operations. There can be no assurance that these projects, if pursued, will not lead to material adverse consequences to the Institution, any Obligated Group Member and the System Affiliates.

Impact of Investment Performance. The Institution has significant holdings in a broad range of investments. Investment income (including both realized and unrealized gains on investments) may contribute significantly to the Obligated Group's financial results. Market fluctuations have affected and will likely continue to affect materially the value of those investments, and those fluctuations may be, and historically have been, material. The state of the economy and market disruptions may exacerbate the market fluctuations. Reduction in investment income and the market value of its investments may have a negative impact on the financial condition of the Obligated Group and the System Affiliates, including their ability to fund capital expenses from cash and investments. See MANAGEMENT'S DISCUSSION AND ANALYSIS OF UTILIZATION AND FINANCIAL PERFORMANCE -- "Investment Policy" in Appendix A for a more detailed description of the Health System's investment policy. In addition, the previously lower interest rate environment has caused many organizations to reduce the discount rate used to measure liabilities under defined benefit pension plans, resulting in increased liabilities and the need to increase funding levels under these plans.

Access to Credit Markets. Adverse conditions in the credit markets may limit the ability of the Obligated Group to borrow to fund capital expenditures and increased borrowing costs may result in the postponement or revision of planned and approved capital projects, which may be integral to the financial condition and operations of the Obligated Group.

Federal Debt Limit. The federal government has, through legislation, created a debt "ceiling" or limit on the amount of debt that may be issued by the United States Treasury. In the past several years, political disputes have arisen within the federal government in connection with discussions concerning the authorization for an increase in the federal debt ceiling that have threatened to shut down substantial portions of the federal government. Any failure by Congress to increase the federal debt limit may impact the federal government's ability to incur additional debt, pay its existing debt instruments and satisfy its obligations relating to the Medicare and Medicaid programs. Management of the Institution is unable to determine at this time what impact any future failure to increase the federal debt limit may have on the operations and financial condition of the Obligated Group, although such impact may be material. Additionally,

the market price or marketability of the Series 2025 Bonds in the secondary market may be materially adversely impacted by any failure to increase the federal debt limit.

Federal Budget Cuts. The Budget Control Act of 2011 (the "Budget Control Act") mandated significant reductions and spending caps on the federal budget for fiscal years 2012-2021, including a reduction on all Medicare payments during this period. Subsequent legislation under the Bipartisan Budget Act of 2019 extended these reductions through 2029. It is possible that Congress could act to extend or increase these across-the-board reductions. Because Congress may make changes to the budget in the future, it is impossible to predict the impact any spending cuts that are approved may have on the Obligated Group and System Affiliates. Further, with no long-term resolution in place for federal deficit reduction, hospital and physician reimbursement may continue to be targets for reductions with respect to any interim or long-term federal deficit reduction efforts. These and any additional reductions in Medicare and Medicaid spending could have a material adverse effect upon the financial condition or operations of the Obligated Group and the System Affiliates.

Acquisitions, Affiliations, Mergers and Divestitures

The Institution has undertaken several acquisitions and other affiliations in the last decade. The Institution has also conveyed all or a portion of its interest in certain operations and assets from time to time and may consider the divestiture of other operations or properties that are currently owned or operated by the Institution and affiliates. As part of its ongoing planning process, the Institution expects to consider potential affiliations and acquisitions of operations or properties in the future. Further acquisitions, affiliations, mergers and divestures could materially affect the business, organizational structure and control of the Health System and could have a material adverse effect on the financial condition or results of operations of the Obligated Group.

The Cures Act

The 21st Century Cures Act (the "Cures Act") is intended to create broadened patient access to care, involving patients in new research, and leveraging technology to create efficiencies. The Cures Act will support efforts to improve telehealth services in Medicare and is intended to improve the process for determining which Medicare treatments are covered, potentially leading to increased access to treatments for Medicare beneficiaries. In addition to numerous provisions related to research and clinical trials, the Cures Act includes a number of changes to the Medicare program, some of which are described herein. New regulations for the Cures Act were finalized in May 2020. These regulations focus on patient access to healthcare records and interoperability of electronic healthcare records between providers to improve patient care. Additional regulations were finalized in June 2023 and January 2024 that generally establish penalties and disincentives for entities that engage in information blocking, which is defined as, "a practice that interferes with, prevents, or materially discourages access, exchange, or use of electronic health information." Another regulation finalized in December 2023 refined certain standards for health information technology, and established new requirements for the use of artificial intelligence and other predictive algorithms.

CARES Act Compliance

In March 2020, the federal Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") created a "Public Health and Social Services Emergency Fund" to reimburse eligible health care providers for "health care related expenses or lost revenues that are attributable to coronavirus" ("Provider Relief Fund"). Payments in excess of health care-related expenses or lost revenue attributable to COVID-19 were required to be repaid. The retention of funds from the Provider Relief Fund is conditioned on eligibility and the acceptance of terms and conditions, and other guidelines or requirements that may change from time to time, including with respect to recordkeeping and repayment requirements. The Department of Health and Human Services ("DHHS") is actively auditing recipients of Provider Relief Fund funds to ensure compliance with the terms and conditions thereof. Failure to comply with such terms and conditions could result in recoupment, False Claims Act liability, or other penalty.

The Institution and its affiliates received $15,447,880 from the Provider Relief Fund. The Institution monitored compliance with the terms and conditions relating to the spending of such funds to ensure that such funds were spent on health-care related expenses or represented lost revenue related to COVID-19.

Affordable Care Act

The discussion in this section and otherwise in this Official Statement describes risks associated with certain existing federal and state laws, regulations, rules, and governmental administrative policies and determinations to which the Institution, Brook Lane and future Obligated Members which are healthcare institutions (collectively, as used in this section, the "Healthcare Obligated Group Members") and the healthcare industry are subject. While these are regularly subject to change, many of the existing provisions were enacted by or promulgated pursuant to the Affordable Care Act, which has been politically controversial.

In 2010, the United States Congress enacted the Affordable Care Act. The comprehensive healthcare reform mandated by the Affordable Care Act was intended to expand the availability of health insurance coverage, control the costs of healthcare and improve the manner in which healthcare is delivered. The Affordable Care Act required all individuals, with certain exceptions, to purchase health insurance; substantially expands Medicaid coverage; provides premium subsidies to certain individuals; imposes certain taxes on individuals and employers; creates insurance pooling mechanisms or state run health insurance exchanges; imposes new requirements on the insurance industry regarding access and coverage; provides for certain cost containment mechanisms and new models of care delivery; and includes provisions designed to reduce Medicare spending and improve the quality of outcomes and health system performance.

Funding cutbacks in Medicare are to be achieved by, among other means, reducing Medicare and Medicaid Disproportionate Share Hospital ("DSH") payments and annual market basket updates (used to adjust Medicare payments for inflation) for inpatient hospitals and other Medicare providers. DSH payments cover the increased costs of hospitals that provide a disproportionate amount of care to uninsured patients and low-income patients covered by Medicaid. Although these provisions will not directly impact Maryland hospitals, as long as the TCOC Model or AHEAD Model remain in effect, reductions in Medicare payments nationally will limit the amount of revenue that will be made available to Maryland hospitals by the Rate Commission. See "REGULATORY ENVIRONMENT – Maryland Health Services Cost Review

Commission" above. Under the CARES Act and the Consolidated Appropriations Act of 2021, Medicaid DSH funding cutbacks were eliminated for fiscal year 2020 and reduced for fiscal year 2021, and the remaining four years of Medicaid DSH cutbacks are delayed until calendar year 2025.

The Affordable Care Act also establishes a Shared Savings Program ("MSSP") that promotes accountability for the care of Medicare beneficiaries and encourages coordination of care and other efficiencies through entities called Accountable Care Organizations ("ACOs"). CMS has issued numerous updates to its MSSP rules in 2011 and each year from 2014 through 2024 updating various requirements governing the administration of MSSP. It remains unclear to what extent providers will pursue federal ACO status or whether the required investment would be warranted by increased payment. Nevertheless, it is anticipated that private insurers may seek to establish similar incentives for providers, while requiring less infrastructural and organizational change. The potential impacts of these initiatives are unknown but introduce greater risk and complexity to health care finance and operations.

The Affordable Care Act extends existing pay for performance initiatives for hospitals and creates a value-based purchasing program ("VBP") for hospitals that are paid under Medicare's inpatient prospective payment system ("IPPS"). Under the VBP program, incentive payments are available to hospitals that achieve certain quality performance measures during performance periods. Hospitals that fail to report certain quality measures or satisfy the performance standards are subject to a decrease in their Medicare payments. Funding for the VBP program comes from withholding a percentage of annual reimbursement payments to hospitals. CMS continues to implement the VBP with annual updates to the performance standards and measures. As noted above, under the TCOC Model and AHEAD Model, Maryland has a waiver from the VBP contingent on the State's submission of a report that provides evidence of a similar state program each year and therefore the exemption is not guaranteed to continue.

Possible impacts of the Affordable Care Act on Maryland's rate-setting system in general and on the Healthcare Obligated Group Members include, without limitation, significant regulatory changes that increase the cost of operations; increased activity by government agencies regarding fraud, waste and abuse; decreased reimbursements for hospital services from third-party payers, including Medicare and Medicaid; significant changes to current payment methodologies for hospital services; and changes to costs of providing health insurance coverage to hospital employees. Although many of the reimbursement changes are not expected to directly affect Maryland hospitals, many of the changes will likely impact the TCOC Model and AHEAD Model, and it is likely that revenue increases approved by the Rate Commission for Maryland hospitals will be constrained as regulators attempt to assure that Medicare spending in Maryland does not grow faster than Medicare spending nationally and generally to assure compliance with the terms of the TCOC Model and AHEAD Model. See "REGULATORY ENVIRONMENT – Maryland Health Services Cost Review Commission" herein. Expansion of Medicaid coverage may result in a significant shift in the payer mix of the Health System. Increased insurance coverage and a reduction in the number of uninsured patients could result in increased demand for the services of the Health System, straining the existing operating capacity of the facilities of the Health System, and is likely to create a need to recruit or employ additional physicians and other health services providers to meet increased demand.

The Affordable Care Act added Section 501(r) of the Internal Revenue Code of 1986, as amended (the "Code"), imposing the following new requirements on, among others, tax-exempt hospitals: (i) hospitals are required to conduct a community needs assessment at least every three years and adopt an implementation strategy to meet the community needs identified through such assessment; (ii) hospitals must adopt, implement and publicize a written financial assistance policy and an emergency medical care policy; (iii) hospitals must limit charges to individuals who qualify for financial assistance under the hospitals' financial assistance policies to no more than the amounts generally billed to individuals who have insurance covering such care and refrain from using "gross charges" when billing such individuals; and (iv) hospitals may not undertake extraordinary collection actions (even if otherwise permitted by law) against individuals without first making reasonable efforts to determine whether the individuals are eligible for assistance under the hospitals' financial assistance policies. Failure to complete a community health needs assessment in any applicable three-year period can result in a financial penalty or revocation of the hospital's status as a Section 501(c)(3) organization.

The Affordable Care Act requires the Secretary of the Treasury, in consultation with the Secretary of DHHS, to submit annually a report to Congress with information regarding the levels of charity care, bad debt expenses and unreimbursed costs of government programs, as well as costs incurred by tax-exempt hospitals for community benefit activities. This statutory requirement is expected to increase IRS surveillance over such organizations and may increase the likelihood of IRS examinations challenging the Section 501(c)(3) status of hospitals, as well as the likelihood that Congress will consider additional requirements for Section 501(c)(3) hospitals in the future.

The Affordable Care Act requires states to either establish and operate a health insurance exchange or participate in a multi-state or federal exchange. Maryland established its own health insurance exchange. Maryland has also elected to pursue Medicaid expansion up to 138% of the federal poverty levels based on modified adjusted gross income. The increased Medicaid enrollment could affect State of Maryland budget allocations for Medicaid services and payment rates to healthcare providers.

Opponents of the Affordable Care Act have repeatedly taken steps to repeal and replace certain provisions of the Affordable Care Act. These actions include introducing and voting on various bills aimed at repealing and replacing all or portions of the Affordable Care Act. In addition to actual and possible legislative changes, implementation of the Affordable Care Act may be impacted by executive branch actions. To date, the Senate has not passed any legislation to repeal the Affordable Care Act in full. However, on December 22, 2017, the Tax Cuts and Jobs Act of 2017 was signed into law, which included a provision repealing the individual mandate penalty of the Affordable Care Act beginning in 2019. Individuals will still receive a premium tax credit for buying health coverage from a government marketplace. The repeal of the individual mandate penalty has likely been the cause of an increase in the number of uninsured individuals.

Other efforts to weaken the Affordable Care Act include a federal case filed in Texas, where plaintiffs argued that the Affordable Care Act is unconstitutional as a result of the repeal of the individual mandate tax penalty. On December 14, 2018, a Texas Federal District Court judge, in the case of *Texas v. Azar* declared the Affordable Care Act unconstitutional, reasoning that the individual mandate tax penalty was essential to and not severable from the remainder of the Affordable Care Act. The case was appealed to the U.S. Court of Appeals for the Fifth

Circuit (the "Court of Appeals") and on appeal the U.S. Department of Justice supported affirmation of the district court's judgment. On December 18, 2019, the Court of Appeals affirmed the district court's judgment that the individual mandate tax penalty was unconstitutional but vacated the district court's judgment that the remainder of the Affordable Care Act was also unconstitutional as inseverable from the individual mandate tax penalty. The Court of Appeals remanded the case to the district court for a detailed analysis as to whether all or a portion of the remaining provisions of the Affordable Care Act are severable from the individual mandate tax penalty and can remain law. The U.S. Supreme Court granted *certiorari* to review the decisions in this case. On June 17, 2021, the U.S. Supreme Court rendered an opinion that the plaintiffs had no legal standing to challenge the individual mandate of the Affordable Care Act and as a result the Affordable Care Act remains law.

In addition, the DHHS has taken steps to streamline the process by which states obtain waivers of Medicaid coverage mandates. DHHS has also permitted the implementation of work and community engagement requirements as a condition of eligibility for Medicaid benefits.

It is not possible to predict with any certainty whether or when the Affordable Care Act or any specific provision or implementing measure will be repealed, withdrawn or modified in any significant respect, but a unified administration and majority in both chambers of Congress could enact legislation, withdraw, modify or promulgate rules, regulations and policies, or make determinations affecting the healthcare industry and the Obligated Group, any of which individually or collectively may have a material adverse effect on the operations, financial condition, and financial performance of the Obligated Group. In addition, any repeal or modification of the Affordable Care Act could reduce the number of individuals qualifying for treatment as Medicaid patients, resulting in the Obligated Group's care for greater numbers of uninsured individuals.

Federal and State Reimbursement Regulation

The Healthcare Obligated Group Members are subject to regulatory actions and oversight by a number of governmental and private agencies, including those that administer the Medicare and Medicaid programs, the Rate Commission, The Joint Commission (a private nonprofit corporation that accredits health care programs and providers in the United States), other private agencies and federal, state and local agencies. These bodies may promulgate new regulatory provisions from time to time, and it is not possible to predict the effect of any such future promulgations on the Obligated Group. Additionally, actions by the federal government with respect to Medicare and by the federal and state governments with respect to Medicaid that have the effect of reducing the total amount of funds available for either or both of these programs or changing the reimbursement regulations or their interpretation could adversely affect the amount of reimbursement available to the Healthcare Obligated Group Members.

The federal government, the largest health care purchaser in the country, uses reimbursement as a key tool to implement health care policies, to allocate health care resources, and to control utilization and promote the use and development of health technology. The amount of reimbursement available to the Healthcare Obligated Group Members is adversely affected by various federal cost containment programs designed to reduce federal payments to health care facilities by limiting the amount of reimbursement for health care costs. In particular, for inpatient services, Medicare pays hospitals fixed amounts for specific services based upon patient diagnosis. With certain exceptions, such payments are not adjusted for actual costs,

varying services, or length of stay. Maryland currently has a waiver from this federal prospective payment system and, therefore, at present the Medical Center is paid for most services in accordance with the Rate Commission's rate-setting system. See "REGULATORY ENVIRONMENT – Maryland Health Services Cost Review Commission" herein. However, there can be no assurance that Maryland's exemption from the federal prospective payment system or the Rate Commission's jurisdiction over rate setting will be maintained, or that Maryland's participation in the AHEAD model will continue.

The Rate Commission's Global Budget Revenue program includes incentives for hospitals to control unnecessary utilization and improve population health. Because hospital annual patient service revenue under the Global Budget Revenue program is capped, the program puts hospitals at risk for managing utilization and costs and shifts incentives to focus on appropriate volume and patient health status. Moreover, to constrain cost growth over time, the Rate Commission may reduce hospital revenue budgets in line with volume declines and increase true population health risk incentives to hospitals. Hospitals that are unable to control utilization, reduce inappropriate volume, or reduce costs as volumes decline may perform poorly under the Global Budget Revenue program. Future actions by the Rate Commission, changes in Rate Commission regulations, rate approval guidelines, structure or operations, or the termination of the Waiver Model may adversely affect the operations of the healthcare facilities operated by the Obligated Group. See "REGULATORY ENVIRONMENT – Maryland Health Services Cost Review Commission" herein. There can be no assurance that the Rate Commission will approve rates in the future sufficient to ensure payment by the Obligated Group of the outstanding Parity Debt.

A portion of the Obligated Group's revenues comes from nonhospital services that are not regulated by the Rate Commission, including the services of physicians and other licensed providers who participate in Medicare. For certain professional services provided to Medicare beneficiaries by its employees, Healthcare Obligated Group Members bill under Part B of Medicare, which pays for the professional services of physicians and certain other licensed providers. Under Part B, these services are reimbursed in an amount equal to the lesser of actual charges or the amount determined under a fee schedule known as the "resource-based relative value scale" or "RBRVS." The RBRVS sets a relative value for each service and that value is then multiplied by a geographic adjustment factor and a nationally-uniform conversion factor to determine the amount Medicare will pay for each service. The relative values for professional services contained in the RBRVS are based on a work component intended to reflect the time and intensity of effort required to provide the service, a practice expense component which includes costs such as office rents, allied health support salaries, equipment and supplies, and a component for the cost of malpractice insurance.

There can be no assurance that the current rate-setting system will continue in effect or that the Rate Commission will continue to utilize the current methodology by which it determines rate adjustments or approve rates in the future that produce revenues sufficient for the Obligated Group to pay amounts payable due under the Series 2025 Bonds. Future action by the Rate Commission, changes in the Rate Commission regulations, rate approval guidelines, structure or operations, or the loss of the Medicare Waiver may adversely affect the operations of the Obligated Group.

The Medicare Physician Fee Schedule ("MPFS") covers payments for more than 7,000 types of services. The MPFS is adjusted regularly by CMS. Changes to the MPFS and

other regulatory changes affecting reimbursement for physicians and other licensed providers may result in decreased revenue or, if bills are not submitted correctly, in false claims liability for the Healthcare Obligated Group Members.

Medicare inpatient payments to hospitals are determined, in part, based on a program under which value-based incentive payments are made in a fiscal year to hospitals that meet certain performance standards during that fiscal year. The program is funded through the reduction of hospital inpatient care payments. Hospitals that perform poorly under the value-based purchasing program will receive reduced Medicare inpatient hospital payments. This reduction may be offset by incentive payments for hospitals that meet or exceed certain quality standards.

The Affordable Care Act established a voluntary Medicare bundled payment pilot program, under which Medicare will make a single payment for an episode of care, such as heart bypass surgery, covering some combination of hospital, physician, and post hospital care for the episode. CMS has also implemented a mandatory bundled payment demonstration for certain joint replacement procedures in selected urban areas. CMS issued a finalized rule on December 20, 2016 for additional clinical conditions. Private insurers are also developing bundled payment programs. While bundled payments offer opportunities to provide better coordinated care and to save costs, they also entail financial risk if the episode is not well managed.

Future actions by the federal government with respect to Medicare and by the federal and state governments with respect to Medicaid, reducing the total amount of funds available for either or both of these programs or changing the reimbursement regulations or their interpretation, could adversely affect the amount of reimbursement available to the Healthcare Obligated Group Members. Revision and expansion of effective regulations or the proposal of additional regulations may affect hospitals and other healthcare facilities and providers which seek payment under the Medicare and Medicaid programs. See "CERTAIN BONDHOLDERS' RISKS – Medicare and Medicaid Programs" below. Furthermore, loss of accreditation by The Joint Commission could result in loss of Medicare and Medicaid reimbursement.

Future federal or state legislation or regulations and their impact upon the Healthcare Obligated Group Members cannot be determined at this time. No assurance can be given that any future health care legislation that is enacted will not materially adversely affect the Obligated Group.

Effect of Healthcare Reform on the Insurance Market

The Affordable Care Act provides for insurance market reforms that, among other things, require individual and group health insurance plans to offer coverage (including renewability) on a guaranteed basis. The Affordable Care Act prohibits pre-existing conditions limitations, certain coverage limitations, lifetime and annual dollar limits for essential health benefits, and requires coverage of certain preventive health benefits. As part of the Affordable Care Act, every individual is required to enroll in a health plan through an employer, a federal government health program such as Medicare, Medicaid or Tricare, or purchase insurance through a health insurance exchange established by the state or run by the federal government, or pay a tax penalty. Tax reform legislation enacted in December 2017, colloquially known as the Tax Cuts and Jobs Act, eliminated the individual mandate penalty.

The Affordable Care Act establishes minimum essential benefits that must be covered by health plans offered to consumers on a state's healthcare exchange, sets minimum coverage amounts to be offered under each plan level, and limits the variations in premiums that may be charged for exchange coverage on the basis of age and tobacco use.

To address affordability, individuals with family income under 400% of the FPL are eligible for subsidized premiums, deductibles, and co-pays for coverage purchased on the exchange. Initially, only individuals and small employers will be able to access coverage through the exchanges.

In addition, new federal regulations on limited duration insurance coverage, which coverage will remain subject to state insurance law requirements, and on health reimbursement accounts may lead some insurers to offer less comprehensive, but more affordable, coverage without the Affordable Care Act consumer protections such as essential health benefits requirements, premium age-ratio limits, prohibitions on pre-existing condition limitations, guaranteed issue, and lifetime and annual coverage limits.

At this time, it is not possible to project what impact these developments might have on the number of uninsured or underinsured patients that the Healthcare Obligated Group Members will still need to treat.

Medicare and Medicaid Programs

Medicare and Medicaid are the commonly used names for reimbursement or payment programs governed by certain provisions of the federal Social Security Act. Medicare is an exclusively federal program, and Medicaid is a combined federal and state program. Medicare provides certain healthcare benefits to beneficiaries who are 65 years of age or older, blind, disabled or qualify for the End Stage Renal Disease Program. Medicare Part A covers inpatient and outpatient hospital services, some skilled nursing care, hospice and some home healthcare, and Medicare Part B covers physician services, outpatient services and some supplies. Medicaid is designed to pay providers for care given to the medically indigent and others who receive federal aid. Medicaid is funded by federal and state appropriations and administered by the various states.

Medicare. Medicare is a federal governmental health insurance system under which physicians, hospitals and other healthcare providers are reimbursed or paid directly for services provided to eligible elderly and disabled persons and persons with end-stage renal disease. Medicare is administered by CMS within DHHS. In order to achieve and maintain Medicare certification, a healthcare provider must meet CMS's "Conditions of Participation" on an ongoing basis, as determined by the state in which the provider is located and The Joint Commission. The federal government frequently revises the laws, regulations and policies governing Medicare eligibility, coverage, payment and participation under the Medicare program. The Affordable Care Act institutes multiple mechanisms for reducing the costs of the Medicare program. The demonstration and pilot projects authorized and funded by the Affordable Care Act are also likely to precipitate other significant modifications in the future to the Medicare payment system. Management cannot project the extent of these modifications, or what impact such modifications may have on the financial operations of the System. See "CERTAIN BONDHOLDERS' RISKS – Affordable Care Act" above. Also, at this time, it is not known whether future changes to such laws, regulations or policies will have a material adverse financial effect on the Obligated Group.

Future reductions in Medicare reimbursement, or the failure of increases in Medicare reimbursement to keep pace with increases in the costs of providing care, may have a material adverse financial effect on the Obligated Group.

Eligible hospitals are paid for a portion of their direct and indirect medical education costs. These payments are vulnerable to reduction or elimination. The direct and indirect medical education reimbursement programs have repeatedly emerged as programs to be reduced or eliminated in the legislative efforts to reduce the federal budget deficit. The formulae used to determine payments for medical education do not necessarily reflect the actual costs of such education, and the federal government is expected to continue to evaluate its policy on graduate medical education and teaching hospital payments. There can be no assurance that payments to a System Affiliate under the Medicare program will be adequate to cover their direct and indirect costs of providing medical education to interns, residents, fellows and allied health professionals.

Additional payments may be made to hospitals that treat a disproportionately large number of low-income patients (Medicaid and Medicare patients eligible to receive supplemental Social Security income) in the form of DSH payments, but these payments are significantly reduced by the Affordable Care Act.

Additional payments are made to hospitals that treat patients who are costlier to treat than the average patient; these additional payments are referred to as "outlier payments." Following an audit of aggressive pricing strategies at one of the nation's largest hospital chains, and a determination that some hospitals might be manipulating current hospital charge data to maximize reimbursement from Medicare under the outlier payment provisions, the Office of the Inspector General of DHHS ("OIG") began investigating past outlier billing practices, and CMS amended the regulations on how outlier payments were to be calculated in the future. The methodology for calculating outlier payments is designed to prevent hospitals from manipulating the outlier formula to maximize reimbursement and allows for recovery of overpayments in certain cases.

The OIG continues to scrutinize outlier payments in an effort to determine whether outlier payments to the hospitals were paid in accordance with Medicare regulations or whether such payments were the result of potentially abusive billing practices. While the Healthcare Obligated Group Members believe that they have calculated their outlier payments appropriately, there can be no assurance that the Healthcare Obligated Group will not become the subject of an investigation or audit with respect to their past outlier payments, or that such an audit would not have a material adverse impact on the Obligated Group. Moreover, there can be no assurance that any future revisions to the formula for calculating outlier payments will not reduce the payments to the Healthcare Obligated Group Members.

Effective October 1, 2013, CMS adopted a policy known as the Inpatient Hospital Prepayment Review "Probe & Educate" review process, or the "Two-Midnight" rule. The "Two-Midnight" policy specifies that hospital stays spanning two or more midnights after the beneficiary is properly and formally admitted as an inpatient will be presumed to be "reasonable and necessary" for purposes of inpatient reimbursement. With some exceptions, stays not expected to extend past two midnights should not be admitted and instead be billed as outpatient. CMS delayed enforcement of the "Two-Midnight" rule on a number of occasions. Effective October 1, 2015, responsibility for enforcement of the "Two-Midnight" rule shifted from Medicare administrative contractors to quality improvement organizations ("QIO"), and recovery

audit contractors will only conduct reviews for providers that have been referred by the related QIO. The 2016 Medicare Hospital Outpatient Prospective Payment System ("OPPS") Final Rule, effective January 1, 2016, revised the "Two-Midnight" rule to allow an exception for Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the two-midnight benchmark if documentation in the medical records supports that the patient required inpatient care. Following ongoing industry criticism and a legal challenge, in the 2017 IPPS final rule effective October 1, 2016, CMS removed the inpatient payment cuts of 0.2% that were in place from 2014-2016 to offset the estimated increase in IPPS expenditures as a result of the "Two Midnight" rule and provided a temporary increase of 0.6% in payment rates for fiscal year 2017 to help offset the prior cuts. The "Two-Midnight" rule has had an adverse financial impact on hospitals. In December 2016, the OIG issued a report concluding that "vulnerabilities remain" under the CMS "Two-Midnight" rule and that CMS needs to improve oversight of hospital billing under this policy. OIG issued a report on June 11, 2024 identifying weaknesses in CMS program safeguards for preventing and detecting improper payments related to the "Two Midnight" rule, and recommending that oversight of payments for inpatient stays be strengthened. Therefore, CMS may be increasing scrutiny of short inpatient stays in the near future.

Medicare Bad Debt Reimbursement. Under Medicare, the costs attributable to the deductible and coinsurance amounts that remain unpaid by a Medicare beneficiary can be added to the Medicare share of allowable costs as cost reports are filed. Hospitals generally receive interim pass-through payments during the cost report year which are determined by the Medicare Administrative Contractor ("MAC") from the prior cost report filing. Bad debts must meet the following criteria to be allowable:

- the debt must be related to covered services and derived from deductible and coinsurance amounts;
- the provider must be able to establish that reasonable collection efforts were made;
- the debt was actually uncollectible when claimed as worthless; and
- sound business judgment established that there was no likelihood of recovery at any time in the future.

The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be uncollectible. In some cases, an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period. In these cases, the recoveries must be used to reduce the cost of beneficiary services for the period in which the collection is made. In determining reasonable costs for hospitals, the amount of bad debt otherwise treated as allowable costs is reduced by 35%. Amounts incurred by a hospital as reimbursement for bad debt are subject to audit and recoupment by the MAC. Bad debt reimbursement has been a focus of MAC audit/recoupment efforts in the past.

Medicare Advantage. Hospitals also receive payments from health plans under the Medicare Advantage program. The Affordable Care Act includes significant changes to federal payments to Medicare Advantage plans resulting in a transition to benchmark payments tied to the level of fee-for-service spending in the applicable county. For calendar year 2025, CMS

announced that the effective growth rate for non-end stage renal disease payments under the Medicare Advantage programs will be 2.33%. However, these payments may be reduced again, which may result in increased premiums or out-of-pocket costs to Medicare beneficiaries enrolled in Medicare Advantage plans and may also lead to decreased payments to providers by managed care companies operating Medicare Advantage programs. Decreased federal payments to the Medicare Advantage plans could in turn affect the scope of coverage of these plans or cause plan sponsors to negotiate lower payments to providers.

Electronic Health Information Systems, Medicare and Medicaid Incentive Payments and Payment Reductions. The American Recovery and Reinvestment Act of 2009 ("ARRA") provides for Medicare and Medicaid incentive payments that began in 2011 to hospital providers meeting designated deadlines for the installation and use of electronic health information systems. For those hospital providers failing to meet applicable deadlines, Medicare payments will be significantly reduced. Additionally, beginning in 2014, the federal government began auditing hospitals' and providers' records related to their attestation of being "meaningful users" in order to obtain the incentive payments. A hospital or provider that fails the audit will have an opportunity to appeal. Ultimately, hospitals or providers that fail on appeal will have to repay any incentive payments they received through those programs. In the fiscal year 2019 IPPS final rule, CMS overhauled the Medicare and Medicaid Electronic Health Record Incentive Programs to focus on interoperability, improve flexibility, relieve burden and place emphasis on measures that require the electronic exchange of health information between providers and patients. To better reflect this new focus, CMS has re-named the Meaningful Use program "Promoting Interoperability." The Medicaid Promoting Interoperability Program ended in calendar year 2022. The program is currently known as the Medicare Promoting Interoperability Program.

Physician Reimbursement under Medicare. Certain physician services are reimbursed by Medicare on a national fee schedule called the "resource-based-relative-value scale" ("RBRVS"). The RBRVS fee schedule establishes payment amounts for all physician services, including services of provider-based physicians, and is subject to annual updates. The Sustainable Growth Rate ("SGR"), which is a limit on the growth of Medicare payments for physician services, is linked to changes in the U.S. Gross Domestic Product over a ten-year period. SGR targets are compared to actual expenditures in order to determine subsequent physician fee schedule updates. Since 2003, Congress has passed legislation to delay application of the SGR. In April 2015, the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") was enacted, which included a so-called "doc fix." This law replaces the SGR formula with statutorily prescribed physician payment updates and provisions, and substituted annual 0.5% payment increases through 2019. The Bipartisan Budget Act of 2018 reduced the 2019 update to 0.25 percent. Thereafter, payment rates will be frozen at 2019 levels through 2025. Beginning in 2026, physicians and other professionals paid under the Medicare physician fee schedule will receive an annual update of 0.75% for participating in eligible alternative payment models, while all other professionals will receive annual updates of 0.25%. In addition to the base payment methodology, physicians can earn merit-based payments based on factors including compliance with meaningful use of electronic health records requirements and demonstration of quality-based medicine. While the payment cuts associated with the SGR formula have been eliminated, there is uncertainty regarding the impact of the merit-based and alternative payment models, and it is possible that future legislative action will be taken that would once again trigger physician payment reductions.

MACRA has substantially altered how physicians and other practitioners are paid by Medicare for services furnished to program beneficiaries. Generally, physicians are required to choose whether to participate in an Advanced Alternative Payment Model or the Merit-based Incentive Payment System ("MIPS"). Payments to physicians and other practitioners are adjusted depending on which pathway is chosen, and based on performance within each pathway. A substantial amount of payments are linked to that performance: poorly performing practitioners will have Medicare payments reduced; while those who perform well against prescribed measures could have payment increased. These changes will influence physician referral and utilization behaviors, which could affect utilization of hospital services.

Hospital Outpatient Departments. Under the Bipartisan Budget Act, effective January 1, 2017, off-campus provider-based clinics, physician offices, and ambulatory surgical centers ("off-campus hospital outpatient departments") established or acquired after November 2, 2015 are scheduled to receive reimbursement payments for only the professional fee under the Medicare Physician Fee Schedule or Ambulatory Surgical Center Payment System and will no longer receive an additional facility fee paid under the OPPS. This decrease in reimbursement payments does not apply to (i) any off-campus hospital outpatient departments that existed and were billing as off-campus hospital outpatient departments for covered off-campus hospital outpatient department services prior to November 2, 2015, (ii) any on-campus hospital outpatient departments, (iii) dedicated emergency departments or (iv) any off-campus organizations, other than off-campus hospital outpatient departments, that are required to satisfy the provider-based regulations including satellite facilities and provider-based entities such as rural health clinics.

Effective January 1, 2016, the OPPS Final Rule required hospitals to use new modifiers for services provided to Medicare beneficiaries at off-campus hospital outpatient departments. The stated purpose of the new modifiers was to permit CMS to obtain information regarding the effect of the trend of the conversion of physician offices to off-campus hospital outpatient departments. CMS's interest in collecting this information demonstrated a potential intent to reduce reimbursement for certain services provided at certain types of off-campus hospital outpatient departments. Moreover, failure to use the modifiers correctly could jeopardize the provider-based status of associated off-campus locations.

CMS published a final rule implementing the site neutral provisions of the Bipartisan Budget Act on November 1, 2016. This final rule limited hospitals' ability to replace or expand their existing off-campus hospital outpatient departments and continue to be reimbursed under the OPPS Final Rule, issued in November 2015 and effective January 1, 2016. The final rule also established reduced reimbursement for services provided at new off-campus hospital outpatient departments established after enactment of the Bipartisan Budget Act.

The Cures Act, enacted in December 2016, expanded the categories of projects that would be exempt from the decrease in OPPS reimbursement payments. They include: (i) off-campus outpatient departments if the host hospital had submitted a voluntary provider-based attestation to CMS before December 2, 2015, as long as the construction of the new off-campus outpatient department was complete and the hospital was accepting or poised to accept patients; (ii) off-campus outpatient department locations providing services on or after January 1, 2018, that had a "binding written agreement with an outside unrelated party for the actual construction" of the new off-campus outpatient department before November 2, 2015, as long as the host hospital made certain attestations and certifications within 60 days of the enactment of the Cures Act; and (iii) off-campus outpatient departments of certain cancer hospitals that filed provider-

based attestations within 60 days of the date of enactment of the Cures Act (for departments meeting provider-based requirements between November 2, 2015, and the date of enactment) or within 60 days of the date of meeting provider-based requirements.

The calendar year 2019 OPPS final rule reflected changes that demonstrated CMS's continued concern with payment disparities between off-campus hospital outpatient departments and physician clinics. Specifically, the rule applied the lower physician fee schedule facility rate to clinic visits in all provider-based, off-campus hospital outpatient departments, including those that were excepted from the reduced rate in 2018. This lower rate was set to be phased in over two years. Several industry stakeholders challenged this rule, but a federal appeals court rejected their claims in 2020 and the Supreme Court declined to consider the case in 2021, allowing CMS to fully implement the 2019 final rule.

Medicaid

Medicaid is a health insurance program for certain low-income and needy individuals and their dependents that is jointly funded by the federal government and the states. Pursuant to broad federal guidelines, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the payment rates for services; and administers its own programs.

Under the Medicaid program, the federal government supplements funds provided by the various states for medical assistance to the medically indigent. Payment for medical and health services is made to providers in amounts determined in accordance with procedures and standards established by state law under federal guidelines. Fiscal considerations of both federal and state governments in establishing their budgets will directly affect the funds available to the providers for payment of services rendered to Medicaid beneficiaries.

Some states also participate in Medicaid waiver programs, which allow states to adjust eligibility criteria beyond what the federal requirements allow.

Medicaid. Maryland's Medicaid waiver program, known as HealthChoice, covers childless adults with incomes up to 138% of the federal poverty level. In 2009, the Maryland General Assembly imposed a tax on hospital net patient revenues to fund a deficit in the State of Maryland's Medicaid program. Although the assessment was intended to be temporary, it has been continued. A majority of the assessments for individual hospitals are built into the hospitals' rate structures. There can be no assurance that the Rate Commission will continue to provide funding to cover these assessments.

It cannot be determined at this time the impact of the TCOC Model or AHEAD Model on the State of Maryland's Medicaid program as the State implements the TCOC Model and AHEAD Model and its Medicaid plan to ensure compliance with the TCOC Model and AHEAD Model requirements.

See "REGULATORY ENVIRONMENT – Maryland Health Services Cost Review Commission" herein.

Section 340B Drug Pricing Program. Hospitals that participate in the prescription drug discount program established under Section 340B of the federal Public Health Service Act (the "340B Program") are able to purchase certain outpatient drugs for their patients at reduced cost.

The Health Resources and Services Administration within DHHS ("HRSA"), through the Office of Pharmacy Affairs, administers the 340B Program.

There are a number of pending legal and regulatory actions that may impact the availability of 340B pricing to hospitals and other entities that participate in the program:

- Beginning in 2020, a number of pharmaceutical manufacturers implemented policies refusing or restricting 340B pricing for drugs dispensed through contract pharmacies. These restrictions have hampered the ability of hospitals to dispense certain drugs acquired at 340B pricing through relationships with outside pharmacies, and thereby reducing the savings available to hospitals through the 340B program. HRSA has challenged the manufacturers restrictions as violations of the 340B law in federal court; however, two federal appellate courts have upheld the restrictions in favor of the manufacturers (D.C. Circuit and 3rd Circuit) and a third appellate court has not yet issued its opinion (7th Circuit). Notably, Maryland enacted a state law (H.B. 1056) effective July 1, 2024 that prohibits manufacturers from denying, restricting or limiting the acquisition or delivery of 340B drugs to pharmacies contracting with Maryland hospitals and covered entities. While certain manufacturers have voluntarily complied with the law and restored access to 340B drugs for Maryland covered entities dispensed at contract pharmacies, this law is being challenged by PhRMA and several drug manufacturers in federal court and those suits are pending.

- There are several bills pending in the federal legislature that, if enacted, would modify the 340B statute and may impact the scope of the program.

- HRSA issued a Final Rule effective June 18, 2024 that clarifies provisions of its alternative dispute resolution ("ADR") process. The ADR process allows 340B covered entities (including hospitals) to bring claims against manufacturers for services on sales of drugs at the 340B discounted price, and also allows manufacturers to bring claims against 340B covered entities for violations of certain provisions of the 340B statute. The rule only clarifies the procedural requirements for covered entities and manufacturers to challenge violations of the 340B statute; however, it is possible this may lead to an uptick in manufacturer requests to HRSA for audits of 340B covered entities or challenges related to compliance with program requirements.

The effects of future legislation with respect to the 340B Program on the Obligated Group are uncertain at this time. No assurance can be given that the 340B Program will continue in effect.

Medicare and Medicaid Audits. The Healthcare Obligated Group Members participating in Medicare and Medicaid are subject to audits and retroactive audit adjustments with respect to reimbursement claimed under those programs, and the representations upon which such reimbursements are claimed. There can be no assurance that any such future adjustments will not be material or that the reserves, if any, of the Healthcare Obligated Group Members for such a purpose will be adequate to cover any such adjustments. Both Medicare and Medicaid regulations also provide for withholding payments in certain circumstances. Any such withholding with respect to a Healthcare Obligated Group Member could have a material adverse effect on the financial condition and results of operations of the Obligated Group. In addition, contracts between hospitals and third-party payers often have contractual audit, setoff

and withholding provisions that may cause substantial, retroactive adjustments. Such contractual adjustments also could have a material adverse effect on the financial condition and results of operations of Obligated Group. No assurance can be given that in the future a Medicare payment or other payment will not be withheld that would materially and adversely affect the financial condition or results of operations of the Obligated Group.

Under both the Medicare and the Medicaid programs, certain health care providers, including hospitals, are required to report certain financial information on a periodic basis, and with respect to certain types of classifications of information, penalties are imposed for inaccurate reports. These penalties may be material and could include criminal, civil or administrative liability and exclusion from participation in the federal health care programs. Under certain circumstances, payments based on improper claims or overpayments that are not refunded on a timely basis can implicate the federal Civil False Claims Act (the "False Claims Act") or other federal statutes, subjecting the provider to civil and criminal sanctions. The United States Department of Justice has initiated a number of national investigations involving proceedings under the False Claims Act relating to alleged improper billing practices by hospitals. These actions have resulted in substantial settlement amounts being paid in certain cases.

CMS has implemented a Recovery Audit Contractor ("RAC") program on a nationwide basis where CMS contracts with private contractors to conduct pre- and post-payment reviews to detect and correct improper payments in the fee-for-service Medicare program. The Affordable Care Act expanded the RAC program's scope to include managed Medicare plans and Medicaid claims. CMS also employs Medicaid Integrity Contractors to perform post-payment audits of Medicaid claims and identify overpayments. These programs tend to result in retroactively reduced payment and higher administration costs to hospitals.

Authorized by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Medicare Integrity Program ("MIP") was established to deter fraud and abuse in the Medicare program. Funded separately from the general administrative contractor program, the MIP allows CMS to enter into contracts with outside entities and ensure the "integrity" of the Medicare program. CMS contracts with Medicare Unified Program Integrity Contractors ("UPICs"), formerly known as program safeguard contractors and zone program integrity contractors, to review claims and medical charts, both on a prepayment and post-payment basis, conduct cost report audits and identify cases of suspected fraud. UPICs have the authority to deny and recover payments and to refer cases to the OIG. UPICs have the ability to compile claims data from multiple sources in order to analyze the complete claims histories of beneficiaries for inconsistencies.

In addition, CMS has instituted a Medicaid Integrity Program, modeled on the MIP. Medicaid Integrity Program contractors assist state Medicaid agencies by analyzing Medicaid claims data to identify high-risk areas and potential vulnerabilities and conducting post-payment field audits and desk review audits of Medicaid provider payments.

Medicare and Medicaid audits may result in reduced reimbursement or repayment obligations related to past alleged overpayments, may delay payments to providers pending resolution of the appeals process and may result in OIG investigations that could lead to monetary or other penalties. The Affordable Care Act explicitly gives DHHS the authority to suspend Medicare and Medicaid payments to a provider or supplier during a pending

investigation of fraud. The Affordable Care Act also amended certain provisions of the False Claims Act to include retention of overpayments as a violation and added provisions respecting the timing of the obligation to identify, report and reimburse overpayments.

Children's Health Insurance Program

The Children's Health Insurance Program ("CHIP") is a federally funded insurance program for children whose families are financially ineligible for Medicaid, but cannot afford commercial health insurance. The CMS administers CHIP, but each state creates its own program based upon minimum federal guidelines. CHIP insurance is provided through private health plans contracting with the state.

Each state must submit its CHIP plan to CMS for review to determine if it meets the federal requirements. If it does not meet the federal requirements, a state can lose its federal funding for the program. Any such loss of funding or federal or state budget cuts to the program could have an adverse effect on provider revenues.

On May 6, 2016, CMS published a final rule to modernize and enhance the provision of quality care to Medicaid managed care and CHIP beneficiaries. The final rule aligns Medicaid and CHIP managed care requirements with other major health coverage programs; enhances the beneficiary experience of care and strengthens beneficiary protections; strengthens the actuarial soundness payment provisions and program integrity provisions; promotes quality of care; and supports efforts to reform the delivery systems that serve Medicaid and CHIP beneficiaries. It is uncertain what impact the final rule will have on the Health System.

The Bipartisan Budget Act of 2018 extended CHIP funding through 2027, but the Affordable Care Act-increased funding for CHIP was phased-out through fiscal year 2020 and eliminated entirely in fiscal year 2021.

Patient Transfers

In response to concerns regarding inappropriate hospital transfers of emergency room patients based on the patient's ability to pay for the services provided, Congress enacted the Emergency Medical Treatment and Active Labor Act ("EMTALA") in 1986. This law requires most hospitals to provide assessments and stabilizing treatment to all individuals who seek emergency care and imposes certain requirements that hospitals must meet before transferring a patient to another facility. Physicians who refuse to assess or care for patients covered by EMTALA are also subject to sanctions. Failure of a hospital to meet its responsibilities under EMTALA could result in termination of its provider agreements and civil monetary penalties, and repeated or flagrant violation of EMTALA by a physician could result in the physician's exclusion from the Medicare and Medicaid programs, all of which could adversely affect the financial condition of the Health System. EMTALA and its implementing regulations are complex, and a hospital's compliance is dependent, in part, upon the volition of medical staff members. EMTALA also requires hospital departments that are located anywhere on the hospital's main campus to comply with EMTALA, even if such departments are not located within the hospital itself. Allegations that a Healthcare Obligated Group Member has violated EMTALA could have a material adverse effect on the future operations or financial condition of the Health System.

Waiver Co-Payments and Deductibles

The Healthcare Obligated Group may at times waive certain Medicare coinsurance and deductible amounts. Certain waiver programs may be considered to be in violation of certain rules and policies applicable to the Medicare program and may be subject to enforcement action. If an agency or court were to conclude that a waiver by an Obligated Group Member violates applicable law, there is a possibility that the Healthcare Obligated Group Member involved could be assessed fines, which could be substantial, that certain Medicare payments might be withheld or, in a serious case, that the Healthcare Obligated Group Member could be excluded from the Medicare program. While management is not aware of any challenge or investigation with respect to such matters, there can be no assurance that such a challenge or investigation will not occur in the future.

Health Insurance Portability and Accountability Act

Congress enacted HIPAA as part of a broad healthcare reform effort. Among other things, HIPAA established a program administered jointly by the Secretary of DHHS and the U.S. Attorney General designed to coordinate federal, state and local law enforcement programs to control fraud and abuse in connection with the federal healthcare programs. In addition, Congress greatly increased funding for healthcare fraud enforcement activity, enabling the OIG to substantially expand its investigative staff and authorizing the Federal Bureau of Investigation to quadruple the number of agents assigned to healthcare fraud. The result has been a dramatic increase in the number of civil, criminal and administrative prosecutions for alleged violations of the laws relating to payment under the federal healthcare programs, including the Anti-Kickback Law and the False Claims Act.

HIPAA added two prohibited practices, the commission of which may lead to civil monetary penalties: (1) the practice or pattern of presenting a claim for an item or service on a reimbursement code that the person knows or should know will result in greater payment than appropriate ("upcoding"), and (2) engaging in a practice of submitting claims for payment for medically unnecessary services. Violation of such prohibited practices could result in civil monetary penalties, which could be substantial.

HIPAA also included administrative simplification provisions intended to facilitate the processing of health care payments by encouraging the electronic exchange of information and the use of standardized formats for health care information. Congress recognized, however, that standardization of information formats and greater use of electronic technology present additional privacy and security risks due to the increased likelihood that databases of personally identifiable health care information will be created and the ease with which vast amounts of such data can be transmitted. Therefore, HIPAA requires the establishment of distinct privacy and security protections for individually identifiable health information.

Regulations of the DHHS to protect patient medical records and other personal health information maintained by health care providers, hospitals, health plans, health insurers and health care clearinghouses provide specific federal penalties for noncompliance with HIPAA. Non-criminal violations of the applicable standards may result in civil monetary penalties, while criminal penalties are available under HIPAA for certain types of violations of the statute that are committed knowingly.

Like other major health systems, certain Healthcare Obligated Group Members may be the subject of the OIG, U.S. Attorney General or Justice Department investigations and any Healthcare Obligated Group Member may be the subject of such investigations in the future. Failure to comply with the complex Medicare and Medicaid billing laws can result in exclusion from the Medicare programs as well as civil and criminal penalties. A substantial failure of a Healthcare Obligated Group Member to meet its responsibilities under the law could materially adversely affect the financial condition of such Healthcare Obligated Group Member.

The Cures Act and Health Information Technology and Privacy

The Cures Act contains a number of provisions regarding health information technology and healthcare privacy, including: (i) the privacy of protected health information used and disclosed as part of research; (ii) permitted uses and disclosures of mental health and substance abuse treatment information; and (iii) the interoperability of certified electronic health record technology ("CEHRT") networks and patient access to their information in CEHRTs. The legislation calls for a number of studies and for guidance from DHHS implementing and clarifying Cures Act provisions. Certain of the Cures Act provisions and anticipated regulations are intended to reduce regulatory or administrative burdens related to CEHRTs in the Medicare CEHRT incentive program and other Medicare programs.

Health Information Technology for Economic and Clinical Health Act

ARRA appropriated funds for the development and implementation of health information technology standards and the adoption of electronic healthcare records. ARRA also includes the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), which contains a number of provisions that affect HIPAA' s privacy regulations that provide generally that covered entities must keep a person's personal health information private. The HITECH Act limits a covered entity's discretion in determining what healthcare information about a person may be properly disclosed under the HIPAA privacy regulations. The HITECH Act also significantly expanded the HIPAA privacy and security provisions applicable to covered entities and their business associates. The law includes an individual notice requirement when there is a breach of unsecured electronic personal health information, increases civil monetary and criminal penalties for HIPAA violations, and authorizes state attorneys general to enforce its provisions. The HITECH Act also provides that individuals harmed by violations will be able to recover a percentage of monetary penalties or a monetary settlement based upon methods to be established by DHHS for this private recovery, although DHHS has not yet issued rulemaking to effectuate this statutory provision. Each covered entity must report any breach involving over 500 individuals in a state to DHHS and the local media. All other breaches must be reported annually to DHHS. The financial costs of continuing compliance with HIPAA and its administrative simplification regulations are substantial and have increased as a result of ARRA amendments.

Covered entities that use an "electronic health record" are required by the HITECH Act to account for disclosures of information, payment and healthcare operations. In addition, if a covered entity maintains an electronic health record, individuals have a right to receive a copy of the protected health information maintained in the record in an electronic format.

The HITECH Act requires covered entities to comply with a patient's request to restrict disclosure of information to a health plan if the disclosure's purpose is to carry out payment or healthcare operations (not treatment) or if the information pertains solely to an item or service

for which the provider was paid in full from sources other than such health plan. The HITECH Act also includes a prohibition on the payment or receipt of remuneration in exchange for protected health information without specific patient authorization, except in limited circumstances, and places additional restrictions on the use and disclosures of protected health information for marketing and fundraising communications.

The HITECH Act increases the civil monetary penalties associated with violations of HIPAA and provides state attorneys general with authority to enforce the HIPAA privacy and security regulations in some cases, through a monetary damages assessment or an injunction against the violator. However, because there has been limited regulatory guidance about the meaning and scope of certain requirements, no assurance can be given that Healthcare Obligated Group Members would be found to be in full compliance with those requirements or that they will be HIPAA compliant in the future. Moreover, future regulations to implement the HITECH Act may increase the cost to Healthcare Obligated Group Members of compliance with HIPAA and the HITECH Act.

Security Breaches and Unauthorized Releases of Personal Information

Federal, state and local authorities are increasingly focused on the importance of protecting the confidentiality of individuals' personal information, including patient health information. In addition to regulations promulgated under HITECH, many states, including Maryland, have enacted their own laws requiring businesses to notify individuals of security breaches that result in the unauthorized release of personal information. In some states, notification requirements may be triggered even where information has not been used or disclosed, but rather has been inappropriately accessed. State consumer protection laws may also provide the basis for legal action for privacy and security breaches and frequently, unlike HIPAA, authorize a private right of action. In particular, the public nature of security breaches exposes health organizations to increased risk of individual or class action lawsuits from patients or other affected persons, in addition to government enforcement. Failure to comply with restrictions on patient privacy or to maintain robust information security safeguards, including taking steps to ensure that contractors who have access to sensitive patient information maintain the confidentiality of such information, could damage a health care provider's reputation and materially adversely affect business operations.

Cybersecurity Risks

Similar to other large organizations, the Obligated Group Members rely on electronic systems and technologies to conduct their operations. There have been numerous attempts to gain unauthorized access to electronic systems of large organizations for the purposes of misappropriating assets or personal, operational, financial or other sensitive information, or causing operational disruption. These attempts, which are increasing, and often target health care organizations, include highly sophisticated efforts to electronically circumvent security measures or freeze assets as well as more traditional intelligence gathering aimed at obtaining information necessary to gain access. Any such breach or attack compromises information technology systems and the information stored thereon, including protected health information or other personally identifiable information of patients, students, faculty or employees, Obligated Group proprietary and confidential business performance data, payment systems or other sensitive or confidential data. Any such disruptions or other loss of information could result in a disruption in the efficiency of the services provided or revenues received by the Obligated

Group. The Obligated Group maintains a security posture designed to deter cyberattacks, and is committed to deterring attacks on its electronic systems and responding to such attacks to minimize their impact on operations. However, no assurances can be given that the Obligated Group's security measures will prevent cyber-attacks on their electronic systems, and no assurances can be given that any cyber-attacks, if successful, will not have a material adverse effect on the operations or financial condition of the Obligated Group.

In March 2022, the Cyber Incident Reporting for Critical Infrastructure Act ("CIRCIA") was signed into law containing a provision that would require hospitals and health systems to report cybersecurity breaches within certain timeframes to the Cybersecurity and Infrastructure Agency ("CISA"). The CISA is developing regulations to implement CIRCIA, so the potential impact on the Obligated Group of CIRCIA's reporting requirements is presently unknown.

Additionally, the Obligated Group's IT systems routinely interface with and rely on third-party electronic systems that are also subject to the risks outlined above and may not have or use appropriate controls to protect confidential information. A breach or attack affecting a third-party service provider could harm the Obligated Group's business or financial condition. An example of a recent cybersecurity event impacting the healthcare landscape was the Change Healthcare ransomware attack in February 2024. See "ADDITIONAL INFORMATION – Cybersecurity Program" in Appendix A.

Federal, State and Local Legislation

The Obligated Group Members are subject to a wide variety of federal, state and local regulatory actions and legislative and policy changes that could have a significant impact on the Obligated Group. Federal, state and local legislative bodies have broad discretion in altering or eliminating programs that contribute significantly to the revenues of the Obligated Group, including the Medicare and Medicaid programs and funding to support education, including tuition assistance for certain qualifying students of the Medical School. In addition, such entities may enact legislation which imposes significant new burdens on the operations of the Obligated Group Members. There can be no assurance that such legislative bodies will not make legislative policy changes (or direct governmental agencies to promulgate regulatory changes) that have adverse effects upon the ability of the Obligated Group Members to generate revenues or upon the favorable utilization of their facilities.

Federal Landscape

The evolving priorities and policies of the executive branch may have a significant effect on the health care industry. For example, changes in leadership at executive agencies including DHHS, CMS, and the Food and Drug Administration ("FDA"), and the creation of executive commissions such as the Department of Government Efficiency, may create uncertainty for health care providers around regulatory priorities, Medicare and Medicaid reimbursement, and other federal funding to health care providers. Similarly, the planned restructuring of DHHS to consolidate its existing 28 divisions into 15 divisions, reduce the number of regional offices from ten to five, and create a new Assistant Secretary of Enforcement creates uncertainty around executive branch enforcement priorities and may result in delays in grant funding and payments. The imposition of tariffs on products, equipment, and pharmaceutical products may create supply chain issues that could materially increase operating costs and adversely affect the operations of the Obligated Group Members.

Corporate Compliance

Because penalties for noncompliance with various requirements imposed upon the Healthcare Obligated Group Members for violation of Medicare, Medicaid and other healthcare laws and regulations may be substantial, the Healthcare Obligated Group has implemented a comprehensive compliance plan consistent with the model compliance plan offered by the OIG ("Compliance Plan"). The purpose of a Compliance Plan is to detect and deter violations of law. One of the major goals is to identify and address issues involving the submission of claims to governmental payers such as Medicare and Medicaid and to assure that those claims comply with statutes, regulations and other guidance provided by the programs. Integral components of the Compliance Plan include education, adoption of written standards, policies and procedures, auditing and monitoring, and encouraging employees to identify potential compliance issues. It is possible that the Compliance Plan may bring to the attention of the Obligated Group issues with respect to prior practices and payments. Depending upon the nature of the issue and whether an overpayment has occurred, voluntary or involuntary refunds to governmental payers may result. Although one goal of the Compliance Plan is to identify violations at an early stage or prevent inappropriate actions, there can be no assurance that the Compliance Plan will detect all potential violations and improprieties.

Managed Care and Commercial Payers

A significant portion of the revenues of the Healthcare Obligated Group Members is received from health maintenance organizations, preferred provider organizations or other managed care arrangements, including Medicaid managed care health plans. These arrangements differ significantly from traditional indemnity insurers. Managed care plans generally accept uniform per-person payments, with fees based on the number of enrollees, and in return agree to provide all, or substantially all, of an enrollee's healthcare needs without additional charges. Managed care payers rely upon case management to reduce or eliminate unnecessary utilization, including discouraging admissions to a hospital unless absolutely necessary. Case management efforts of managed care payers may in the future adversely affect utilization of the facilities of the Healthcare Obligated Group Members. In addition, some Medicaid managed care health plans may from time to time experience financial difficulties. The insolvency of such plans or their failure to pay amounts owed to the Healthcare Obligated Group Members in a timely manner could have an adverse effect on the financial condition of the Obligated Group. As managed care enrollments increase, managed care payers become significant purchasers of healthcare services and often select health providers offering the most cost-effective services. Hospitals may be adversely affected by the ability of these payers to negotiate low payment rates and to exclude hospitals from participation in their programs. In general, Maryland hospitals currently are not allowed to grant discounts from rates approved by the Rate Commission to specific payers, but the Rate Commission does grant a uniform discount to managed care payers meeting certain criteria. Not all of the Healthcare Obligated Group Members are covered by the Maryland rate-setting system and there can be no assurance that the Maryland rate-setting system will be maintained or that current Rate Commission methodology will continue to be used. See "REGULATORY ENVIRONMENT – Maryland Health Services Cost Review Commission" above.

High deductible insurance plans have also become more common in recent years, and the Affordable Care Act has encouraged the increase in high deductible insurance plans as the healthcare exchanges include a variety of plans, many of which offer lower monthly premiums in

return for higher deductibles and copayments. Many plans offered on the exchanges and an increasing number of employer group health plans have high deductibles. High deductible plans may contribute to lower elective inpatient admissions as patients may forgo or choose less expensive medical treatment to avoid having to pay the costs of the admissions as a result of the high deductibles. There is also a potential concern that some patients with high deductible plans will not be able to pay their medical bills as they may not be able to cover costs that are not covered by their insurance plans as a result of the high deductible. This factor may increase bad debt expense for healthcare providers.

Certain health maintenance and preferred provider organization contracts of the Obligated Group can be terminated by the third-party payer at any time without the necessity of showing cause upon short notice. Termination could have an adverse effect on the financial performance of the Obligated Group. In addition, contracts between hospitals and third-party payers often have contractual audit, setoff and withholding provisions that may cause substantial, retroactive adjustments. Such contractual adjustments also could have a material adverse effect on the financial condition and results of operations of the Obligated Group. No assurance can be given that in the future payment will not be withheld that would materially and adversely affect the financial condition or results of operations of the Healthcare Obligated Group Members.

Uninsured Patients

Future increases in unemployment in the areas served by the Healthcare Obligated Group Members could adversely affect revenues and increase the acuity and costs of care. Those who lack health insurance may delay elective procedures. They also may delay screening and preventive or basic care and may ultimately require more extensive services as a result. In addition, in times of greater unemployment and economic hardship, the amount of uncompensated care provided by the Healthcare Obligated Group Members would be expected to increase. Federal law requires hospitals to provide certain medical treatment to individuals who come to hospitals, regardless of the ability of the individuals to pay. The Maryland hospital rate-setting system currently includes a provision for charity care and bad debt, but not all of the Healthcare Obligated Group Members are covered by the Maryland rate-setting system and there is no assurance that the current rate-setting system will continue in effect or that the Rate Commission will continue to utilize the current methodology by which it approves rates. See "REGULATORY ENVIRONMENT – Maryland Health Services Cost Review Commission" above.

Although the Affordable Care Act may reduce uncompensated care by providing coverage to a larger portion of the population, there will continue to be individuals who lack insurance and will be unable to afford care. In addition, the Medicaid program is dependent on the continued availability of federal and state funding, which could be curtailed in the future in response to growing budget deficits at all governmental levels. The continued availability, comprehensiveness of coverage and adequacy of reimbursement for care for the indigent and disabled cannot be assured.

Pension and Benefit Funds

As large employers, hospitals may incur significant expenses to fund pension and benefit plans for employees and former employees, and to fund required workers' compensation benefits. Funding obligations in some cases may be erratic or unanticipated and may require

significant commitments of available cash needed for other purposes which could have a material adverse effect on the Obligated Group.

Cost and Availability of Medical Malpractice Insurance

The Healthcare Obligated Group Members are subject to malpractice suits arising out of the services they provide. The Healthcare Obligated Group Members are self-insured and maintain excess liability coverage for losses in excess of the self-insured retention. See "ADDITIONAL INFORMATION – Insurance" in Appendix A. Although the Healthcare Obligated Group Members maintain insurance coverage, to the extent that coverage is inadequate to cover judgments against them, such claims may be required to be discharged by payments from the Obligated Group's own funds. Further, if insurance coverage maintained by others with whom a Healthcare Obligated Group Member has joint and several liability is inadequate, the Healthcare Obligated Group Members (or their insurers to the extent of applicable coverage) may incur additional liability for such claims. Although legislation has been enacted in the State of Maryland to mitigate the impact of malpractice claims, there can be no assurance that medical malpractice insurance will continue to be available at reasonable rates. Moreover, there is no guarantee that such legislation will not be amended in a manner that adversely affects healthcare providers such as the Healthcare Obligated Group Members, or that the legislation will continue to withstand legal challenges. Further increases in the cost or limitations on the availability of malpractice insurance could adversely affect the operating results of the Obligated Group. In addition, increases in medical malpractice premiums could result in a shortage of medical professionals and may disrupt the delivery of healthcare. Any judgments or settlements that exceed insurance coverages or reserves could have a material adverse impact on the Healthcare Obligated Group Members. For information relating to the insurance coverage of the Healthcare Obligated Group Members, see "ADDITIONAL INFORMATION – Insurance" in Appendix A.

Maryland Professional Liability Insurance

Over the past several years, Maryland's medical professional liability environment has become more difficult. Although the number of claims has remained flat from year to year, the severity of claims (the cost to resolve those claims) has gone up faster in Maryland than most other jurisdictions around the country. In 2019, a jury in Baltimore City awarded approximately $229 million in connection with a malpractice claim filed against another major health system. The Court of Special Appeals in Maryland later overturned the jury's award. However, the trend in increased severity of claims, coupled with this jury verdict, has caused several commercial excess insurance carriers to move their business out of Maryland, and those that remain are looking to raise their rates or reduce their capacity (the amount of insurance they are willing to provide). Should this trend continue, it could make it more difficult for any healthcare system in Maryland to secure the excess insurance coverages it needs.

Environmental Laws and Regulations

Healthcare facilities are subject to a wide variety of federal, state and local environmental and occupational health and safety laws and regulations that address, among other things, hospital operations and facilities or properties owned or operated by hospitals. In their role as owners and operators of properties or facilities, hospitals may be subject to liability for investigating and remedying any hazardous substances that have come to be located on the

property, as well as any such substances that may have migrated off the property. Typical hospital operations include the handling, use, storage, transportation, disposal and discharge of hazardous, infectious, toxic, radioactive, flammable and other hazardous materials, wastes, pollutants and contaminants. For these reasons, hospital operations are particularly susceptible to the practical, financial and legal risks associated with compliance with such laws and regulations. Such risks may result in damage to individuals, property or the environment; may interrupt operations and increase their cost; may result in legal liability, damages, injunctions and fines; and may trigger investigations, administrative proceedings, penalties and other governmental agency actions.

There can be no assurance that the Healthcare Obligated Group Members will not encounter such risks in the future, or that such risks will not result in material adverse consequences to the operations or financial condition of the Obligated Group. At the present time, management of the Institution is not aware of any pending or threatened claim, investigation or enforcement action regarding any environmental issues which, if determined adversely would have a material adverse effect on the results of operations or financial condition of the Obligated Group.

Accreditation of MSOM

MSOM is seeking to offer a Doctor of Osteopathic Medicine (DO) degree, which requires full accreditation from COCA. COCA currently accredits all osteopathic medical schools in the United States and Canada. As part of the accreditation process, the Institution, on behalf of MSOM, deposited approximately $50 million in a segregated escrow fund. This amount will not be released from escrow to the Institution until after the first cohort of students graduates, which is expected in Fiscal Year 2029. MSOM can be considered for Full Accreditation status following the graduation of its first class, which it anticipates will occur in Fiscal Year 2029. The attainment of Full Accreditation status is subject to review and approval by COCA. Failure to obtain and maintain full accreditation will result in significant oversight and reporting requirements, accreditation proceedings such as a show-cause directive, an action to defer or deny action related to an institution's application for a new grant of accreditation or an action to suspend an institution's accreditation. While MSOM expects to obtain Full Accreditation status, no assurances can be made as to if and when MSOM will obtain Full Accreditation status.

COCA also sets enrollment maximums and requires clinical affiliation agreements for clerkships/rotation slots and residency slots with regional healthcare providers. These criteria will limit the number of students MSOM can admit each year and failure to secure clinical affiliation agreements will affect pre-accreditation. MSOM must attain pre-accreditation and Full Accreditation in order to attract students and to qualify under federal, state, and private student financial aid programs. There is no guarantee on the timing of accreditation status or that it will be successfully maintained in the future. Failure or delay or loss of accreditation status by MSOM could have a material adverse impact on the financial condition and operations of MSOM and consequently, on the Obligated Group.

Competition

A key factor in generating its revenues is MSOM's ability to attract a sufficient number of qualified students. MSOM competes with other medical schools throughout the country that

are fully accredited. In addition, attracting and retaining qualified faculty is essential to attracting qualified students and is dependent on the MSOM's ability to offer competitive compensation and facilities. No assurances can be given that MSOM will attract sufficient numbers of qualified students and faculty at levels of tuition and fees and compensation, respectively, so that it will be competitive with other medical schools. The inability of MSOM to attract students for admission to the Medical School may also adversely affect the amount of rental rates received by MSOM with respect to the housing provided at Meritus Commons. For a discussion regarding MSOM's admissions and demand, on-campus student housing at Meritus Commons, including the rental rates for such housing, and other key features of the Medical School, see "THE 2025 PROJECT – Meritus School of Osteopathic Medicine" in Appendix A.

Faculty

The ability of MSOM to attract and retain quality faculty members is an important factor in MSOM's academic reputation and its ability to attract students. Any inability of MSOM to attract and retain quality faculty members may adversely affect the admissions efforts of MSOM and its ability to attract and retain students.

Private Funding Required; Future Dependence on Financial Aid

The initial graduating class of the Medical School is not eligible for federal financial aid since MSOM has not yet received full accreditation from COCA. Rather, those students seeking financial assistance are required to secure funding through private lenders. Any reduction in the ability or willingness of such lenders to make such funding available could adversely affect the number of students able to enroll at the Medical School.

In the future, it is expected that a substantial portion of MSOM's revenues from tuition and fees will be funded by student loans and other federal government programs. Financial assistance in the form of scholarships, grants, loans and employment is a significant factor in the decision of many students to attend medical school. The level of financial assistance is directly affected by funding levels of federal and state financial aid programs, the level of private giving to MSOM and income derived from the investment of endowment and other funds.

Fundraising

MSOM raises funds from a variety of sources to finance its operating and capital needs and to build its endowment. While MSOM plans to continue these efforts, there can be no assurance that it will be able to continue to raise funds at a substantial level. Fundraising may be adversely affected by a number of factors, including changes in general economic conditions and changes in tax law affecting the deductibility of charitable contributions.

Factors Affecting the Financial Performance of MSOM

There are a number of factors affecting educational institutions in general, including the Medical School, that could have an adverse effect on the MSOM ability to collect revenues. These factors include, but are not limited to, the availability to MSOM of revenues from a variety of sources sufficient to meet obligations such as MSOM's operating expenses, debt service on any other debt and extraordinary costs or expenses which may occur from time to time. Revenues and expenses of MSOM will be affected by future events and conditions relating generally to, among other things: decreases in the number of students seeking to attend the

Medical School at optimum levels for each year; economic developments or demographic changes in the affected service area; diminution of the Medical School's reputation; competition from other educational institutions; lessened ability of MSOM to attract and retain qualified faculty and staff; increased costs associated with technological advances and the costs of security breaches in information technology systems; changes in government regulation of the education industry; future claims for accidents at MSOM's facilities and the extent of insurance coverage for such claims; and the occurrence of natural disasters such as hurricanes, floods or earthquakes; the abilities of MSOM's Board and administration to effectively direct, manage and operate MSOM; the ability of MSOM to control expenses; MSOM's ability to maintain or increase rates for tuition and other fees without adversely affecting enrollment; MSOM's ability to generate rental income from and otherwise successfully operate Meritus Commons; the ability of MSOM to maintain, or increase its endowment and other investments; and the results of investments of MSOM's endowment and other funds. No assurances can be given that these or other sources of revenue will be adequate to meet the expenses of MSOM.

Future revenues and expenses of MSOM will be subject to conditions which may differ from current conditions to an extent that cannot be determined at this time.

Tax Exemptions

Tax-Exempt Status of Interest on the Series 2025 Bonds

The Internal Revenue Code of 1986, as amended (the "Internal Revenue Code" or the "Code") imposes a number of requirements that must be satisfied for interest on state and local obligations, such as the Series 2025 Bonds, to be excludable from gross income for federal income tax purposes. These requirements include limitations on the use of proceeds of the Series 2025 Bonds and the facilities financed or refinanced with such proceeds, limitations on the investment of amounts deemed to be proceeds of the Series 2025 Bonds prior to expenditure, a requirement that certain investment earnings on amounts deemed to be proceeds of the Series 2025 Bonds be paid periodically to the United States and a requirement that the Authority file an information report with the IRS.

The Authority and the Obligated Group make certain covenants regarding actions required to maintain the excludability from gross income for federal income tax purposes of interest on the Series 2025 Bonds. Failure to comply with the requirements stated in the Code and related regulations, rulings, and policies may result in the treatment of interest on the Series 2025 Bonds as taxable, retroactively to the date of issuance. If interest on the Series 2025 Bonds were declared includable in gross income for purposes of federal income taxation, no additional amounts would be payable on the Series 2025 Bonds to compensate the holders or former holders thereof for the taxes which they may be required to pay, and the Series 2025 Bonds do not provide for a mandatory redemption in such event.

The IRS has increased the number of audits of tax-exempt bonds in the charitable organization sector in recent years and, as described above under "Regulatory Environment – Other Laws and Regulations Affecting Nonprofit Health Care Institutions," IRS officials have indicated that more resources will be invested in these audits. Tax-exempt organizations must complete a number of schedules to IRS Form 990 - Return of Organizations Exempt From Income Tax, including Schedule H, which requires hospitals and health systems to report how they provide community benefit and specify certain billing and collection practices; Schedule K,

which requires detailed information related to outstanding tax-exempt bond issues, including information regarding operating, management and research contracts, as well as private use compliance; and Schedule J, which requires reporting of compensation information for the organizations' officers, directors, trustees, key employees and other highly compensated employees. There can be no assurance that responses by the Obligated Group to Form 990 will not lead to an IRS audit.

No ruling with respect to the tax-exempt status of the Series 2025 Bonds has been or will be sought from the IRS, and the opinion of Bond Counsel to the Authority as to the excludability from gross income of the interest on the Series 2025 Bonds for federal income tax purposes is not binding on the IRS or the courts. See "TAX MATTERS."

If the Series 2025 Bonds were to be audited by the IRS, the market for and the market value of the Series 2025 Bonds could be adversely affected during the pendency of the examination and thereafter, even if the outcome of the audit were to be favorable.

Tax-Exempt Status of the Obligated Group Members

The tax-exempt status of the Series 2025 Bonds depends upon the maintenance by the Obligated Group Members of their status as organizations described in Section 501(c)(3) of the Code. In addition, if an Obligated Group Member were to lose its tax-exempt status, its property and its revenues could become subject to federal, state and local income taxation. Loss of the tax-exempt status of an Obligated Group Member also could result in loss of the tax-exempt status of other debt issued on behalf of such Obligated Group Members, and defaults in covenants regarding the Series 2025 Bonds and other tax-exempt debt would likely result. For these reasons, loss of the tax-exempt status of an Obligated Group Member could have a material adverse effect on the financial condition of the Obligated Group.

The maintenance of the federal tax-exempt status of an organization is contingent on compliance with general rules promulgated in the Code and related regulations regarding the organization and operation of tax-exempt entities, including their operation for charitable and educational purposes and their avoidance of transactions which may cause their earnings or assets to inure to the benefit of private individuals. As these general principles were developed primarily for public charities which do not conduct large-scale technical operations and business activities, they often do not adequately address the myriad of operations and transactions entered into by modern health care organizations.

One of the tools available to the IRS to discipline a tax-exempt entity for private inurement or unlawful private benefit is revocation of the entity's tax-exempt status. Although the IRS has not often revoked the tax-exempt status of an organization, it could do so in the future.

No Obligated Group Member is presently the subject of an IRS audit. However, there is no assurance that any of the Obligated Group Members will not be the subject of an audit in the future. Management believes that the Obligated Group Members have properly complied with the tax laws. Nevertheless, because of the complexity of the tax laws and the presence of issues about which reasonable persons can differ, an audit could result in additional taxes, interest and penalties. An audit could ultimately affect the tax-exempt status of an Obligated Group Member

as well as the exclusion from gross income for federal income tax purposes of the interest payable on tax-exempt debt issued on behalf of the Obligated Group.

Policies or legislation aimed at revising or eliminative tax-exempt status of nonprofit hospitals, health systems, or other nonprofit entities may materially affect the operations, financing condition, and tax-exempt status of the Obligated Group Members.

State Income Tax Exemption and Local Property Tax Exemption

It is likely that the loss by any Obligated Group Member of federal tax exemption would also result in a challenge to the state tax exemption of such Obligated Group Member. Depending on the circumstances, such event could be adverse and material.

In recent years, state, county and local taxing authorities have been undertaking audits and reviews of the operations of tax-exempt health care providers and other tax-exempt entities with respect to their real property tax exemptions. In some cases, particularly where such authorities are dissatisfied with the amount of services provided to indigents, the real property tax exemption of the health care providers has been questioned. The real property owned by tax-exempt entities and used for hospital, educational and other tax-exempt purposes of the Obligated Group Members is currently exempt from real property taxation.

Unrelated Business Income

In recent years, the IRS and state, county and local taxing authorities also have been undertaking audits and reviews of the operations of tax-exempt hospitals with respect to their exempt activities and the generation of unrelated business taxable income ("UBTI"). Some Obligated Group Members engage in activities which generate UBTI. Management believes it properly accounts for and reports UBTI; nevertheless, an investigation or audit could lead to a challenge which could result in taxes, interest and penalties with respect to unreported UBTI and in some cases could affect the tax-exempt status of the Obligated Group Members as well as the exclusion from gross income for federal income tax purposes of the interest payable on the Series 2025 Bonds and other tax-exempt debt issued on behalf of the Obligated Group Members.

Legislative Developments

Legislative proposals under consideration or proposed after issuance and delivery of the Series 2025 Bonds could adversely affect the market value of the Series 2025 Bonds. Further, if enacted into law, any such legislation could cause the interest on the Series 2025 Bonds to be subject, directly or indirectly, to federal income taxation, could limit the amount or availability of tax exempt financing for organizations described in Section 501(c)(3) of the Code or could otherwise alter or amend one or more of the provisions of federal tax law described below under "Tax Matters" or their consequences. Prospective purchasers of the Series 2025 Bonds should consult with their tax advisors as to the status and potential effect of legislative proposals, as to which Bond Counsel expresses no opinion.

In recent years, the activities of nonprofit tax-exempt corporations have been subject to increased scrutiny by federal, state and local legislative and administrative agencies. Various proposals either have been considered previously or are presently being considered at the federal, state and, in various states, at the local level which would restrict the definition of tax-exempt or

nonprofit status, impose new restrictions on the activities of tax-exempt nonprofit corporations, and/or tax or otherwise burden the activities of such corporations (including proposals to broaden or strengthen federal and local tax law provisions regarding unrelated business income of nonprofit corporations).

Changes in law may also impose new or added financial or other burdens on the operations of the Obligated Group Members. Developments may include: (i) legislative or regulatory requirements for maintaining status as an organization exempt from taxation as described in Section 501(c)(3) of the Code; or (ii) challenges to State and local exemptions from real property tax and other taxes.

There can be no assurance that future changes in the laws, rules, regulations, interpretations and policies relating to the definition, activities and/or taxation of nonprofit tax-exempt corporations or challenges to real property tax and other taxes will not have material adverse effects on the future operations of the Obligated Group Members.

Alliances and Affiliations with Physicians, Hospitals and Other Healthcare Providers

Many hospitals and health systems have pursued strategic alliances with physicians and other providers. These integration strategies involve multiple forms, including management service organizations, physician-hospital organizations, and ownership of physician practices. More recent integration models include joint ventures for delivery of services and assumption of risk. The Affordable Care Act encourages the development of healthcare delivery models that are designed to enhance quality, improve outcomes and reduce cost and that will effectively require greater integration between and collaboration among hospitals and physicians by allowing the formation of ACOs that meet quality thresholds to share in the savings achieved for the Medicare Program. The Affordable Care Act requires the Secretary of DHHS to implement a shared savings program through ACOs requiring integration between hospitals and physicians that will deliver healthcare services to Medicare beneficiaries, and to implement a demonstration project to develop ACOs for pediatric patients, under the MSSP. Participation in the Medicare ACOs is voluntary. ACOs that achieve quality performance standards will be eligible to share in a portion of the amounts saved by the Medicare program and, depending on their participation status, may share in a portion of any losses suffered by the Medicare program.

To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. From the final rule establishing the MSSP in November 2011 to the recent final rule published on December 31, 2018, CMS policies governing the MSSP continue to evolve based on changes to the law, including MACRA's creation of the Quality Payment Program. The regulations are complex, involve different tracks or levels of participation and require participants to undergo realistic risk-reward projections that present challenges for healthcare provider communities. In spite of its complexity, CMS recognizes the need to waive the application of certain Medicare payment rules to ACO providers in order to accommodate and incentivize their participation. However, there remain regulatory risks for participating hospitals, as well as financial and operational risks. The outcomes of these final regulations and guidance, and the impact they will have upon the healthcare marketplace, are unknown. Commercial health insurance companies are also adopting incentive payment programs modeled after the Medicare ACOs.

Often, the sponsoring hospital or health system will be the primary capital source for such alliances. Depending on the size and organizational characteristics of a particular development, these capital requirements may be substantial. While there are many benefits which may be derived from such alliances, most are relatively new developments with uncertain outcomes, and, therefore, it is uncertain whether the benefits and savings will be adequate to recoup the initial investment. CMS is also developing and implementing more advanced ACO payment models, such as the Next Generation ACO Model, which require ACOs to assume greater risk for attributed beneficiaries.

These types of alliances are generally designed to respond to existing trends in the delivery of medical care, to increase physician availability to the community or to enhance the managed care capability of the affiliated hospital and physicians. However, these goals may not be achieved, and, if the development is not successful, it may produce materially adverse results that are counterproductive to some or all of the above-stated goals.

All such integrated delivery developments carry with them the potential for legal or regulatory risks in varying degrees. Such developments may call into question compliance with the anti-referral laws and relevant antitrust laws (discussed below under "– Other Regulatory and Contractual Matters" and "– Antitrust"). Such developments may also subject the Healthcare Obligated Group Members to state insurance department regulation. Questions of federal or state tax exemption may arise in certain types of developments or as a result of formation, operation or future modification of such developments (see "CERTAIN BONDHOLDERS' RISKS – Tax Exemptions – Maintenance of Tax-Exempt Status of Tax-Exempt System Affiliates" above). In addition, depending on the type of development, a wide range of governmental billing and reimbursement issues may arise, including questions of the authorization of the entity to bill or collect revenue for or on behalf of the physicians involved. Other legal and regulatory risks may arise, relating to employment, pension and benefits, and corporate practice of medicine, particularly in the current atmosphere of frequent and often unpredictable changes in federal and state legal requirements regarding healthcare. There can be no assurance that such issues and risks will not lead to material adverse consequences in the future.

Furthermore, the success of risk-based arrangements, including but not limited to ACOs, depends, in part, on the timeliness and quality of data. Contracts involving population health management frequently have multiple-year terms. Data regarding the covered patient population and performance of the providers, however, often may not be available until the contract is well underway. Any delay in the availability of quality data may materially impact a provider's ability to adjust care delivery practices and achieve success in managing risk-based arrangements. In addition, because of accounting guidance that requires accrual of deficiency reserves, a delay in receipt of data regarding a provider's under-performance in managing care for a covered patient population may be accelerated rather than amortized with the term of the contract if losses under a multi-year contract are not identified until the contract is well underway. Such a circumstance could cause a material and adverse effect on the financial condition of the provider in the particular fiscal period in which the loss must be recognized.

Antitrust

Enforcement of the antitrust laws against healthcare providers is becoming more common, and antitrust liability may arise in a wide variety of circumstances, including medical staff privilege disputes, third-party contracting, physician relations, and joint venture, merger,

affiliation and acquisition activities. In some respects, the application of federal and state antitrust laws to healthcare is still evolving, and enforcement activity by federal and state agencies appears to be increasing. At various times, the Healthcare Obligated Group Members may be subject to an investigation by a governmental agency charged with the enforcement of antitrust laws, or may be subject to administrative or judicial action by a federal or state agency or a private party. Violators of the antitrust laws could be subject to criminal and civil enforcement by federal and state agencies, as well as by private litigants.

The ability to consummate mergers, acquisitions or affiliations may also be impaired by the antitrust laws, potentially limiting the ability of healthcare providers to fulfill their strategic plans. Liability in any of these or other antitrust areas of liability may be substantial, depending on the facts and circumstances of each case.

Other Regulatory and Contractual Matters

The Healthcare Obligated Group Members are subject to additional extensive federal, state and local regulations governing licensure, and operations. Failure by the Healthcare Obligated Group Members to meet applicable standards could result in the loss of licensure, the delay in or loss of reimbursement or the loss of an ability to deliver services. There can be no assurance that federal, state or local governments will not impose additional restrictions on the operations of the Healthcare Obligated Group Members that might adversely affect their businesses, financial condition and results of operations. In addition, enforcement activity against healthcare providers has increased, and enforcement authorities have adopted aggressive approaches. Enforcement authorities are often in a position to compel settlements by providers charged with or being investigated for false claims violations by withholding or threatening to withhold Medicare, Medicaid and/or similar payments and/or by instituting criminal action. The cost of defending such an action, the time and management attention consumed, and the facts of a case may dictate settlement. Therefore, regardless of the merits of a particular case, a hospital could experience materially adverse settlement costs, as well as materially adverse costs associated with implementation of any settlement agreement. Prolonged and publicized investigations could be both costly and damaging to the reputation and business of a hospital regardless of the outcome. See "REGULATORY ENVIRONMENT" for additional risks related to governmental regulation.

Anti-Fraud and Abuse Laws. The federal anti-kickback law (the "Anti-Kickback Law") makes it a felony to knowingly and willfully offer, pay, solicit or receive remuneration, directly or indirectly, in order to induce business that is reimbursable under any federal healthcare program. The statute has been interpreted to cover any arrangement where one purpose of the remuneration is to obtain referrals or to induce further referrals. The Affordable Care Act amended the intent requirement to provide that a person need not have actual knowledge of the Anti-Kickback Law or specific intent to commit a kickback violation to violate the statute, and it added penalties for the failure to grant timely access to DHHS. Violation of the Anti-Kickback Law may result in imprisonment and fines, which could be substantial. In addition, DHHS, through the OIG, has the authority to impose civil assessments and fines and to exclude hospitals engaged in prohibited activities from the Medicare, Medicaid, TRICARE (a healthcare program providing benefits to dependents of members of the uniformed services) and other federal healthcare programs for not less than five years. The Anti-Kickback Law also authorizes the imposition of penalties against any person who contracts with a provider that the person knows or should know is excluded from the federal healthcare programs. Although the Anti-Kickback

Law applies only to federal healthcare programs, a number of states, including Maryland, have passed similar statutes that contain similar types of prohibitions that are applicable to all other health plans or third-party payers. In addition to certain statutory exceptions to the Anti-Kickback Law, the OIG has promulgated regulatory "safe harbors" under the Anti-Kickback Law designed to protect certain payment and business practices. However, these safe harbors are narrow and do not cover a wide range of common economic relationships involving hospitals. The regulations do not purport to comprehensively describe all lawful or unlawful economic arrangements or other relationships between healthcare providers and referral sources. While the failure to comply with a statutory exception or regulatory safe harbor does not mean that an arrangement is unlawful, such failure may increase the likelihood of a regulatory challenge or the potential for investigation. To date, a limited number of final safe harbors have been established.

In November 2020, the OIG released a final rule implementing a number of new safe harbors and modifying existing safe harbors. This new rule may increase the Healthcare Obligated Group Members' costs for remaining compliant with the Anti-Kickback Law, as the Healthcare Obligated Group Members may have to make adjustments to remain compliant with the revised Anti-Kickback Law implementing regulations.

HIPAA created a new program operated jointly by DHHS and the U.S. Attorney General to coordinate federal, state and local law enforcement with respect to fraud and abuse, including violations of the Anti-Kickback Law.

The Healthcare Obligated Group Members seek to comply with the Anti-Kickback Law and have implemented mechanisms designed to assure compliance. Nevertheless, because of the breadth of the Anti-Kickback Law and the limitations of the safe harbor regulations, there can be no assurance that the Healthcare Obligated Group Members will not be found to have violated the Anti-Kickback Law.

Stark Law. The federal physician self-referral law (commonly known as the "Stark Law") prohibits a physician who has a financial relationship, or whose immediate family has a financial relationship, with an entity (including a hospital) from referring federal health care program patients to such entity for the furnishing of designated health services, with limited statutory and regulatory exceptions. Designated health services under the Stark Law include physical therapy services, occupational therapy services, speech-language pathology services, radiology or other diagnostic services (including MRIs, CT scans and ultrasound procedures), durable medical equipment, radiation therapy services, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics and prosthetic devices, home health services, outpatient prescription drugs, inpatient and outpatient hospital services and clinical laboratory services. The Stark Law also prohibits the entity receiving the referral from filing a claim or billing for the services arising out of the prohibited referral. No finding of intent to violate the Stark Law is required. Violations of the Stark Law, even if inadvertent, carry substantial penalties, including denial of payment for the services provided in violation of the prohibition, refunds of amounts collected in connection with prohibited referrals, exclusion from the federal health care programs and civil penalties, which could be significant. Knowing violations of the Stark Law may also serve as the basis for liability under the False Claims Act. The types of financial arrangements between a physician and an entity that trigger the self-referral prohibitions of the Stark Law are broad, and include ownership and investment interests and compensation arrangements. Arrangements that implicate the Stark Law that do not fall within a

statutory or regulatory exception are not subject to a case-by-case review, unlike violations of the Anti-Kickback Law. Rather, such arrangements are prohibited in all cases by the Stark Law.

CMS has established a voluntary self-disclosure program under which hospitals and other entities may report Stark violations and seek a reduction in potential refund obligations. However, the program is relatively new and therefore it is difficult to determine at this point in time whether it will provide significant monetary relief to hospitals that discover inadvertent Stark law violations and make a voluntary disclosure to the agency. The limited publicly available information with respect to the self-disclosure program and the short period it has been available make it difficult to predict how CMS will react to any specific voluntary disclosure of a Stark violation. Any submission pursuant to the self-disclosure program does not waive or limit the ability of the OIG or Department of Justice to seek or prosecute violations of the Anti-Kickback Law or impose civil monetary penalties. In November 2020, CMS released a final rule implementing a number of new exceptions related to value-based arrangements, certain limited remuneration payments to physicians and the donation of electronic health record related items and services. The final rule also provides guidance regarding the application of the Stark Law and its exceptions, by making changes or clarifications to existing exceptions and to the definitions contained in the Stark Law's implementing regulations. This final rule may increase the Healthcare Obligated Group Members' costs for remaining compliant with the Stark Law, as the Healthcare Obligated Group Members may have to make adjustments to remain compliant with the revised Stark Law implementing regulations.

Maryland, like many other states, has enacted a statute (the "Maryland Patient Referral Law" or "MPRL") that is generally parallel to the Stark Law. The Maryland statute applies to all patients, not just those insured by a federal health care program as is the case under the Stark Law, and to all patients, not just those insured by a federal health care program as is the case under the Stark Law, and to all health care providers, not just physicians.

Because of the complexity of the Stark Law and the Maryland Patient Referral Law, there can be no assurance that the Healthcare Obligated Group Members will not be found to have violated the Stark Law or the MPRL. Penalties for such violations, which may include exclusion from the Medicare and Medicaid programs and, for physicians and other practitioners, the loss of their license to practice, could have a material adverse effect on the future operations and financial condition of the Obligated Group, as could any significant penalties, demands for refunds or denials of payment.

False Claims Act and Civil Monetary Penalties Law. There are three principal federal statutes that address the issue of "false claims." First, the federal False Claims Act imposes civil liability (including substantial monetary penalties and treble damages) on any person or entity that (1) knowingly presents or causes to be presented a false or fraudulent claim for payment to the United States government; (2) knowingly makes, uses or causes to be made or used a false record or statement to obtain payment; (3) engages in a conspiracy to defraud the federal government by getting a false or fraudulent claim allowed or paid; (4) has possession, custody, or control of property or money used, or to be used, by the federal government and knowingly delivers, or causes to be delivered, less than all of that money or property; (5) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the federal government and, intending to defraud the federal government, makes or delivers the receipt without completely knowing that the information on the receipt is true; (6) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the

federal government, or a member of the U.S. Armed Forces, who lawfully may not sell or pledge property; or (7) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the federal government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the federal government. One need not be found to have had specific intent to defraud the federal government to be found to have acted with knowledge. This statute authorizes private persons to file *qui tam* actions (sometimes called "whistleblower" actions) on behalf of the United States of America. The government may choose to intervene and jointly litigate *qui tam* actions. These private persons, also known as "relators," can collect between 15% and 30% of the proceeds of any fines or damages paid in the event their cases are successful, depending on whether the government intervenes.

False Claims Act investigations and cases have become common in the healthcare field and may cover a range of activity from submission of intentionally inflated billings to highly technical billing infractions, to allegations of inadequate care. Penalties under the False Claims Act are severe and may include damages equal to three times the amount of the alleged false claims, as well as substantial civil monetary penalties. As a result, violations or alleged violations of the False Claims Act frequently result in settlements that require multi-million dollar payments and costly corporate integrity agreements. In June 2016, the United States Department of Justice issued a rule that more than doubled civil monetary penalties under the False Claims Act.

Under the Affordable Care Act, the False Claims Act has been expanded to include overpayments that are discovered by a healthcare provider and are not promptly refunded to the applicable federal healthcare program, even if the claims relating to the overpayment were initially submitted without any knowledge that they were false. The final rule which took effect on March 14, 2016 requires that providers report and return identified overpayments by the later of 60 days after identification and quantification of the overpayment, or the date the corresponding cost report is due, if applicable. If the overpayment is not so reported and returned, it becomes an "obligation" under the False Claims Act. This expansion of the False Claims Act exposes hospitals and other healthcare providers to liability under the False Claims Act for a considerably broader range of claims than in the past. There was initially great uncertainty in the industry as to when an overpayment is technically "identified" and the ability of a provider to determine the total amount of an overpayment and satisfy its repayment obligation within the required time period. The March 14, 2016 final rule clarified that an overpayment is considered to have been identified when the person has or should have, through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment. That final rule also established a six-year lookback period, meaning overpayments must be reported and returned only if a person identifies the overpayment within six years of the date the overpayment was received.

In June 2016, the United States Supreme Court announced its decision in *Universal Health Services, Inc. v. United States ex rel. Escobar*, No. 15-7 (U.S. June 16, 2016). Prior to *Escobar*, lower courts had split on the issue of whether the False Claims Act extended to so-called "implied certification" of compliance with laws, and whether such compliance was limited to express conditions of payment or extended to conditions of participation. The United States Supreme Court affirmed the theory of "implied certification" and rejected the distinction between conditions of payment and conditions of participation for these purposes, ruling that the relevant inquiry is whether the alleged noncompliance, if known to the government, would have

in fact been material to the government's determination as to whether to pay the claim. There is considerable uncertainty as to the application of the *Escobar* holding, but depending on how it is interpreted by the lower courts, it could result in an expanded scope of potential False Claims Act liability for noncompliance with applicable laws, regulations and regulatory guidance.

The Civil Monetary Penalties Law ("CMP") authorizes the imposition of substantial civil monetary penalties against an entity that engages in activities such as, but not limited to, (1) knowingly presenting or causing to be presented to a federal or state officer, employee or agent a claim for services not provided as claimed or that is otherwise false or fraudulent in any way; (2) knowingly giving or causing to be given false or misleading information reasonably expected to influence the decision to discharge a hospital patient covered under Medicare; (3) offering or giving remuneration to any beneficiary of a federal health care program likely to influence the receipt of reimbursable items or services; (4) arranging for reimbursable services with an entity that is excluded from participation from a federal health care program; (5) knowingly or willfully soliciting or receiving remuneration for a referral of a federal health care program beneficiary; or (6) using a payment intended for a federal health care program beneficiary for another use. The Secretary of DHHS, acting through the OIG, also has both mandatory and permissive authority to exclude individuals and entities from participation in federal health care programs pursuant to this statute as well as to impose penalties on providers that contract with individuals or entities that the provider knows is excluded from the federal health care programs.

Finally, it is a federal criminal offense to: (1) knowingly and willfully execute or attempt to execute any scheme to defraud any health care benefit program; or (2) obtain, by means of false or fraudulent pretenses, representations or promises any money or property owned or controlled by any health care benefit program. Penalties for a violation of this federal law include fines and imprisonment and forfeiture of any property derived from proceeds traceable to the offense.

A number of states (including Maryland) have passed similar statutes expanding the prohibition against the submission of false claims to nonfederal third-party payors.

Although the False Claims Act has been in effect for many years, in recent years there has been a significant increase in the number of allegations filed under the False Claims Act, a large number of which involve the health care and pharmaceutical industries. This is due in part to the ability of *qui tam* relators, acting on the government's behalf, to collect a sizable percentage of the verdict or settlement. In 2009, the Fraud Enforcement and Recovery Act ("FERA") was enacted, which authorized increased funding for fraud investigation and prosecution and expanded the scope of the False Claims Act.

The threats of large monetary penalties and exclusion from participation in Medicare, Medicaid and other federal health care programs, and the significant costs of mounting a defense, create serious pressures on providers that are targets of false claims actions or investigations to settle. Therefore, an action under the False Claims Act, FERA or CMP could have an adverse financial impact on the Obligated Group, whether or not the particular claims are valid.

Physician Recruitment. The IRS and DHHS have issued various pronouncements that could limit physician recruiting and retention arrangements. In an IRS General Counsel Memorandum concerning hospital-physician joint ventures, the IRS ruled that tax-exempt hospitals that provide recruiting and retention incentives to physicians risk loss of tax-exempt

status unless the incentives are necessary to obtain an overriding public benefit; improvement of a charitable hospital's financial condition does not necessarily constitute such a purpose. The IRS has also issued guidelines for its agents to follow in conducting audits that emphasize these restrictions, and has established special audit teams and procedures to ensure compliance. The OIG has taken the position that any arrangement between a federal healthcare program-certified facility and a physician that is intended to encourage the physician to refer patients may violate the federal Anti-Kickback Law unless a statutory or regulatory exception applies. While the OIG has promulgated a practitioner recruitment regulatory safe harbor, the safe harbor is limited to practice recruitment in areas that are health professional shortage areas and to the recruitment of new physicians who are relocating their practices. Therefore, the safe harbor does not cover physician retention arrangements.

The Stark Law also is implicated by physician recruiting and retention arrangements. An exception applies to payments from a hospital to a physician to induce the physician to relocate to the hospital's service area and join the hospital's medical staff, provided several requirements are met. No assurance can be given that future regulations under the Stark Law will not adversely affect the Healthcare Obligated Group Members.

Joint Ventures. The OIG has expressed concern in various advisory bulletins that many types of joint venture arrangements involving hospitals may implicate the Anti-Kickback Law, since the parties to joint ventures are typically in a position to refer patients of federal health care programs.

In 2003, the OIG issued a Special Advisory Bulletin on so-called "contractual joint ventures," a subset of joint venture arrangements that the OIG believed were proliferating and that raise Anti-Kickback Law concerns. According to the OIG, contractual joint venture arrangements are arrangements where a provider such as a hospital expands into a new line of business by contracting with an entity that already provides the items or services.

As with any analysis under the Anti-Kickback Law, the government reviews the totality of the facts and circumstances presented by a proposed joint venture arrangement and concludes how much risk it poses under the Anti-Kickback Law, and whether, based on that risk, it would subject the parties to sanctions under the statute.

U.S. Supreme Court Ruling on the Chevron Doctrine

On June 28, 2024, in *Loper Bright Enterprises v. Raimondo, No. 22-451 and Relentless, Inc. v. Department of Commerce, No. 22-1219*, the United States Supreme Court overturned the decades-old Chevron doctrine of judicial deference to a federal agency's interpretation of an ambiguous statute. Although (i) the underlying cases were not health care related, (ii) the Court emphasized that prior decisions that relied on the *Chevron* framework are not overturned, and (iii) the Court stated that a court may look to the federal agency's interpretation of a statute, as reflected in regulation or other agency action, for guidance in interpreting its meaning, the decision may significantly affect the highly regulated health care industry.

At this time, management of the Institution is unable to predict the potential impact of this ruling on the Healthcare Obligated Group Members or the health care industry in general. However, the ruling is expected to result in a delay or chill in future federal agency rulemaking and an increase in litigation challenging existing and future federal rules and regulations governing health care. Some have argued that federal agencies under DHHS, such as CMS, have

exceeded the authority granted by Congress in the statutes governing government funded health programs such as Medicare and Medicaid. Therefore, the rules and regulations promulgated by such agencies may be particularly susceptible to challenge under the new ruling. Less judicial deference to federal agencies may introduce uncertainty in the federal regulatory framework governing health care, which could make it more difficult for health care providers, such as the Healthcare Obligated Group Members, to fully comply with the federal laws governing health care.

Risks in Healthcare Delivery

Utilization. A number of factors have contributed to a reduction of hospital utilization at various times in recent history. Changes in physicians' practice patterns have in some cases resulted in fewer inpatient admissions and shorter lengths of stay for those who are admitted. In addition, third-party payers, such as Medicare, Medicaid, Blue Cross and other insurers and health maintenance organizations, have sought to contain their costs by reviewing and questioning the need for certain procedures, inpatient admissions and hospital stays. Implementation of various aspects of the Affordable Care Act, including the development of accountable care organizations, may also impact hospital utilization.

Utilization of the facilities of the Healthcare Obligated Group Members could be adversely affected by a decline in the population of their service areas, a change in the age composition of the population, a decline in the economic conditions of their service areas or other demographic shifts. Adverse economic conditions, particularly increased unemployment, in the service areas of the Healthcare Obligated Group could reduce the number of potential patients carrying adequate health insurance coverage and decrease the number of patients who are able to pay fully for the cost of their care at the facilities of the Healthcare Obligated Group Members.

Although the TCOC Model and AHEAD Model moderate the financial consequences to Maryland hospitals of utilization reductions, the long-term effect of reduced hospital utilization cannot be predicted at this time.

Competition. A significant portion of the Healthcare Obligated Group Members' revenues is derived from the treatment of patients at their facilities by members of their medical staffs. Physicians on the medical staff have the option of treating a particular patient at the facilities of the Healthcare Obligated Group Members or at other healthcare facilities with which the physicians may be affiliated. Although the referral practices of physicians who are employed by the Healthcare Obligated Group Members may be governed by the terms of their employment agreements, physicians, even if employed, typically retain the right to direct patients in accordance with their understanding of the patient's best interests and patient choice. The revenues of the Obligated Group could decrease if medical staff members treat patients at, or refer or direct patients to, other healthcare providers or facilities, or if medical staff members employed by the Healthcare Obligated Group Members leave their employment and become employed by, or choose to refer their patients to, competitors of the Healthcare Obligated Group Members.

In addition to competition from other hospitals and inpatient facilities, increased competition from a wide variety of potential sources, including, but not limited to, ambulatory surgery facilities, radiology facilities and other outpatient healthcare facilities, clinics, physicians, home healthcare agencies, private pathology laboratories, drug and alcohol abuse

programs and others, may adversely and increasingly affect the utilization and revenues of the Obligated Group. Existing and potential competitors may not be subject to various regulations and restrictions applicable to the Healthcare Obligated Group Members, and may be more flexible in their ability to adapt to competitive opportunities and risks. Certain new competitors specifically target hospital patients as their prime source of revenue growth. Certain of these forms of healthcare delivery are designed to offer comparable services at lower prices and the federal government and private third-party payers may increase their efforts to encourage the development and use of such programs. Competition may, in the future, arise from new sources not currently prevalent, such as telemedicine providers, or from other sources that have not yet been identified.

Also, payers are increasingly entering into narrow network contracts that exclude from participation in the network all providers who are not in the narrow network. Payers also enter into exclusive contracts with certain providers from time to time. In addition, increasingly, providers are pursuing ownership interest in health insurance companies that may exclude non-owner providers from certain products. The net effect of these practices, singularly or in the aggregate, may be to foreclose and exclude the Healthcare Obligated Group Members from a material population of individuals who can choose or access the Healthcare Obligated Group Members for their care and could have a material adverse effect on the Obligated Group.

Additionally, scientific and technological advances, new procedures, drugs and appliances, preventive medicine and outpatient healthcare delivery may reduce utilization and revenues of the hospitals in the future or otherwise lead the way to new avenues of competition. These advances may add greatly to the costs of providing healthcare services with potentially no or little offsetting increase in reimbursement from payers and may also render obsolete certain of the health services provided by healthcare providers. In some cases, hospital investment in facilities and equipment for capital-intensive services may be lost as a result of rapid changes in diagnosis, treatment or clinical practice brought about by new technology or new pharmacology.

Throughout the past decade, market forces, including changes as a result of the Affordable Care Act and other reimbursement issues, have resulted in an increased trend toward consolidation of healthcare facilities, through either merger or acquisition, into larger hospitals or health systems. As a result of such consolidation, these hospitals and health systems are able to reduce costs and offer a wider variety of and greater access to core and specialty services. Many hospitals in Maryland have become members of larger systems. These changes may affect market share and may have a negative effect on the operations of the Healthcare Obligated Group Members and utilization of their facilities, thereby potentially reducing revenues.

Labor Relations. Hospitals are large employers with a wide diversity of employees. Increasingly, employees of hospitals are becoming unionized, and many hospitals have collective bargaining agreements with one or more labor organizations. Employees subject to collective bargaining agreements may include essential nursing and technical personnel, as well as food service, maintenance and other trade personnel. Renegotiation of such agreements upon expiration may result in significant cost increases to hospitals. Employee strikes or other adverse labor actions may have an adverse impact on operations, revenue and reputation.

Physician Contracting and Relations. Certain of the Healthcare Obligated Group Members have entered into a wide variety of relationships with physicians. Many of these relationships may be of material importance to the operations of the Obligated Group, and, in an

increasingly complex legal and regulatory environment, these relationships pose a variety of legal and business risks.

The primary relationship between a hospital and physicians who practice in it is through the hospital's organized medical staff. Medical staff bylaws, rules and policies establish the criteria and procedures by which a physician may have his or her privileges or membership curtailed, denied or revoked. Physicians who are denied medical staff membership or certain clinical privileges, or who have such membership or privileges curtailed, denied or revoked often file legal actions against hospitals and medical staffs. Such actions may include a wide variety of claims, some of which could result in substantial uninsured damages to a hospital. In addition, failure of the hospital governing body to adequately oversee the conduct of its medical staff may result in hospital liability to third parties. All hospitals, including the Healthcare Obligated Group Members, are subject to such risks.

Certain contracts entered into with physicians or physician groups create exclusive relationships. With increased competition among healthcare providers and the increasing frequency of the application of antitrust principles in healthcare, such exclusive relationships are subject to challenge, generally by other physicians competing with those who have the exclusive relationship. Absent facts which may arise from a specific challenge or controversy, the validity of such agreements cannot in many cases be accurately determined, nor can the materiality of the loss of the exclusive relationship to a hospital or the damages, if any, which might be assessed against the parties to it. Certain of the Healthcare Obligated Group Members presently have exclusive relationships of the type described above. As of the date hereof, management of Institution is not aware of specific controversies which management believes might lead to the loss of an exclusive contractual relationship, or to an award of damages, that would be material with respect to the operation or financial condition of the Obligated Group.

Because physician organizations are separate legal entities with their own goals, obligations to shareholders, financial status, and personnel, there are risks involved in contracting with the physician organizations. These and other financial relationships with physicians (including hospital-physician contracts for individual services) may involve financial and legal compliance risks for the hospitals and systems involved. From a compliance standpoint, these types of financial relationships may raise federal and state "anti-kickback" and federal "Stark" and related state issues (see "REGULATORY ENVIRONMENT," above), as well as other legal and regulatory risks, and these could have a material adverse impact on hospitals and health facilities.

The success of the Obligated Group will be partially dependent upon the ability of the Healthcare Obligated Group Members to attract physicians to join the physician organizations and to participate in their networks, and upon the ability of the physicians, including the employed physicians, to perform their obligations and deliver high quality patient care in a cost-effective manner. There can be no assurance that the Healthcare Obligated Group Members will be able to attract and retain the requisite number of physicians, or that physicians will deliver high quality healthcare services. Without paneling a sufficient number and type of providers, the Obligated Group could fail to be competitive, could fail to keep or attract payer contracts, or could be prohibited from operating until its panel provided adequate access to patients. Such occurrences could have a material adverse effect on the business or operations of the Obligated Group.

Technology and Services. Scientific and technological advances, new procedures, drugs and appliances, preventive medicine, occupational health and safety and outpatient healthcare delivery may reduce utilization and revenues of the Obligated Group in the future. Technological advances in recent years have accelerated the trend toward the use by hospitals of sophisticated, and costly, equipment and services for diagnosis and treatment. The acquisition and operation of certain equipment or services may continue to be a significant factor in hospital utilization, but the ability of the Obligated Group to offer such equipment or services may be subject to the availability of equipment or specialists, governmental approval or the ability to finance such acquisitions or operations. The American Recovery and Reinvestment Act of 2009 allocated $20 billion to healthcare information technology, and the Affordable Care Act mandated that certain healthcare providers implement electronic medical records by 2014 or be subject to reductions in reimbursement from federal programs.

The ability to adequately price and bill healthcare services and to accurately report financial results depends on the integrity of the data stored within information systems, as well as the operability of such systems. Information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards. There can be no assurance that the information systems of the Healthcare Obligated Group Members will adequately address these challenges.

Electronic media are also increasingly being used in clinical operations, including the conversion from paper to electronic medical records, computerization of order entry functions and the implementation of clinical decision-support software. The reliance on information technology for these purposes imposes new expectations on physicians and other workforce members to be adept in using and managing electronic systems. It also introduces risks related to patient safety and to the privacy, accessibility and preservation of health information. See "CERTAIN BONDHOLDERS' RISKS – Health Insurance Portability and Accountability Act" and "– Health Information Technology for Economic and Clinical Health Act" above. Technology malfunctions and any failure to understand and use information systems properly could result in the dissemination of or reliance on inaccurate information, as well as in disputes with patients, physicians and other healthcare professionals. Health information systems may also be subject to different or higher standards or greater regulation than other information technology or the paper-based systems previously used by healthcare providers, which may increase the cost, complexity and risks of operations. All of these risks may have adverse consequences for hospitals and healthcare providers.

Enforcement Affecting Clinical Research. In addition to increasing enforcement of laws governing payment and reimbursement, the federal government has also stepped up enforcement of laws and regulations governing the conduct of clinical trials at hospitals. The DHHS elevated and strengthened its Office of Human Research Protection, one of the agencies with responsibility for monitoring federally funded research. In addition, the National Institutes of Health significantly increased the number of facility inspections that these agencies perform. The FDA also has authority over the conduct of clinical trials performed in hospitals when these trials are conducted on behalf of sponsors seeking FDA approval to market the drug or device that is the subject of the research. Moreover, the OIG, in its "Work Plans," has included several enforcement initiatives related to reimbursement for experimental drugs and devices (including kickback concerns) and has issued compliance program guidance directed at recipients of extramural research awards from the National Institutes of Health and other agencies of the U.S.

Public Health Service. There have been a number of government investigations and settlements involving hospital use of federal grant funding in connection with clinical trials and also a settlement involving the submission of claims to Medicare for services provided in a clinical trial. These agencies' enforcement powers range from substantial fines and penalties to exclusion of researchers and suspension or termination of entire research programs, and errors in billing of the Medicare Program for care provided to patients enrolled in clinical trials that is not eligible for Medicare reimbursement can subject the System Affiliates to sanctions as well as repayment obligations. In January 2017, DHHS issued new final regulations governing clinical research activities (effective in 2019), which among other things, significantly changed the requirements applicable to institutions that engage in clinical research using human subjects. In addition to risks under the False Claims Act, should there be a finding of improper conduct on the part of any of the Healthcare Obligated Group Members related to research, it is possible that the government could suspend such Healthcare Obligated Group Member's research operations or terminate its ability to participate in government-sponsored research programs.

The Cures Act contains many provisions related to research and clinical trials, including making significant changes to the way that FDA approves new drugs and medical devices. Among other things, the legislation calls on FDA to consider new types of data, such as patient experience data, in its drug approval process. The legislation also permits drug manufacturers to utilize new types of clinical trial designs in order to collect data in the drug approval process. The intent of many of the statute's provisions is to speed the approval of new drugs and medical devices. Whether the Cures Act realizes these goals will depend on the adoption of new FDA regulations, policy guidance, and FDA approval practices. Also see "CERTAIN BONDHOLDERS' RISKS – The Cures Act and Health Information Technology and Privacy" herein. Furthermore, final revisions to the Federal Policy for the Protection of Human Subjects (known as the "Common Rule") were issued on January 19, 2017 in order to reduce burden, delay and ambiguity for investigators and better protect human subjects involved in research. The impact of these and regulatory, policy and legislative changes on the operations of the Health System related to research could be adverse.

Class Actions. Hospitals and health systems have long been subject to a wide variety of litigation risks, including liability for care outcomes, employer liability, property and premises liability, billing, charging and collections practices, and peer review litigation with physicians, among others. In recent years, class action litigation has emerged as a potentially significant source of liability for hospitals and health systems.

One frequent basis of class action litigation has been hospital billing and collections practices. Federal law and the laws of many states (including Maryland) impose standards related to worker classification, eligibility and payment for overtime, liability for providing rest periods and similar requirements. Large employers with complex workforces, such as hospitals, are susceptible to actual and alleged violations of these standards, and there has been a proliferation of lawsuits over these issues in recent years. Another basis of recent class actions relates to breaches of privacy. Class actions may also be used for a variety of other causes of action.

Class action lawsuits can involve multi-million dollar claims, judgments and settlements. Further, the subject matter of class action suits may involve uninsured risks. Since such actions often involve large potential classes of plaintiffs, a major class action decided or settled adversely to any of the Healthcare Obligated Group Members could have a material adverse impact on the financial condition and results of operations of the Obligated Group.

Personnel Shortages. From time to time, the healthcare industry suffers from a scarcity of nursing personnel, respiratory therapists, pharmacists and other trained healthcare technicians. In addition, aging medical staffs and difficulties in recruitment to the medical profession are predicted to result in physician shortages. A significant factor underlying this trend includes a decrease in the number of persons entering such professions. As hospitals and other healthcare providers transition to a population health model of care delivery, there is expected to be a greater need for care coordinators and such need may outpace the supply of qualified personnel. In addition, state budget cuts to university programs may impact the training available for nursing personnel and other healthcare professionals. Competition for physicians and other healthcare professionals, coupled with increased recruiting and retention costs, will increase hospital operating costs, possibly significantly, and growth may be constrained. This trend is expected to intensify in the future, aggravating the general shortage and increasing the likelihood of hospital-specific shortages. Competition for physicians and employees, coupled with increased recruiting and retention costs, may increase hospital operating costs, possibly significantly. This trend could have a material adverse impact on hospitals. As reimbursement amounts are reduced to healthcare facilities and organizations that employ or contract with physicians, nurses and other healthcare professionals, pressure to control and possibly reduce wage and benefit costs may further strain the supply of those professionals.

The healthcare industry is facing a nationwide shortage of nursing and allied healthcare professionals, including registered nurses. A shortage of nursing staff and allied healthcare professionals could result in escalating labor costs, delays in providing care, and patient care management issues, among other adverse effects. The shortage of nurses and allied healthcare professionals may be exacerbated if the increase in access to coverage provided under the Affordable Care Act leads to an increase in demand for medical care or a greater reliance on nursing staff and allied healthcare professionals. The Affordable Care Act includes numerous workforce programs that should have an impact on existing and projected shortages of nurses and allied healthcare professionals and increase their availability. There can be no assurance that a shortage of nurses and allied healthcare professionals will not adversely affect the operations of the Healthcare Obligated Group Members or financial condition of the Obligated Group.

In addition to personnel shortages, contract labor, including contract nurses, is substantially more expensive and has led to escalating operating expenses for hospitals and health care organizations. Continued increases in the cost of labor may adversely affect the financial condition of the Obligated Group.

Action by Purchasers of Hospital Services and Consumers. Major purchasers of hospital services also could take action to restrain hospital charges or charge increases. As a result of increased public scrutiny, it is also possible that the pricing strategies of hospitals may be perceived negatively by consumers, and hospitals may be forced to reduce fees for their services. Decreased utilization could result, and hospitals' revenues may be negatively impacted. In addition, consumers and groups on behalf of consumers are increasing pressure for hospitals and other healthcare providers to be transparent and provide information about cost and quality of services that may affect future consumer choices about where to receive healthcare services.

Negative Rankings Based on Clinical Outcomes, Cost, Quality, Patient Satisfaction and Other Performance Measures. Health plans, Medicare, Medicaid, employers, trade groups and other purchasers of health services, private standard-setting organizations and accrediting agencies increasingly are using statistical and other measures in efforts to characterize, publicize,

compare, rank and change the quality, safety and cost of healthcare services provided by hospitals and providers. The Affordable Care Act shifts the basis of payments from the volume of services to the value of services, based on various health outcome measures. Published rankings such as Medicare's "Hospital Compare" quality ranking systems, "score cards," "pay for performance" and other financial and non-financial incentive programs are being introduced to affect the reputation and revenue of hospitals, the members of their medical staffs and other providers and influence the behavior of consumers and providers such as the System Affiliates. Currently prevalent are measures of quality based on clinical outcomes of patient care, reduction in costs, patient satisfaction and investment in health information technology. Measures of performance set by others that characterize a hospital or a provider negatively may adversely affect its reputation and financial condition.

Licensing, Surveys, Investigations and Accreditations

Certain of the facilities operated by the Healthcare Obligated Group Members are certified as providers for Medicare services, and such Healthcare Obligated Group Members intend to continue to participate in the Medicare program. The requirements for Medicare certification are subject to change, and in order to remain qualified for the program, it may be necessary for the Healthcare Obligated Group Members to effect changes from time to time in their facilities, equipment, personnel, billing processes, policies and services.

Health facilities, including those of the Healthcare Obligated Group Members, are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. These include, but are not limited to, requirements relating to Medicare and Medicaid participation and payment, state licensing agencies, and private payers and accreditation by The Joint Commission. Renewal and continuance of certain of these licenses, certifications and accreditations are based on inspections, surveys, audits, investigations or other reviews, some of which may require or include affirmative action or response by a Healthcare Obligated Group Member. These activities generally are conducted in the normal course of business of health facilities. Nevertheless, an adverse action could result in a loss or reduction in a Healthcare Obligated Group Member's scope of licensure, certification or accreditation, or could reduce the payment received or require repayment of amounts previously remitted.

Management of the Institution currently anticipates no difficulty renewing or continuing currently held licenses, certifications or accreditations, nor does it anticipate a reduction in third-party payments from such events that would materially adversely affect the operations or financial condition of the Obligated Group. See "ADDITIONAL INFORMATION – Licenses Accreditation" in Appendix A hereto as to the current status of the licenses and accreditations of the Healthcare Obligated Group Members. Nevertheless, actions in any of these areas could result in the loss of utilization or revenues, or the Obligated Group's inability to operate all or a portion of their health facilities, and, consequently, could have a material adverse effect on the Obligated Group's ability to make the debt service payments relating to the Series 2025 Bonds.

Additional Parity Debt

The Loan Agreement permits the Obligated Group to incur additional Indebtedness and other obligations constituting Parity Debt. Any such additional Parity Debt would be entitled to share ratably with the holders of the Series 2025 Bonds and other outstanding Parity Debt in any money realized from the exercise of remedies in the event of a default by the Obligated Group to the extent provided in the Resolution. See "ADDITIONAL DEBT - Parity Debt."

Bond Ratings

There is no assurance that the ratings assigned to the Series 2025 Bonds at the time of issuance will not be lowered or withdrawn at any time, which could adversely affect the market price and marketability of the Series 2025 Bonds. See "RATINGS" herein.

Secondary Market

There can be no assurance that there will be a secondary market for the purchase or sale of the Series 2025 Bonds. Neither the Underwriters nor any other financial institution is obligated to make a market in the Series 2025 Bonds, and any financial institution that does so may discontinue its market-making activities at any time without notice. From time to time there may be no market for the Series 2025 Bonds depending upon prevailing market conditions, the financial condition or market position of firms who may make the secondary market and the financial condition and results of operations of the Obligated Group. The Series 2025 Bonds should therefore be considered long-term investments in which funds are committed to maturity.

Prepayment Risks

The Series 2025 Bonds are subject to redemption or purchase, without premium, in advance of their stated maturities under certain circumstances. See "THE SERIES 2025 BONDS – Redemption Provisions" herein. Upon the occurrence of certain events of default, the payment of the principal of and interest on the Series 2025 Bonds may be accelerated. See "Summary Of Certain Provisions Of The Resolution – Events of Default and Remedies" in Appendix C. Thus, there can be no assurance that the Series 2025 Bonds will remain outstanding until their stated maturities.

Certain Other Risks

The following factors, among others, may also adversely affect the Obligated Group to an extent that cannot be determined at this time:

(1) Changes in key management personnel.

(2) Loss of accreditations. See "ADDITIONAL INFORMATION – Licenses and Accreditation" in Appendix A.

(3) Reductions in utilization of health care facilities as a result of preventive medicine, improved occupational health and safety, development and utilization of medical and scientific research and technological advances and other developments.

(4) Future legislation and regulations affecting hospitals, governmental and commercial medical insurance and the health care industry in general, including reductions in federal or state funding of Medicare, Medicaid or other government-financed health care reimbursement programs.

(5) Changes in reimbursement procedures or in contracts under public or private insurance programs.

(6) Increased costs of attracting and retaining or decreased availability of a sufficient number of physicians, registered nurses and other allied health professionals.

(7) Increased costs resulting from unionization of the employees of the Obligated Group Members or the utilization by a non-union employee of an Obligated Group Member of proceedings available under the National Labor Relations Act.

(8) The health care facilities owned by the Healthcare Obligated Group Members are comprised of special-purpose facilities which are not suitable for industrial or commercial use; consequently, it could be difficult to find a buyer or lessee for such facilities if the Healthcare Obligated Group Members seek to sell any of their facilities.

(9) Depletion of the Medicare Trust Fund, further reductions in the funds of the state available for the payment of Medicaid reimbursement or any failure of third-party payors to pay amounts owed to the Healthcare Obligated Group Members in a timely manner.

(10) Increases in costs, including costs associated with, among other things, salaries, wages and fringe benefits, supplies, technology and equipment, insurance, energy and other utilities, compliance with or violation of laws and regulations concerning work safety, accommodating persons with disabilities and other matters, and other costs that could result in a sizable increase in expenditures without a corresponding increase in revenues.

(11) Increased shift of health care costs from employer-based commercial insurance plans to employees, who may have insufficient resources to pay for health care services.

(12) Inability of the Obligated Group Members to obtain governmental approvals required to undertake additional projects necessary to remain competitive as to rates, charges and the quality and scope of care or any limitation on the availability of tax-exempt or other financing for future projects.

(13) A decline in the demand for medical school education or increasing demand for financial aid, arising from a change in the demographics or age composition of the population or from adverse or declining economic conditions of the areas from which MSOM draws a significant portion of its enrollment.

(14) Reduced availability of qualified faculty to teach the programs offered by the Medical School.

(15) Changes in federal, state or local taxation of non-for-profit corporations such as the Obligated Group Members or a reduction or elimination of the real estate tax exemption available to charitable organizations.

(16) The occurrence of natural disasters, including floods, hurricanes, tornadoes, epidemics, pandemics and earthquakes, or the occurrence of criminal or terrorist acts, epidemics or other calamities, which could damage the facilities of the Obligated Group Members, interrupt utility service to their facilities or otherwise impair the operations of the Obligated Group Members and the generation of revenues from their facilities, and any failure of the insurance carried by the Obligated Group Members to cover any losses resulting from the occurrence of any such event.

(17) Lack of demand for on-campus housing at the Medical School.

The paragraphs above discuss certain Bondholders' risks, but are not intended to be a complete enumeration of all risks associated with the purchase or holding of the Series 2025 Bonds.

UNDERWRITING

Truist Securities, Inc. ("Truist Securities") and BofA Securities, Inc. ("BofA Securities" and together, the "Underwriters") have agreed, subject to certain conditions, to purchase the Series 2025 Bonds at an aggregate price of $367,306,450.96 (which constitutes the $361,030,000 aggregate principal amount of the Series 2025 Bonds plus the net original issue premium of $7,977,350.65 and less an Underwriters' discount of $1,700,899.69). The purchase contract (the "Bond Purchase Agreement") provides that the Underwriters will purchase all of the Series 2025 Bonds, if any are purchased, and requires the Obligated Group Members to indemnify the Underwriters and the Authority against certain losses, claims, damages and liabilities arising out of any incorrect statements or information contained in this Official Statement.

The initial offering prices set forth on the cover of this Official Statement may be changed from time to time by the Underwriters.

The Underwriters may offer and sell Series 2025 Bonds to certain dealers (including dealers depositing Series 2025 Bonds into investment trusts, certain of which may be sponsored or managed by the Underwriters) and others at prices lower than the offering prices set forth on the cover page hereof.

Truist Securities has entered into an agreement (the "Truist Distribution Agreement") with Truist Investment Services, Inc. ("TIS") for the retail distribution of certain municipal securities offerings, including the Series 2025 Bonds. Pursuant to the Truist Distribution Agreement, Truist Securities will share a portion of its underwriting compensation, as applicable,

with respect to the Series 2025 Bonds with TIS. Each of Truist Securities and TIS is a subsidiary of Truist Financial Corporation.

Truist Securities is the trade name for the corporate and investment banking services of Truist Financial Corporation and its subsidiaries. Securities and strategic advisory services are provided by Truist Securities, Inc., member FINRA and SIPC. Lending, financial risk management, and treasury management and payment services are offered by Truist Bank. Deposit products are offered by Truist Bank, Member FDIC. In its normal course of business Truist Bank may currently, or in the future, provide credit, treasury management, or other commercial banking services to the Authority, the Institution or the System Affiliates or MSOM.

BofA Securities has entered into a distribution agreement with its affiliate Merrill Lynch, Pierce, Fenner & Smith Incorporated ("MLPF&S"). As part of this arrangement, BofA Securities may distribute securities to MLPF&S, which may in turn distribute such securities to investors through the financial advisor network of MLPF&S. As part of this arrangement, BofA Securities may compensate MLPF&S as a dealer for their selling efforts with respect to the Series 2025 Bonds.

The Underwriters and their affiliates are full service financial institutions engaged in various activities, which may include securities trading, commercial and investment banking, financial advisory, investment management, principal investment, hedging, financing and brokerage services. The Underwriters and their affiliates have, from time to time, performed and may in the future perform, various financial advisory, commercial banking, investment banking and swap counterparty services for the Institution, the System Affiliates and MSOM, for which they received or will receive customary fees and expenses.

In the ordinary course of their various business activities, the Underwriters and their affiliates may make or hold a broad array of investments and actively trade debt and equity securities (or related derivative securities, which may include credit default swaps) and financial instruments (including bank loans) for their own account and for the accounts of their customers and may at any time hold long and short positions in such securities and instruments. Such investment and securities activities may involve securities and instruments of the Authority, the Institution, the System Affiliates and MSOM.

The Underwriters and their affiliates may also communicate independent investment recommendations, market color or trading ideas and publish or express independent research views in respect of such assets, securities or instruments and may at any time hold, or recommend to clients that they should acquire, long or short positions in such assets, securities and instruments.

RATINGS

Each of Fitch Ratings Inc. ("Fitch") and Standard & Poor's Global Ratings Services ("S&P") has assigned the Series 2025 Bonds a long-term rating of "A" (Stable Outlook) and "A-" (Stable Outlook), respectively. The Obligated Group Members furnished to the rating agencies certain materials and information respecting the Series 2025 Bonds and themselves.

Concurrently with the delivery of the Series 2025 Bonds, S&P is expected to assign an insured rating of "AA" with respect to the 2025 Insured Bonds, based up on the issuance of the 2025 Insurance Policy by the 2025 Insurer.

Generally, rating agencies base their ratings on such materials and information and on investigations, studies and assumptions by the rating agencies. The ratings reflect only the views of Fitch and S&P, respectively.

No assurance can be given that such ratings or either of them will remain in effect for any given period of time or that they may not be reduced or withdrawn by the rating agencies, if in their judgment, circumstances so warrant. Any downward change in or withdrawal of such ratings could adversely affect the market price of the Series 2025 Bonds.

TAX MATTERS

The following is only a general summary of certain provisions of the Internal Revenue Code, as enacted and in effect on the date hereof and does not purport to be complete; holders of the Series 2025 Bonds should consult their own tax advisors as to the effects, if any, of the Code (and any proposed or subsequently enacted amendments to the Code) in their particular circumstances.

Tax Exemptions

McKennon Shelton & Henn LLP, Bond Counsel to the Authority, is of the opinion that, under existing statutes, regulations and decisions (i) assuming compliance with certain covenants described herein, the interest on the Series 2025 Bonds is excludable from gross income for purposes of federal income taxation, and (ii) by the terms of the Act, the interest on the Series 2025 Bonds, their transfer and any income derived from the Series 2025 Bonds, including profits made in their sale or transfer, are exempt from all Maryland state and local taxes. No opinion is expressed as to estate or inheritance taxes or any other taxes not levied or assessed directly on the Series 2025 Bonds, their transfer or the income therefrom.

Under the provisions of the Code, there are certain restrictions that must be met subsequent to the delivery of the Series 2025 Bonds in order for interest on the Series 2025 Bonds to remain excludable from gross income for federal income tax purposes, including restrictions that must be complied with throughout the term of the Series 2025 Bonds. These include the following: (i) a requirement that certain earnings received from the investment of amounts deemed to be proceeds of the Series 2025 Bonds be rebated to the United States of America under certain circumstances (or that certain payments in lieu of rebate be made); (ii) other requirements applicable to the investment of the proceeds of the Series 2025 Bonds; and (iii) other requirements applicable to the use of the proceeds of the Series 2025 Bonds and the facilities financed or refinanced with proceeds of the Series 2025 Bonds. Failure to comply with one or more of these requirements could result in the inclusion of the interest payable on the Series 2025 Bonds in gross income for federal income tax purposes, effective from the date of their issuance. The Authority and the Obligated Group Members and certain of their affiliates have made certain covenants regarding actions required to maintain the excludability of interest on the Series 2025 Bonds from gross income for federal income tax purposes. It is the opinion of Bond Counsel that, assuming compliance with such covenants, the interest on the Series 2025

Bonds will remain excludable from gross income for federal income tax purposes under the provisions of the Code.

Further, Bond Counsel is of the opinion that under existing statutes, regulations and decisions, interest on the Series 2025 Bonds is not included in the alternative minimum taxable income of individuals as an enumerated item of tax preference or other specific adjustment, however, interest on the Series 2025 Bonds will be part of the adjusted financial statement income in computing the alternative minimum tax imposed on applicable corporations. For this purpose, in general, applicable corporations are corporations with more than $1.0 billion in average annual adjusted financial statement income determined over a three-year period. Interest income on the Series 2025 Bonds will be subject to the branch profits tax imposed by the Code on certain foreign corporations engaged in a trade or business in the United States of America.

In rendering its opinion, McKennon Shelton & Henn LLP will rely on the Obligated Group's Tax and Section 148 Certificate and Agreement with respect to certain material facts within the knowledge of the Obligated Group Members relevant to the tax-exempt status of interest on the Series 2025 Bonds and will assume the correctness of the opinion of the Chief Legal Officer and Vice President of Legal Services of the Institution, with respect to the tax-exempt status of the Obligated Group Members, in each case without independent investigation.

See Appendix D hereto for the proposed form of opinion of Bond Counsel for the Series 2025 Bonds.

Tax Accounting Treatment of Discount Bonds

Certain maturities of the Series 2025 Bonds with fixed interest rates may be issued at an initial public offering price which is less than the amount payable on such Series 2025 Bonds at maturity (the "Discount Bonds"). The difference between the initial offering price at which a substantial amount of the Discount Bonds of each maturity was sold and the principal amount of such Discount Bonds payable at maturity constitutes original issue discount. In the case of any holder of Discount Bonds, the amount of such original issue discount which is treated as having accrued with respect to such Discount Bonds is added to the original cost basis of the holder in determining, for federal income tax purposes, gain or loss upon disposition (including sale, early redemption or purchase or repayment at maturity). For federal income tax purposes (i) any holder of a Discount Bond will recognize gain or loss upon the disposition of such Discount Bond (including sale, early redemption, purchase or payment at maturity) in an amount equal to the difference between (a) the amount received upon such disposition and (b) the sum of (1) the holder's original cost basis in such Discount Bond, and (2) the amount of original issue discount attributable to the period during which the holder held such Discount Bond, and (ii) the amount of the basis adjustment described in clause (i)(b)(2) will not be included in the gross income of the holder.

Original issue discount on Discount Bonds will be attributed to permissible compounding periods during the life of any Discount Bonds in accordance with a constant rate of interest accrual method. The yield to maturity of the Discount Bonds of each maturity is determined using permissible compounding periods. In general, the length of a permissible compounding period cannot exceed the length of the interval between debt service payments on the Discount Bonds and must begin or end on the date of such payments. Such yield then is used to determine an amount of accrued interest for each permissible compounding period. For this purpose,

interest is treated as compounding periodically at the end of each applicable compounding period. The amount of original issue discount which is treated as having accrued in respect of a Discount Bond for any particular compounding period is equal to the excess of (i) the product of (a) the yield on the Discount Bond (adjusted as necessary for any initial short period) divided by the number of compounding periods in a year multiplied by (b) the amount that would be the tax basis of such Discount Bond at the beginning of such period if held by an original purchaser who purchased at the initial public offering price, over (ii) the amount actually payable as interest on such Discount Bond during such period. The tax basis of a Discount Bond, if held by an original purchaser, can be determined by adding to the initial public offering price of such Discount Bond the original issue discount that is treated as having accrued during all prior compounding periods. If a Discount Bond is sold or otherwise disposed of between compounding dates, then interest which would have accrued for that compounding period for federal income tax purposes is to be apportioned in equal amounts among the days in such compounding period.

Holders of Discount Bonds should note that, under applicable regulations, the yield and maturity of a Discount Bond is determined without regard to commercially reasonable sinking fund payments and any original issue discount remaining unaccrued at the time that a Discount Bond is redeemed or purchased in advance of stated maturity will be treated as taxable gain. Moreover, tax regulations prescribe special conventions for determining the yield and maturity of certain debt instruments that provide for alternative payment schedules applicable upon the occurrence of certain contingencies.

The yields (and related prices) provided by the Underwriters shown on the cover of this Official Statement may not reflect the initial issue prices for purposes of determining the original issue discount for federal income tax purposes.

The foregoing summarizes certain federal income tax consequences of original issue discount with respect to the Discount Bonds but does not purport to deal with all aspects of federal income taxation that may be relevant to particular investors or circumstances, including those set out above. Prospective purchasers of Discount Bonds should consider possible state and local income, excise or franchise tax consequences arising from original issue discount on Discount Bonds. In addition, prospective corporate purchasers should consider possible federal tax consequences arising from original issue discount on such Discount Bonds under the branch profits tax. The amount of original issue discount considered to have accrued may be reportable in the year of accrual for state and local tax purposes or for purposes of the branch profits tax without a corresponding receipt of cash with which to pay any tax liability attributable to such discount. Purchasers with questions concerning the detailed tax consequences of transactions in the Discount Bonds should consult their tax advisors.

Tax Accounting Treatment of Premium Bonds

A Series 2025 Bond will be considered to have been issued at a premium if, and to the extent that immediately after the acquisition of such Series 2025 Bond, the holder's tax basis in such Series 2025 Bond exceeds the amount payable at maturity (or, in the case of a Series 2025 Bond callable prior to maturity, the amount payable on an earlier call date). Under regulations applicable to the Series 2025 Bonds, the amount of the premium is determined with reference to the amount payable on that call date (including for this purpose the maturity date) which produces the lowest yield to maturity on a Series 2025 Bond. The holder will be required to reduce his tax basis in a Series 2025 Bond for purposes of determining gain or loss upon

disposition of such Series 2025 Bond by the amount of amortizable bond premium that accrues, determined in the manner prescribed in the regulations. Generally, no deduction (or other tax benefit) is allowable in respect of any amount of amortizable bond premium on the Series 2025 Bonds.

Purchasers with questions concerning the detailed tax consequences of transactions in the Series 2025 Bonds issued at a premium should consult their tax advisors.

Additional Federal Income Tax Considerations

Certain Federal Tax Consequences of Ownership

There are other federal income tax consequences of ownership of obligations such as the Series 2025 Bonds under certain circumstances, including the following: (i) deductions are disallowed for certain expenses of taxpayers allocable to interest on tax-exempt obligations, as well as interest on indebtedness incurred or continued to purchase or carry tax-exempt obligations and interest expense of financial institutions allocable to tax-exempt interest; (ii) for property and casualty insurance companies, the amount of the deduction for losses incurred must be reduced by 25% of the sum of tax-exempt interest received or accrued and the deductible portion of dividends received by such companies; (iii) interest income which is exempt from tax must be taken into account for the purpose of determining whether, and what amount of, social security or railroad retirement benefits are includable in gross income for federal income taxation purposes; (iv) for S corporations having Subchapter C earnings and profits, the receipt of certain levels of passive investment income, including interest on tax-exempt obligations such as the Series 2025 Bonds, can result in the imposition of tax on such passive investment income and, in some cases, loss of S corporation status; (v) net gain realized upon the sale or other disposition of property such as the Series 2025 Bonds generally must be taken into account when computing the 3.8% Medicare tax with respect to net investment income or undistributed net investment income, as applicable, imposed on certain high income individuals and specified trusts and estates; and (vi) receipt of certain investment income, including interest on the Series 2025 Bonds, is considered when determining qualification limits for obtaining the earned income credit provided by Section 32(a) of the Code.

Purchase, Sale and Retirement of Series 2025 Bonds

Except as noted below with respect to accrued market discount, the sale or other disposition of a Series 2025 Bond may result in capital gain or loss to its holder. A holder's initial tax basis in a Series 2025 Bond will be its cost. Upon the sale or retirement of a Series 2025 Bond, for federal income tax purposes a holder will recognize capital gain or loss upon the disposition of such Series 2025 Bond (including sale, early redemption, mandatory tender or purchase or repayment at maturity) in an amount equal to the difference between (a) the amount received upon such disposition and (b) the tax basis in such Series 2025 Bond, determined by adding to the original cost basis in such Series 2025 Bond the amount of original issue discount that is treated as having accrued as described above under "Tax Accounting Treatment of Discount Bonds," as applicable. Such gain or loss will be long-term capital gain or loss if at the time of the sale or retirement the Series 2025 Bond has been held for more than one year. Under present law both long and short-term capital gains of corporations are taxed at the rates applicable to ordinary income. For noncorporate taxpayers, however, short-term capital gains are taxed at the rates applicable to ordinary income, while net capital gains are taxed at lower

rates. Net capital gains are the excess of net long-term capital gains (gains on capital assets held for more than one year) over net short-term capital losses.

If a holder acquires a Series 2025 Bond at a discount from its principal amount (or in the case of a Series 2025 Bond issued at an original issue discount, at a price that produces a yield to maturity higher than the yield to maturity at which such Series 2025 Bond was first issued), the holder will be deemed to have acquired the Series 2025 Bond at "market discount," unless the amount of market discount is *de minimis*, as described in the following paragraph. If a holder that acquires a Series 2025 Bond with market discount subsequently realizes a gain upon the disposition of the Series 2025 Bond, such gain shall be treated as taxable ordinary income to the extent such gain does not exceed the accrued market discount attributable to the period during which the holder held such Series 2025 Bond, and any gain realized in excess of such market discount will be treated as capital gain. Potential purchasers should consult their tax advisors as to the proper method of accruing market discount.

In the case of a Series 2025 Bond not issued at an original issue discount, market discount will be *de minimis* if the excess of such Series 2025 Bond's stated redemption or purchase price at maturity over the holder's cost of acquiring such Series 2025 Bond is less than 0.25% of the stated redemption or purchase price at maturity multiplied by the number of complete years between the date the holder acquires such Series 2025 Bond and its stated maturity date. In the case of a Series 2025 Bond issued with original issue discount, market discount will be *de minimis* if the excess of such Series 2025 Bond's revised issue price over the holder's cost of acquiring such Series 2025 Bond is less than 0.25% of the revised issue price multiplied by the number of complete years between the date the holder acquires such Series 2025 Bond and its stated maturity date. For this purpose, a Series 2025 Bond's "revised issue price" is the sum of (i) its original issue price and (ii) the aggregate amount of original issue discount that is treated as having accrued with respect to such Series 2025 Bond during the period between its original issue date and the date of acquisition by the holder.

U.S. Federal Backup Withholding and Information Reporting

In general, information reporting requirements apply with respect to payments to certain non-corporate United States holders of interest and original issue discount on, and payments to such holders of the proceeds of the sale, exchange, redemption, retirement or other disposition of a Series 2025 Bond. If a United States holder of a Series 2025 Bond (other than a corporation or other specified exempt entity) fails to satisfy applicable information reporting requirements imposed by the Code, payments to such holder will be subject to "backup withholding", which means that the payor is required to deduct and withhold a tax equal to 24% of the payments. In general, the information reporting requirements (where applicable) are satisfied if the holder completes, and provides the payor with, a Form W-9, "Request for Taxpayer Identification Number and Certification." Backup withholding should not occur if a holder purchases a Series 2025 Bond through a brokerage account with respect to which a Form W-9 has been provided, as generally can be expected. Any amounts withheld pursuant to backup withholding would be subject to recovery by the holder through proper refund or credit.

Legislative Developments

Legislative proposals under consideration or proposed after issuance and delivery of the Series 2025 Bonds could adversely affect the market value of the Series 2025 Bonds. Further, if enacted into law, any such legislation could cause the interest on the Series 2025 Bonds to be

subject, directly or indirectly, to federal income taxation and could otherwise alter or amend one or more of the provisions of federal tax law described above or their consequences. Prospective purchasers of the Series 2025 Bonds should consult with their tax advisors as to the status and potential effect of legislative proposals, as to which Bond Counsel expresses no opinion.

LEGALITY OF SERIES 2025 BONDS FOR INVESTMENT AND DEPOSIT

The Act provides that the Series 2025 Bonds are securities in which all public officers and public bodies of the State of Maryland and its political subdivisions, all insurance companies, state banks and trust companies, savings banks, savings and loan associations, investment companies, executors, administrators, trustees and other fiduciaries in the State of Maryland may properly and legally invest funds.

The Series 2025 Bonds, under the Act, may be deposited with and received by any State or municipal officer or any agency or political subdivision of the State of Maryland for any purpose for which the deposit of bonds or obligations of the State of Maryland may be authorized by law.

STATE NOT LIABLE ON SERIES 2025 BONDS

The Series 2025 Bonds are special obligations of the Authority payable solely from the Revenues, and neither the faith and credit nor the taxing power of the State of Maryland, of any political subdivision thereof or of the Authority is pledged to the payment of the principal of or interest on the Series 2025 Bonds.

The sources of revenues or money of the Authority are limited to those provided by the Act, and the issuance of the Series 2025 Bonds does not directly or indirectly or contingently obligate, morally or otherwise, the State of Maryland, any political subdivision thereof or the Authority to levy or to pledge any form of taxation whatever therefor or to make any appropriation for their payment. The Authority has no taxing power.

CORPORATE EXISTENCE OF THE AUTHORITY

The Act states that the Authority and its corporate existence shall continue until terminated by law, provided that no such law shall take effect so long as the Authority shall have bonds, notes or other obligations outstanding, unless adequate provision has been made for the payment thereof. Upon termination of the existence of the Authority, all of its rights and properties shall pass to and be vested in the State of Maryland.

FINANCIAL ADVISOR

PFM Public Financial Advisors LLC ("PFM") has served as financial advisor to the Authority in connection with the issuance of the Series 2025 Bonds. PFM is not obligated to undertake, and has not undertaken, either to make an independent verification of or to assume responsibility for, the accuracy, completeness or fairness of the information contained in this Official Statement. PFM is an independent financial advisory firm and is not engaged in the business of underwriting, trading or distributing securities.

LEGAL MATTERS

McKennon Shelton & Henn LLP is acting as Bond Counsel to the Authority in connection with the issuance of the Series 2025 Bonds. The proposed form of Bond Counsel's approving opinion appears as Appendix D. Certain legal matters will be passed upon for the Underwriters by Ballard Spahr LLP. Certain legal matters will be passed upon for the Obligated Group Members by the Chief Legal Officer and Vice President of Legal Services of the Institution and Gallagher Evelius & Jones LLP.

INDEPENDENT AUDITORS

The consolidated financial statements of Meritus Health, Inc. and Subsidiaries as of June 30, 2024 and 2023, and for the years then ended, included in Appendix B, have been audited by KPMG LLP, independent auditors as stated in their report appearing therein. Such consolidated financial statements include affiliates of the Obligated Group that have no liability with respect to the Series 2025 Bonds.

VERIFICATION OF MATHEMATICAL COMPUTATIONS

Causey Public Finance, LLC ("CPF"), a firm of independent public accountants, will deliver to the Authority, on or before the date of issuance of the Series 2025 Bonds, its verification report indicating that it has reviewed, in accordance with standards established by the American Institute of Certified Public Accountants, certain information and assumptions provided by the Underwriters with respect to the Refunded Bonds. Included in the scope will be a verification of the mathematical accuracy of the mathematical computations of the adequacy of the cash to be deposited with the Bond Trustee to pay the principal of and interest on the Refunded Bonds upon their redemption on July 1, 2025.

The verification performed by CPF will be solely based upon data, information and documents provided to CPF by the Underwriters. The CPF report will state that CPF has no obligation to update the reports because of events occurring, or data or information coming to its attention, subsequent to the dates of the reports.

RELATIONSHIPS

Bank of America, N.A., an affiliate of BofA Securities, an underwriter for the Series 2025 Bonds, is the holder of the Parity Note.

McKennon Shelton & Henn LLP serves as general counsel to the Authority and is acting as Bond Counsel in connection with the issuance of the Series 2025 Bonds.

CONTINUING DISCLOSURE

In accordance with Rule 15c2-12 (the "Rule") promulgated by the Securities and Exchange Commission, the Obligated Group Members undertake for the benefit of the Holders of the Series 2025 Bonds to provide certain financial information or operating data and audited financial statements, and to provide notices of certain material events as described under

"Summary of Certain Provisions of the Loan Agreement - Continuing Disclosure" in Appendix C.

The Obligated Group Members' annual operating information initially filed with the Municipal Securities Rulemaking Board (the "MSRB") through its Electronic Municipal Market Access System ("EMMA") for the fiscal year ended June 30, 2024 omitted Meritus Medical Center's licensed bed capacity. The Obligated Group Members have made a supplemental filing to address such omission. In addition, certain annual and quarterly filings made during the last five years have been made after the date required by the Loan Agreement; the Obligated Group Members have filed with EMMA a notice of such failure to make such timely filings.

MISCELLANEOUS

The references herein to the Act, the Resolution, the Loan Agreement and other materials are brief outlines of certain provisions thereof. Such outlines do not purport to be complete and, for full and complete statements of such provisions, reference is made to such instruments, documents and other materials, copies of which are on file at the offices of the Authority.

The information contained in this Official Statement has been compiled or prepared from information obtained from the Institution and official and other sources deemed to be reliable and, while not guaranteed as to completeness or accuracy, is believed to be correct as of this date. Any statements involving matters of opinion, whether or not expressly so stated, are intended as such and not as representations of fact.

The Authority has either provided or reviewed the information under the headings "The Authority," "State Not Liable on Series 2025 Bonds" and "Corporate Existence of the Authority" as it relates to the Authority and will not be responsible for any other statements or information in this Official Statement.

The attached Appendices are integral parts of this Official Statement and should be read in their entirety together with all of the foregoing information.

The Obligated Group Members have reviewed the information contained herein and have authorized certain officers of the Institution to approve this Official Statement.

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The execution and delivery of this Official Statement by the Chairman or other authorized Member and the Executive Director of the Authority have been duly authorized by the Authority.

MARYLAND HEALTH AND HIGHER
EDUCATIONAL FACILITIES AUTHORITY

By: /s/ Arnold Williams
Arnold Williams
Chairman

By: /s/Barlow T. Savidge
Barlow T. Savidge
Executive Director

Approved: May 29, 2025

MERITUS MEDICAL CENTER, INC.

By: /s/ Joshua Repac
Joshua Repac
Treasurer, Vice President and
Chief Financial Officer

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APPENDIX A

MERITUS HEALTH AND THE OBLIGATED GROUP

This Official Statement contains statements related to future business and financial performance and future events or developments that may constitute forward-looking statements. These statements may be identified by words such as "expects," "looks forward to," "anticipates," "intends," "plans," "budgets," "pro forma," "believes," "seeks," "estimates," "will," "may," "continue," "projects" or words of similar meaning. Such statements are based on current expectations and certain assumptions and are, therefore, subject to various risks and uncertainties. A variety of factors, many of which are beyond the control of the Obligated Group, affect operations, performance, business strategy and results and could cause actual results, performance or achievements to be materially different from any future results, performance or achievements that may be expressed or implied by such forward-looking statements or anticipated on the basis of historical trends. Should one or more of these risks or uncertainties materialize, or should underlying assumptions prove incorrect, actual results, performance or achievements may vary materially from those expressed or implied in any forward-looking statements. The Obligated Group neither intends, nor assumes any obligation, to update or revise these forward-looking statements if or when changes in its expectations, or events, conditions or circumstances on which such statements are based, occur.

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Table of Contents

INTRODUCTION

History and General Background

Meritus Health, Inc. ("MHI"), together with its subsidiaries, constitutes a regional, community-based academic healthcare delivery system committed to serving the healthcare needs of Washington County, Maryland and surrounding areas in Maryland, Pennsylvania, and West Virginia. As used in this Appendix A, "Meritus Health" or the "System" means MHI and each other entity that is consolidated with MHI for financial reporting purposes under generally accepted accounting principles.

Meritus Health traces its origins to October 26, 1905, when the Washington County Hospital Association opened a small, community-focused hospital in Hagerstown, Maryland. The hospital, housed in a repurposed Victorian-style home, opened with 10 beds, 12 physicians, and served 106 patients in its first year. At the time, Hagerstown was rapidly emerging as a regional transportation hub within the Great Appalachian Valley, located approximately 70 miles northwest of Washington, D.C. What began as a modest healthcare facility has evolved into one of the region's most vital and innovative healthcare systems.

Today, Meritus Health offers a comprehensive continuum of care, including general and specialty services for medical, surgical, pediatric, geriatric, and obstetrical patients, as well as an integrated network of physician practices and outpatient services. With approximately 4,300 employees and 500 medical staff, Meritus Health is the largest private employer in the five most western Maryland counties. Meritus Health generated approximately $607.4 million in consolidated operating revenue for the fiscal year ended June 30, 2024 (*see* "Financial Performance"). As of June 30, 2024, Meritus Health is one of the few remaining independent, community-based health systems in Maryland - anchored by its mission to improve the health of the region by providing the best healthcare, health services and medical education. The vision of Meritus Health is to serve as a model community-based, academic health system.

The members of the Obligated Group, each of which is a component of Meritus Health, are: Meritus Medical Center, Inc. ("MMC"), which owns and operates Meritus Medical Center, an acute care hospital with 259 licensed beds (the "Medical Center"), MSOM, Inc. ("MSOM"), which operates the Meritus School of Osteopathic Medicine (the "Medical School"), and Brook Lane Health Services, Inc. ("Brook Lane"), which owns and operates the second largest freestanding psychiatric hospital ("Brook Lane Hospital") in Maryland with 65 licensed beds. MMC owns the Medical School's facilities and the land on which they are located, which MMC intends to convey to MSOM in the near term. MHI is the sole member of MMC and MSOM, and is the sole member of Brook Lane, Inc. ("Brook Lane Parent"), the sole member of Brook Lane. MHI and Brook Lane Parent are not members of the Obligated Group.

As of June 30, 2024, the members of the Obligated Group accounted for approximately 93% of Meritus Health's total consolidated assets and 80% of total unrestricted revenue, gains, and other support of Meritus Health.

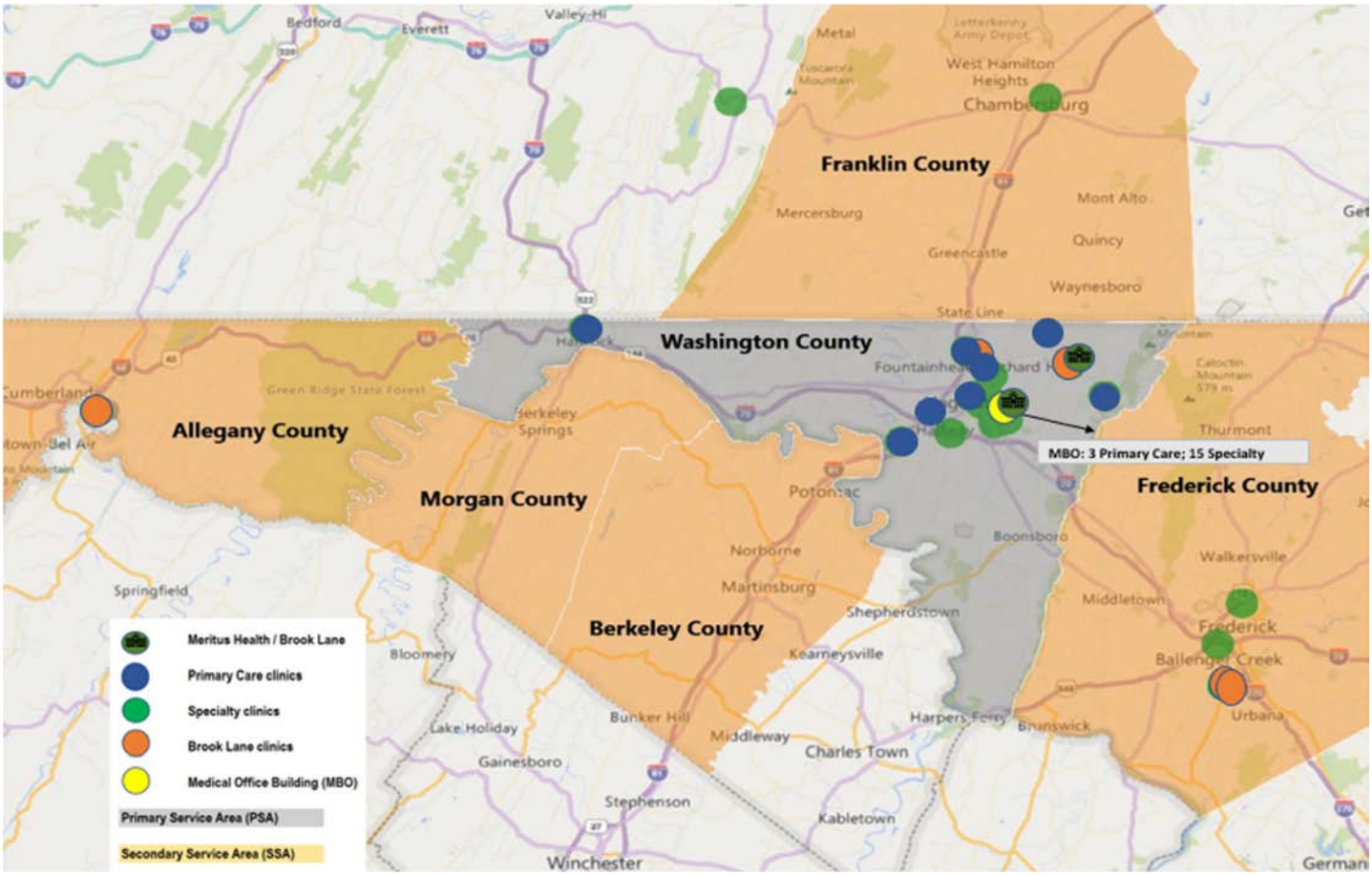
Unless otherwise indicated, all references to financial and statistical data are based on Meritus Health's internal records.

In 2021, Meritus Health embarked on a bold, mission-driven initiative to address the growing national and regional physician shortage through the creation of a community-based academic health system. This initiative led to the formation of MSOM in 2022, for the purpose of establishing the Medical School, along with Meritus Commons, a purpose-built student housing complex. For details of the Medical School and Meritus Commons, *see* "THE 2025 PROJECT." In 2024, Meritus Health further expanded the

scope of services it provides through an affiliation with Brook Lane Parent, which, through its subsidiaries, including Brook Lane and Brook Lane Behavioral Services, Inc., is a leading behavioral health provider, to meet growing demand for mental health services across the state (collectively, "Brook Lane Health").

Below is a map depicting Meritus Health locations throughout its primary and secondary service areas:

Meritus Health Locations Map



The Medical Center dominates its Primary Service Area ("PSA") with an 86% inpatient market share, for the year ended June 30, 2024, and is the only acute care hospital located within Washington County, Maryland. The Medical Center serves a tri-state region of approximately 600,000 people, including Western Maryland, Southern Pennsylvania, and the Eastern Panhandle of West Virginia (*see* "Service Area" in this Appendix A). The PSA has a projected population of over 155,000 residents and is forecasted to grow an additional 1.3% by 2028 (*see* "Service Area – Population Trends").

The following chart shows the licensed bed capacity by category for the Medical Center:

Meritus Medical Center – Licensed Bed Capacity[1]

Licensed Categories	FY 2023	FY 2024	FY 2025
Medical/Surgical	209	195	209
Pediatrics	4	1	1
Obstetrics	17	15	15
Psychiatric	18	14	14
Total Acute Care	**248**	**225**	**239**
Medical Rehabilitation	20	20	20
Total Beds	**268**	**245**	**259**
Nursery Bassinets[2]	41	41	41

(1) The number of licensed acute care beds is adjusted pursuant to the regulations of the Maryland Health Care Commission ("MHCC") providing for annual adjustments based upon the prior year's average daily inpatient census. Medical rehabilitation beds are not subject to annual adjustment.

(2) In addition to the bed complement approved by the MHCC, the Institution operates a 41-bassinet nursery. These bassinets do not require licensure in Maryland, and do not contribute to the total bed count.

Organizational Structure and Obligated Group

MHI is, directly or indirectly, the sole member of, and retains certain reserved corporate powers over, the entities that own the Medical Center, Brook Lane Hospital and the Medical School (*see* "Governance" in this Appendix A). MHI is not a member of the Obligated Group. MHI and affiliates of MHI that are not part of the Obligated Group have no liability for repayment of the Series 2025 Bonds. The chart on the following page depicts the organizational structure of Meritus Health and highlights the members of the Obligated Group. The chart omits certain other affiliates, none of which are members of the Obligated Group.

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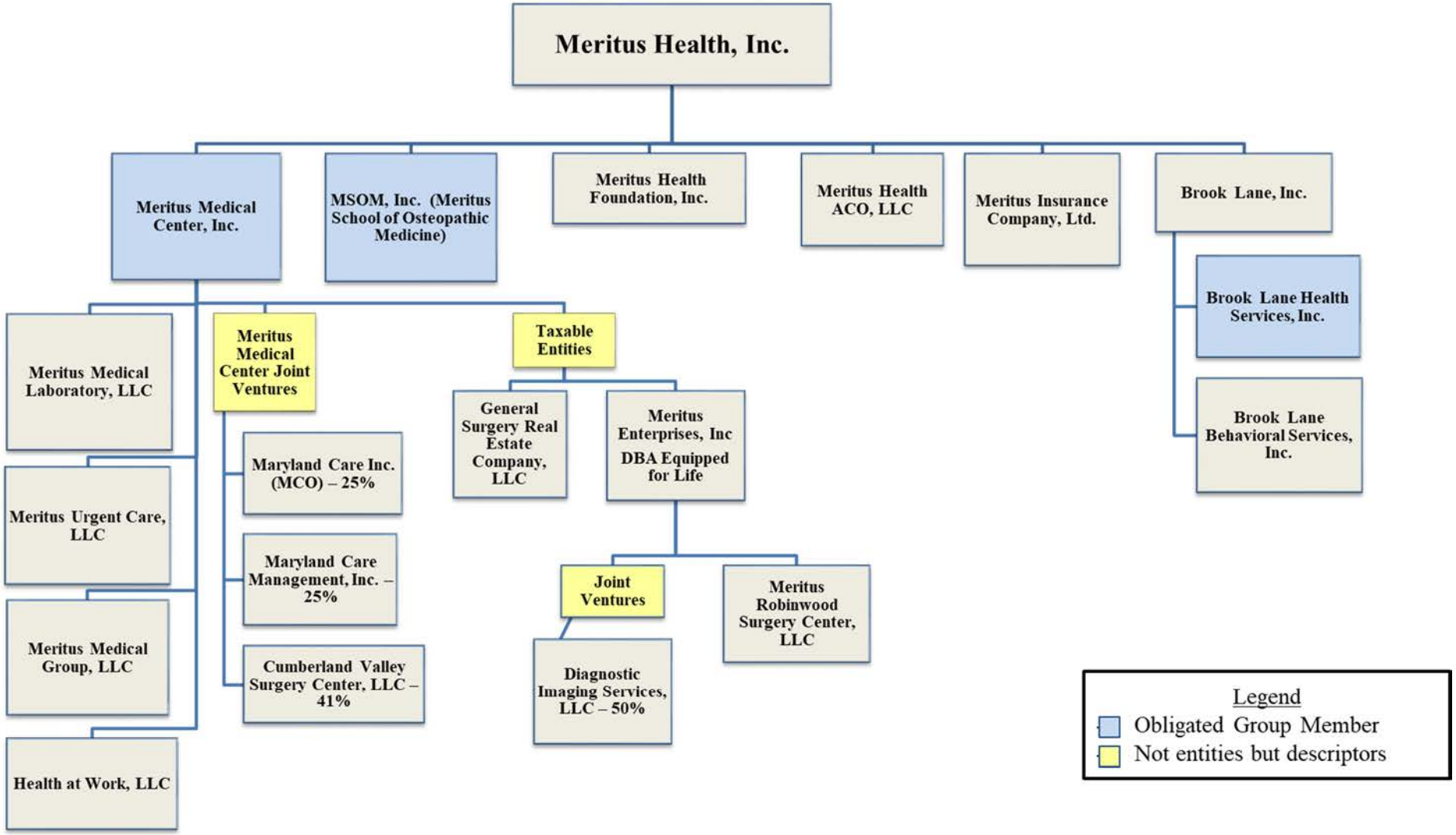
Meritus Health Organizational Chart



Mission, Vision and Values

As an independent, community-based health system, Meritus Health is anchored by its mission, vision, and values, as described below.

Mission: Improve the health of our community by providing the best healthcare, health services and medical education.

Vision: To serve as a model community-based, academic health system.

Values: At Meritus Health, we support our mission and vision by living our values each and every day. By following our pledge, "I ACT", we each support Meritus with:

- I = Integrity - We do the right thing, no matter what.
- A = All in for quality and outcomes - Quality improvement isn't just something we talk about, it's a commitment we each live.
- C = Community obsessed - We are our community, and we are here to take care of our neighbors. This isn't just about medical care; it's about caring for the whole person.
- T = Teamwork - Nobody can do it alone. At Meritus Health we are one team that is diverse and inclusive, and we support one another and our goals.

THE 2025 PROJECT

In furtherance of its mission, Meritus Health has launched the strategic capital projects described below.

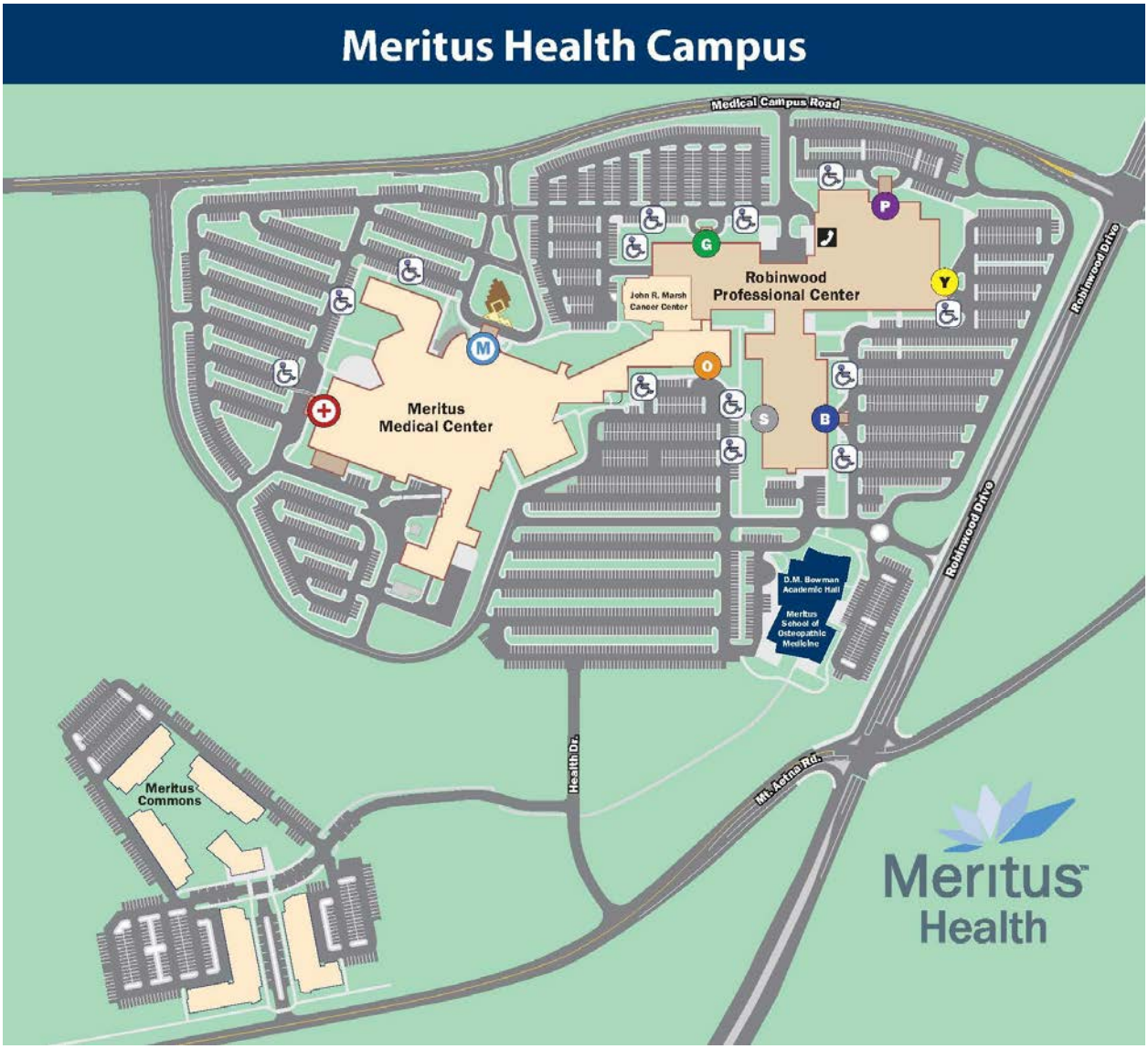
Use of 2025 Bond Proceeds – Strategic Capital Projects

A portion of the proceeds of the Series 2025 Bonds will finance a portion of the costs of two transformational capital projects that support Meritus Health's strategic evolution into a community-based academic health system:

1. The design, construction, and equipping of D.M. Bowman Academic Hall, which will house the Medical School; and
2. The design, construction, and equipping of Meritus Commons, an on-campus, fully furnished apartment complex designed to support the Medical School students.

Both of these projects are integral to Meritus Health's long-term goals of addressing regional physician shortages, enhancing healthcare access, and creating a pipeline of mission-aligned, community-oriented medical professionals.

The map below depicts the Meritus Health Campus and shows the locations of Bowman Academic Hall and Meritus Commons in relation to the Medical Center:



Meritus School of Osteopathic Medicine

The Medical School is the first new medical school in the State of Maryland in over 100 years, and represents a major investment in medical education and regional health infrastructure. The majority of medical schools in the country, and all existing Maryland medical schools, are located in urban environments. The Meritus Health campus is a non-urban location for medical students, offering unique rural health perspectives.

MSOM was incorporated in 2022 for the purpose of establishing the Medical School as a private osteopathic medical school. In August 2024, the Medical School was granted pre-accreditation status from the Commission on Osteopathic College Accreditation ("COCA"), the accrediting body of the American

Osteopathic Association. As part of the accreditation process, to establish an osteopathic medical school COCA requires that Meritus Health provide an escrow in the amount of $50 million (*see* Financial Reporting and Affordability, COCA-Required Escrow in this Appendix A). The Medical School expects to receive its full accreditation upon the graduation of its inaugural class in 2029.

For additional detail on the Medical School's accreditation milestones, including pre-accreditation and licensure by the State of Maryland, *see* "Licenses and Accreditation." For information regarding the Medical School's tuition and fees, *see* Financial Performance and Affordability – Meritus Medical School's Cost of Attendance.

Academic Program Overview

The Medical School expects to provide a four-year Doctor of Osteopathic Medicine ("D.O.") curriculum structured as follows:

- Years One – Two: Classroom-based education and community-based research conducted on the Meritus Health Campus.
- Years Three – Four: Clinical rotations at Meritus Medical Center and other hospitals throughout the State of Maryland.

Admissions and Demand

As required by COCA, all newly established medical schools must follow a structured enrollment ramp-up during the first three years of operation. This phased approach allows COCA to ensure the school has the capacity, faculty, and resources to support its full student body as it scales up. The Medical School's approved full class size is 180 students, with an allowable 8% enrollment overage. The enrollment ramp-up schedule for incoming class size, excluding the allowable 8% enrollment overage, is as follows:

- Year One: 50% of full enrollment (90 students)
- Year Two: 75% of full enrollment (135 students)
- Year Three: 100% of full enrollment (180 students)

The inaugural admissions cycle has demonstrated strong regional and national interest. As of May 1, 2025:

- Over 1,150 applications have been received.
- 97 students have submitted deposits to enroll in the inaugural class (beginning July 2025).
- More than 100 students remain on the waitlist.
- Applications were received from 42 states, with 25% originating from states adjacent to Maryland and 25% from Maryland residents.

These early indicators signal a robust and diverse pipeline of future physicians eager to contribute to the Medical School's mission of advancing community-based medical education.

D.M. Bowman Academic Hall

The Medical School is housed in the D.M. Bowman Academic Hall ("Bowman Academic Hall"), a 200,000-square-foot state-of-the-art facility situated adjacent to the Medical Center and Meritus

Commons. This strategic location is intended to immerse students in a dynamic clinical environment from the onset of their education, fostering early and continuous exposure to patient care.

Conference Center and Cafeteria (First Floor)

Conference Center

The first floor of Bowman Academic Hall features a versatile conference center designed to accommodate a variety of events, including academic conferences, seminars, and community gatherings. This modern facility can host up to 1,000 attendees, providing ample space for large-scale functions. The conference center is equipped with state-of-the-art audiovisual technology and offers flexible seating arrangements, providing an optimal environment for both in-person and hybrid events. Its strategic location within the academic hall fosters seamless integration with MSOM's educational and research activities, enhancing collaborative opportunities among students, faculty, and the broader medical community.

Cafeteria

Bowman Academic Hall hosts a dining hall where fresh meals are prepared daily. With ample indoor and outdoor seating, students can enjoy convenient and nutritious dining options without leaving campus.

Library, Classroom and Fitness Center (Second Floor)

The second floor of Bowman Academic Hall is thoughtfully designed to enhance student learning, collaboration, and well-being. This level features an extensive library, versatile study spaces, classrooms optimized for team-based learning, and a modern fitness center.

Library and Study Spaces

The library serves as an academic hub, offering an extensive collection of medical texts, journals, and digital resources. Adjacent to the library are various study areas, including quiet zones for individual focus and collaborative spaces equipped with technology to support group work.

Classrooms Facilitating Team-Based Learning

The second-floor houses state-of-the-art classrooms specifically designed to support team-based learning methodologies. These classrooms feature flexible seating arrangements and advanced audiovisual equipment, promoting interactive discussions and collaborative problem-solving among students.

Fitness Center

Recognizing the importance of physical health, the second floor includes a well-equipped fitness center. The facility offers a range of exercise equipment, including treadmills, ellipticals, stair climbers, cycles, rowers, and resistance training machines. Large windows provide natural light and views of the Meritus Health Campus and surrounding countryside, creating an inviting environment for exercise.

Integration of these facilities on a single floor fosters a holistic educational environment that supports academic excellence, collaborative learning, and student wellness.

Simulation Center, Osteopathic Manipulative Medicine and Anatomy Labs (Third Floor)

The third floor of Bowman Academic Hall is dedicated to advanced clinical training and anatomical education, featuring the expansive Simulation Center, the Osteopathic Manipulative Medicine ("OMM")

Lab, and both virtual and gross anatomy laboratories. These state-of-the-art facilities provide students with a comprehensive, immersive training environment that closely mirrors real-world medical settings.

Simulation Center

Spanning 40,000 square feet, the Simulation Center is among the nation's largest medical simulation learning environments. It is meticulously designed to enhance clinical competencies through realistic, hands-on experiences. Key features include:

- 20 Simulation Exam Rooms: Designed to replicate outpatient settings, allowing students to practice patient interactions and diagnostic skills.
- 4 Hospital/Operating Rooms: Equipped with advanced medical technology to simulate inpatient and surgical environments, providing experience in perioperative care.
- Dedicated Virtual Reality ("VR") Lab: Offers immersive, interactive experiences that enhance understanding of complex anatomical structures and physiological processes.
- 8-Table Gross Anatomy Lab: Provides hands-on dissection experience, fostering a deep understanding of human anatomy.
- Over 2,000 Square Feet of Part-Task Training Space: Allows focused practice on specific clinical skills and procedures using task trainers and simulators.

Osteopathic Manipulative Medicine Lab

The spacious OMM Lab accommodates over 50 exam tables, facilitating hands-on training in osteopathic manipulative techniques. This environment supports the development of palpatory skills and the application of osteopathic principles in patient care.

Virtual and Gross Anatomy Laboratories

The Medical School uniquely integrates both virtual and gross anatomy labs, offering students a multifaceted approach to anatomical education:

- Virtual Anatomy Lab: Utilizes advanced VR technology to provide interactive, 3D explorations of anatomical structures, enhancing spatial understanding and accommodating various learning styles.
- Gross Anatomy Lab: Allows for traditional cadaveric dissection, offering tactile experience and a profound comprehension of human anatomy.

The combination of virtual and gross anatomy labs enriches the learning experience, catering to diverse educational needs and reinforcing a comprehensive understanding of the human body. By integrating these cutting-edge facilities on the third floor, MSOM believes that it is providing an unparalleled educational environment that prepares students for the complexities of modern medical practice.

Administrative Offices and Shell Space (Fourth and Fifth Floors)

Bowman Academic Hall was designed to support not only the school's current academic and clinical training needs but also its future growth as a center for interdisciplinary healthcare education.

Shell Space (Fourth Floor)

The fourth floor is currently a shell space, intentionally designed to accommodate future expansion aligned with MSOM's long-term strategic plan. This space is reserved for the development of additional health professions programs, including, but not limited to, disciplines that complement MSOM's osteopathic medical education mission, do not compete with existing local or regional academic offerings, and directly address unmet needs in the healthcare workforce. This planned expansion supports MSOM's vision of becoming a comprehensive academic hub that responds to evolving healthcare delivery needs and the growing shortage of healthcare professionals across Maryland and the broader region.

Administrative Offices (Fifth Floor)

The fifth floor houses the administrative offices of the Medical School, including leadership, faculty, and academic support services. This centralized office structure is designed to provide students with direct and convenient access to academic advisors, faculty members, and institutional leadership, all within the same building. By co-locating student services and administrative functions, the Medical School fosters an integrated academic environment that encourages collaboration, mentorship, and streamlined communication between students and educators. This alignment supports the Medical School's commitment to personalized education and contributes to a student-centered campus culture.

Meritus Commons – On-Campus Student Housing

To complement the academic experience and cultivate a supportive learning environment, Meritus Health is developing Meritus Commons, an on-campus student housing complex located within walking distance of Bowman Academic Hall. All first- and second-year students are required to reside in Meritus Commons unless granted an exception. This housing model is designed to foster a strong campus community and support the Medical School's mission of integrated, community-based education. Constructed in two phases, Meritus Commons will consist of 340 fully furnished one- and two-bedroom apartments designed specifically for medical students.

Project Phasing

- Phase I: 180 units, with an anticipated completion date of August 2025.
- Phase II: 160 additional units, scheduled to begin construction following the completion of Phase I.

Key Features

- Designed to reduce transition-related stress and enhance student well-being.
- Equipped with modern amenities tailored to the needs of medical students.

Housing Demand

- Phase I capacity is expected to align with Year Two student enrollments shown above.

- Phase II capacity is projected to align with Year Four enrollments, when the Medical School reaches full enrollment of the student population.
- When medical students reach Years Three and Four, a portion of the students will be relocating to hospitals around Maryland to complete clinical rotations.
    - Meritus Health will also host students from other medical schools to complete clinical rotations, with Meritus Commons providing convenient, furnished accommodations for these students as well.

Apartment Rental Rates

Meritus Commons will offer fully furnished apartments that are competitively priced relative to regional and peer market rates. This pricing structure supports both affordability for students and alignment with local market conditions.

The following table provides average rental rates for studio, one-bedroom, and two-bedroom apartments in Frederick, Hagerstown, and peer university locations. The Hagerstown real estate market currently faces a shortage of housing availability, particularly for students and professionals seeking furnished accommodations.

Average Rental Rates for Select Locations

	Frederick Multi-Family	Hagerstown Multi-Family	Peer Universities	Meritus Commons Proposed Rent*
Studio	$1,941	$-	$1,385	$1,650
1 Bedroom	1,983	1,358	1,462	1,750
2 Bedroom	2,306	1,700	2,029	2,100
Weighted Average	$2,183	$1,623	$2,395	$1,786
Delta to Frederick		*74%*	*110%*	*82%*

*Rental rates exclude $225/month for utilities and furniture. Due to availability, Frederick presents more comparable housing.

**Peer universities include Alabama College of Osteopathic Medicine, Duquesne University, and the Philadelphia College of Osteopathic Medicine.

Source: Costar, accessed August 22, 2024; Peer University Academic Year 2024-25 Data from Alabama College of Osteopathic Medicine, Duquesne University, and the Philadelphia College of Osteopathic Medicine.

OVERVIEW OF FACILITIES AND SERVICES

Meritus Medical Center

The Medical Center is an acute general hospital, with 259 licensed beds and 327 total physical beds. Hospitals in Maryland are assigned a licensed bed count annually by the Maryland Health Care Commission based on a simple formula: 140% of the hospital's average daily patient census for the preceding 12-month period. The licensed bed count generally reflects the maximum number of patients that may occupy beds in the hospital at one time. Licensed bed designations take effect July 1 of each year. Hospitals are permitted to exceed their licensed bed counts in certain situations, such as to accommodate surges in patient volumes, provided certain requirements are met. Meritus Medical Center has significant surge capacity with its additional 68 physical beds available for patient care when needed.

The Medical Center is designated as a Level III Trauma Center by the Maryland Institute for Emergency Medical Services Systems ("MIEMSS"), one of nine trauma centers in Maryland. The main hospital building is an approximately 525,000 square foot, six story complex supported by an approximately 40,000 square foot two-story administrative building. Formerly known as Washington County Hospital, the Medical Center or its predecessor facilities have been in continuous operation since October 26, 1905.

The Medical Center provides an extensive scope of inpatient and outpatient services including neonatology, psychiatry, Level III trauma care, stroke care, wound care, joint replacement program, and cardiac diagnostic laboratory services. In calendar year 2024, the Medical Center assisted in the births of approximately 2,100 babies, handled more than 70,000 emergency room visits, and admitted more than 17,500 patients.

Connected to the Medical Center is a two-story condominium medical office building owned by Robinwood Medical Center Condominium, Inc. and known as the Robinwood Professional Center ("RPC"). MMC owns or leases 80% of the RPC condominium units, consisting of approximately 310,000 square feet of the RPC out of a total of approximately 373,000 square feet. Key Meritus Health patient service operations in the RPC include three imaging suites, two outpatient rehabilitation clinics, three primary care practices, 15 specialty care practices, a laboratory patient service center, and a pharmacy.

In addition to hospital-based services, Meritus Health offers a broad range of outpatient services including primary care, specialty services, rehabilitation, mental health counseling, medical laboratory services, occupational medicine, home care and urgent care. In total, these service offerings make up a broad continuum of care for residents of the tri-state region, which makes up Meritus' primary and secondary service areas. Below is an overview of key services provided:

Acute Inpatient and Outpatient Hospital Services

The Medical Center delivers a broad spectrum of medical services. The hospital is equipped with advanced technologies and offers specialized programs, including a Level III trauma center, a primary stroke center, and a wound care center. Outpatient services include services provided at the John R. Marsh Cancer Center, Meritus Physical Therapy, and the Center for Clinical Research.

Voluntary and Involuntary Adult Inpatient Psychiatric Care

Meritus Health provides comprehensive behavioral health services, including both voluntary and involuntary adult inpatient psychiatric care. These services address a range of mental health conditions, ensuring that patients receive appropriate care in a secure environment.

Obstetrics and Maternal Services

The Meritus Family Birthing Center at the Medical Center offers expectant mothers expert medical care in a family-centered environment. Each birthing suite is fully equipped for labor, delivery, postpartum, and newborn care, allowing mothers and babies to remain together throughout their stay.

Home Health and Durable Medical Equipment

Meritus Equipped for Life provides a wide range of durable medical equipment and products to support patients at home. Offerings include oxygen equipment, hospital beds, CPAP machines and supplies, wheelchairs, medical alert services, and aids for daily living. Equipment repairs and installations to further patient safety and comfort are also offered.

Outpatient Physical Therapy

Meritus Physical Therapy delivers comprehensive rehabilitation programs with a team of occupational, physical, and speech therapists, as well as social workers. Many staff members hold advanced

certifications in areas such as hand therapy and orthopedics. Facilities feature state-of-the-art equipment and a heated indoor pool for aquatic therapy.

Urgent Care, Primary Care, and Specialty Services

Meritus Health operates two urgent care centers providing treatment for conditions ranging from earaches and sore throats to sprains and strains. Primary care services are available for patients of all ages, focusing on preventive care, wellness, and chronic disease management. Specialty services include cardiology, oncology, orthopedics, and more, providing comprehensive care for diverse medical needs.

Telehealth Services via Meritus Now

Meritus Now offers a secure and user-friendly virtual care option for both primary and urgent care needs. Accessible seven days a week, patients can connect with healthcare professionals without the need to download an app, facilitating convenient consultations from any location.

Mental Health Crisis Center and Mental Health Urgent Care

Meritus Health provides immediate support for individuals experiencing behavioral health emergencies through its Mental Health Walk-In Care facility located on the Meritus Health Campus. This service offers therapy for conditions such as anxiety, depression, and addiction issues, with providers available to deliver immediate assistance and plan next steps, including referrals if necessary.

These services reflect Meritus Health's commitment to delivering high-quality, accessible healthcare to the community.

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Clinical Services Ranked by Volume

The following chart shows the Medical Center's clinical services in descending order of discharges for the fiscal year ending June 30, 2024.

Clinical Services Ranked by Volume

Clinical Service	Cases	% of Total
Obstetrics/Gynecology	1,896	10.6%
Neonatology	1,894	10.6%
Infectious Disease	1,838	10.3%
Pulmonary	1,799	10.1%
Cardiology	1,660	9.3%
Psychiatry/Substance Abuse	1,130	6.3%
Gastroenterology	1,110	6.2%
General Surgery	1,070	6.0%
Orthopedics	821	4.6%
Neurology	813	4.6%
Nephrology	697	3.9%
Endocrinology	651	3.7%
General Medicine	635	3.6%
Rehabilitation	371	2.1%
Oncology	252	1.4%
Hematology	177	1.0%
Neurological Surgery	107	0.6%
Urology	105	0.6%
Other	779	4.4%
Total	**17,805**	**100.0%**

Source: Meritus Medical Center

Brook Lane Health

Brook Lane owns and operates Brook Lane Hospital, founded in 1949 as a 23-bed psychiatric facility, which has grown into the second-largest freestanding psychiatric hospital in Maryland, with 65 licensed inpatient beds. Brook Lane Parent is also the sole member of Brook Lane Behavioral Health Services, Inc. Brook Lane Health provides behavioral health services to both adolescent and adult populations through:

- Three outpatient clinics, one located in each of Allegany, Washington, and Frederick Counties.
- Two Type I schools serving students in Washington and Frederick Counties - a Type I school is a publicly funded nonpublic school that receives State funding to provide special education services to students placed through Individualized Education Programs.
- A broad range of inpatient and outpatient mental health services.

Brook Lane Health's main campus, located in Smithsburg, Maryland, is situated approximately six miles northeast of the Meritus Health Campus. This proximity facilitates seamless collaboration between Brook Lane Health and the Medical Center, enhancing the continuum of care for patients who require both medical and behavioral health services. The formal affiliation between MHI and Brook Lane Health, effective July 1, 2024, reflects a joint commitment to expand access to mental health services across the region and the state, and advance integrated healthcare delivery.

Access to pediatric inpatient psychiatric care in Maryland is notably limited. According to a 2024 report by the Maryland Health Care Commission, only three hospitals in the state provide such services, underscoring a significant gap in care for younger populations.

Among these limited resources, Brook Lane Hospital stands out as a critical asset, particularly for families in Washington County and surrounding regions. Brook Lane Hospital offers a range of specialized programs that support both pediatric and adult populations. Additionally, Brook Lane Hospital is the only psychiatric hospital with child and adolescent beds within a 75-mile radius.

Advantages of Meritus Health's partnership with Brook Lane Health include:

- Economies of scale between MMC and Brook Lane Health
- Enhanced services to a full and robust continuum of behavioral health services
- Increased financial stability, innovation, and access to timely care
- Improved quality of care and crisis assessment, intervention, and response
- Shared electronic health record system allows for efficient access across the enterprise

With the support of Meritus Health, Brook Lane Hospital is poised for continued growth and enhancement of its services. Following the affiliation of Brook Lane Health with Meritus Health on July 1, 2024, the System launched several capital and operational initiatives to improve care coordination and operational integration, including the migration of Brook Lane Health to Epic, unifying electronic health

records across the System, and the incorporation of Brook Lane Health into Meritus Health's Enterprise Resource Planning system. In July 2025, Brook Lane Hospital will break ground on a new therapeutic gymnasium, which will be connected to the inpatient facility. This space will provide patients with access to structured physical activity, supporting their mental and physical recovery as part of a holistic treatment approach.

Furthering this growth, MHI has committed to investing $25 million in Brook Lane Health's facilities and programming over the next five years. These investments are planned to include:

- The modernization of IT infrastructure
- Strategic facility improvements
- Expansion of behavioral health program offerings

Together, these efforts will help solidify Brook Lane Health's position as a statewide leader in behavioral health care, increasing timely access to high-quality psychiatric services for some of Maryland's most vulnerable populations.

Only Brook Lane, which owns and operates Brook Lane Hospital, is included in the Obligated Group. The following entities, although components of Meritus Health, are excluded from the Obligated Group:

- Brook Lane, Inc. – Parent service organization with no direct revenue.
- Brook Lane Behavioral Services, Inc. – Owns and operates the unregulated clinics, professional services, and Type I schools.

Other Meritus Health Entities

The following is a brief description of some of the direct and indirect subsidiaries of MHI. None of the below described entities is a member of the Obligated Group.

Meritus Medical Group, LLC ("MMG") – MMG, a subsidiary of MMC, is a multi-specialty practice network within Meritus Health, serving as a cornerstone of comprehensive healthcare delivery in Western Maryland and the surrounding tri-state region. Comprising over 160 providers, MMG offers a wide array of services, including primary care, specialty care, urgent care, and behavioral health. MMG's integration with MMC and other System entities facilitates seamless patient transitions across various levels of care, from outpatient services to inpatient treatment. This collaborative approach enhances patient outcomes and supports Meritus Health's mission to improve community health through high-quality, patient-centered care.

Meritus Insurance Company, Ltd. ("MICL") – MICL is a wholly owned for-profit insurance captive domiciled in the Cayman Islands that provides general liability and professional liability insurance for MHI and its subsidiaries.

Meritus Health Foundation, Inc. (the "Foundation") – The Foundation is a Maryland non-stock corporation that has been determined by the Internal Revenue Service to be a tax-exempt organization described in Section 501(c)(3) of the Code. The Foundation's primary purpose is charitable fund raising and development to support Meritus Health. In addition to capital and endowment campaigns, the Foundation also raises money for medical programs, healthcare objectives, scientific research, educational programs, and related community activities. Corporate partners, community members, board members, grateful patients and employees support Foundation-led initiatives.

Maryland Care, Inc. d/b/a Maryland Physicians Care ("MPC") – MPC, together with Maryland Care Management, Inc., constitutes a Medicaid Managed Care Organization ("MCO") that has delivered high-quality, no-cost healthcare services to Maryland's HealthChoice enrollees for more than two decades. Established in 1996, MPC provides comprehensive coverage to over 200,000 qualified individuals, including children, pregnant women, and adults aged 19 and older.

The MCO is co-owned by four leading health systems in Maryland, including MMC, which holds a 25% ownership interest. This collaborative structure enables MPC to operate a coordinated statewide network of hospitals, primary care providers, specialists, clinics, and pharmacies, promoting broad access to high-quality care for its members.

As the third-largest Medicaid MCO in Maryland, MPC plays a significant role in advancing the health of underserved populations. The organization offers a robust set of benefits and services without copays, including:

- Preventive and primary care
- Maternity and women's health services
- Behavioral health and substance use disorder treatment
- Prescription drug coverage
- Chronic disease management and care coordination

Local Impact and Community Engagement

In Washington County, MPC is particularly impactful, serving approximately 63% of the Medicaid population, making it the largest MCO in the region. Its strong presence positions MPC as a key healthcare partner in improving local health outcomes and addressing social determinants of health.

MPC is an active participant in Meritus Health's Bold Goal initiatives, including:

- Healthy Washington County's "Lose 1 Million Pounds" campaign, a community-wide wellness initiative focused on reducing obesity and improving physical health
- Funding the purchase of wheelchair-accessible vans, supporting Meritus Health's complimentary transportation services for patients facing mobility or access barriers
- Investing in programs that reduce health disparities, especially among Medicaid populations and historically underserved communities

Through these efforts, MPC plays an instrumental role in supporting Meritus Health's mission to advance community health, promote equity, and expand access to essential services for Maryland residents.

Quality and Award Recognition

The System's hospitals and other patient care sites have received several national and local awards and distinctions, some of which are listed below:

- Get with the Guidelines – Stroke Gold Plus Award (2024 and 2023)
- CDC's Full Plus Recognition for Diabetes Prevention
- 2022 Partnership for Excellence Platinum Award (2022)
- The Leapfrog Group – "A" grade for the last five consecutive reporting periods

- U.S. News & World Report's High Performing Hospital 2023-2024 in treatment of heart failure and stroke
- 2022 Human Experience Guardian of Excellence Award – Press Ganey Award for Meritus PT
- 2023 Foster McGaw Award Finalist – Excellence in Community Service
- Soliant Most Beautiful Hospitals in the Country – Brook Lane Hospital was Top 20

STRATEGIC APPROACH

2030 Bold Goals

The future success of Meritus Health is grounded in the execution of its 2030 Bold Goals, a set of long-term strategic initiatives launched in 2020 at the onset of the COVID-19 pandemic. These goals have provided a clear framework for aligning the organization around its mission while driving operational and clinical excellence.

The 2030 Bold Goals serve as the foundation for Meritus Health's annual strategic planning cycle. Each year, these goals are incorporated into True North organizational goals, which then translate into category aims, and department-specific objectives. A True North strategy is a concept derived from lean management principles, where "True North" represents an organization's ultimate vision or strategic direction. This structured and disciplined process promotes alignment across all levels of the System and reinforces a culture of accountability, data-driven decision-making, and measurable progress.

Original Bold Goal Categories (Established CY 2020)

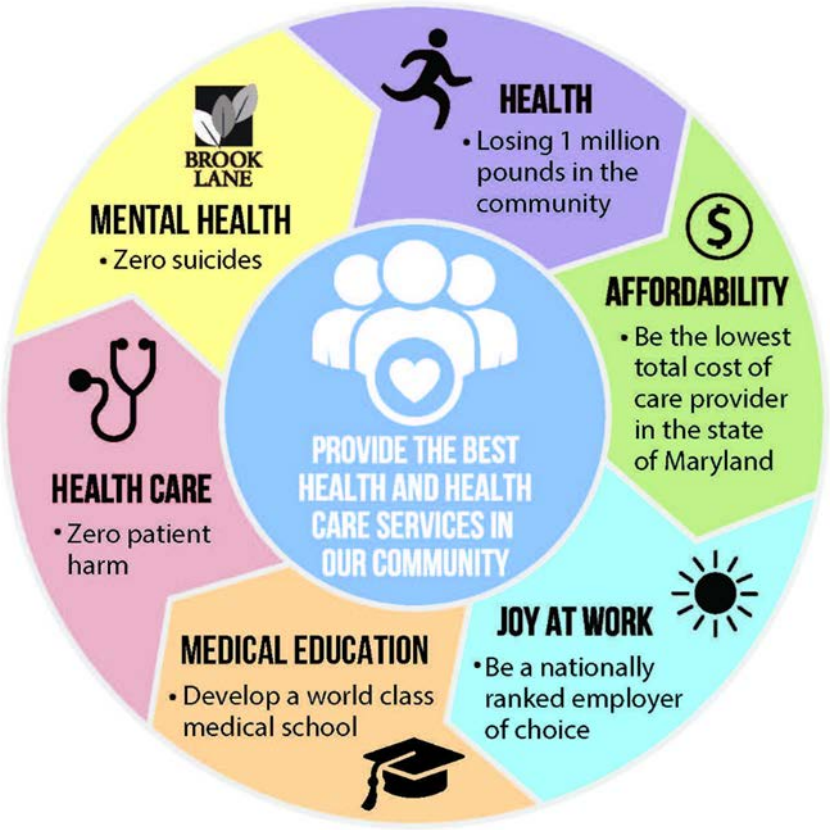
- Health: Support the community in losing 1 million pounds
- Healthcare: Achieve zero patient harm
- Affordability: Become the lowest total cost of care provider in Maryland
- Joy at Work: Be recognized as a nationally ranked employer of choice

Expanded Bold Goals (Post-2020 Evolution)

With the establishment of MSOM and the affiliation with Brook Lane Health, two additional Bold Goals were added:

- Medical Education: Develop a world-class medical school
- Mental Health: Achieve zero suicides in the community

2030 Bold Goals



True North Metrics and Performance Accountability

The True North Metrics are key performance indicators ("KPIs") that align Meritus Health's system-wide activities with the organization's long-term strategic framework – specifically the 2030 Bold Goals. These metrics are monitored monthly at both the System and entity levels, serving as the foundation for measuring performance, driving continuous improvement, and tracking progress toward organizational objectives.

Each department and operating entity contributes to overall performance through department-level dashboards that are directly linked to the True North framework and Annual Operating Plan ("AOP") targets. This integrated structure reinforces a high-performance culture, promoting transparency, accountability, and strategic alignment across all levels of the System.

True North Metrics span clinical, operational, financial, and workforce domains, supporting Meritus Health's commitment to:

- Improving community health outcomes.
- Advancing care quality and safety.
- Enhancing patient and team member experience.
- Ensuring financial sustainability.
- Promoting equitable access to care.

A core principle underlying this framework is Meritus Health's definition of success: the organization's ability to elevate community health while ensuring its financial viability. A critical element of this mission is maintaining equitable access to care throughout Washington County and the broader tri-state region.

Each entity—including MMC, Brook Lane, and MSOM—utilizes its own tailored True North dashboard. Metrics are reviewed monthly by senior leadership, and results are integrated into performance evaluations. Notably, bonus eligibility for all senior leaders and management-level employees is directly tied to achievement of these metrics, reinforcing ownership and accountability at all levels.

Below is an example of the FY 2024 True North Dashboard for MMC. Brook Lane and MSOM maintain similar dashboards tailored to their respective operational and mission-specific goals.

Quadruple Aim	Metric	Calculation / Measurement of Metric	FY 2023 Results	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Results YTD	FY 2024 Target
Improving Health	Engage community to lose 1 million pounds	Partners and team members document pounds lost	FY22=40k+ FY23 YTD=89k+	119,694	122,846	126,465	129,105	132,065	140,056	140,056	175,000 pounds
	Improve health outcomes	Increase the % of MMG PCP diabetic patients with HbA1C < 9	FY22=79% FY23 YTD=86.7%	88.1%	89.1%	89.2%	89.4%	89.4%	89.9%	88.6%	89%
Improving Health Care	Improve access to care	**Access composite score:**									
		Reduce ED median arrival to discharge wait time (ED OP18b) (50% weight)	FY22=230 FY23=219	230	220	217	219	217	218	218	< 210 minutes
		Readmission Rate measured Observed to Expected (O/E) (50% weight)	FY22=1.01 FY23=1.02	1.12	1.14	1.10	1.08	1.07	1.15	1.09	< 1.0
	Reduce harm events	Decrease serious patient harm events by 10%	FY22= 77 FY23=69	7	1	1	5	1	2	49	≤ 59
	Exceed customer expectations system wide	**Patient experience composite score**									
		Overall hospital rating (65% weight)	FY22=64.6% FY23=66.3%	67.6%	63.0%	76.8%	64.8%	70.0%	68.0%	69.6%	> 69%
		ED overall care rating (10% weight)	FY22=53.1% FY23=55.3%	65.5%	71.1%	71.5%	72.2%	70.7%	68.5%	68.6%	> 64%
		Home Health overall care rating (5%weight)	FY22=88.7% FY23 YTD=87.6%	PG: 93.3% MMC: 90.9%	PG: 90.0% MMC: 84.2%	PG: 87.5% MMC: 93.9%	PG: 100% MMC: 93.1%	PG: 100% MMC: 96.1%	PG: 100% MMC: 91.3	92.8%	> 90%
		MMG Likely to recommend provider (20% weight)	FY22=83% FY23 YTD=84.6%	92.1%	92.9%	92.2%	92.7%	92.3%	91.0%	91.9%	> 91%
Having Joy at Work	Reduce overall turnover	Reduce overall turnover by 10% Total employee turnover vol. and invol, annualized / average headcount FY24	FY22=27.3% FY23=26.4%	25.8%	25.9%	25.1%	25.0%	25.2%	25.4%	25.4%	< 24%
Improving Affordability	Achieve operating margin	**Budget**	FY22=1.4% FY23=3.1%	4.3%	1.6%	0.6%	3.3%	-4.2%	0.7%	2.2%	Budget + 0.1%

Medical Education

MSOM's mission is to deliver a world-class medical education focused on academic rigor, professional development, and community engagement. The Medical School employs a team-based learning model, encouraging students to:

- Prepare for class in advance.

- Identify and close knowledge gaps.
- Collaborate on high-priority learning objectives.

The Medical School was established on five strategic pillars:

1. Academic and professional excellence
2. Research
3. Social responsibility
4. Community engagement
5. Fostering joy in work and learning

All students will participate in community-based research and volunteer service, reinforcing the integration of health and healthcare delivery as experienced by patients.

Strategic Impact and Physician Pipeline

The establishment of the Medical School represents a strategic extension of Meritus Health's long-term commitment to improving regional health outcomes. The Medical School:

- Supports the recruitment and retention of physicians.
- Offers current providers opportunities to teach and mentor.
- Builds a pipeline of graduates more likely to practice locally, strengthening access to care in underserved communities.

Graduate Medical Education Expansion

Meritus Health currently operates an 18-resident Family Medicine Residency Program, launched in 2019. In June 2025, the organization will expand its graduate medical education efforts with the introduction of a Psychiatry Residency Program. Over the next four years, Meritus Health plans to grow its residency offerings significantly, with a projected increase to 122 total residents across multiple specialties.

The following table outlines the planned residency program expansion:

Meritus Health Medical Residency Program Projected Expansion

Program	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031
Family Medicine	6	12	18	18	18	18	18	18	22	26	30	30	30
Psychiatry							5	10	15	20	20	20	20
Surgery								3	6	9	12	15	15
Internal Medicine									15	30	45	45	45
Anesthesiology										3	6	9	12
Total Number of Residents	**6**	**12**	**18**	**18**	**18**	**18**	**23**	**31**	**58**	**88**	**113**	**119**	**122**

Mental and Behavioral Health Services

Meritus Health is committed to supporting the holistic well-being of the communities it serves, addressing both physical and mental health needs. Historically, the Medical Center focused on adult inpatient and outpatient services within the traditional care model. However, in response to the growing opioid crisis, particularly acute in Washington County, Meritus Health identified a critical gap in transitional care for individuals experiencing substance use disorders.

To address this need, Meritus Health developed and launched a six-bed crisis center, offering a safe and supportive environment for individuals undergoing drug withdrawal before transitioning to a detoxification program. The crisis center promotes continuity of care through "warm handoffs" to treatment facilities and has demonstrated measurable reductions in patient relapse.

To expand access to behavioral health services, Meritus Health and Brook Lane Health established a joint venture to launch a mental health walk-in clinic on the Meritus Health Campus. Following Brook Lane Health's affiliation with Meritus Health, the clinic continues to operate successfully – though it is no longer structured as a joint venture. This facility plays a critical role in the provision of behavioral health services by:

- Providing prompt access to behavioral health care for individuals in crisis or experiencing urgent needs.
- Reducing delays in treatment for patients unable to wait for scheduled appointments.
- Diverting psychiatric patients from emergency departments, which may not be appropriately equipped to meet their specific needs.

Following the affiliation of Brook Lane Health with the System on July 1, 2024, Meritus Health now delivers a continuum of mental health services, including care for pediatric, adolescent, and adult populations.

In 2023, Washington County reported 12 suicide deaths. In response, Meritus Health launched a mental health Bold Goal, committing to zero suicides by 2030. This initiative emphasizes timely access to mental health services, proactive prevention strategies, and a system-wide focus on supporting community members when and where they need care.

As part of its outreach efforts, Brook Lane Health embeds licensed social workers in schools across Washington County. These professionals support students in managing social and emotional challenges and serve as liaisons to broader health services within the System.

Workforce Development and Physician Recruitment

Meritus Health recognizes that achieving excellence in care is intrinsically tied to investing in its workforce. The organization's "Joy at Work" initiative reflects a commitment to supporting the well-being of employees and physicians through targeted strategies focused on retention, organizational pride, and burnout prevention. Initiatives include:

- Structured onboarding and "stay interviews."
- Enhanced clinical communication.
- Designated spaces for mindfulness and restoration.

A triennial Physician Community Needs Assessment guides Meritus Health's recruitment strategy and furthers alignment with both strategic and operational goals. The 2022 assessment identified that Meritus Health had a shortage of 52 providers across primary and specialty care. Contributing factors include:

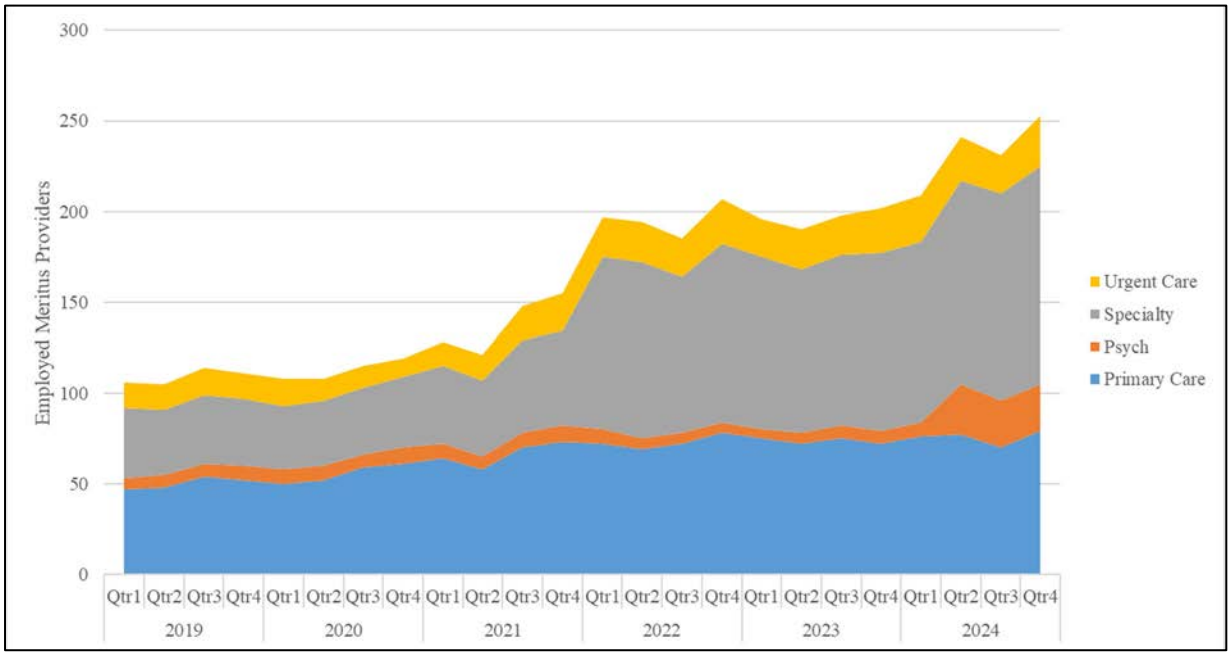
- A high percentage of aging physicians.
- A growing elderly population requiring increased care.
- The challenges of recruiting providers to rural regions.

To address these gaps, Meritus Health has implemented a multi-pronged approach:

- Annual recruitment targets focused on high-need specialties
- Expansion of graduate medical education programs to establish a sustainable pipeline of future physicians
- Enhanced telehealth services to extend access to care in underserved areas

The following chart illustrates Meritus Health's progress in provider recruitment over recent years.

Meritus Health Provider Employment



Meritus Health fosters a culture of collaboration, appreciation, and continuous professional development and offers a broad array of training and advancement opportunities designed to support long-term employee retention, career growth, and the sustainability of a high-performing workforce.

Employee engagement has shown marked improvement in recent years. This progress is reflected in Meritus Health's Net Promoter Score ("NPS")—a quarterly employee engagement survey scored on a scale from -100% to +100%. Meritus Health's NPS increased from 6% in FY 2022 to 25% in FY 2025, signaling a significant rise in organizational loyalty, employee satisfaction, and workplace culture alignment. This positive trend in employee sentiment has occurred alongside a reduction in workforce vacancy rates, which declined from 9.2% to 6.7% over the same period.

Despite this progress, ongoing volume pressures and the national healthcare labor shortage have resulted in continued reliance on agency staffing, though at levels reduced from pandemic-era highs. For context:

- Pre-pandemic agency expense: $5 million–$10 million annually.
- Peak pandemic agency expense: $34 million in a single year.
- Current agency expense: approximately $20 million annually.

Meritus Health continues to implement strategic initiatives to reduce agency dependency and enhance workforce stability.

To further support workforce development and strengthen recruitment pipelines, Meritus Health has launched several programs, including:

- **Minimum Wage Increases**: From $11.50 in 2019 to $18.00 in FY 2025, with a target of $20.00 by January 2027.
- **Student Apprentice Program**: Partnership with Washington County Public Schools to cultivate future healthcare professionals.
- **Virtual Nursing Program**: Use of remote technology to support bedside teams and optimize staffing.
- **Nursing Scholarship Programs**: Financial assistance for students enrolled in local nursing schools.
- **Meritus Scholarship Program**: Funding support for current team members pursuing nursing degrees.
- **International Nurse Recruitment**: Attracts skilled international nurses to address staffing shortages and enhance workforce diversity.

These initiatives are part of Meritus Health's comprehensive strategy to build a resilient, engaged, and mission-aligned workforce, allowing the System to continue to meet the evolving healthcare needs of the region while advancing its Bold Goals. As a result, Meritus Health has been ranked as a top employer in Maryland for the second time in three years.

Quality and Performance Improvement

Meritus Health drives quality and performance improvement through a systematic, organization-wide approach that is continuously evaluated and aligned with the System's long-term strategic goals. This process informs the Annual Operating Plan and is guided by True North Metrics, which support achievement of Meritus Health's 2030 Bold Goals.

Improvement priorities are identified through a structured strategic planning process, which includes a comprehensive review of performance in key focus areas:

- Patient care outcomes
- Quality pay-for-performance measures
- Operational efficiency
- Innovation and population health

Meritus Health monitors both inpatient and outpatient metrics to drive system-wide improvements in care delivery. Targeted Key Performance Indicators include:

- Preventable harm
- Mortality rate
- 30-day readmissions
- Patient falls
- Hospital-acquired pressure injuries and infections
- Patient experience metrics

In the ambulatory setting, Meritus Health monitors core population health measures such as:

- Hemoglobin A1C control
- Blood pressure management
- Colorectal and breast cancer screenings
- Smoking cessation
- Timely post-discharge follow-up appointments

Once priority areas are defined, Meritus Health deploys its Performance Excellence Plan ("PEP") to support and manage improvement efforts across all departments. The PEP framework enables teams to launch initiatives that directly support system-level improvements and strategic goals.

- All projects are vetted by the PEP Steering Committee to ensure strategic alignment and measurable outcomes.
- The Operations Improvement Team provides continuous coaching and support to departments.
- Projects are executed using Kata, a lean-based methodology grounded in iterative Plan-Do-Study-Act improvement cycles.

Progress on improvement projects is reviewed weekly through Leadership Rounding, where senior leaders, including the Executive Team, engage directly with frontline teams to provide support, remove obstacles, and reinforce accountability.

Meritus Health uses a multi-tiered dashboard system to track progress and ensure alignment at all levels of the System:

- True North Dashboard – system-wide strategic metrics
- Annual Operating Plan Dashboard – alignment with annual goals
- Departmental Dashboards – unit-level accountability
- PEP Tracker – monitoring of improvement projects

This framework fosters transparency, consistency, and operational discipline in quality improvement across the enterprise. These efforts are further supported by the Organizational Playbook, which outlines how Kata methodology, dashboards, and improvement science are embedded into Meritus Health's culture.

In 2020, Meritus Health established a Bold Goal to achieve Zero Patient Harm. At the time of its inception, the organization averaged over seven preventable harms per month. By 2025, Meritus Health achieved a 67% reduction, averaging two harms per month—a measurable advancement in its pursuit of high reliability and patient safety.

Community Health and Population Wellness

Meritus Health has adopted a bold community health goal: to support the residents of Washington County and surrounding areas in collectively losing one million pounds. This initiative aims to improve population health outcomes while fostering collaboration among individuals, employers, and community partners. To date, the initiative has:

- Engaged more than 8,000 active participants.
- Partnered with over 50 local employers.
- Achieved a total weight loss exceeding 167,000 pounds.

Participants log progress through a digital platform centered on the "Do, Eat, Believe" framework:

- **Do** – Encourages regular physical activity
- **Eat** – Promotes healthy and sustainable dietary habits
- **Believe** – Focuses on mental well-being and stress reduction

Meritus Health's approach to community wellness is systematic, integrated, and data-driven, aligning with key priorities outlined in the Community Health Needs Assessment. The System implements targeted programs to address the social determinants of health, including:

- Care Caller Program: Initiated during the COVID-19 pandemic, this program connects trained volunteers with individuals who self-identify as socially isolated. Volunteers make weekly phone calls to 340 participants, with 95% reporting reduced feelings of loneliness. For calendar year 2024, the Care Caller Program facilitated an average of 13,400 minutes of calls per month.
- Care to Share Boxes: Located at four Meritus Health sites, these food distribution boxes provide free access to non-perishable food and essential items. The program has distributed more than $100,000 in provisions, serving the estimated 13% of residents and 15% of children in Washington County facing food insecurity.
- Complimentary Patient Transportation: Meritus Health operates a fleet of eight wheelchair-accessible vans, offering approximately 16,000 free rides annually. This door-to-door transportation service, integrated with the patient scheduling system, eliminates transportation as a barrier to accessing care.

In addition to its population-wide initiatives, Meritus Health emphasizes personalized, patient-centered care through its "What Matters Most" program. During clinical encounters, patients are asked to identify personal goals and values. This information is then displayed at the top of the patient's electronic medical record, ensuring that care teams across the continuum are aligned with the individual's priorities and life context.

Financial Performance and Affordability

MMC has demonstrated sustained financial strength, with only two years of negative operating margins over the past 20 years. Even during the COVID-19 pandemic, positive operating margins were maintained through the implementation of effective cost-containment measures. The only negative-margin years occurred immediately following the implementation of the Epic electronic health record system, reflecting the one-time investment and transition costs associated with digital infrastructure upgrades.

This long track record of operating surpluses has enabled Meritus Health to build a strong balance sheet, positioning the System to undertake significant strategic investments, including the installation of

solar energy infrastructure and the development of MSOM. In 2023, Meritus Health began a multi-phased microgrid resiliency project, with a total investment of $12 million. As of May 1, 2025, over 3.3 megawatts of power have been produced, resulting in an enhanced, uninterrupted power supply for the Meritus Health Campus. The total estimated investment in MSOM is approximately $250 million, consisting of:

- A $50 million escrow reserve, per COCA guidelines (discussed below)
- Operational funding for start-up phase losses
- Construction of a $90 million medical school facility (Bowman Academic Hall)
- Development of a $90 million on-campus student housing complex (Meritus Commons)

COCA-Required Escrow Reserve

As part of the accreditation process, an applicant for a new college of osteopathic medicine must fund and demonstrate funding of escrow accounts equal to the cash value of tuition multiplied by the approved number of students for the proposed college of osteopathic medicine multiplied by four years. COCA requires that Meritus Health fund an escrow reserve in the amount of $50 million. Funds held in the escrow reserve are classified as restricted cash and are excluded from the Obligated Group's Days Cash on Hand calculation. The escrow reserve consists of two distinct components:

- Operating Escrow Account – $10 million
    - Funds are restricted but can accrue interest
    - Interest earned may be transferred to an unrestricted account
- Student Escrow Account – $40 million
    - Interest in this account must remain within the account and cannot be accessed or swept into operating funds
    - Student escrow funding calculation = Full class size × four years × annual tuition This amount may increase if tuition increases, requiring the escrow balance to be adjusted accordingly. The interest accruing on these funds is expected to be sufficient to cover any anticipated tuition increases.

The full $50 million reserve will be released from escrow upon the graduation of the Medical School's first class in 2029, in accordance with COCA guidelines. Should a new medical school fail for any reason, the escrow reserve provides the medical students the funds to finish their degree at another institution. The table below shows the estimated cost of attendance for each incoming Medical School student:

Meritus Medical School Cost of Attendance – Academic Year 2025-26

Item	Cost
Tuition	$55,000
Comprehensive Fee	3,500
Housing	24,132
Food	4,000
Total	**$86,632**

Global Budget Revenue

As part of Maryland's regulated hospital payment model, the Health Services Cost Review Commission ("HSCRC") uses the Global Budget Revenue ("GBR") methodology to set and monitor hospital revenue. To promote fairness and efficiency across the State, the HSCRC applies the Inter-Hospital Cost Comparison ("ICC") methodology, which evaluates the reasonableness of hospital costs by comparing them to those of their peers, with adjustments based on hospital-specific factors such as trauma designation, residency programs, and disproportionate share hospital status, which is when a hospital receives additional funds from the federal government to help offset the costs of caring for a large number of low-income patients.

The ICC is recalculated annually, using current-year GBR revenue and prior-year service volumes. For more information, see "Payment Model and Regulatory Framework" in this Appendix A.

Over the past five years, the Medical Center has consistently ranked among the most efficient hospitals in Maryland, with rankings ranging from second to sixth statewide. As of May 1, 2025, the Medical Center was the most efficient hospital in Maryland based on the HSCRC's inter-hospital cost comparison data.

Meritus Health has achieved a long-term affordability goal – to become the most efficient hospital in Maryland by 2030 – five years ahead of schedule, and is dedicated to continuing its efficiency.

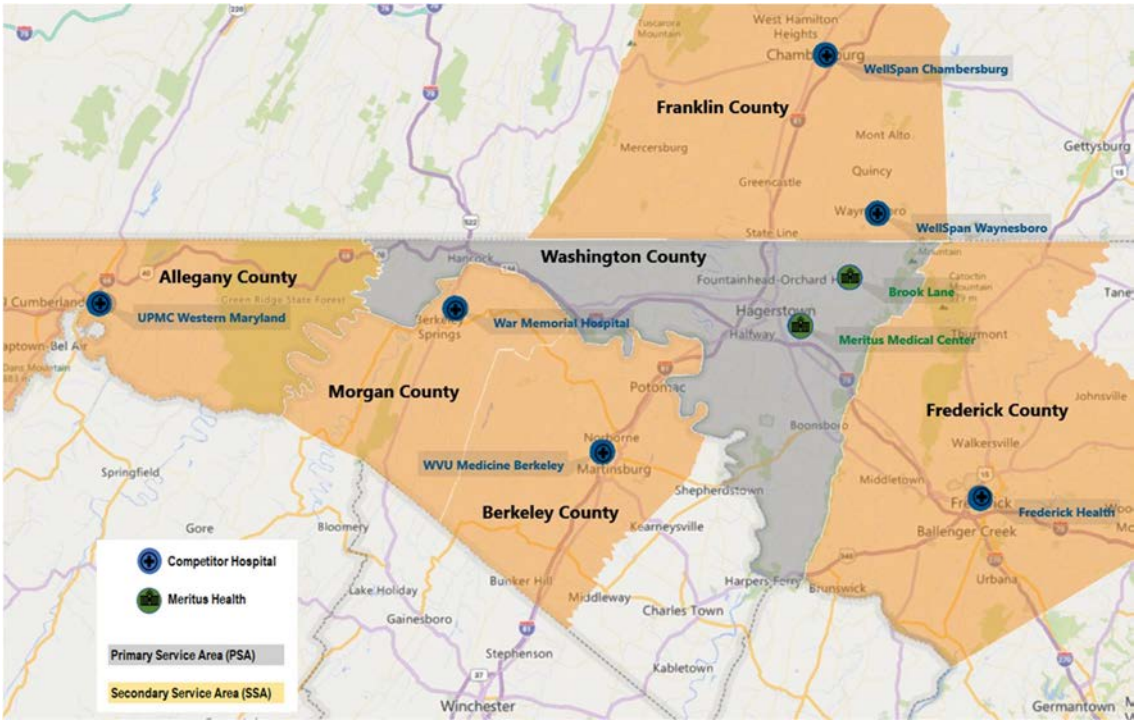
SERVICE AREA AND MARKET SHARE

Service Area

Meritus Health is located in Hagerstown, Maryland which is in Washington County in western Maryland. The city of Hagerstown has an estimated population of 44,000 and is positioned within close proximity to two major metropolitan areas: Baltimore, Maryland (75 miles west) and Washington D.C. (73 miles southeast) as well as a short distance from the Pennsylvania and West Virginia borders. The System's entire service area encompasses 97 zip codes that span six counties and three states. The System defines its PSA as Washington County, Maryland, with a current estimated total population 155,000 which is expected to grow 1.3% by 2028. (Source: US Census Bureau)

The System's secondary service area ("SSA") includes a portion of Franklin County located within Southern Pennsylvania, portions of Frederick and Allegany Counties in Maryland, and portions of Morgan and Berkeley counties in the Eastern Panhandle of West Virginia resulting in an estimated total population of 625,000. The SSA has a projected five-year population growth rate of 3.7%. The map below shows the location of MMC and its hospital competitors and the boundaries of the counties containing the primary and secondary service areas. Only one hospital in Waynesboro, PA is located within 20 miles of MMC.

Service Area Map



Facility	Miles from MMC
WellSpan Waynesboro, PA	12.7
WVU Medicine Berkeley, WV	24.0
WellSpan Chambersburg, PA	26.2
Frederick Health, MD	27.1
War Memorial Hospital, WV	38.6
UPMC Western Maryland, MD	70.3

Discharge Data by Service Area

The following table contains the inpatient discharges for the Medical Center across the primary and secondary service areas for FY 2023 and FY 2024.

Meritus Medical Center Discharge Data by Service Area

	FY 2023		FY 2024	
Service Area	**Discharges**	**% of Total Meritus Discharges**	**Discharges**	**% of Total Meritus Discharges**
Primary Service Area - Counties				
Washington	12,519	-	13,680	-
Total Primary Service Area	**12,519**	**78.6%**	**13,680**	**79.3%**
Secondary Service Area - Counties				
Allegany	48	2.1%	39	1.5%
Berkeley	714	30.6%	843	32.0%
Franklin	906	38.8%	964	36.6%
Frederick	595	25.5%	715	27.1%
Morgan	70	3.0%	73	2.8%
Total Secondary Service Area	**2,333**	**14.7%**	**2,634**	**15.3%**
Other	1,066	-	938	-
Total Other	**1,066**	**6.7%**	**938**	**5.4%**
Total	**15,918**	-	**17,252**	-

Source: IP MD Statewide Data

The following table presents inpatient discharge data for Brook Lane Hospital across the primary and secondary service areas of Meritus Health for fiscal years 2023 and 2024. As illustrated in the chart, more than 50% of Brook Lane Hospital's inpatient discharges originate from outside the primary and secondary service areas, representing communities throughout the State of Maryland. This distribution underscores Brook Lane Hospital's role as a unique and essential statewide resource for behavioral health services. Its ability to provide specialized inpatient psychiatric care—particularly for pediatric and adolescent populations—positions Brook Lane Hospital as a vital component of Maryland's mental health infrastructure.

Brook Lane Hospital Discharge Data by Service Area

	FY 2023		FY 2024	
Service Area	**Discharges**	**% of Total Meritus Discharges**	**Discharges**	**% of Total Meritus Discharges**
Primary Service Area - Counties				
Washington	485	-	430	-
Total Primary Service Area	**485**	**15.5%**	**430**	**18.6%**
Secondary Service Area - Counties				
Allegany	80	9.9%	97	14.0%
Frederick	537	66.4%	435	62.9%
Border State: Pennsylvania	119	14.7%	73	10.5%
Border State: West Virginia	73	9.0%	87	12.6%
Total Secondary Service Area	**809**	**25.9%**	**692**	**29.9%**
Other	1,828	-	1,195	-
Total Other	**1,828**	**58.6%**	**1,195**	**51.6%**
Total	**3,122**	-	**2,317**	-

Source: Brook Lane IP Case Mix HSCRC submission

Market Share

The Medical Center holds a dominant market share within its PSA. As of June 30, 2024, the Medical Center commands:

- 86% of the inpatient market, up from 83% in FY 2022
- 83% of the outpatient market

The following table presents market share data for the Medical Center across its PSA.

Medical Center PSA Market Share

	Washington County, Maryland (PSA)			
MMC Market Share	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Inpatient	83%	83%	85%	86%
Outpatient	83%	83%	83%	83%

Source: HSCRC Market Shift Data

In addition to its hospital-based services, Meritus Health maintains a robust presence in primary care, with approximately 57% of office-based providers in Washington County affiliated with the System. This alignment enhances care coordination, supports population health initiatives, and reinforces Meritus Health's leadership in local healthcare delivery.

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The following tables present inpatient and outpatient market share by service line for Washington County for the 12-month period ending June 30, 2024.

Inpatient and Outpatient Market Share by Service Line

Inpatient Market Share

Service Line	% Meritus Cases
Urology	98%
Infectious Disease	96%
Pulmonary	95%
General Medicine	95%
Psychiatry	92%
Rehabilitation	91%
Cardiology	91%
Hematology	91%
Gastroenterology	91%
Neurology	90%
Neonatology	88%
OB/GYN	86%
Invasive Cardiology	81%
Vascular Surgery	80%
Trauma	79%
Gynecological Surg.	77%
Ventilator Support	77%
General Surgery	74%
Endocrinology Surgery	73%
Oncology	68%
Orthopedic Surgery	60%
Inj./complic. of prior care	59%
Neurological Surgery	52%
Thoracic Surgery	50%
Urological Surgery	48%
Ophthalmology	45%
Spinal Surgery	41%
Cardiothoracic Surgery	8%
ENT Surgery	7%
Total	**86%**

Outpatient Market Share

Service Line	% Meritus Cases
Psychiatry	96%
ED	94%
Oncology Related Services	90%
Other	79%
Lab	73%
Minor Surgery	72%
Cardiovascular	69%
Radiology	68%
Major Surgery	62%
CT/MRI/PET	51%
Clinic	37%
Rehab & Therapy	3%
Total	**83%**

Source: HSCRC Market Shift Data

Volume Change

Since Fiscal Year 2019, the Medical Center has experienced significant volume growth, driven primarily by increased demand within its PSA with additional contributions from the broader SSA. The table below highlights key entry-point service lines and compares volume growth between FY 2019 and FY 2024:

Service Line Changes in Volume

	Fiscal Year Ended June 30,							
Service Lines	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2024 vs 2019**	**% Change**
Emergency Room	67,141	60,335	57,255	61,537	67,073	75,814	8,673	13%
Urgent Care	25,517	24,579	16,135	34,408	44,315	42,957	17,440	68%
Primary Care	140,562	122,598	119,135	144,622	152,709	166,257	25,695	18%
Inpatient Admissions	12,211	10,880	11,309	10,995	10,707	12,511	300	2%
Inpatient Days	52,923	47,293	50,486	56,888	50,073	58,150	5,227	10%
Observation Days	5,570	4,456	7,017	10,758	13,386	13,182	7,612	137%
Surgery	7,733	6,762	7,016	7,265	7,996	8,665	932	12%
Outpatient Therapy	41,883	43,780	44,830	50,679	62,202	74,829	32,946	79%

Service Line Trends

Service Line	Key Growth Drivers	Geographic Trends
Emergency Room	Growth largely attributable to increased demand from Washington County residents	Patients from PA, WV, and Frederick County increased by over 23%
Urgent Care	Expanded access and extended hours in Washington County	Patient volumes from WV and Frederick grew by over 50%
Primary Care	Driven by new location openings and the addition of resident physicians	Volumes from Frederick and West Virginia increased by 20%
Outpatient Therapy	Alignment with orthopedic practices and three new therapy locations across the region	Volumes increased by 756% in Frederick, 192% in Pennsylvania, and 90% in West Virginia

The ability of Meritus Health and the Medical Center to attract and retain patients from outside its PSA illustrates the regional demand for Meritus Health services, the impact of strategic service line development, and the effectiveness of expanded physical access points across the tri-state region.

DEMOGRAPHIC AND ECONOMIC INFORMATION

Population Trends

The following table provides information on population trends in counties in the PSA and the SSA.

Projected Population Trends

	2020 Actual	2025 Proj.	2028 Proj.	8-Year % Change
Primary Service Area				
Washington County	151,012	156,329	158,347	4.90%
Secondary Service Area East				
Frederick	143,691	171,003	180,736	25.80%
Middletown	36,930	40,236	42,005	13.70%
Mount Airy	57,478	67,241	70,475	22.60%
North Frederick County	36,858	38,781	40,188	9.00%
SSA East Sub-Total	**274,957**	**317,261**	**333,404**	**21.30%**
Secondary Service Area North				
Chambersburg	82,811	85,455	86,789	4.80%
Greencastle	29,178	29,120	29,407	0.80%
Waynesboro	33,618	34,419	35,203	4.70%
SSA North Sub-Total	**145,607**	**148,994**	**151,399**	**4.00%**
Secondary Service Area West				
Allegany County	72,360	69,019	68,939	-4.70%
Berkeley County	120,034	137,069	144,775	20.60%
Morgan County	14,744	15,047	15,526	5.30%
SSA West Sub-Total	**207,138**	**221,135**	**229,240**	**10.70%**
Service Area Total	**778,714**	**843,719**	**872,390**	**12.00%**
Maryland	6,177,224	6,274,647	6,314,839	2.23%
Pennsylvania	13,002,700	13,172,278	13,152,250	1.15%
West Virginia	1,793,716	1,787,175	1,769,870	-1.33%
United States	331,449,281	338,016,259	342,384,777	3.30%

Source: U.S. Census Bureau and Claritas.

Meritus Health's primary and secondary service areas are forecasted to experience faster population growth than neighboring states. Notably, Berkeley County (WV) and Frederick County (MD) are projected

to see a population increase exceeding 20% over an eight-year period, supporting sustained demand for healthcare services.

Employment Statistics

Below is a list of major employers located in Washington County, Maryland. Meritus Health is the largest non-governmental employer in the five most western counties in Maryland.

Washington County Major Employers 2023-24

Employer	Industry	Employment
Meritus Health	Medical Services	2,740*
FedEx Ground	General Freight Trucking, Local	2,654
FiServ	Credit Card Processing	2,185
Volvo Group	Diesel Engines and Transmissions	1,836
Amazon	General Freight Trucking, Local	1,500
The Bowman Group	Hotels Management and Logistics	830
Walmart	Warehouse Club and Supercenter	565
Hagerstown Community College	Higher Education	545
Merkle Response Management Group	Mail Order Processing	545
Brook Lane Health Services	Medical Services	485
Giant Food Stores/MARTIN'S Food Markets	Grocery	465
Direct Mail Processors	Mail Order Processing	450
Dot Foods	Refrigerated Warehousing and Storage	440
Staples Distribution	General Warehousing and Storage	390
A.C.&T. Co.	Fuel Dealers	375

*As of January 1, 2025, Meritus Health employs approximately 4,300 employees
Source: Maryland Department of Commerce, Brief Economic Facts (2024). Excludes post offices, state and local governments, national retail and national foodservice.

Set forth below are annual average unemployment rates for the years 2022 through 2024 for the primary and secondary service areas, Maryland, Pennsylvania, West Virginia, and the United States. In 2024, all primary and secondary service areas had lower unemployment rates than the United States.

Annual Average Unemployment Rates from 2022 to 2024

	2022	2023	2024
Primary Service Area			
Washington	3.1%	2.4%	3.2%
Secondary Service Area			
Allegany	3.7%	2.9%	3.7%
Berkeley	2.9%	3.4%	3.5%
Franklin	3.5%	3.1%	3.1%
Frederick	2.7%	2.0%	2.8%
Morgan	2.8%	3.1%	3.3%
States and National			
Maryland	3.0%	2.2%	3.0%
Pennsylvania	4.1%	3.7%	3.6%
West Virginia	3.9%	3.9%	4.1%
United States	3.6%	3.6%	4.0%

Source: US Bureau of Labor Statistics

Income in the PSA & SSA

The following table provides average household income for 2023:

Average Household Income for 2023

Primary Service Area	
Washington	$74,157
Secondary Service Area	
Allegany	$57,393
Berkeley	77,329
Franklin	74,946
Frederick	120,458
Morgan	63,805
States and National	
Maryland	$101,652
Pennsylvania	76,081
West Virginia	57,917
United States	78,538

Source: US Census Bureau

GOVERNANCE

Meritus Health, Inc.

The governance structure of Meritus Health facilitates system-wide oversight, operational alignment, and the execution of strategic priorities across all entities.

Meritus Health, Inc. ("MHI") is governed by a nine-member Board of Directors (the "MHI Board"), with all directors holding voting privileges. Pursuant to the bylaws of MHI, the Board may consist of up to 10 members, including *ex officio* directors. Directors are elected to staggered three-year terms, and no director may serve more than three consecutive terms.

Ex officio voting members of the MHI Board include the President of MHI and the Board Chairs of:

- Meritus Medical Center, Inc. ("MMC")
- MSOM, Inc. ("MSOM")
- Brook Lane, Inc. ("Brook Lane Parent")

These individuals serve concurrently with their leadership roles at their respective entities.

Meetings and Committees

The MHI Board meets regularly five times per year, with additional meetings convened at the discretion of the Board Chair. The MHI Board oversees governance through one standing committee, the Finance Committee – composed of representatives from each of the MMC, MSOM, and Brook Lane Parent boards and chaired by a MHI Board member. The current members of the MHI Board are as follows:

Name	Occupation	Year of Initial Term	First Term Ends	Second Term Ends	Third Term Ends
Wayne Alter	Retired - Founder Security Center Company	2023	2024	2027	2030
Fr. Stuart Dunnan	Headmaster, St. James School	2023	MSOM Chair – Ex-Officio		
BJ Goetz, Jr	President & CEO, Middletown Valley Bank	2023	MMC Chair – Ex-Officio		
Steve Hull	President, Ewing Oil	2023	2023	2026	2029
Mary J.C. Hendrix, PhD	President, Shepherd University	2023	2023	2026	2029
Lauren Huguenin	Consulting	2023	Brook Lane Chair – Ex-Officio		
Neil Jesuele	Retired - Healthcare Admin	2023	2024	2027	2030
Maulik Joshi, Dr.P.H.	President & CEO, Meritus Health & MSOM	Ex-Officio	Ex-Officio	Ex-Officio	Ex-Officio
Greg Snook	President & CEO for Washington Cty Industrial Foundation	2023	2025	2028	2031
James Stojak	Retired - Banking President	2023	2025	2028	2031

Governance Structure – Members of the Obligated Group

Each member of the Obligated Group is governed by a Board of Directors or a Board of Trustees (a "Subsidiary Board"), members of which are appointed by MHI. Under the organizational documents of each member of the Obligated Group, MHI retains specific reserved powers that ultimately benefit MHI, enabling operational cohesion and integrated oversight across the System.

MMC, MSOM, and Brook Lane Parent maintain standing committees as follows: MMC maintains an Executive Committee, a Quality and Safety Committee, a Finance and Capital Committee, and an Audit and Business Integrity Committee. MSOM maintains a Finance Committee, an Audit and Institutional Risk Management Committee, and an Academic and Student Affairs Committee. Brook Lane Parent maintains a Joint Conference Committee, a Budget and Finance Committee, and a Development Committee.

Reserved Powers of MHI over the Obligated Group Members

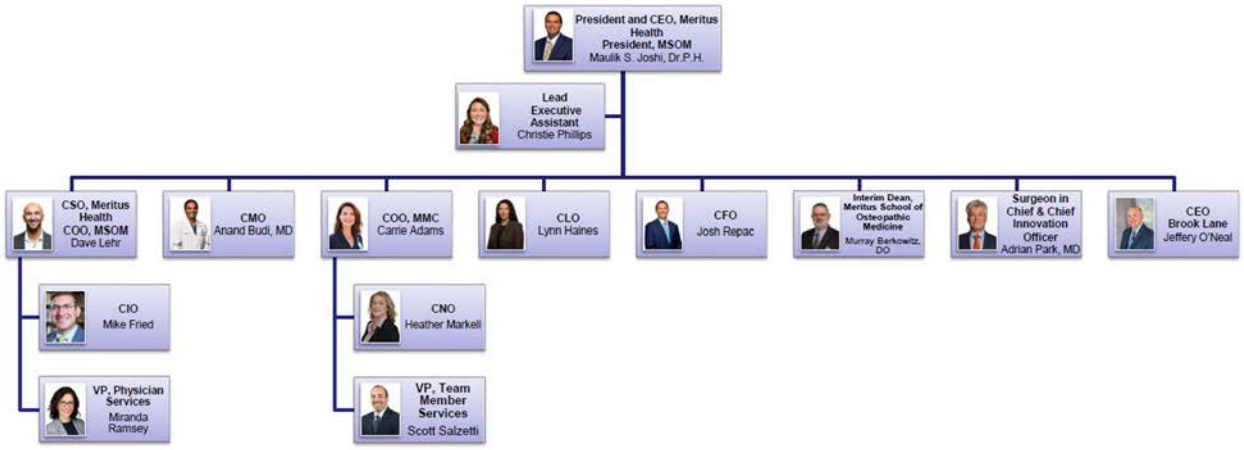
As the sole member of MMC and MSOM, and the indirect parent of Brook Lane Health Services, Inc., MHI holds reserved powers that provide system-level governance and control. These powers include, for example:

- Approving any amendments to the organizational documents of each Obligated Group Member
- Exercising oversight of business operations
- Appointing, replacing, and removing directors or trustees, as applicable, of each corporation

Additional reserved powers are set forth in the respective Obligated Group Member's organizational documents and may be granted to MHI directly by the Obligated Group Member pursuant to a written agreement.

This governance structure, through which MHI retains control over the Board membership of the Obligated Group Members and holds substantial reserved powers over each Obligated Group Member, promotes strategic alignment, organizational accountability, and governance consistency across all members of the Obligated Group.

Executive Management Team



Maulik Joshi, Dr.P.H. – President and Chief Executive Officer

Maulik Joshi, Dr.P.H., serves as the President and CEO of MHI. Previously, Dr. Joshi was the Chief Operating Officer and Executive Vice President at Anne Arundel Health System. He has also held leadership roles at the American Hospital Association, the Institute for Healthcare Improvement, the Agency for Healthcare Research and Quality, the University of Pennsylvania Health System, and The HMO Group.

He holds a Doctorate in Public Health and a Master's degree in Health Services Administration from the University of Michigan. He was Editor-in-Chief for the *Journal for Healthcare Quality* and co-edited *The Healthcare Quality Book: Vision, Strategy, and Tools* (5th edition, 2022). He has authored over 50 peer-reviewed articles and serves as adjunct faculty at the University of Michigan School of Public Health. Currently, he serves as a Commissioner for the Maryland Health Services Cost Review Commission.

Carrie Adams, Pharm.D. – Chief Operating Officer

Carrie Adams, Pharm.D., is the Chief Operating Officer of MHI, overseeing hospital and ambulatory quality and performance improvement, environmental services, and security services. Previously, she led the clinical process redesign and the installation of a new electronic health record system. She began her career at Meritus as the pharmacy director and later became the corporate director of pharmacy services at Trivergent Health Alliance Managed Services Organization.

Ms. Adams successfully aligned and implemented best practice pharmacy models, leading drug utilization initiatives that resulted in a three-year cumulative savings of $11 million. She holds a Doctor of

Pharmacy degree from Shenandoah University and a bachelor's degree in pharmaceutical sciences from Ohio Northern University. She is also certified as a Green Belt in Six Sigma.

Josh Repac, CPA, M.B.A. – Chief Financial Officer

Josh Repac is the Chief Financial Officer and Vice President of Revenue Cycle and Clinical Support Services of MHI. Previously, he served as Executive Director of Revenue Cycle and Reimbursement at MHI. Before joining MHI, he was a Director at the Berkeley Research Group and an Advisory Manager at KPMG, LLP, both healthcare reimbursement firms in the Baltimore region.

Mr. Repac is a Certified Public Accountant with an MBA from the University of Baltimore/Towson University and a Bachelor of Science in Accounting from the Robert H. Smith School of Business at the University of Maryland, College Park.

Dave Lehr – Chief Strategy Officer

Dave Lehr is MHI's first Chief Strategy Officer. In 2021, Governor Larry Hogan appointed him as a Commissioner to the Community Health Resources Commission. He also serves on the board of the Washington County Chamber of Commerce.

Before joining MHI, Mr. Lehr was the Chief Information Officer for Luminis Health in Annapolis, where he was recognized as one of *Modern Healthcare's* Top 25 Emerging Leaders in Healthcare in 2019. He also co-chaired the national opioid task force for CHIME, which unites CIOs across the country in the fight against the opioid epidemic.

Adrian Park, M.D. – Chief Surgical Officer

Dr. Adrian Park serves as the Surgeon-in-Chief and Clinical Innovation Officer. Prior to joining Meritus Health, he was the James and Sylvia Earl Chair of Surgery and Surgeon-in-Chief at Luminis Health in Annapolis, Maryland, and a Professor of Surgery at Johns Hopkins University School of Medicine.

Dr. Park has made significant advancements in laparoscopic techniques, complex hernia repair, and foregut and spleen surgery. He holds over 20 patents and has played a key role in the development and application of new technologies in endoscopic surgery.

Anand Budi, M.D. – Chief Medical Officer

Dr. Anand Budi is the Chief Medical Officer of the Medical Center. Born and raised in India, he graduated from the All India Institute of Medical Sciences, one of Southeast Asia's premier medical schools. He completed his pediatric residency at AIIMS before pursuing a neonatology fellowship in Sydney, Australia.

After relocating to the U.S., he completed a pediatric residency at the University of Connecticut and later served as Chief Resident at All Children's Hospital in St. Petersburg, Florida. Since 1998, Dr. Budi has practiced in Hagerstown and joined Weiss & Becker, PA in 2003. Since 2008, he has held various

leadership roles at the Medical Center and was instrumental in establishing the Special Care Nursery, After Hours Pediatrics urgent care, and the Pediatric Hospitalist program in Washington County.

Lynn Haines, Esq. – Chief Legal Officer

Lynn Haines, Esq., is the Chief Legal Officer and Vice President of Legal Services of MHI. Previously, she served as Associate General Counsel at Meritus Health, where she provided legal counsel, negotiated contracts, and advised various departments.

She has also worked as in-house counsel for Access World (USA) LLC and as corporate counsel for Magnolia Management Inc. She holds a Juris Doctor degree from the University of Baltimore School of Law and a bachelor's degree in psychology from West Virginia University. She is a member of the American Health Law Association and is licensed to practice in Maryland.

Murray Berkowitz, D.O., M.A., M.S., M.P.H., FAOCOPM, FAAO – Interim Dean of Meritus School of Osteopathic Medicine

Dr. Murray Berkowitz completed his medical degree at the University of Osteopathic Medicine and Health Sciences (now Des Moines University College of Osteopathic Medicine and Surgery) in Des Moines, Iowa. He holds a Master of Public Health from the Johns Hopkins University Bloomberg School of Public Health, a Master of Arts and a Master of Science from Columbia University, and an engineering degree from what is now the Tandon School of Engineering at NYU.

Board-certified in Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine, as well as in Preventive Medicine and Public Health, Dr. Berkowitz also holds certification in Occupational Medicine. He completed post-graduate study and research at Oxford University's Laboratory for Molecular Biophysics in the Department of Zoology, focusing on the structure of fibrous proteins. In addition, he undertook post-graduate and doctoral study and research in Computer Science and Engineering, as well as in Information Technology/Command, Control, Communications, and Intelligence Systems Engineering at the University of Texas at Arlington and George Mason University. He also completed a Health Policy Fellowship with the American Osteopathic Association and a Research Fellowship with the Osteopathic Research Center at UNTHSC/TCOM in Fort Worth, Texas.

Jeffery O'Neal, MBA, LCPC, FACHE – CEO, Brook Lane, Inc.

Jeffery D. O'Neal, MBA, LCPC, FACHE, brings 36 years of experience in behavioral healthcare as both a clinical counselor and an administrator. He has worked in and supervised programs in outpatient counseling and case management, emergency crisis services, intensive outpatient and partial hospitalization services, and inpatient psychiatric services.

Before joining Brook Lane Health in October 2021 as its Chief Executive Officer, Mr. O'Neal served as Executive Director of Clinics, Practices, and Behavioral Health Services at UPMC Western Maryland for 18 years, where he oversaw psychiatric services as well as primary care, urgent care, and specialty service lines. Mr. O'Neal earned his Bachelor of Arts in Sociology from West Virginia Wesleyan College, a Master of Arts in Counseling Psychology from Hood College, and an MBA from American Sentinel University. He is a Fellow of the American College of Healthcare Executives, a Certified Medical Practice Executive, a National Certified Counselor, a Certified Employee Assistance Counselor, and a Licensed Clinical Professional Counselor in Maryland. Additionally, he is an honorably discharged US Army veteran, having achieved the rank of Captain.

Additional Leadership

- Miranda Ramsey – Vice President of Physician Services
- Scott Salzetti – Vice President of Team Member Services
- Heather Markell, MSN, RN, CEN – Chief Nursing Officer
- Michael Fried – Vice President and Chief Information Officer

MANAGEMENT'S DISCUSSION AND ANALYSIS OF UTILIZATION AND FINANCIAL PERFORMANCE

Historical Utilization

The following table sets forth the utilization statistics for the two Obligated Group Hospitals:

	Obligated Group Hospitals Utilization			
	Fiscal Years Ended June 30,		Nine Months Ended March 31,	
	2023	2024	2024	2025
Meritus Medical Center				
Licensed Beds[1]	268	245	245	259
Adult Admissions (includes Peds)	14,059	15,586	11,512	12,046
Adult Inpatient Days (includes Peds)	62,032	69,389	51,610	55,293
Average Daily Census	170.0	190.1	188.4	201.8
Average Length of Stay	4.41	4.45	4.48	4.59
Adult Percentage of Occupancy	64.40%	77.90%	76.90%	77.91%
Equivalent Inpatient Admissions[2]	28,204	32,467	23,952	24,295
Observation Cases	3,073	3,023	2,217	2,092
Emergency Room Visits	64,722	71,281	53,070	52,072
Inpatient Surgical Cases	3,194	3,517	2,619	2,370
Outpatient Surgical Cases	4,994	5,445	4,139	4,152
Outpatient Ambulatory Visits	205,832	187,524	155,609	166,491
Newborn Admissions	1,945	1,886	1,398	1,566
Newborn Patient Days	4,839	4,755	3,527	4,053
Newborn Average Length of Stay	2.49	2.52	2.52	2.59
Brook Lane Hospital				
Psychiatric Inpatient Adult Patient Days[3]	6,248	5,765	4,429	4,626
Psychiatric Inpatient Pediatric Patient Days[3]	11,459	10,856	7,878	8,417

Source: Meritus Health, Inc. records.

(1) Licensed Beds exclude observation beds.
(2) Equivalent Inpatient Admission factor in an equivalency for outpatient volumes.
(3) Brook Lane Hospital affiliated with Meritus Health on July 1, 2024.

Management Discussion and Analysis of Financial Performance

Set forth on the following page are comparative statements of operations for MHI and its consolidated subsidiaries for the fiscal years ended June 30, 2023 and June 30, 2024. These financial results are derived from the audited consolidated financial statements of MHI. The summary information presented herein should be read in conjunction with the audited financial statements, supplementary information, and the report of the independent certified public accountants for the fiscal years ended June 30, 2023 and 2024, which are included in Appendix B to this Official Statement. Of note, Brook Lane was not affiliated with Meritus Health until July 1, 2024, and therefore was not included in the consolidated financial statements prior to that date.

As of and for the fiscal year ended June 30, 2024, the Obligated Group accounted for approximately:

- 93% of total assets, and
- 80% of total unrestricted revenue, gains, and other support of MHI and its consolidated subsidiaries.

In addition, a summary of revenue and expenses for MHI and consolidated subsidiaries is provided for the nine-month periods ended March 31, 2024 and March 31, 2025, along with a balance sheet as of March 31, 2025. This interim financial information was derived by management from internally prepared, unaudited financial statements, which have been prepared in accordance with Generally Accepted Accounting Principles (GAAP) and applied on a basis substantially consistent with the audited financial statements for the fiscal year ended June 30, 2024.

These unaudited statements do not include all disclosures and footnotes required by GAAP for a complete set of financial statements. However, in the opinion of management, all adjustments necessary for a fair presentation have been included. The results for the nine months ended March 31, 2025, are not necessarily indicative of the results that may be expected for the full fiscal year ending June 30, 2025.

The results for the nine months ended March 31, 2025, are not necessarily indicative of the results that may be expected for the full fiscal year ending June 30, 2025. The summary financial information should be read in conjunction with the audited consolidated financial statements, related notes, and other financial information included in this Official Statement.

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Consolidated Statements of Operations

(Dollars in Thousands)	Fiscal Years Ended June 30, (audited) 2023	2024	Nine Months Ended March 31, (unaudited) 2024	2025
Unrestricted revenue, gains and other support				
Net patient service revenue	$502,005	$579,606	$427,499	$504,161
Other revenue	37,474	27,609	19,743	39,762
Net assets released from restrictions for operations	154	182	114	90
Total unrestricted revenue, gains and other support	539,633	607,397	447,356	544,013
Expenses				
Salaries and wages	241,527	282,520	207,905	269,332
Employee benefits	46,101	51,744	37,082	48,587
Professional fees	41,510	45,456	32,914	35,282
Supplies and other expenses	150,201	176,228	128,337	151,898
Interest expense	11,864	11,688	8,755	8,709
Depreciation and amortization	29,733	30,646	22,417	26,653
Total expenses	520,936	598,282	437,410	540,461
Operating income	18,697	9,115	9,946	3,552
Non-operating revenue (expense)				
Equity earnings in affiliates	15,862	14,189	11,309	6,837
Investment returns, net	26,936	41,172	35,208	16,436
Other, net	(1,746)	(1,116)	(107)	(114)
Income tax (expense)	(276)	(413)	(111)	(91)
Excess of revenue over expenses	$59,473	$62,947	$56,245	$26,620

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Consolidated Balance Sheets

(Dollars in Thousands)	As of Years Ended June 30, (audited) 2023	2024	As of March 31, (unaudited) 2025
ASSETS			
Current assets			
Unrestricted cash and cash equivalents	$43,495	$12,640	$44,898
Short-term investments	127,770	89,009	0
Current portion of assets whose use is limited	11,049	62,614	52,696
Accounts receivable, net	45,096	61,932	97,323
Supplies	7,899	12,025	15,171
Prepaid and other current assets	15,360	25,524	28,367
Total current assets	250,669	263,744	238,455
Equity investments in affiliates	63,492	43,983	49,413
Assets whose use is limited	254,960	288,560	278,022
Property, plant and equipment, net	236,698	299,506	361,036
Other assets	42,933	46,524	45,103
Total assets	$848,752	$942,317	$972,029
LIABILITIES AND NET ASSETS			
Current liabilities			
Accounts payable and accrued expenses	$28,296	$52,391	$34,744
Accrued salaries, wages and withholdings	11,648	14,389	21,525
Accrued compensation benefit	15,026	14,420	17,586
Advances from third-party payors	17,303	17,056	11,145
Accrued interest payable	5,442	5,314	2,612
Current portion of long-term debt	8,491	8,759	9,022
Total current liabilities	86,206	112,329	96,634
Long-term debt, net of current portion	285,905	277,146	273,118
Accrued retirement benefits	6,451	8,891	8,757
Other long-term liabilities	33,613	41,716	39,818
Total liabilities	412,175	440,082	418,327
Net Assets			
Unrestricted net assets	425,952	490,751	538,131
Permanently restricted	10,625	11,484	15,571
Total net assets	436,577	502,235	553,702
Total liabilities and net assets	$848,752	$942,317	$972,029

Financial Results – Fiscal Years ended June 30, 2023 and 2024 ($ in thousands)

Operating Revenue

Total operating revenue for the fiscal year ended June 30, 2024 was $607,397, representing an increase of $67,764 (12.6%) compared to the fiscal year ended June 30, 2023. The increase was primarily attributable to growth in net patient service revenue, which rose by $77,601 (15.5%) year-over-year. This growth was driven largely by a 10.9% increase in the Meritus Medical Center regulated rate order, effective July 1, 2023. For more information, see "Payment Model and Regulatory Framework" in this Appendix A.

Operating Expenses

Total operating expenses for FY2024 were $598,282, an increase of $77,346 (14.8%) compared to FY2023.

- Salaries and benefits increased by $46,636 (16.2%), driven by market adjustments, merit-based compensation, and a rise in contract labor costs due to workforce shortages.
    - Contract labor costs increased $11,975 year-over-year.
- Supplies and other expenses rose $26,027 (17.3%) and accounted for 30.4% of net patient service revenue in FY2024, compared to 29.9% in FY2023.
    - Key drivers of this increase included higher surgical volumes, retail pharmacy activity, and oncology drug utilization.

Non-operating revenue and expenses

The non-operating gain for FY2024 was $53,832, up from $40,776 in FY2023. This increase is primarily attributable to favorable capital market performance.

Unrestricted cash and cash equivalents and short-term investments

Unrestricted cash and cash equivalents and short-term investments totaled $101,649 as of June 30, 2024, compared to $171,265 at fiscal year end June 30, 2023. The decrease of $69,616 was primarily due to capital expenditures related to the construction of Bowman Academic Hall and Meritus Commons. Proceeds from the Series 2025 Bonds will be used to reimburse these expenditures and thereby increase unrestricted cash.

Financial Results – Nine-Months ended March 31, 2024 and 2025 ($ in thousands)

Operating Revenue

Total operating revenue for the nine months ended March 31, 2025 was $544,013, an increase of $96,657 (21.6%) over the same period in 2024.

This increase was driven by:

- An 10% increase in the Meritus Medical Center regulated rate order, effective July 1, 2024.
- The consolidation of Brook Lane Health with MHI, effective July 1, 2024.

- Brook Lane Health contributed $32,270 in operating revenue during the period.

Operating Expenses

Total operating expenses for the nine months ended March 31, 2025, were $540,461, representing an increase of $103,051 (23.6%) compared to the same period in 2024.

- Brook Lane's consolidated operating expenses were $34,415 as of March 31, 2025
- Salaries and benefits increased by $72,932 (29.8%), driven by:
  - Wage increases
  - Market and merit adjustments
  - Brook Lane Health integration
  - A $22,366 increase in contract labor expenses related to persistent clinical workforce shortages
- Supplies and other expenses rose by $23,561 (18.4%), representing 30.1% of net patient service revenue, compared to 30.0% in the prior year period.
  - Cost increases were primarily associated with retail pharmacy expansion and higher oncology drug costs.

Non-operating revenue and expenses

The non-operating gain for the nine-month period ended March 31, 2025, was $23,068, compared to $46,299 for the same period in 2024. The year-over-year variance is primarily attributable to fluctuations in capital market performance.

Payment Model and Regulatory Framework

In 1977, the Centers for Medicare & Medicaid Services ("CMS") granted the state of Maryland a waiver exempting the State from national Medicare and Medicaid reimbursement principles. Maryland has broad authority to regulate hospital rates, which are set by the Maryland Health Services Cost Review Commission (the "HSCRC") annually. In January of 2014, CMS and Maryland entered into a new initiative called the "All-Payer Model" with a goal of reducing health care costs and improving patient outcomes. The All-Payer Model required the HSCRC to set annual Global Budget Revenue ("GBR") for each acute care hospital in the state, subjecting annual revenues from hospital-based inpatient and outpatient services to a fixed cap. Prior to the All-Payer Model, the Medical Center operated under a predecessor payment structure known as Total Patient Revenue that began in 2010.

In 2018, the model shifted into the current Total Cost of Care ("TCOC") model, which expanded the focus from per capita hospital costs to the total cost of care for each Medicare beneficiary. The TCOC model continued the use of GBR – hospitals are paid a fixed annual revenue amount, regardless of the volume of services provided, with limited adjustments made for demographic shifts, out-of-state volumes, and market share changes. These adjustments are implemented in subsequent periods and are governed by HSCRC policies. Approximately 72% of Meritus Health's revenues are derived through GBR. While Brook Lane Hospital is regulated by the HSCRC, it is not currently subject to a GBR arrangement.

The TCOC model is designed to incentivize hospitals to:

- Improve efficiency and reduce avoidable costs.
- Decrease unnecessary utilization of services.
- Enhance quality through coordinated care delivery.

A specific focus is placed on reducing Potentially Avoidable Utilization (PAU)—such as hospital readmissions and preventable hospitalizations for conditions including diabetes, hypertension, and heart failure—by investing in disease management and preventive care in community settings.

AHEAD Model Participation

The State of Maryland has entered into a new agreement with the Centers for Medicare & Medicaid Innovation to transition from the current TCOC model to participate in the All-Payer Health Equity Approaches and Development ("AHEAD") model, a total cost of care model based largely on Maryland's current regulatory structure. In addition to Maryland, Vermont, Connecticut, Hawaii, Rhode Island, and New York (in five downstate counties: Bronx, Kings, Queens, Richmond, and Westchester) have been selected to participate in the AHEAD model. Participation in the AHEAD model is expected begin in January 2026 and will require the development of a Statewide Health Equity Plan. The model emphasizes community-level investment in population health, reduction of health disparities, and coordination of health-related social needs. For more detail, *see* REGULATORY ENVIRONMENT in the front part of this Preliminary Official Statement.

As part of this initiative, Maryland has been awarded $4 million in Cooperative Agreement funding to support: investments in community-level population health initiatives; programs addressing health-related social needs; and technology platforms for coordinated screening and referral services.

This evolving regulatory and payment environment positions Meritus Health to continue advancing high-quality, value-based care delivery while strengthening its role in improving community health outcomes.

Payor Mix Trends

The following table sets forth the mix of gross revenues from patients, third-party payors for Meritus Medical Center and Brook Lane for the fiscal years ended June 30, and as of March 31, 2025.

Payor Mix Trends

Meritus Medical Center and Brook Lane Hospital	As of Year Ended June 30,	As of March 31,
	2024	**2025**
Medicare	37%	35%
Medicare MCO	14%	14%
Medicaid	2%	3%
Medicaid MCO	16%	18%
Blue Cross	13%	13%
Commercial	16%	15%
Workers Comp	0%	0%
Self-Pay	2%	2%
	100%	**100%**

Note: Meritus Medical Center and Brook Lane Health Services - Hospital Only

Meritus Medical Center's payor mix qualifies the Medical Center for the federal drug discount program established under Section 340B of the Public Health Service Act. Section 340B requires pharmaceutical manufacturers to give specified discounts on covered outpatients drugs to certain categories of providers, including disproportionate share hospitals. As a disproportionate share hospital, the Medical Center serves low-income patients and receives additional payments from the Centers for Medicare & Medicaid Services to cover the costs of providing care to these patients.

Outstanding Long-Term Debt of the Obligated Group

In addition to the Series 2025 Bonds, outstanding long-term debt secured as Parity Debt under the Master Loan Agreement includes a term loan to MMC in the outstanding principal amount of $55,465,000.

Investment Policy

All investments made by Meritus Health are governed by a System-wide Investment Policy, which is developed and overseen by the MHI Finance Committee. The policy outlines asset allocation targets aligned with the System's strategic objectives and long-term financial plans. The investment portfolios, which include both fixed income and equity holdings, are subject to clearly defined guidelines regarding:

- Investment style and objectives
- Asset concentration limits
- Credit quality standards
- Performance benchmarks
- Allowable and non-allowable asset classes

MHI maintains an agreement with an external investment advisor who provides discretionary investment management services for board-designated funds. Under this agreement, the advisor is granted full authority to allocate and rebalance assets as needed, in accordance with the parameters set forth in the investment policy, without requiring prior consultation with MHI. The MHI Finance Committee meets quarterly with the investment advisor to review portfolio performance, confirm adherence to asset allocation targets, and monitor ongoing compliance with the Investment Policy.

The asset allocation targets and actual allocations for the board designated investment portfolio for the quarter ended March 31, 2025 are as follows:

Asset	Actual	Target Range (%)
Public Equity	54.2%	30% - 65%
Public Debt	32.4%	20% - 50%
Hedge Funds	6.4%	0% - 15%
Public Real Assets	2.4%	0% - 10%
Multi-Assets	4.3%	0% - 30%
Cash	0.5%	0% - 20%
	100%*	

*Actual asset allocation percentages may not add due to rounding.

Cash and cash equivalents, approximating $45 million as of March 31, 2025, are maintained on hand for day-to-day operational needs and are maintained separately from the investments shown in the table.

KEY FINANCIAL RATIOS

Historical and Pro Forma Liquidity

The following table sets forth liquidity for the Obligated Group measured by unrestricted and board designated cash and investments.

Historical and Pro Forma Days Cash on Hand – Obligated Group

	As of Years Ended June 30,		As of Nine Months ended March, 31
(Dollars in Thousands)	**2023**	**2024**	**2025**
Cash and cash equivalents	$41,524	$9,723	$41,820
Short term investments	127,770	89,009	-
Board designated funds	227,073	256,193	245,537
Total cash and investments	$396,367	$354,925	$287,357
Total operating expenses less: Depreciation and amortization expense	363,795	413,333	381,837*
Existing days cash on hand	398	313	206
Pro forma days cash on hand**	-	-	299

* Results are for the nine-month period ending March 31, 2025

** Pro forma days cash on hand assumes $128.9 million of new long-term debt is reimbursement funds to Meritus Health Obligated Group.

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Historical and Pro Forma Debt Service Coverage

The table below shows the historical and proforma debt service coverage for the Obligated Group. The pro forma long-term debt service requirement and pro forma debt service coverage ratio reflect figures as if the Series 2025 Bonds had been issued as of June 30, 2024.

Historical and Pro Forma Long-Term Debt Service Coverage Ratio – Obligated Group

	For Years Ended June 30,		9-Months Ended
(Dollars in Thousands)	**2023**	**2024**	**March 2025**
Excess of revenues over expenses	$83,624	$98,198	$59,086
Plus:			
Change in net unrealized losses (gains) on investments	(20,071)	(26,922)	(5,536)
(Gain) loss on disposal of assets	(3)	(19)	0
Depreciation and amortization expense	26,276	26,899	23,773
Interest expense	11,862	11,685	8,709
Income available for debt service	$101,688	$109,841	$86,032
Historical maximum annual debt service requirement	20,443	20,429	15,322[(1)]
Historical debt service coverage ratio (x)	4.97	5.38	5.62
Pro forma MADS requirement	28,410	28,410	21,308[(2)]
Pro forma debt service coverage ratio (x)	3.58	3.87	4.04

(1) Annual maximum annual debt service is adjusted for nine-month stub period
(2) Pro forma maximum annual debt service assumes $160.8 million of new long-term debt and uniform refunding of the Series 2015 bonds.

ADDITIONAL INFORMATION

Cybersecurity and Technology Innovation

Meritus Health is committed to sustained investment in its information technology ecosystem to support mission-critical functions, including electronic health records, enterprise resource planning, population health management, clinical decision support, financial operations, and cybersecurity. These efforts are foundational to Meritus Health's mission to deliver expert care, foster innovation, and provide fully integrated services to the community.

Cybersecurity Program

Meritus Health maintains a robust and comprehensive information security program that integrates technical safeguards with a risk-based institutional framework. This approach upholds the confidentiality, integrity, and availability of sensitive data while promoting resilience and operational continuity.

Key components of the cybersecurity program include:

Regular Penetration Testing: Meritus Health conducts recurring internal and external penetration assessments through a rotating selection of specialized cybersecurity firms. Findings are tracked in a

centralized risk register reviewed regularly by the internal audit, privacy, and legal teams to advance mitigation efforts and maintain accountability.

Framework Compliance: Cybersecurity assessments adhere to leading industry standards, including:

- Cybersecurity Implementation Framework (14 domains)
- HIPAA Security Rule compliance
- National Institute of Standards and Technology (NIST) Cybersecurity Framework 2.0
- Payment Card Industry Data Security Standard (PCI DSS) 4.0

Data Encryption and Endpoint Protection: All data backups are encrypted using NIST-approved Advanced Encryption Standard with a 256-bit key and SHA-256 hashing. Workstations and servers are equipped with advanced Endpoint Detection and Response software to safeguard against evolving cyber threats.

Medical Device Cybersecurity: A dedicated platform is used to manage medical devices and operational technology. The clinical engineering team monitors cybersecurity risks and reports weekly to executive leadership, ensuring real-time visibility and continuous improvement.

Multi-layered Network Defense: The network security architecture includes intrusion detection and prevention systems, next-generation firewalls, and threat intelligence platforms. These systems enable real-time detection and automated response to cyber threats.

Employee Awareness and Training: Meritus Health fosters a culture of cybersecurity through ongoing employee education, simulated phishing campaigns, and awareness training. Recognizing that human error remains a leading cause of security incidents, Meritus Health prioritizes staff engagement as a key defense mechanism.

Cybersecurity Resilience

Meritus Health has demonstrated strong cybersecurity preparedness and operational resilience in the face of two major industry-wide cybersecurity incidents that have disrupted healthcare systems across the country over the past two years.

Change Healthcare Incident

The first incident involved Change Healthcare, a major national claims processor. While the event had minimal operational impact on MMC, it did temporarily affect retail pharmacy operations for a period of approximately two weeks. During this time, MMC acted swiftly to switch to an alternate claims processor, ensuring that community members continued to receive uninterrupted prescription services. The financial impact of the disruption was limited to less than $12,000. Importantly, hospital claims were unaffected due to the System's intermediary having a redundant processing solution already in place, allowing for an immediate transition to a secondary processor.

CrowdStrike Incident

The second incident involved a major security event related to CrowdStrike, a prominent cybersecurity provider. Again, Meritus Health experienced only minimal disruption. The internal IT team acted rapidly to identify and remediate affected workstations, effectively mitigating operational risk and maintaining system continuity.

These incidents underscore Meritus Health's agility, technical preparedness, and strong internal governance in navigating complex, industry-wide cybersecurity threats. Layered defense strategies, proactive risk assessments, and dedicated IT response capabilities have been instrumental in safeguarding operations and maintaining uninterrupted patient care.

Artificial Intelligence ("AI") and Machine Learning ("ML")

In alignment with its innovation strategy, Meritus Health is actively integrating artificial intelligence and machine learning technologies across clinical, operational, and administrative domains. A cross-functional governance team ensures that AI/ML implementations align with organizational priorities, patient safety, and regulatory compliance.

- Strategic Evaluation: All AI-related investments are evaluated for their capacity to deliver measurable value while protecting patient privacy and data integrity.
- Collaborative Partnerships: Meritus Health collaborates with academic institutions and industry partners to assess emerging technologies and develop responsible deployment strategies.
- Internal Capabilities: Ongoing investment in software engineering and data analytics enables Meritus Health to develop, evaluate, and manage AI/ML tools internally, accelerating innovation while maintaining high standards for safety and reliability.

These efforts help Meritus Health to remain technologically resilient, secure, and capable of leveraging cutting-edge solutions to improve patient care, streamline operations, and enhance long-term organizational sustainability.

Insurance

Meritus Insurance Company Ltd. ("MICL") is a captive insurance company domiciled in the Cayman Islands, with MHI as its sole member. MICL provides professional and general liability insurance for MMC and retains the first $1,000,000 per claim. For claims that exceed this threshold, MICL has secured reinsurance contracts with third-party insurers to mitigate risk.

MMC pays periodic premiums to MICL, which are established through actuarial analysis, risk management assessments, legal review, and historical claims experience. In addition to coverage through MICL, Meritus Health utilizes independent insurance providers for other operational risk areas, including workers' compensation, property, and casualty insurance. These coverages are reviewed annually in collaboration with an external insurance broker. Management considers current insurance levels and deductibles to be adequate and appropriate for operational needs.

Litigation

The members of the Obligated Group are involved in various legal proceedings and claims in their normal course of operations. Management does not believe that any pending or threatened litigation will have a material adverse impact on the financial conditions or operations of the Obligated Group Members, taken as a whole, or on the ability of the Obligated Group members to meet their obligations related to the Series 2025 Bonds.

Community Benefit

As the sole community hospital in Washington County, the Medical Center is committed to delivering measurable community benefit. The Medical Center has been recognized by the Lown Institute as ranking within the top 1.5% of hospitals nationally for community benefit as a percentage of total revenue for two consecutive years.

Over the past five years, Meritus Health has more than doubled its annual community benefit, increasing from $41 million to $83 million. This increase reflects mission-driven expansion in healthcare services and a significant rise in charity care, which has quadrupled since fiscal year 2019.

Licenses and Accreditation

The Medical Center and Brook Lane Hospital are both licensed by the Maryland Department of Health and operate in full compliance with the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation.

- Brook Lane Hospital received its most recent Joint Commission survey in 2024.
- The Medical Center received its most recent Joint Commission survey in 2025.

The Medical Center is designated as a Level III Trauma Center by the MIEMSS. It is one of only three Level III Trauma Centers in Maryland, which has a total of nine trauma centers statewide.

In August 2024, the Commission on Osteopathic College Accreditation ("COCA") granted the Medical School pre-accreditation status, which is the highest level of recognition attainable prior to the graduation of a first class. This milestone confirms that the Medical School meets COCA's rigorous standards for academic, clinical, and administrative readiness and represents a critical step toward full accreditation.

The Maryland Higher Education Commission issued conditional approval for the Medical School to operate as a degree-granting institution within the State of Maryland. This approval authorizes the Medical School to offer the Doctor of Osteopathic Medicine (D.O.) degree and affirms the school's compliance with the state's academic and operational standards.

These approvals allow MSOM to formally enroll students, with the Medical School's inaugural class set to begin coursework in July 2025.

MERITUS HEALTH, INC. AND SUBSIDIARIES

Consolidated Financial Statements and
Supplementary Financial Information

June 30, 2024 and 2023

(With Independent Auditors' Report Thereon)

MERITUS HEALTH, INC. AND SUBSIDIARIES

Table of Contents

KPMG LLP
750 East Pratt Street, 18th Floor
Baltimore, MD 21202

Independent Auditors' Report

The Board of Directors
Meritus Health, Inc.:

Opinion

We have audited the consolidated financial statements of Meritus Health, Inc. and its subsidiaries (the Company), which comprise the consolidated balance sheets as of June 30, 2024 and 2023, 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.

In our opinion, the accompanying consolidated financial statements present fairly, in all material respects, the financial position of the Company as of June 30, 2024 and 2023, and the results of its operations and changes in net assets and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Consolidated Financial Statements section of our report. We are required to be independent of the Company and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with U.S. generally accepted accounting principles, and for 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.

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for one year after the date that the consolidated financial statements are issued.

Auditors' Responsibilities for the Audit of the Consolidated Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.
- Obtain an understanding of internal control relevant to the audit 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 Company's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information in Schedules 1 and 2 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

Baltimore, Maryland
October 31, 2024

MERITUS HEALTH, INC. AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2024 and 2023

(Dollars in thousands)

Assets		2024	2023
Current assets:			
Cash and cash equivalents	$	12,640	43,495
Short-term investments		89,009	127,770
Current portion of assets whose use is limited		62,614	11,049
Accounts receivable		61,932	45,096
Supplies		12,025	7,899
Prepaid and other current assets		25,524	15,360
Total current assets		263,744	250,669
Assets whose use is limited		288,560	254,960
Property, plant, and equipment, net		299,506	236,698
Equity investments in affiliates		43,983	63,492
Other assets		46,524	42,933
Total assets	$	942,317	848,752
Liabilities and Net Assets			
Current liabilities:			
Accounts payable and accrued expenses	$	52,391	28,296
Accrued salaries, wages, and withholdings		14,389	11,648
Accrued compensation benefit		14,420	15,026
Advances from third-party payors		17,056	17,303
Accrued interest payable		5,314	5,442
Current portion of long-term debt		8,759	8,491
Total current liabilities		112,329	86,206
Long-term debt, net of current portion		277,146	285,905
Accrued retirement benefits		8,891	6,451
Other long-term liabilities		41,716	33,613
Total liabilities		440,082	412,175
Net assets:			
Net assets without donor restrictions		490,751	425,952
Net assets with donor restrictions		11,484	10,625
Total net assets		502,235	436,577
Total liabilities and net assets	$	942,317	848,752

See accompanying notes to consolidated financial statements.

MERITUS HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2024 and 2023

(Dollars in thousands)

	2024	2023
Unrestricted revenue, gains, and other support:		
Net patient service revenue	$ 579,606	502,005
Other revenue	27,609	37,474
Equity earnings in affiliates	14,189	15,862
Net assets released from restriction used for operations	182	154
Total unrestricted revenue, gains, and other support	621,586	555,495
Operating expenses:		
Salaries and wages	282,520	241,527
Employee benefits	51,744	46,101
Professional fees	45,456	41,510
Supplies and other	176,228	150,201
Interest	11,688	11,864
Depreciation and amortization	30,646	29,733
Total expenses	598,282	520,936
Operating income	23,304	34,559
Nonoperating gains (losses), net:		
Investment returns, net	41,172	26,936
Other, net	(1,529)	(2,022)
Excess of revenues over expenses	$ 62,947	59,473

(Continued)

MERITUS HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2024 and 2023

(Dollars in thousands)

		2024	2023
Net assets without donor restrictions:			
Excess of revenues over expenses	$	62,947	59,473
Other, net		1,852	516
Increase in net assets without donor restrictions		64,799	59,989
Net assets with donor restrictions			
Contributions		2,100	10,245
Other, net		(109)	(3,854)
Net assets released from restriction for capital		(950)	—
Net assets released from restriction for operations		(182)	(154)
Increase in net assets with donor restrictions		859	6,237
Increase in net assets		65,658	66,226
Net assets:			
Beginning of year		436,577	370,351
End of year	$	502,235	436,577

See accompanying notes to consolidated financial statements.

MERITUS HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended June 30, 2024 and 2023

(Dollars in thousands)

	2024	2023
Cash flows from operating activities:		
Increase in net assets	$ 65,658	66,226
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	30,646	29,733
Net realized and unrealized gains on investments	(31,994)	(21,179)
Gain on disposal of assets	(19)	(3)
Equity earnings in affiliates	(14,189)	(15,862)
Restricted contributions and other	(3,866)	(6,907)
Changes in assets and liabilities:		
Accounts receivable	(16,836)	(3,023)
Supplies, prepaid, and other current assets	(14,283)	982
Other assets	(3,391)	(631)
Accounts payable, accrued expenses, and other long-term liabilities	21,202	(1,290)
Accrued salaries, wages, and withholdings	2,741	(3,168)
Accrued compensation benefit	(606)	761
Advances from third-party payors	(247)	(12,032)
Interest payable	(128)	(145)
Accrued retirement benefits	2,440	829
Net cash provided by operating activities	37,128	34,291
Cash flows from investing activities:		
Purchase of property, plant, and equipment	(82,439)	(26,630)
Proceeds from the disposal of assets	—	3
Sales of other short-term investments, and assets whose use is limited, net	(38,058)	17,847
Purchases of alternative investments	(36,551)	(40,404)
Sales of alternative investments	71,674	37,376
Equity contributions to affiliates, net	33,698	3,255
Net cash used in investing activities	(51,676)	(8,553)
Cash flows from financing activities:		
Payments on long-term debt and finance leases	(8,491)	(5,841)
Restricted contributions and other	3,659	2,739
Net cash used in financing activities	(4,832)	(3,102)
Net (decrease) increase in cash and cash equivalents	(19,380)	22,636
Cash, cash equivalents, and restricted cash:		
Beginning of year	43,495	20,859
End of year	$ 24,115	43,495
Cash and cash equivalents	$ 12,640	43,495
Cash included in short term investments and assets limited to use	11,475	—
Cash, cash equivalents, and restricted cash at end of year	$ 24,115	43,495
Supplemental disclosure of cash flow information:		
Cash paid for interest	$ 11,688	11,864
Cash paid for income taxes	108	277
Amount included in accounts payable for construction in progress	10,996	84
Non-cash restricted contributions and other	207	4,168

See accompanying notes to consolidated financial statements.

(1) Description of Organization

Organization

Meritus Health, Inc. (MHI or the Company) is the parent corporation of the Meritus Medical Center, Inc. (the Hospital), Meritus Health Foundation, Inc. (the Foundation) and MSOM, Inc. (MSOM). The Hospital is the parent corporation of the Meritus Insurance Company, Ltd. (MIC); Meritus Health ACO, LLC (MACO); and Meritus Holdings, LLC (Holdings), which owns Meritus Enterprises (MEI). These entities are collectively referred to as "Meritus."

The Hospital is a not-for-profit acute-care hospital located in Hagerstown, Maryland and serves the residents of western Maryland, southern Pennsylvania, and the panhandle of West Virginia. The Hospital currently offers acute general hospital inpatient services, including adult medical/surgical care, obstetrics and newborn care, including a family birthing center, cardiac catheterizations, comprehensive inpatient rehabilitation, radiology and diagnostic services, inpatient and outpatient mental health services, a regional Level III Trauma Center, an intensive care unit, an intermediate care unit, and a pediatric unit. The Hospital also manages gifts, donations, or bequests given for the benefit of Meritus and owns real estate properties for rental to medical provider entities and development opportunities.

The Foundation is a not-for-profit corporation whose purpose is to raise philanthropic support for the capital and endowment campaigns of the Hospital and MSOM. The Foundation also raises money for the Hospital's medical programs, healthcare objectives, scientific research, educational programs, and related community activities. Resources for the Foundation's activities are primarily provided by donors.

MIC is a Cayman Island captive insurance company, wholly owned by the Hospital that provides primary limits of insurance to Meritus for professional liability, employed physician's professional liability, comprehensive general liability, deductible, and stop-loss coverage for health insurance.

As of June 30, 2024, MEI, a for-profit corporation, held ownership interests in the following joint venture:

- Diagnostic Imaging Services, LLC (DIS), an outpatient imaging services provider

Holdings is the sole member of Medical Practices of Antietam, LLC, which employs physicians and operates clinics in the Meritus primary service area.

As of June 30, 2024, Holdings, held ownership interests in the following joint venture:

- General Surgery Real Estate, LLC (GSRE), a real estate holding company

MEI also owns and operates Equipped for Life (EFL), a durable medical equipment company.

MACO is an Accountable Care Organization (ACO), wholly owned by the Hospital. MACO participates in the following CMS programs:

- Maryland Primary Care Program (MDPCP), as an approved Care Transformation Organization for Washington County, MD, effective January 1, 2019

MSOM, Inc. (Meritus School of Osteopathic Medicine) was established to operate a school of osteopathic medicine. MSOM, Inc. received conditional approval from the Maryland Higher Education Commission to operate as an in-state degree-granting institution and pre-accreditation from the Commission on Osteopathic College Accreditation. Medical school enrollment trends indicate an ample supply of qualified applicants to support the proposed class size of 180 students. The school is under construction, and the first class is planned to begin in August 2025. The Meritus Board of Directors have approved financial commitments totaling $190,000, including a reserve obligation of $50,000. Meritus will fund the project through current cash and investment holdings.

The Hospital is building a student housing development adjacent to the campus. Phase 1 of the project has an expected completion date of the summer of 2025 with 180 one and two bedroom units. Phase 2 of the project will increase the residential complex to 364 units. Phase 1 and 2 will cost approximately $90,000.

(2) Summary of Significant Accounting Policies

(a) Principles of Consolidation

The Company's consolidated financial statements include the subsidiaries in which the Company has more than 50% voting interests or when the Company is deemed to have control. Significant intercompany accounts and transactions have been eliminated in consolidation. The accompanying consolidated financial statements include the accounts of MHI, the Hospital, Holdings, MEI, the Foundation, MACO, MSOM, and MIC. All material intercompany balances and transactions have been eliminated in consolidation.

(b) Use of Estimates

The preparation of consolidated financial statements, in conformity with accounting principles generally accepted in the United States of America, requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Accordingly, actual results could differ from those estimates.

(c) Cash and Cash Equivalents

Cash and cash equivalents consist of short-term, highly liquid investments held with large well-known financial institutions, that are readily convertible to cash and have original maturities of three months or less. Cash and cash equivalents are carried at cost that approximates fair value.

(d) Patient Accounts Receivable

Patient accounts receivable result from the healthcare services provided by Meritus and are recorded at the net realizable value based on certain assumptions determined by each payor. For third-party payors, including Medicare, Medicaid, and commercial insurance, the net realizable value is based on the estimated contract adjustments, which is based on approved discounts on charges as permitted by the Health Services Cost Review Commission (HSCRC). For self-pay accounts, which included patients who are uninsured and the patient responsibility portion for patients with insurance, the net realizable value is determined using estimates of historical collection experience. See note 2(m) for revenue recognition policies.

(e) Assets Whose Use is Limited

Assets whose use is limited include assets set aside by the Board of Directors for specific purposes, for supplemental retirement benefit investments, to fulfill donor purposes, assets held by trustees under bond indenture agreement, and funds designated for insurance purposes. Amounts required to meet current liabilities are shown as current assets in the consolidated balance sheets. Cash and cash equivalents, as defined above, within assets whose use is limited are treated as investments.

(f) Investments and Investment Income

Investments in equity securities (i.e., investments that have readily determinable fair values and are not accounted for by the equity method) and all investments in debt securities are reported at fair value on the consolidated balance sheets. Institutional funds are recorded at their readily determinable fair values (RDFV). All securities with the exception of alternative investments are reported at fair value. Alternative investments are recorded under the equity method of accounting.

A significant portion of Meritus' investments are held in an investment portfolio maintained for the benefit of Meritus and its affiliates and its subsidiaries. Investments are classified as trading securities except for certain investments, which are limited or restricted as to use or do not have the liquidity to qualify as trading securities and are classified as investments available for sale.

Investment income and realized gains are recorded as nonoperating revenue. Unrealized gains and losses on trading securities are recorded as nonoperating revenue. Unrealized gains and losses on available for sale investments are included in other changes in net assets. Investment income and realized gains and losses on assets restricted by donors for specific purposes or endowment are included in net assets with donor restrictions.

Investment income, which includes interest and dividends, on proceeds of borrowings that are held by a trustee are reported as other revenue. Other investment income, which includes interest, dividends and realized and unrealized gains and losses on assets limited as to use by Board of Directors, and funds designated for insurance purposes are recorded as nonoperating gains (losses), net, unless the income or loss is restricted by donor or law.

Meritus' investments are managed by investment managers. Investment securities, in general, are exposed to various risks, such as interest rate, credit, and overall market volatility. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the values of investment securities will occur in the near term and that such change could materially affect the amounts reported in the consolidated financial statements.

(g) Supplies

Supplies for the Hospital are carried at cost on a weighted average basis.

(h) Property, Plant and Equipment

Property, plant and, equipment acquisitions are recorded at cost. Those assets acquired by gift are carried at amounts established as fair value at the time of acquisition. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line

(Dollars in thousands)

method. Equipment under finance leases are amortized by the straight-line method over the shorter of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the consolidated financial statements. 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. No interest was capitalized during the year ended June 30, 2024 or 2023. Leasehold improvements are amortized over the lesser of the useful life or the lease life. Durable medical equipment held for resale is included in supplies. The remainder of durable medical equipment is rented to patients and is included in property, plant, and equipment. Assets are retired or disposed of at book value and related gains or losses are recorded for assets sold. Useful lives range as follows:

Land improvements	5–25 Years
Buildings	10–40 Years
Equipment	3–20 Years

Gifts of long-lived assets such as land, buildings, or equipment are reported as other changes in net assets without donor restrictions unless explicit donor stipulations specify how the donated assets must be used. When applicable, 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-lived assets must be maintained, expirations of donor restrictions, occur when the donated or acquired long-lived assets are placed into service.

Meritus continually evaluates whether events and circumstances have occurred that indicate the remaining estimated useful life of long-lived assets is appropriate, or whether the remaining balance may not be recoverable. When factors indicate that long-lived assets should be evaluated for possible impairment, Meritus uses an estimate of the related undiscounted operating income over the remaining life of the long-lived asset in measuring whether the long-lived asset is recoverable.

The impairment loss on these assets is measured as the excess of the carrying amount of the asset over its fair value. Fair value is based upon market prices, where available, or discounted cash flows. Management believes that no revision to the remaining useful lives is required, and there was no impairment of long-lived assets during the years ended June 30, 2024 or 2023.

(i) Deferred Financing Costs

Financing costs incurred in issuing debt have been capitalized and are being amortized over the life of the debt.

(j) Compensated Absences

Meritus records a liability for amounts due to employees for future absences, which are attributable to services performed in the current and prior periods. This liability is included in accrued compensation benefit on the consolidated balance sheets.

(k) Net Assets with Donor Restrictions

Net assets with donor restrictions are those whose use by Meritus have been limited by donors to a specific time period or purpose. When donor restrictions expire, that is, when a time restriction ends or a purpose restriction is accomplished, net assets with donor restrictions are reclassified into net assets without donor restrictions and reported as net assets released from restrictions. Net assets with donor restrictions also include funds that have been restricted by donors to be maintained by Meritus in perpetuity.

Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions if for operating purposes and as other changes in net assets without donor restrictions if for capital purposes in the consolidated statements of operations and changes in net assets.

(l) Excess of Revenues Over Expenses

The consolidated statements of operations include a performance indicator, the excess of revenue over expenses. Changes in net assets without donor restrictions that are excluded from the excess of revenues over expenses, consistent with industry practice, include net assets released from restrictions for property, plant, and equipment.

(m) Net Patient Service Revenue

For services provided at the Hospital's campus, all payors are required to pay the HSCRC approved rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered.

The Hospital's charges are subject to review and approval by the HSCRC. The total rate of reimbursement for services to patients under the Medicare and Medicaid programs is based on an arrangement between the Centers for Medicare and Medicaid Service and the HSCRC. The Hospital has an agreement with the HSCRC under a rate regulation concept called Global Budget Revenue (GBR).

Services not located on the Hospital's campus and certain other services are not regulated by the HSCRC. Medicare and Medicaid pay the revenues associated with these services based upon established fee schedules. Commercial payors pay at negotiated rates for these services.

Laws and regulations governing the HSCRC, Medicare, and Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Meritus believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action.

Net patient service revenue is recognized, over time, as performance obligations are satisfied. Performance obligations are determined based on the nature of the services provided. Revenue for

(Dollars in thousands)

performance obligations satisfied over time is recognized at the estimated net realizable amounts from patients and third-party payors for services rendered.

The Company generates revenues, primarily by providing healthcare services to its customers. Revenues are recognized when control of the promised good or service is transferred to customers, in an amount that reflects the consideration to which the Company expects to be entitled from patients, third-party payors (including government programs and insurers), and others, in exchange for those goods and services.

The majority of the Company's healthcare services represent a bundle of services that are not capable of being distinct and as such, are treated as a single performance obligation satisfied over time as services are rendered. The Company also provides certain ancillary services that are not included in the bundle of services, and as such, are treated as separate performance obligations satisfied at a point in time, if and when those services are rendered.

The Company's estimate of the transaction price includes estimates of price concessions for such items as contractual allowances, charity care, potential adjustments that may arise from payment and other reviews, and uncollectible amounts, which are determined using a portfolio approach as a practical expedient to account for patient contracts as collective groups rather than individually. Estimates for uncollectible amounts are based on the aging of the accounts receivable, historical collection experience for similar payors and patients, current market conditions, and other relevant factors.

Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to net patient service revenue in the period of the change. Subsequent changes that are determined to be the result of an adverse change in the payor's or patient's ability to pay are recorded as bad debt expense. Bad debt expense for the years ended June 30, 2024 or 2023 was not significant to the consolidated financial statements.

Patient service revenue for the years ended June 30, 2024 and 2023, net of contractual allowances and other allowances, recognized in the period by inpatient/outpatient, is as follows:

	Third party	
	2024	**2023**
Net patient service revenue:		
Hospital inpatient	$ 259,274	231,917
Hospital outpatient	228,523	208,429
Other outpatient	395,691	318,694
Gross charges	883,488	759,040
Less contractual and other allowances	(303,882)	(257,035)
Net patient service revenue	$ 579,606	502,005

(Continued)

(n) Charity Care

Meritus provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Meritus does not pursue collection on amounts deemed to qualify as charity. Meritus also estimates that the direct and indirect cost of services and supplies furnished to patients eligible for charity care using a ratio of cost to gross charges based on internal data is $22,057 and $14,479 for the years ended June 30, 2024 and 2023, respectively.

Meritus' patient acceptance policy is based upon its mission statement and its charitable purposes. This policy results in Meritus' assumption of higher-than-normal credit risk from its patients. To the extent that Meritus realizes additional losses resulting from such higher credit risks and clients are not identified or do not meet Meritus' defined charity care policy, such additional losses are recognized as a reduction to net patient service revenue.

Meritus also sponsors certain other charitable programs, which provide substantial benefit to the broader community. Such programs include services to needy and elderly populations that require special support, as well as health and education for the general community welfare. In addition, all other uncollectible amounts resulting from the patients' inability to pay are recorded as a reduction to net patient service revenue, consistent with Meritus' policy.

(o) Other Revenue

Other revenue comprises rental income, gains and losses on disposal of assets, 340B contract pharmacy income, grants related to COVID-19 funding, including funding from the Coronavirus Aid, Relief, and Economic Security (CARES) Act and Federal Emergency Management Agency (FEMA) reimbursement, and other miscellaneous items.

The Company received $5,492 in CARES Act payments on August 24, 2022 and recognized the amount in other revenue for the year ended June 30, 2023.

On August 9, 2022, the Company received a letter of final determination from FEMA in the amount of $10,498, which was recognized in other revenue for the year ending June 30, 2023.

On July 6, 2023, the Company received a letter of final determination from FEMA in the amount of $2,461, which was recognized in other revenue for the year ending June 30, 2024.

On January 31, 2024, the Company received a letter of final determination from FEMA in the amount of $2,619, which was recognized in other revenue for the year ending June 30, 2024.

(p) Income Taxes

The Internal Revenue Service has ruled that the Hospital and the Foundation qualify under Section 501(c)(3) of the Internal Revenue Code and are, therefore, not subject to tax under present income tax regulations.

Holdings and MACO are considered a disregarded entity for tax purposes and are reported through the Hospital.

(Dollars in thousands)

MEI accounts for income taxes through the current recognition of deferred tax liabilities and assets for the expected future tax consequences of temporary differences between tax bases and financial reporting bases of other assets and liabilities.

At present, no income, profit, or capital gain taxes are levied in the Cayman Islands and accordingly, no provision for taxation has been made for MIC. In the event that such taxes are levied, MIC has been granted an exemption until September 14, 2043 for any such taxes that might be introduced. MIC intends to conduct its affairs so as not to be liable for taxes in any other jurisdiction.

Meritus follows the accounting guidance for uncertainties in income tax positions, which requires that a tax position be recognized or derecognized based on a “more-likely-than-not” threshold. This applies to positions taken or expected to be taken in a tax return. Meritus does not believe its consolidated financial statements include any material uncertain tax positions. As of June 30, 2024, the Meritus tax years ended June 30, 2021, through June 30, 2024, for federal tax jurisdiction remain open to examination.

(q) Concentration of Credit Risk

Meritus invests its excess cash, investments, and assets in financial institutions, which are federally insured under the Federal Deposit Insurance Act (FDIA). Deposits in certain accounts exceed federally insured deposit limits. Meritus has experienced no losses on its deposits and believes it is not exposed to any significant credit risks on its cash deposits.

Meritus grants credit without collateral to the patients it serves who primarily live in the tristate area. The majority of these patients have either insurance through Blue Cross, another insurance company or a health maintenance organization, or qualify for the Maryland Medical Assistance or the Centers for Medicare and Medicaid Services (CMS) programs.

At June 30, Meritus’ patient accounts receivable was made up of the following:

	2024	2023
Medical assistance HMO/Medicaid	12 %	14 %
Medicare	38	41
Commercial insurance, HMO, and other	30	26
Blue Cross/Blue Shield	15	14
Self-pay	5	5
	100 %	100 %

(r) Deferred Compensation Plan

The Hospital is party to a 457(b) deferred compensation plan and a 457(f) deferred compensation plan, both are intended to provide retirement benefits to certain eligible employees. Assets are deposited with the plan managers, pursuant to this agreement, such that the value of the assets determined by the fair value approximately equals the related accrued deferred compensation liability. The funds are

(Dollars in thousands)

placed into a range of investment strategies from conservative to aggressive. The liability associated with this plan is included in accrued retirement benefits on the consolidated balance sheets.

(s) Management's Assessment and Plans

The Company previously adopted Accounting Standards Update (ASU) No. 2014-15, *Presentation of Financial Statements – Going Concern (Subtopic 205-40): Disclosure of Uncertainties about an Entity's Ability to Continue as a Going Concern* (ASU 2014-15). ASU 2014-15 requires management to evaluate an entity's ability to continue as a going concern within one year after the date that the financial statements are issued (or available to be issued, when applicable). Management determined that there were no conditions or events that raise substantial doubt about the Company's ability to continue as a going concern and the Company will continue to meet its obligations through November 1, 2025.

(t) New Accounting Standards

In June 2016, the FASB issued ASU 2016-13, *Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments.* ASU 2016-13 requires financial assets measured at amortized cost to be presented at the net amount expected to be collected. The measurement of expected credit losses is based on relevant information about past events, including historical experience, current conditions, and reasonable and supportable forecasts that affect the collectability of the reported amounts. An entity must use judgment in determining the relevant information and estimation methods that are appropriate in its circumstances. ASU 2016-13 is effective for annual reporting periods beginning after December 15, 2022, and a modified retrospective approach is required, with a cumulative effect adjustment to net assets as of the beginning of the first reporting period in which the guidance is effective. The Company adopted this ASU effective July 1, 2023 with no material impact.

(3) Investments and Investment Income

Investments at June 30 consisted of the following:

		2024	2023
Short-term investments:			
Cash and cash equivalents	$	89,009	76,445
U.S. government notes		—	9,096
Fixed income bonds – corporate		—	1,016
Mutual funds		—	8,611
Mortgage backed securities		—	696
Asset backed securities		—	3,725
Alternative investments		—	28,181
Total	$	89,009	127,770

(Continued)

(Dollars in thousands)

		2024	2023
Assets whose use is limited:			
Cash and cash equivalents	$	64,010	13,408
Fixed income:			
Corporate debt securities		33,761	48,348
Mortgage backed securities		1,239	122
Asset backed securities		1,236	2,972
US government notes		5,366	4,483
Equities:			
Mutual funds		45,294	22,370
Institutional funds:			
Domestic equities		40,604	33,684
International equities		16,028	9,769
Fixed income		—	1,455
Alternative investments		143,636	129,398
Total	$	351,174	266,009

The amount of the board designated funds whose use is limited is $262,235 and $232,520 as of June 30, 2024 and 2023, respectively.

Investment returns, net included in the consolidated statements of operations and changes in net assets comprise the following for the years ended June 30:

		2024	2023
Investment returns, net:			
Interest and dividends, net of investment fees of $424 and $578 in 2024 and 2023, respectively	$	9,178	5,757
Net realized gains on investments		4,360	731
Change in unrealized gains on investments		27,634	20,448
	$	41,172	26,936

As of June 30, 2024 and 2023, the Hospital had invested $16,287 and $14,639, or 11.3% and 9.3%, respectively, of the portfolio in certain alternative investments, which are invested in hedge funds. The

(Continued)

(Dollars in thousands)

following table summarizes redemption terms for the hedge fund-of-funds vehicles held as of June 30, 2024:

	Fund 1	Fund 2
Redemption timing:		
Redemption frequency	Quarterly	Quarterly
Required notice	65 days	100 days

At June 30, 2024 and 2023, the Company has invested in $232,209 and $226,101 of investments and assets whose use is limited for which the value is based on either readily determinable fair value (RDFV) or net asset value (NAV). At June 30, 2024, $88,573 was based on RDFV and $143,636 was based on NAV. At June 30, 2023, $68,522 was based on RDFV and $157,579 was based on NAV. At June 30, 2024 and 2023, $127,349 and $142,940, respectively, of assets based on NAV are commingled funds with the majority having redemption terms of five days or less.

The redemption terms and notification requirements of the institutional funds range from daily to monthly.

(4) Fair Value Measurements

Meritus measures fair value as the price that would be received to sell an asset or paid to transfer a liability (the exit price) in an orderly transaction between market participants at the measurement date. The accounting guidance outlines a valuation framework and creates a fair value hierarchy in order to increase the consistency and comparability of fair value measurements and the related disclosures. The fair value hierarchy is broken down into three levels based on the source of inputs as follows:

Level I – Quoted prices are available in active markets for identical assets or liabilities as of the report date. A quoted price for an identical asset or liability in an active market provides the most reliable fair value measurement because it is directly observable to the market.

Level II – Pricing inputs are other than quoted prices in active markets, which are either directly or indirectly observable as of the report date. The nature of these securities include investments for which quoted prices are available but traded less frequently and investments that are fair valued using other securities, the parameters of which can be directly observed.

Level III – Securities that have little to no pricing observability as of the report date. These securities are measured using management's best estimate of fair value, where the inputs into the determination of fair value are not observable and require significant management judgment or estimation.

Financial instruments consist of cash equivalents, patient accounts receivable, investments, excluding those accounted for by the equity method, accounts payable and accrued expenses, and long-term debt. The carrying amounts reported in the consolidated balance sheets for cash equivalents, patient accounts receivable, and accounts payable and accrued expenses approximate fair value. Management's estimates of other financial instruments are described elsewhere in the notes to the consolidated financial statements.

(Dollars in thousands)

Meritus does not have any Level 3 financial instruments as of June 30, 2024 or 2023.

Investments are valued using a market approach as follows:

Cash and cash equivalents – Cash equivalents are classified as Level 1 inputs and represent short-term, highly liquid investments that are readily convertible to cash and have original maturities of three months or less.

Stock and equity/institutional funds – Common stock and equity funds consist of stock and are valued based upon unadjusted quoted prices in the market.

Mutual Funds – Valued at the closing price reported in the active market in which the mutual fund is traded.

Fixed income bonds – Valued at the closing price reported in the active market in which the bond is traded.

The following table presents Meritus' assets measured at fair value on a recurring basis using the market approach, as of June 30:

	Level 1	Level 2	Level 3	Total
2024:				
Cash and cash equivalents	$ 153,019	—	—	153,019
Mutual funds	45,294	—	—	45,294
Fixed income bonds:				
Corporate debt securities	—	33,761	—	33,761
Mortgage-backed securities	—	1,239	—	1,239
Asset backed securities	—	1,236	—	1,236
U.S. government notes	—	5,366	—	5,366
Institutional funds:				
Domestic equities	—	40,604	—	40,604
International equities	—	16,028	—	16,028
Fixed income	—	—	—	—
Total assets at fair value	$ 198,313	98,234	—	296,547
Assets at NAV				143,636
Total assets				$ 440,183

(Continued)

(Dollars in thousands)

	Level 1	Level 2	Level 3	Total
2023:				
Cash and cash equivalents	$ 89,853	—	—	89,853
Mutual funds	30,981	—	—	30,981
Fixed income bonds:				
Corporate debt securities	—	49,364	—	49,364
Mortgage-backed securities	—	818	—	818
Asset backed securities	—	6,697	—	6,697
U.S. government notes	—	13,579	—	13,579
Institutional funds:				
Domestic equities	—	33,684	—	33,684
International equities	—	9,769	—	9,769
Fixed income	—	1,455	—	1,455
Total assets at fair value	$ 120,834	115,366	—	236,200
Assets at NAV				157,579
Total assets				$ 393,779

There were no Level 3 investments or transfers during the years ended June 30, 2024 or 2023.

(5) Property, Plant, and Equipment

Property, plant, and equipment at June 30 comprise the following:

	2024	2023
Land	$ 28,389	26,307
Buildings and improvements	261,916	249,043
Leasehold improvements	4,828	4,428
Equipment	222,399	232,004
	517,532	511,782
Less accumulated depreciation and amortization	(297,830)	(285,397)
	219,702	226,385
Construction in progress	79,804	10,313
Property, plant, and equipment, net	$ 299,506	236,698

Total depreciation and amortization expense for property, plant, and equipment for the years ended June 30, 2024 and 2023 was $30,646 and $29,733, respectively.

(Continued)

(Dollars in thousands)

(6) Equity Investments in Affiliates

The following investments, recorded under the equity method of accounting, are included in the consolidated balance sheets.

The Hospital holds a 25% equity interest in Maryland Care, Inc. (MPC), a managed care organization (MCO) that was established to serve Maryland's Medicaid population as a result of the State's requirement for Medicaid patients to be a member of an MCO, and Maryland Care Management, Inc. (MCMI), a management services organization that provides management services to MPC. The Hospital holds a 41% equity interest in Cumberland Valley Surgery Center, LLC, an ambulatory surgery center.

Holdings holds a 50% interest in GSRE which is a real estate holding company. MEI has a 50% interest in DIS, which provides radiology imaging services.

Summary of financial information as of June 30, 2024 and 2023 and for the years then ended appears below for the significant equity investments:

		Maryland Care, Inc.		Diagnostic Imaging Services, LLC	
		2024	2023	2024	2023
Assets	$	408,440	484,638	14,641	10,187
Liabilities		264,498	258,307	7,363	3,826
Equity	$	143,942	226,331	7,278	6,361
Revenue	$	1,402,380	1,438,003	24,063	20,988
Expenses		1,353,868	1,370,940	21,824	20,170
Net income	$	48,512	67,063	2,239	818

		Maryland Care Management, Inc.	
		2024	2023
Assets	$	18,722	18,350
Liabilities		3,846	5,040
Equity	$	14,876	13,310
Revenue	$	29,083	28,033
Expenses		27,517	27,034
Net income	$	1,566	999

(Continued)

(Dollars in thousands)

(7) Long-Term Debt

Long-term debt at June 30 consists of the following:

	2024	2023
MHHEFA Revenue Bonds:		
Series 2015 3.50%–5.00% serial bonds, including issue premiums of $10,570	$ 229,687	235,928
Series 2022 2.59%	57,926	60,350
	287,613	296,278
Less current portion of long-term debt	(8,759)	(8,491)
Less debt issuance costs and discounts	(1,708)	(1,882)
	$ 277,146	285,905

On July 9, 2015, Meritus issued Series 2015 Bonds to (i) refund all of the Maryland Health and Higher Educational Facilities Authority's Revenue Bonds, Washington County Hospital Issue, Series 2008 (Series 2008 Bonds) and (ii) finance and refinance the cost of construction, renovation, and equipping of certain additional facilities for Meritus (the 2015 Project). The Series 2015 Bonds were issued in the principal amount of $257,300 plus a premium of $15,100. The Series 2015 Bonds proceeds, together with the outstanding Series 2008 Bonds escrow fund balance totaled $22,000, and Meritus' internal cash of $7,400 were used to pay the cost of issuance, refund Series 2008 Bonds and receive $20,000 of proceeds for capital expenditures. The Series 2015 Bonds are due in annual principal installments through 2045 and bear interest at 3.5% to 5.0% due semiannually in January and July.

The long-term debt related to the Series 2015 Bonds is reflected in the consolidated financial statements including the unamortized bond premium. The original issue bond premiums are being amortized over the life of the debt and are netted against interest expense in the consolidated statements of operations and changes in net assets.

On March 9, 2022, Meritus issued a taxable bond in the amount of $60,350 (Series 2022 Bond) to finance past capital expenditures and pay for the cost of issuance. Maryland Health and Higher Educational Facilities Authority (MHHEFA) and Meritus amended the Master Loan Agreement dated as of July 1, 2015 to recognize the Series 2022 Bond as a parity debt by executing the First Supplemental Master Loan Agreement dated as of March 1, 2022. The Series 2022 Bond are due in various annual principal repayments commencing July 1, 2023 through 2037, and bears a fixed interest at 2.59% due monthly.

All bonds are collateralized by a first lien and claims on all receipts of Meritus, except restricted donations and contributions. In connection with the Series 2015 Bonds, the bond holders have a security interest in existing facilities of Meritus. All bonds require the Hospital to maintain certain financial ratios and stipulated insurance coverage as defined.

(Continued)

(Dollars in thousands)

Scheduled principal repayments on long-term debt are as follows for the next five years as of June 30:

2025	$	8,759
2026		9,094
2027		9,539
2028		9,808
2029		10,185
Thereafter		240,228
	$	287,613

(8) Leases Commitments

Meritus accounts for leases in accordance with Accounting Standards Codification (ASC) Topic 842, *Leases*, and determines if an arrangement contains a lease at the inception of the contract. Right-of-use assets and liabilities are recognized at the contract commencement date for the present value of lease payments over the lease term. Meritus uses its estimated incremental borrowing rate when no implicit rate is noted within the contract. A right-of-use asset and lease liability is not recognized for leases with an initial term of 12 months or less and rent expense for these types of leases are recognized on a straight-line basis over the lease term, or when incurred if a month-to-month lease.

Meritus utilizes operating leases primarily for real estate, including medical facilities and office space. The real estate lease agreements have initial terms of 5 to 20 years. Some real estate leases include one or more options to renew, the exercise of lease renewal options is at the Hospital's discretion. When determining the lease term, options to extend or terminate the lease were included when it was reasonably certain the Meritus would exercise that option.

Supplemental balance sheet information related to leases as of June 30 are as follows:

	Balance sheet classification		2024	2023
Operating leases:				
Operating lease ROU assets – current	Prepaid and other current assets	$	3,699	3,487
Operating lease ROU assets – noncurrent	Other assets		24,581	26,830
Operating lease ROU liabilities – current	Accounts payable and accrued expenses		3,699	3,487
Operating lease ROU liabilities – noncurrent	Other long-term liabilities		24,581	26,830

(Continued)

(Dollars in thousands)

Supplemental cash flow and other information related to leases as of and for the years ended June 30 are as follows:

Other information	2024	2023
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases (1)	$ 2,036	1,979
Weighted average remaining lease term:		
Operating leases	10 Years	11 Years
Weighted average discount rate:		
Operating leases	4.4 %	4.4 %

(1) Included in other assets and accounts payable, accrued expenses, and long-term liabilities in the statement of cash flows

Future maturities of operating lease liabilities as of June 30, 2024 are as follows:

	Leases
Year ending June 30:	
2025	$ 5,066
2026	4,494
2027	3,816
2028	3,736
2029	3,615
Thereafter	14,848
Total minimum lease payments	35,575
Impact of present value discount	(7,295)
Present value of minimum lease payments	$ 28,280

The components of the lease cost and rent expense, which is recorded within supplies and other in the consolidated statements of operations and changes in net assets for the years ended June 30 are as follows:

Lease cost	2024	2023
Operating lease cost:		
Operating lease cost	$ 4,909	4,451
Short-term lease expense	1,024	1,184
Total operating lease cost	$ 5,933	5,635

(Continued)

(Dollars in thousands)

(9) Income Taxes

Holdings and its subsidiaries file a consolidated federal return and separate state returns. The income tax (benefit) expense for the years ended June 30 consists of:

		2024	2023
Current:			
Federal	$	(65)	(207)
State		(46)	(70)
	$	(111)	(277)
Deferred:			
Federal	$	(301)	2
State		—	—
	$	(301)	2

The significant components of the deferred tax assets and deferred tax liabilities, which are included in prepaid and other current assets and other assets at June 30, are as follows:

		2024	2023
Deferred tax asset:			
Accrued vacation	$	120	107
Deferred compensation		276	423
Allowance for bad debts		30	23
NOL carryover		910	1,103
Fixed assets		138	138
Other		167	141
		1,641	1,935
Deferred tax liabilities:			
Unrealized gain/loss		(36)	(29)
Captive insurance premiums		(11)	(11)
		(47)	(40)
	$	1,594	1,895

In assessing 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. Based upon

(Continued)

positive operation trends through 2024 and projections for future taxable income, management believes that it is more likely than not that the Company will realize the benefits of the deductible differences at June 30, 2024 and 2023. Accordingly, the Company has determined that there is no valuation allowance as of June 30, 2024 or 2023. The amount of the deferred tax asset considered realizable, however, could be reduced in the near term if estimates of future taxable income during the carryforward period are reduced.

As of June 30, 2024 or 2023, the Company has no unrecognized tax benefits. Therefore, the Company does not expect any impact on the effective tax rate related to recognition of unrecognized tax benefits. In addition, there are no anticipated reversals of uncertain tax positions in the next 12 months. The Company's policy is to recognize interest and penalties related to unrecognized tax benefits as a component of income tax expense. As of June 30, 2024 or 2023, the Company has no accrued interest or penalties related to uncertain tax positions.

(10) Post Retirement Benefit Plans

Defined Contribution Plans

Meritus has a 401(k) Savings Plan. The plan is available to all Meritus employees. Meritus matches employee contributions for an amount up to 6% of each employee's base salary, subject to limitations.

Amounts charged to expense for the years ended June 30, 2024 and 2023 were $8,799 and $7,835, respectively.

The Hospital and MEI each maintain an employee funded supplemental nonqualified retirement plan for certain employees. The plan requires the benefits be paid upon termination, retirement, or death. The related liability is $8,891 and $6,451 at June 30, 2024 and 2023, respectively. Management has designated investments for the intended purpose of funding the liability when payable.

(11) Insurance Coverage

Meritus has a wholly owned insurance captive, MIC, to provide primary limits of insurance of $1,000 per occurrence/$3,000 aggregate for professional and general liability. In addition, MIC purchased reinsurance in the amount of $30,000 to cover any potential liabilities above the $1,000/$3,000 primary limits, which were covered by MIC. The self-insured liabilities determined by an actuary for professional and general liability claims are included in other long-term liabilities in the consolidated balance sheets. As of June 30, 2024 and 2023, Meritus recorded a liability of $17,188 and $6,820, respectively.

Consistent with most companies with similar insurance operations, the liability for losses is ultimately based on management's reasonable expectations of future events. It is reasonably possible that the expectations associated with these amounts could change in the near term (i.e., within one year) and that the effect of such changes could be material to the consolidated financial statements.

In 2024 and 2023, the Company participated in a self-insured plan for workers' compensation claims. Stop-loss coverage has been purchased through a commercial carrier for claims in excess of $450. As of June 30, 2024 and 2023, Meritus recorded a liability of $2,250 and $2,300, which is included in accrued salaries, wages, and withholdings in the consolidated balance sheets.

(Continued)

(12) Risk and Uncertainties

The Company provides general acute healthcare services in the State of Maryland. The Company and other healthcare providers are subject to certain 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 Health Services Cost Review Commission
- Government regulation, government budgetary constraints, and proposed legislative and regulatory changes
- Lawsuits alleging malpractice or other claims.

Such inherent risks require the use of certain management estimates in the preparation of the Company'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 Company's revenues and the Company's operations are subject to a variety of other federal, state, and local regulatory requirements. Failure to maintain required regulatory approvals and licenses and/or changes in such regulatory requirements could have a significant adverse effect on the Company.

Changes in federal and state reimbursement funding mechanisms and related government budgetary constraints could have a significant adverse effect on the Company.

The federal government and many states have aggressively increased enforcement under Medicare and Medicaid antifraud and abuse laws and physician self-referral laws (STARK law and regulation). Federal healthcare reform initiatives continue to prompt a national review of federally funded healthcare programs. In addition, the federal government and many states continue to fund programs to audit and recover potential overpayments to providers from the Medicare and Medicaid programs. The Company has devoted resources to implement a compliance program to monitor conformance with applicable laws and regulations, but the possibility of future government review and enforcement action exists. However, any negative findings from a future proceeding, if any, could result in substantial financial penalties or awards against the Company, exclusion from future participation in the Medicare and Medicaid programs, and if criminal proceedings were initiated against the Company, possible criminal penalties. At this time, the Company cannot predict the ultimate outcome of any potential inquiries, or the potential range of damages, if any.

As a result of recently enacted and pending federal healthcare reform legislation, substantial changes are anticipated in the United States healthcare system. Such legislation includes 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 affect the 2024 or 2023 consolidated financial statements.

The Company recognizes the increasing importance of cybersecurity in today's digital landscape. As a result, the Company has implemented various measures to mitigate the risk of cyber threats and protect

(Continued)

(Dollars in thousands)

our systems and data as well as monitor the risks our vendors have. However, we understand that no system is completely immune to cyberattacks, and there is a possibility that an unauthorized access, data breach , or other cybersecurity incident may occur at either one of our systems or at one of vendors' systems. In the event of a significant cyber incident, there could be a significant impact to the Company's future operating results, financial condition, or liquidity. However, to mitigate the potential impact to the Company's future operating results, financial condition, or liquidity. However, to mitigate the potential impact to the Company if such an event were to occur, the Company maintains cyber insurance coverage. While we believe our cybersecurity measures and our vendors' measures are robust, there can be no assurance that they will prevent all cyber threats or that there will be a cyber incident in the future that may not have a significant adverse effect on our financial condition, liquidity, or results of operations.

Litigation

Additionally, Meritus is involved in litigation and regulatory investigations arising in the course of business. After consultation with legal counsel, management estimates that these matters will be resolved without a material adverse effect on Meritus' financial position or results of operations.

(13) Functional Expenses

Meritus provides general healthcare services to residents within its geographic location. Expenses related to providing these services for the years ended June 30 are as follows:

	Program services	General and administrative	Fundraising	Total
2024:				
Salaries and wages	$ 239,203	43,317	—	282,520
Employee benefits	43,038	8,706	—	51,744
Professional fees	38,570	6,886	—	45,456
Supplies and other	141,904	34,012	312	176,228
Interest	8,932	2,756	—	11,688
Depreciation and amortization	24,614	6,032	—	30,646
Total expenses	$ 496,261	101,709	312	598,282

(Dollars in thousands)

		Program services	General and administrative	Fundraising	Total
2023:					
Salaries and wages	$	200,467	41,060	—	241,527
Employee benefits		38,264	7,837	—	46,101
Professional fees		34,453	7,057	—	41,510
Supplies and other		124,592	25,349	260	150,201
Interest		9,847	2,017	—	11,864
Depreciation and amortization		24,678	5,055	—	29,733
Total expenses	$	432,301	88,375	260	520,936

(14) Liquidity and Availability of Financial Assets

The following reflects financial assets as of June 30, 2024 and 2023, reduced by amounts not available for general expenditure because of contractual or donor-imposed restrictions within one year.

		2024	2023
Financial assets as of June 30	$	533,856	490,711
Less those unavailable for general expenditures within one year, due to:			
Contractual and donor-imposed restriction:			
Funds designated for insurance purpose		(16,276)	(14,837)
Assets held by trustee		(62,614)	(11,049)
Supplemental retirement benefits investment		(8,891)	(6,451)
Donor restricted		(1,157)	(1,151)
Financial assets available within one year to meet cash needs for general expenditures within one year	$	444,918	457,223

Included in financial assets available are $262,235 and $232,520 of funds set aside for long-term investments as designated by the Board of Directors as of June 30, 2024 and 2023, respectively.

(15) Subsequent Events

Meritus evaluated subsequent events through October 31, 2024, the date these consolidated financial statements were issued. Effective July 1, 2024, Meritus has affiliated with Brook Lane to expand access to mental health services across the region and state. Brook Lane will be included in the Meritus consolidated financial statements beginning July 1, 2024. All other material matters are disclosed in the notes to the consolidated financial statements.

SUPPLEMENTARY INFORMATION

Schedule 1

MERITUS HEALTH, INC. AND SUBSIDIARIES

Consolidating Balance Sheet

June 30, 2024

(Dollars in thousands)

Assets	Meritus Medical Center	Meritus Health Foundation	MSOM	Meritus other	Consolidating total	Consolidating entries	Consolidated total
Current assets:							
Cash and cash equivalents	$ 9,723	18	—	2,899	12,640	—	12,640
Short-term investments	89,009	—	—	—	89,009	—	89,009
Current portion of assets whose use is limited	62,614	—	—	—	62,614	—	62,614
Accounts receivable	51,852	—	—	10,080	61,932	—	61,932
Supplies	10,934	—	—	1,091	12,025	—	12,025
Prepaid and other current assets	30,172	2,407	(4,077)	4,902	33,404	(7,880)	25,524
Total current assets	254,304	2,425	(4,077)	18,972	271,624	(7,880)	263,744
Assets whose use is limited	265,240	6,042	—	17,278	288,560	—	288,560
Property, plant, and equipment, net	289,716	—	1,146	8,644	299,506	—	299,506
Equity investments in affiliates	43,359	—	—	3,748	47,107	(3,124)	43,983
Other assets	28,947	4,085	—	23,598	56,630	(10,106)	46,524
Total assets	$ 881,566	12,552	(2,931)	72,240	963,427	(21,110)	942,317

(Continued)

Schedule 1

MERITUS HEALTH, INC. AND SUBSIDIARIES

Consolidating Balance Sheet

June 30, 2024

(Dollars in thousands)

Liabilities and Net Assets	Meritus Medical Center	Meritus Health Foundation	MSOM	Meritus other	Consolidating total	Consolidating entries	Consolidated total
Current liabilities:							
Accounts payable and accrued expenses	$ 42,747	—	1,249	8,395	52,391	—	52,391
Accrued salaries, wages, and withholdings	12,745	—	258	1,386	14,389	—	14,389
Accrued compensation benefit	11,228	—	256	2,936	14,420	—	14,420
Advances from third-party payors	14,658	—	—	2,398	17,056	—	17,056
Accrued interest payable	5,314	—	—	—	5,314	—	5,314
Current portion of long-term debt	8,759	—	—	—	8,759	—	8,759
Total current liabilities	95,451	—	1,763	15,115	112,329	—	112,329
Long-term debt, net of current portion	277,146	—	—		277,146	—	277,146
Accrued retirement benefits	7,889	—	—	1,002	8,891	—	8,891
Other long-term liabilities	15,142	—	—	34,454	49,596	(7,880)	41,716
Total liabilities	395,628	—	1,763	50,571	447,962	(7,880)	440,082
Stockholder's equity:							
Common stock	—	—	—	820	820	(820)	—
Paid-in capital	—	—	—	1,150	1,150	(1,150)	—
Total stockholders' equity	—	—	—	1,970	1,970	(1,970)	—
Net assets:							
Net assets without donor restrictions	474,458	2,442	(4,694)	19,699	491,905	(1,154)	490,751
Net assets with donor restrictions	11,480	10,110	—	—	21,590	(10,106)	11,484
Total net assets	485,938	12,552	(4,694)	19,699	513,495	(11,260)	502,235
Total liabilities and net assets	$ 881,566	12,552	(2,931)	72,240	963,427	(21,110)	942,317

See accompanying independent auditors' report.

Schedule 2

MERITUS HEALTH, INC. AND SUBSIDIARIES

Consolidating Statement of Operations and Changes in Net Assets

Year ended June 30, 2024

(Dollars in thousands)

Fiscal period ending June 30, 2024	Meritus Medical Center	Meritus Health Foundation	MSOM	Meritus other	Consolidating total	Consolidating entries	Consolidated total
Unrestricted revenue, gains and other support:							
Net patient revenue	$ 458,783	—	—	136,359	595,142	(15,536)	579,606
Other revenue	27,218	—	3	5,907	33,128	(5,519)	27,609
Equity earnings in affiliates	13,044	—	—	1,145	14,189	—	14,189
Net assets released from restriction used for operations	181	205	—	—	386	(204)	182
	499,226	205	3	143,411	642,845	(21,259)	621,586
Operating expenses:							
Salaries and wages	203,123	—	1,858	77,539	282,520	—	282,520
Employee benefits	38,586	—	507	13,171	52,264	(520)	51,744
Professional fees	21,348	—	—	24,108	45,456	—	45,456
Supplies and other	133,894	130	2,332	60,407	196,763	(20,535)	176,228
Interest	11,685	—	—	3	11,688	—	11,688
Depreciation and amortization	26,899	(2)	—	3,749	30,646	—	30,646
	435,535	128	4,697	178,977	619,337	(21,055)	598,282
Operating income (loss)	63,691	77	(4,694)	(35,566)	23,508	(204)	23,304
Nonoperating gains (losses), net:							
Investment returns, net	39,265	594	—	1,313	41,172	—	41,172
Other, net	(64)	(1,296)	—	(373)	(1,733)	204	(1,529)
Excess (deficit) of revenue over expenses	$ 102,892	(625)	(4,694)	(34,626)	62,947	—	62,947

(Continued)

Schedule 2

MERITUS HEALTH, INC. AND SUBSIDIARIES

Consolidating Statement of Operations and Changes in Net Assets

Year ended June 30, 2024

(Dollars in thousands)

Fiscal period ending June 30, 2024	Meritus Medical Center	Meritus Health Foundation	MSOM	Meritus other	Consolidating total	Consolidating entries	Consolidated total
Net assets without donor restrictions:							
Excess (deficit) of revenues over expenses	$ 102,892	(625)	(4,694)	(34,626)	62,947	—	62,947
Equity transfers	(44,528)	—	—	44,528	—	—	—
Other, net	978	872	—	2	1,852	—	1,852
Increase (decrease) in net assets without donor restrictions	59,342	247	(4,694)	9,904	64,799	—	64,799
Net assets with donor restrictions:							
Contributions	1,333	1,898	—	—	3,231	(1,131)	2,100
Other, net	(2,608)	(86)	—	—	(2,694)	2,585	(109)
Net assets released from restriction for capital	(950)	(950)	—	—	(1,900)	950	(950)
Net assets released from restriction for operations	(182)	(205)	—	—	(387)	205	(182)
(Decrease) increase in net assets with donor restrictions	(2,407)	657	—	—	(1,750)	2,609	859
Increase (decrease) in net assets	56,935	904	(4,694)	9,904	63,049	2,609	65,658
Net assets:							
Beginning of year	429,003	11,648	—	9,795	450,446	(13,869)	436,577
End of year	$ 485,938	12,552	(4,694)	19,699	513,495	(11,260)	502,235

See accompanying independent auditors' report.

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APPENDIX C

SUMMARIES OF PRINCIPAL LEGAL DOCUMENTS

TABLE OF CONTENTS

DEFINITIONS OF CERTAIN TERMS

In addition to terms defined elsewhere in this Official Statement, the following are definitions of certain terms used in this Official Statement. Words and terms used and not defined herein shall have the meanings set forth in the Resolution and the Loan Agreement.

"**Additional Facilities**" means any project undertaken by any Obligated Group Member or the Authority that is financed or refinanced by the issuance of Additional Bonds, Parity Obligations or Subordinate Obligations, including (without limitation) land, easements, rights-of-way, leaseholds and other interests in real property and any improvement, addition or betterment to or any construction, replacement, remodeling or equipping of any facilities.

"**Administrative Expenditures**" means any expenditures of the Authority for insurance, fees and expenses of auditing, fees and expenses of the Trustee and any escrow deposit agent not otherwise paid or provided for by the Obligated Group Members, and all other expenditures reasonably and necessarily incurred by the Authority by reason of its issuance of any Bonds or Subordinate Obligations, the certification of any Parity Obligations or Subordinate Obligations, the execution and delivery of the Resolution and the Loan Agreement and the performance of its obligations thereunder, including (without limitation) legal, financing and administrative expenses, fees and expenses of the Authority's financial advisor and expenses incurred by the Authority to compel full and punctual performance of the provisions of the Resolution and the Loan Agreement in accordance with the terms thereof.

"**Agency Obligations**" means direct obligations of, or obligations the timely payment of the principal of and the interest on which are unconditionally guaranteed by any agency or instrumentality of the United States of America.

"**Annual Administrative Fee**" means the annual fee for the general administrative services of the Authority in such amount per year not exceeding an amount equal to one-tenth of one percent (1/10%) of the aggregate principal amount of Bonds issued under the Resolution as shall be prescribed by the Authority from time to time.

"**Balloon Long-Term Indebtedness**" means Long-Term Indebtedness, 25% or more of the principal amount of which matures in the same 12-month period, which portion of such principal amount is not required by the documents governing such Long-Term Indebtedness to be amortized by redemption prior to such period. Optional Tender Indebtedness shall not be deemed to constitute Balloon Long-Term Indebtedness solely by reason of the option of the holder thereof to require the redemption or purchase thereof or any required purchase or redemption thereof in connection with any termination of any Credit Facility securing such Indebtedness, any conversion of the interest rate on such Indebtedness or otherwise prior to the stated maturity thereof.

"**Book Value**," when used with respect to any property or interest therein, means the value of such property or interest, net of accumulated depreciation, as it is carried on the books of its owner or its lessee in conformity with GAAP and, when used with respect to any property

of the Obligated Group, shall be determined in such manner that no portion of such property is included more than once.

"**Business Day**" means any day other than a Saturday, a Sunday, a day on which the New York Stock Exchange is closed or a day on which banks located in the city in which the office of the Authority or the Designated Office of the Trustee is located are authorized or required to remain closed.

"**Code**" means the Internal Revenue Code of 1986, as amended from time to time, or any successor federal income tax statute or code, and the applicable regulations thereunder.

"**Coverage Ratio**" means, when used with respect to any period, the quotient obtained by dividing (a) the Net Income Available for Debt Service of all of the Obligated Group Members for such period by (b) the Maximum Annual Debt Service on all Outstanding Long-Term Indebtedness of the Obligated Group as of the last day of such period; provided, that in any calculation of the actual or projected Coverage Ratio for any Fiscal Year that occurs prior to the earlier of (i) the first Fiscal Year in which any principal amount of Long-Term Indebtedness issued to finance Capital Improvements becomes due and payable and (ii) the first Fiscal Year in which any interest on such Long-Term Indebtedness ceases to be paid from amounts deposited in escrow for the payment of interest on such Long-Term Indebtedness, such Long-Term Indebtedness shall not be taken into account in calculating Maximum Annual Debt Service.

"**Credit Facility**" means any letter of credit, bond insurance policy, bond purchase agreement, guaranty, line of credit, surety bond or similar credit or liquidity facility securing any Indebtedness of any Obligated Group Member.

"**Credit Facility Agreement**" means any agreement between an Obligated Group Member and a Credit Facility Provider pursuant to which a Credit Facility is issued.

"**Credit Facility Provider**" means the issuer of any Credit Facility then in effect.

"**Current Value**" means, when used with respect to any property as of any particular date, at the option of the Obligated Group (a) the fair market value of such property (i) in the case of real or tangible personal property, as shown on a written appraisal made by an M.A.I. appraiser not more than three years prior to such date and delivered to the Authority and the Trustee and (ii) in the case of any other property, as determined in accordance with GAAP or (b) the Book Value of such property.

"**Days' Cash on Hand**" means, as of any date of calculation, the amount determined by dividing (i) the sum of the Unrestricted Cash and Marketable Securities of the Obligated Group Members as of such date by (ii) a fraction, the numerator of which is the total operating expenses of the Obligated Group for the most recent Fiscal Year for which audited financial statements of the Obligated Group or the Health System (as the case may be) have been prepared, exclusive of depreciation, amortization, all unrealized gains and losses on investments and Hedging Transactions, including (without limitation) any other than temporary impairment resulting from any such loss, any losses due to any impairments of goodwill, intangible assets or other long-

lived assets, any other non-cash items of a non-recurring nature and any nonoperating gains or losses on the sale or disposition of any asset (other than any investment security) or on the extinguishment of debt, including (without limitation) any gain or loss on the termination of any Hedging Transaction, and the denominator of which is 365.

"**Debt Service Requirements**" means, when used with respect to any Long-Term Indebtedness for any Fiscal Year as of any particular date of calculation, the amount required to pay the sum of (a) the interest on such Long-Term Indebtedness payable during the period from the second day of such Fiscal Year through the first day of the immediately succeeding Fiscal Year, and (b) the principal of, the Sinking Fund Installment for and any other amount required to effect any mandatory redemption of such Long-Term Indebtedness, if any, during the period from the second day of such Fiscal Year through the first day of the immediately succeeding Fiscal Year, less any amount of such interest or principal for the payment of which money or Investment Obligations, the principal of and interest on which when due will provide for such payment, are held in trust, including (without limitation) any capitalized interest on deposit any Interest Account, Construction Fund or other fund established for the payment thereof. For the purpose of calculating the Debt Service Requirements:

(i) with respect to any Variable Rate Indebtedness:

(A) for the purpose of calculating the principal amount of Balloon Long-Term Indebtedness constituting Variable Rate Indebtedness payable in any Fiscal Year described in clause (ii)(D) below, such Indebtedness shall be deemed to bear interest at the fixed rate that it would have borne had it been issued at a fixed rate on the date of the issuance thereof for the term thereof;

(B) for all other purposes of the Loan Agreement and the Resolution, such Variable Rate Indebtedness shall be deemed to bear interest at an annual rate equal to (1) in the case of any period during which such Indebtedness shall have been outstanding, the weighted average interest rate per annum borne by such Indebtedness during such period and (2) in any other case, the higher of (a) the weighted average interest rate per annum borne by such Indebtedness during a 12-month period ending not more than 60 days prior to the calculation date (or, in the case of any Variable Rate Indebtedness to be issued or issued during the immediately preceding 12-month period, the weighted average interest rate per annum borne by other outstanding Indebtedness having comparable terms and issued by, or secured by agreements issued by, entities of comparable creditworthiness as the obligors with respect to such Variable Rate Indebtedness during a 12-month period ending not more than 60 days prior to the calculation date), and (b) the interest rate per annum borne by such Variable Rate Indebtedness on the date of calculation;

(C) Notwithstanding (B) above, and in lieu of (B) above, at the option of the Obligated Group Representative, Variable Rate Indebtedness shall be deemed to bear interest as provided in the following sentence: for purposes of calculating debt service associated with interest on Variable Rate Indebtedness, there shall be included the expected impact of interest rate swap settlements, whether they be payments or receipts, associated with interest rate swaps

that were, according to GAAP, effective hedges of interest on existing Indebtedness at the time such swap agreements were entered into; provided that if the total notional amount of interest rate swaps in effect on the date of the calculation exceeds the outstanding principal balance of Variable Rate Indebtedness, only those settlements associated with the notional amount that matches such principal balance will be included.

(ii) with respect to any Balloon Long-Term Indebtedness:

(A) the principal amount of such Indebtedness shall be deemed to be payable during the Fiscal Year in which such principal amount becomes due or shall be determined in accordance with clause (B), (C) or (D) below;

(B) if a liquidity facility is then in effect with respect to such Indebtedness, the principal amount of such Indebtedness payable in each Fiscal Year as of any date of calculation may be deemed to be the amount that would be payable during such Fiscal Year if such liquidity facility were used or drawn upon to purchase or retire such Indebtedness on the stated maturity date thereof or on any date established for the mandatory redemption thereof less the aggregate amount required to be on deposit in any irrevocable sinking fund established to provide for the payment of such Indebtedness in accordance with clause (C) below during such Fiscal Year;

(C) if (1) pursuant to a resolution duly adopted by the governing body of an Obligated Group Member, an irrevocable sinking fund shall have been established to provide for the payment of such Indebtedness when due, (2) deposits to such sinking fund are current and timely and (3) verification of such timely deposits is contained in the most recent audited financial statements of the Obligated Group or the Health System (as the case may be) or a Statement from an Independent Public Accountant, then the principal amount of such Indebtedness payable in each Fiscal Year may be deemed to be the amount required to be deposited in such sinking fund for such Fiscal Year;

(D) the principal amount of such Indebtedness payable in each Fiscal Year may be deemed to be the amount that would be payable during such Fiscal Year if such Indebtedness were required to be amortized in full from the date of calculation in either substantially equal annual installments of principal (such principal to be rounded to the nearest $5,000) and interest over a term equal to (i) 30 years or (ii) assuming an amortization that the Obligated Group Representative would otherwise use to refinance the Indebtedness with a final maturity no greater than 30 years; and

(iii) with respect to any Optional Tender Indebtedness, the option of the holder thereof to demand the purchase or redemption of such Indebtedness and any requirement that such Indebtedness be purchased or redeemed in connection with any termination of any Credit Facility securing such Indebtedness, any conversion of the interest rate thereon or otherwise prior to the maturity thereof shall be disregarded;

(iv) with respect to any Guaranty of any Indebtedness that would constitute Long-Term Indebtedness if incurred directly by an Obligated Group Member:

(A) so long as no default shall have occurred and be continuing with respect to such Indebtedness and no demand for payment shall have been made under such Guaranty during the immediately preceding five years, there shall be excluded the percentage of the debt service requirements of such guaranteed Indebtedness set forth in the following table to the extent that the aggregate income available for debt service (determined on a basis consistent with the determination of Net Income Available for Debt Service under the Loan Agreement) of all primary obligors with respect to such guaranteed Indebtedness for their most recent fiscal year, expressed as a percentage of the maximum annual debt service on all outstanding long-term Indebtedness with respect to which such persons are primary obligors for such fiscal year (determined on a basis consistent with the determination of Maximum Annual Debt Service on Long-Term Indebtedness under the Loan Agreement), is equal to the amount set forth in the following table:

Income available for debt service as a percentage of maximum annual debt service	Percentage of debt service requirements to be excluded
150% or more	100%
At least 125 but less than 150%	75
At least 110 but less than 125%	50
At least 100 but less than 110%	25
Less than 100%	0

(B) if a default shall have occurred with respect to such Indebtedness or a demand for payment shall have been made under such Guaranty during the immediately preceding five years, 100% of the debt service requirements of such Indebtedness shall be taken into account in such calculation; and

(C) such Indebtedness shall be taken into account only once in calculating the debt service requirements of Long-Term Indebtedness;

(v) with respect to any Credit Facility Agreement, except as provided in clause (ii)(B) above (A) so long as no demand for payment under the Credit Facility issued under such Credit Facility Agreement shall have been made, the debt service requirements of such Credit Facility Agreement shall be excluded from such calculation and (B) if any amount shall have been realized under such Credit Facility for the purchase or payment of any Indebtedness, then (1) the debt service requirements of such Credit Facility Agreement shall be determined in accordance with the foregoing provisions of this definition, and (2) if the Indebtedness secured by such Credit Facility shall not have been retired by the application of amounts realized under such Credit Facility, such Indebtedness shall be excluded in the calculation of debt service requirements; and

(vi) with respect to any Joint Indebtedness, the amount of the debt service requirements of such Joint Indebtedness that, pursuant to the agreement between or among the primary obligors with respect to such Indebtedness, is required to be paid by persons that are not Obligated Group Members shall be excluded to the extent of the amount of such debt service

requirements that would be excluded if a Guaranty of such amount of such Joint Indebtedness were delivered by an Obligated Group Member, determined in accordance with clause (iv) above.

"**Favorable Opinion of Bond Counsel**" means, when used with respect to or in connection with any action, an Opinion of Bond Counsel to the effect that such action will not adversely affect the excludability from gross income, for federal income tax purposes, of interest paid on any Tax-Exempt Bonds theretofore issued.

"**Finance Lease**" means any sales-type lease or direct financing lease of real or personal property that, in accordance with GAAP, constitutes indebtedness of a Person and involves the transfer of risks and rewards of asset ownership to the lessee. Any lease agreement whereby the risks and rewards of ownership remain with the lessor, which is classified under GAAP as an operating lease, is not a Finance Lease.

"**Fiscal Year**" means the period of 12 consecutive months beginning on July 1 in any calendar year and ending on June 30 of the immediately succeeding calendar year, or such other fiscal year as the Obligated Group Members shall establish as the fiscal year of the Obligated Group, written notice of which shall be provided to of the Authority.

"**Government Obligations**" means direct obligations of, or obligations the timely payment of the principal of and the interest on which are unconditionally guaranteed by, the United States of America.

"**Group Facilities**" means all real and personal property in which any Obligated Group Member shall have any interest.

"**Hedging Transaction**" means any transaction entered into by an Obligated Group Member in order to hedge the interest payable or manage interest cost on all or a portion of any Indebtedness, any asset or any other derivative arrangement then in effect, including (without limitation) an interest rate swap, a forward or futures contract or an option, such as (without limitation) a call, put, cap, floor or collar.

"**Indebtedness**" means (a) any indebtedness or liability for borrowed money, (b) any installment sale obligation, (c) any Finance Lease and (d) any guaranty of any of the foregoing. Indebtedness shall not include any obligation of any Obligated Group Member to any other Obligated Group Member.

"**Investment Obligations**" means:

(a) Government Obligations;

(b) Agency Obligations;

(c) negotiable or nonnegotiable certificates of deposit issued by commercial banks, trust companies or savings and loan associations (including the Trustee) and continuously

secured (to the extent not fully insured by the Federal Deposit Insurance Corporation) for the benefit of the Authority and the Trustee, either (i) by lodging with a bank or trust company, acting as agent for the Trustee or the Authority, as the case may be, as collateral security, Government Obligations or Agency Obligations or other marketable securities eligible as security for the deposit of trust funds under applicable regulations of the Comptroller of the Currency of the United States of America or applicable state law or regulations, having a market value not less than the amount of such deposit, or (ii) if the furnishing of security as provided in clause (i) of this paragraph is not permitted by applicable law, in such other manner as may then be required or permitted by applicable state or federal laws and regulations regarding the security for, or granting a preference in the case of, the deposit of trust funds;

(d) repurchase agreements for Government Obligations or Agency Obligations or investment agreements which are, or are issued or guaranteed by an entity, rated by Moody's or S&P in its highest rating category or fully collateralized by Government Obligations or Agency Obligations (any such collateralized investment agreement being referred to herein as a "Collateralized Investment Agreement"); provided that (i) such Government Obligations or Agency Obligations shall be delivered to the Trustee or supported by a safekeeping receipt from another depository or other confirmatory documentation; (ii) the Trustee or the Authority (as the case may be) shall have a perfected security interest in such Government Obligations or Agency Obligations; (iii) such Government Obligations or Agency Obligations shall be free and clear of any other liens or encumbrances; and (iv) such repurchase agreements or Collateralized Investment Agreements shall provide that the value of the underlying Government Obligations or Agency Obligations shall be continuously maintained at a current market value of not less than 102% of the repurchase price or the amount deposited thereunder, as the case may be (the value of such Government Obligations or Agency Obligations to be determined by the Trustee at least once in each seven day period);

(e) obligations issued by or on behalf of any state of the United States of America or any political subdivision thereof which are rated in one of the three highest rating categories of Moody's or S&P;

(f) obligations of any state of the United States of America or any political subdivision thereof for the payment of the principal or redemption price of and interest on which there shall have been irrevocably deposited Government Obligations maturing as to principal and interest at times and in amounts sufficient to provide such payment;

(g) commercial paper which is rated in the highest rating category of Moody's or S&P; and

(h) shares in investment companies at least 90% of the assets of which consist of obligations described in clauses (a) through (g) above and repurchase agreements backed by such obligations (including any proprietary mutual fund, money market fund or short term investment fund maintained by the Trustee and for which the Trustee or an affiliate is investment advisor, or provides other services, and receives reasonable compensation for such services).

"**Joint Indebtedness**" means any Indebtedness for which one or more Obligated Group Members and one or more persons that are not Obligated Group Members are jointly and severally liable.

"**Long-Term Indebtedness**" means all of the following Indebtedness incurred or assumed by any Obligated Group Member:

(i) any obligation for the payment of money borrowed for an original term, or renewable at the option of the borrower for a period from the date originally incurred, longer than one year;

(ii) any Finance Lease with an original term longer than one year;

(iii) any obligation for the payment of money under installment purchase contracts having an original term in excess of one year;

(iv) at the election of the Obligated Group Representative, any obligation having an original term of one year or less that is intended to be refinanced at maturity;

(v) any obligation that would constitute Short-Term Indebtedness if a liquidity facility were not in effect with respect thereto; and

(vi) any Guaranty of any Indebtedness that would be described in item (i), (ii), (iii), (iv) or (v) above if such Indebtedness were incurred directly by an Obligated Group Member.

"**Maximum Annual Debt Service**" means, when used with reference to any Long-Term Indebtedness for any Fiscal Year, as of any particular date of computation, the greatest amount required in the then-current or any future Fiscal Year to pay the Debt Service Requirements of such Long-Term Indebtedness.

"**Moody's**" means Moody's Investor Service, Inc. or, if Moody's Investors Service, Inc. shall no longer rate obligations such as the Bonds, another nationally recognized statistical rating organization selected by the Authority, and its successors and assigns.

"**Net Income Available for Debt Service**" means, when used with reference to the Obligated Group Members, for any period, an amount determined in accordance with GAAP by deducting (a) the total unrestricted operating and nonoperating expenses of the Obligated Group Members, exclusive of depreciation, interest and amortization, from (b) the sum of all unrestricted operating and nonoperating revenues of Obligated Group Members; provided, however, that there shall be excluded from such calculation all unrealized gains and losses on investments and Hedging Transactions, including (without limitation) any other than temporary impairments resulting from any such loss, any losses due to any impairments of goodwill, intangible assets or other long-lived assets, any other non-cash items of a non-recurring nature and any nonoperating gains or losses on the sale or disposition of any asset (other than any

investment security), including (without limitation) any gain or loss on the termination of any Hedging Transaction, and any gain or loss on the extinguishment of debt.

"**Non-Recourse Indebtedness**" means Indebtedness that does not constitute a general obligation of any Obligated Group Member and that is payable solely from (a) property of an Obligated Group Member, or the revenues of such property (i) the purchase or improvement of which was financed by such Indebtedness or (ii) that could be disposed of by an Obligated Group Member pursuant to the Loan Agreement; (b) payments made to any Obligated Group Member pursuant to pledges or contributions to such Obligated Group Member; or (c) guarantees or payments from a person other than an Obligated Group Member.

"**Operating Assets**" means any land, buildings, machinery, equipment, hardware, inventory or other property or interest therein (except cash, investment securities and other property held for investment purposes) of any Obligated Group Member used in its trade or business.

"**Operating Expenses**" means expenses incurred by the Obligated Group or the Authority for operation and maintenance of the Group Facilities, including (without limitation) the Administrative Expenditures.

"**Optional Tender Indebtedness**" means any Indebtedness that is subject to optional or mandatory tender by the holder thereof (including, without limitation, any mandatory tender in connection with the expiration of any Credit Facility securing such Indebtedness, any conversion of the interest rate on such Indebtedness or otherwise) for purchase or redemption prior to the stated maturity date thereof if the purchase or redemption price of such Indebtedness is under any circumstances payable by any Obligated Group Member.

"**Parity Debt**" means all Bonds and Parity Obligations, collectively.

"**Parity Obligation**" means any bond, note, lease, agreement or other obligation of any Obligated Group Member, including (without limitation) any Hedging Transaction entered into by an Obligated Group Member, that is certified as such pursuant to the Resolution. See "Additional Debt -- Parity Debt" in the forepart of this Official Statement.

"**Permitted Encumbrance**" means:

(a) any lien arising by reason of any good faith deposit by any Obligated Group Member in connection with any lease of real estate, bid or contract (other than any contract for the payment of money), any deposit by any Obligated Group Member to secure any public or statutory obligation, or to secure, or in lieu of, any surety, stay or appeal bond, and any deposit as security for the payment of taxes or assessments or other similar charges;

(b) any lien arising by reason of any deposit with, or the giving of any form of security to, any governmental agency or any body created or approved by law or governmental regulation for any purpose at any time as required by law or governmental regulation as a condition to the transaction of any business or the exercise of any privilege or license or to

enable any Obligated Group Member to maintain self-insurance or to participate in any funds established to cover any insurance risk or in connection with workers' compensation, unemployment insurance, any pension or profit sharing plan or other social security, or to share in the privileges or benefits required for the participation of such Obligated Group Member in such arrangements;

(c) any judgment lien against any Obligated Group Member that does not exceed five percent (5.0%) of the Total Revenues of the Obligated Group for the most recent Fiscal Year for which audited financial statements of the Health System have been prepared, so long as such judgment is being contested in good faith and is fully bonded or covered by insurance reasonably acceptable to the Authority;

(d) any right reserved to or vested in any municipality or public authority by the terms of any right, power, franchise, grant, license, permit or provision of law affecting any property of any Obligated Group Member; any lien on any property of any Obligated Group Member for taxes, assessments, levies, fees, water and sewer rents or charges and other governmental and similar charges and any lien of any mechanic, materialman, laborer, supplier or vendor for work or services performed or materials furnished in connection with such property that is not due and payable or that is not delinquent or the amount or validity of which is being contested and execution thereon stayed;

(e) the Resolution and the Loan Agreement ;

(f) any lien or encumbrance on the Receipts securing any Indebtedness permitted by the Loan Agreement, provided that, except in the case of liens and encumbrances securing Parity Debt, such lien or encumbrance is subordinate to the lien of the Loan Agreement, unless such lien or encumbrance qualifies as a Permitted Encumbrance without reference to this clause;

(g) any lien with respect to money deposited by patients or others with any Obligated Group Member as security for, or as prepayment of, the cost of patient or other client care and any lien arising under law or by contract with respect to initial deposits made under life care or continuing care contracts;

(h) any lien on property received by any Obligated Group Member through any gift, grant or bequest constituting a restriction imposed by the donor, grantor or testator on such gift, grant or bequest or the income therefrom;

(i) any lien of any third-party payor for recoupment of amounts paid to any Obligated Group Member for patient care;

(j) any lien or encumbrance on inventory, *provided* that the aggregate principal amount of all Indebtedness secured by any such lien or encumbrance does not exceed 25% of the Book Value thereof;

(k) statutory reverters under Hill-Burton grants (42 U.S.C. Section 291, *et seq*.) and similar federal or state legislation;

(l) any lien on any property securing any Non-Recourse Indebtedness;

(m) any lien granted for the benefit of all holders of outstanding Parity Debt;

(n) any operating or ground lease of any Operating Assets which is reasonably necessary or appropriate for or incidental to the operation thereof;

(o) any lien placed upon any real or tangible personal property being acquired or constructed by any Obligated Group Member to secure all or a portion of the cost of acquisition or construction thereof; and any landlord's lien under any lease;

(p) any lien or encumbrance on any property of any Obligated Group Member existing on the date on which such Obligated Group Member became an Obligated Group Member or on the date on which such property was acquired by an Obligated Group Member, including (without limitation) any acquisition as a result of a merger or consolidation permitted by the Loan Agreement involving the owner of such property, provided that (i) such lien was not created to avoid the limitations on the creation of liens contained in the Loan Agreement, (ii) such lien is not extended, renewed or modified to apply to any property of any Obligated Group Member not subject to such lien on such date, unless the lien, as so extended, renewed or modified, otherwise qualifies as a Permitted Encumbrance without reference to this clause and (iii) the Indebtedness secured by such lien does not constitute Parity Debt;

(q) any lien or encumbrance on any accounts receivable, *provided* that the aggregate principal amount of all Indebtedness secured by any such lien or encumbrance does not exceed 25% of the total value of the net accounts receivable of the Obligated Group Members;

(r) any lien or encumbrance securing any Hedging Transaction permitted under the Loan Agreement;

(s) any lien or encumbrance arising by reason of any escrow or reserve fund established to pay debt service or the redemption price or purchase price of Indebtedness;

(t) any lien or encumbrance in favor of a trustee on the proceeds of Indebtedness and earnings thereon prior to the application of such proceeds and such earnings;

(u) liens in favor of banking or other depository institutions encumbering the deposits of any Obligated Group Member held in the ordinary course of business by such banking institutions (including any rights of setoff or statutory bankers' liens) so long as such deposit account is not established or maintained for the purpose of providing such lien, right of setoff or bankers' lien;

(v) such easements, rights-of-way, servitudes, restrictions and other defects, liens and encumbrances as do not materially impair the use of the Operating Assets for their intended purposes; and

(w) any other lien or encumbrance;

provided, however, that the Current Value of all property subject to any lien described in clause (l) (o) (r) or (w) above, in the aggregate, shall not exceed twenty-five percent (25%) of the unrestricted net assets of the Obligated Group Members for the most recent Fiscal Year for which audited financial statements of the Obligated Group or the Health System (as the case may be) have been prepared.

For the definition of "**Receipts**," see "Security and Sources of Payment for the Series 2025 Bonds -- Loan Agreement -- Security Interest in Receipts" in the forepart of this Official Statement.

"**Record Date**" means the fifteenth day of the calendar month preceding each interest payment date or, if there is a default in the payment of the interest due on the Series 2025 Bonds, a subsequent date fixed by the Trustee that is at least 10 and not more than 15 days before the date set for payment of such defaulted interest.

"**Redemption Price**" means, when used with respect to any Bond or portion thereof, the principal amount of such Bond or such portion thereof plus the applicable premium, if any, payable upon redemption thereof pursuant to the Resolution.

"**Revenue Test**" means, when used in connection with any admission to or withdrawal from the Obligated Group, the disposition of any assets, the incurrence of any Indebtedness or any other action, that:

(a) there shall have been delivered to the Authority and the Trustee a Certificate of the Obligated Group Representative to the effect that the Coverage Ratio for the most recent Fiscal Year for which audited financial statements of the Obligated Group or the Health System (as the case may be) have been prepared was not less than 1.10, and

(b) either:

(i) there shall have been delivered to the Authority and the Trustee a Certificate of the Obligated Group Representative to the effect that the Coverage Ratio for the most recent Fiscal Year for which audited financial statements of the Obligated Group or the Health System (as the case may be) have been prepared would not have been less than 1.25 if such action had occurred as of the first day of such Fiscal Year; or

(ii) after giving effect to such action, the projected Coverage Ratio for each of the first two Fiscal Years after the date on which such action is taken or, at the option of the Obligated Group in the case of the incurrence of any Indebtedness in order to finance any Capital

Improvements, the date on which such Capital Improvements are expected to be placed in service is either:

(A) not less than 1.25; or

(B) with the consent of the Authority (which consent shall not be unreasonably withheld), not less than 1.00, provided that (1) the Coverage Ratio is greater than the projected Coverage Ratio for each such Fiscal Year assuming such action is not taken or (2) under applicable governmental requirements, the Obligated Group Members are unable to achieve a higher Coverage Ratio.

Under the Resolution and the Loan Agreement, compliance with paragraph (b)(ii) above shall be evidenced by the opinion of a Management Consultant, provided that compliance with paragraph (b)(ii) above may be determined by a Certificate of the Obligated Group Representative if the Coverage Ratio for the most recent Fiscal Year for which audited financial statements of the Obligated Group or the Health System (as the case may be) have been filed with the Authority and the projected Coverage Ratio for each of the two Fiscal Years referred to in clause (b)(ii) above is not less than 1.50.

For the definition of "**Revenues**," see "Security and Sources of Payment for the Series 2025 Bonds -- Pledge of Revenues" in the forepart of this Official Statement.

"**Short-Term Indebtedness**" means any Indebtedness (a) incurred or assumed by any Obligated Group Member for a term not exceeding 365 days, except any such Indebtedness (i) with respect to which a liquidity facility is then in effect or (ii) that is expected to be refinanced at maturity and that the Obligated Group elects to treat as Long-Term Indebtedness, and (b) any Guaranty of any Indebtedness that would be described in clause (a) above if such Indebtedness were incurred directly by an Obligated Group Member. Optional Tender Indebtedness shall not be deemed to constitute Short-Term Indebtedness for the purposes of the Loan Agreement solely by reason of the option of the holder thereof to require the redemption or purchase thereof or any required redemption or purchase thereof in connection with the termination of the liquidity facility securing such Indebtedness, the conversion of the interest rate on such Indebtedness or otherwise prior to the stated maturity thereof.

"**Sinking Fund Installment**" means the amount of money provided in the Resolution to redeem or pay at maturity Term Bonds at the times and in the amounts provided in the Resolution, less the amount of any credit against such amount arising from the purchase or redemption of Term Bonds in any prior year as provided in the Resolution. The Sinking Fund Installments for the Series 2025 Bonds are set forth under "The Series 2025 Bonds -- Redemption Provisions -- Mandatory Sinking Fund Redemption" in the forepart of this Official Statement.

"**Subordinate Obligations**" means any subordinate obligation issued and certified as such by the Authority as described under "Summary of Certain Provisions of the Resolution -- Subordinate Obligations" below.

"**Tax-Exempt Bonds**" means the Series 2015 Bonds, the Series 2025 Bonds and any other Indebtedness with respect to which there shall have been delivered to the Authority a written opinion of Bond Counsel to the effect that the interest on such Indebtedness is excludable from gross income for federal income tax purposes.

"**Total Revenues**" means, when used with reference to the Obligated Group for any period, the sum of all operating and nonoperating revenues of the Obligated Group for such period, determined in accordance with GAAP; provided, however, that there shall be excluded from such calculation any unrealized gain on any investment or any Hedging Transaction and any nonoperating gain on the disposition of any asset (other than any investment) or on the termination of any Hedging Transaction.

"**Unrestricted Cash and Marketable Securities**" means unrestricted cash and marketable securities, including (without limitation) board-designated funds, of the Obligated Group Members less each of the following to the extent that any of the following shall otherwise be included in unrestricted cash and marketable securities: (i) trustee-held funds, debt service funds, debt service reserve funds, construction funds, litigation reserve funds, malpractice funds or other self-insurance or captive insurance funds, pension or retirement funds and any other funds set aside or reserved in such manner so that such funds are not available to the Obligated Group to pay debt service on Indebtedness, (ii) any amounts realized from the sale or factoring of accounts receivable during the 90-day period preceding the date of calculation, and (iii) amounts pledged or posted, or required to be pledged or posted, to secure obligations under a Hedging Transaction.

SUMMARY OF CERTAIN PROVISIONS OF THE RESOLUTION

The following is a summary of certain provisions of the Resolution. It is not a complete recital of the terms of the Resolution and reference should be made to the Resolution for a complete statement of its terms.

Funds and Accounts

(Sections 4.01 and 4.02)

The following funds and separate accounts within funds are created by the Resolution for the benefit of the holders of all Outstanding Bonds, subject to the provisions of any Supplemental Resolution authorizing the issuance of any Additional Bonds: Construction Fund (Costs of Issuance Account); Debt Service Fund (Interest Account and Principal Account); Redemption Fund; and Rebate Fund.

The Construction Fund shall be held by the Authority. The Debt Service Fund, the Redemption Fund and the Rebate Fund shall be held by the Trustee. The Authority shall deposit the Construction Fund with the Trustee, which shall act as custodian of the Construction Fund.

The Rebate Fund and the Costs of Issuance Account are not pledged to the payment of any Bonds.

Deposit and Application of Revenues
(Section 4.05)

Except as otherwise described herein, the Revenues received by the Trustee for the payment of outstanding Bonds shall be deposited by the Trustee as follows and in the following order of priority:

FIRST: to the Interest Account, the amount required to make the amount on deposit in such Interest Account equal to the interest becoming due on the outstanding Bonds on the immediately succeeding interest payment date on such Bonds;

SECOND: to the Principal Account, the amount required to make the amount on deposit in such Principal Account equal to the principal of and the Sinking Fund Installment for the outstanding Bonds due on the immediately succeeding July 1.

After making the payments required above, any balance of Revenues shall be paid to the Obligated Group Representative unless such amount constitutes the proceeds of Tax-Exempt Bonds or investment earnings thereon, in which case such amount shall be transferred to such funds and accounts as the Authority, upon advice of Bond Counsel, shall direct.

If any Supplemental Resolution provides for the establishment of separate funds and accounts for any Bonds, then the Revenues received by the Authority or the Trustee pursuant to the Loan Agreement on any date shall be deposited *pro rata* among the Debt Service Funds on the basis of the respective amounts required to be deposited in such Debt Service Funds on such date.

Debt Service Fund
(Section 4.07)

The Trustee shall pay from the Interest Account the interest due on the Outstanding Bonds on each interest payment date and any amounts required for the payment of accrued interest upon any purchase or redemption of Outstanding Bonds.

The Trustee shall on each July 1 pay from the Principal Account the principal of and the Sinking Fund Installments for the Outstanding Bonds, if any, due on such date upon presentation and surrender of the requisite Bonds.

Additional Facilities Fund
(Section 4.08)

Money in the Additional Facilities Fund shall be available to the Obligated Group Members to assist the Obligated Group Members in defraying the cost of financing or refinancing (i) any Additional Facilities or (ii) Capital Improvements.

Insurance and Condemnation Award Fund
(Section 4.10)

Money in the Insurance and Condemnation Award Fund shall be applied by the Trustee in accordance with the provisions of the Loan Agreement described below under "Summary of Certain Provisions of the Loan Agreement -- Application of Proceeds of Insurance and Condemnation."

If such money is to be used to pay the costs of repair or replacement of lost, damaged, destroyed or taken property, such money shall be disbursed by the Trustee from time to time to or at the direction of the Obligated Group Representative in accordance with Requisitions meeting the requirements of the Resolution delivered to the Authority and the Trustee.

If such money is to be applied to the redemption of Bonds, such money shall be transferred by the Trustee to the Redemption Fund to be applied to the extraordinary redemption of Bonds; provided that to the extent provided in the Supplemental Resolution certifying any Parity Obligations, such money shall be allocated by the Trustee between the payment of outstanding Bonds and Parity Obligations, proportionately on the basis of the respective aggregate principal amounts of Bonds and Parity Obligations then Outstanding.

Investment of Money
(Section 4.12)

Money in any of the funds and accounts established pursuant to the Resolution that are held by the Trustee shall be invested by the Trustee as directed by the Authority, but only in Investment Obligations maturing in such amounts and on such dates as may be necessary to provide money to meet the payments from such funds and accounts.

Interest earned, profits realized and losses suffered by reason of any investment of any of the funds and accounts created by the Resolution shall be credited or charged to the fund or account for which such investment shall have been made.

In determining the value of the assets of the funds and accounts created by the Resolution, investments and accrued interest thereon shall be deemed a part thereof. Investments shall be valued at the market value thereof.

Neither the Trustee nor the Authority shall be liable for any depreciation in the value of any obligation in which money of the funds or accounts created by the Resolution shall be invested, or for any loss arising from any permitted investment.

Rebate Fund
(Section 4.13)

Upon the direction of the Authority, the Trustee shall transfer amounts on deposit in any fund or account created by the Resolution to the Rebate Fund, any other provision of the Resolution to the contrary notwithstanding. Amounts on deposit in the Rebate Fund from time to

time required to be paid to the United States of America pursuant to Section 148 of the Code as a rebate or payment in lieu thereof shall be made available by the Trustee to the Authority for such payment.

Additional Bonds
(Sections 2.07)

The Resolution authorizes the issuance of Additional Bonds for the purposes and with the effect described under "Additional Debt -- Parity Debt -- Additional Bonds and Parity Obligations" in the forepart of this Official Statement. The Supplemental Resolution authorizing the issuance of any Additional Bonds shall specify the maturities and redemption provisions of such Additional Bonds and the form, denomination and other details of such Additional Bonds. Any Supplemental Resolution authorizing the issuance of Additional Bonds may provide for the creation of a separate Debt Service Fund, Debt Service Reserve Fund, Construction Fund and Redemption Fund for such Bonds.

Subordinate Obligations
(Section 2.08)

In addition to any Additional Bonds, the Authority may issue from time to time Subordinate Obligations for the benefit of any Obligated Group Member for the benefit of whom the Authority's obligations may be issued under the Act and shall certify any obligation of any Obligated Group Member as a Subordinate Obligation upon compliance with the provisions of the Resolution. The Authority may pledge the Revenues and the Obligated Group Members may pledge the Receipts to the payment of any Subordinate Obligations, but any such pledge shall be junior and subordinate to the pledge of the Revenues and the Receipts to secure outstanding Parity Debt.

So long as no Event of Default under the Resolution or the Loan Agreement shall have occurred and be continuing, the Authority or the Obligated Group Members may pay or prepay, or authorize the payment or prepayment of, the principal of and interest on any Subordinate Obligation and the holders of Parity Debt shall have no recourse against the person to whom any such payment shall have been made unless such person shall have had, at the time of receipt of such payment, actual knowledge that an Event of Default has occurred under the Resolution or the Loan Agreement. During the continuance of any Event of Default under the Resolution or the Loan Agreement, no payments shall be made with respect to the principal of or interest on any Subordinate Obligation.

Amendments or Modifications of Resolution and Loan Agreement
(Sections 8.01, 8.02, 8.05 and 8.06)

Without notice to or the consent of the Holders of the Parity Debt, the Authority may adopt at any time or from time to time a Supplemental Resolution amending the Resolution or any Supplemental Resolution for the following purposes, among others: (i) to grant to the Trustee for the benefit of the holders of Parity Debt any additional rights, remedies or security; (ii) to add to the agreements of the Authority contained in the Resolution; (iii) to confirm any

pledge of the Revenues or the Loan Agreement; (iv) to cure any ambiguity or to cure or correct any defect or inconsistent provisions in the Resolution or to make such provisions in regard to matters or questions arising under the Resolution as may be necessary or desirable and not inconsistent with the Resolution; (v) to authorize the issuance of Additional Bonds or to certify Parity Obligations, including (without limitation) any modifications or amendments required to secure for the Holders of such Additional Bonds and Parity Obligations a parity interest in the security granted to the holders of then Outstanding Parity Debt, or to grant to the holders of such Subordinate Obligations a subordinate interest in the security therefor; (vi) to permit the qualification of the Resolution or any Supplemental Resolution under any federal statute or state blue sky law; (vii) to obtain or maintain any ratings on Parity Debt; (viii) to make any other change in the Resolution, including (without limitation) any change necessary in connection with the issuance of any Subordinate Obligation, which the Authority determines shall not materially prejudice the rights of the Holders of Parity Debt; and (viii) to preserve the excludability from gross income for federal income tax purposes of the interest paid on any Tax-Exempt Bonds theretofore issued.

With the consent of the Holders of a majority in aggregate principal amount of the outstanding Parity Debt, a Supplemental Resolution may be adopted modifying any of the provisions of the Resolution, any Supplemental Resolution or any Bond, but no such modification may (i) change any terms of redemption of the Bonds (except as otherwise provided in the Supplemental Resolution authorizing the issuance of such Bonds) or the due date for the payment of principal of or interest on the Bonds, make any reduction in the principal, Redemption Price or purchase price of or interest on the Bonds without the consent of the Holders thereof or (ii) reduce the percentage of Parity Debt the consent of the Holders of which is required for any modification of the Resolution, except with the unanimous consent of the Holders of all Parity Debt Outstanding.

Without notice to or the consent of the Holders of Parity Debt, the Authority may at any time and from time to time enter into any amendment of the Loan Agreement that is (i) required or permitted by the provisions of the Loan Agreement, including (without limitation) any supplements or modifications thereto required in connection with any admission to or withdrawal from the Obligated Group permitted by the Loan Agreement, or (ii) required to cure any ambiguity, formal defect, inconsistency or omission therein, or (iii) permitted by the Resolution and the Loan Agreement with respect to amendments of the Project or any Additional Facilities, or (iv) required or permitted pursuant to the Resolution in connection with the issuance of any Additional Bonds, Parity Obligations or Subordinate Obligations, or (v) required to obtain or maintain any ratings on Parity Debt from any nationally recognized securities rating agency, or (vi) not prejudicial in any material respect to the rights of the Holders of Parity Debt in the judgment of the Authority. Otherwise, the Authority shall not enter into any amendment of the Loan Agreement without the prior written consent of the Holders of a majority in aggregate principal amount of the Parity Debt Outstanding at the effective date of such amendment.

Without limiting the generality of the foregoing, the purchasers of any Parity Debt upon the original issuance thereof may be deemed to have consented to any amendment to the Resolution, any Supplemental Resolution, any Bond or the Loan Agreement permitted to be

made with the consent of the Holders of Parity Debt with the same effect as if such Holders shall have filed a written consent to such amendment.

Enforcement of Loan Agreement
(Sections 5.03)

Notwithstanding the pledge and assignment of the Loan Agreement to the Trustee pursuant to the Resolution, the Trustee shall not be entitled to enforce the Loan Agreement prior to the occurrence of an Event of Default under the Resolution.

The Authority shall take reasonable action to cause the Obligated Group Members to perform fully all duties and acts and comply fully with the covenants contained in the Loan Agreement. The holders of a majority in aggregate principal amount of the outstanding Parity Debt shall have the right, by an instrument in writing executed and delivered to the Authority, to direct the method and place of conducting all remedial proceedings to be taken by the Authority under the Loan Agreement; provided that such direction shall not be otherwise than in accordance with law or the provisions of the Loan Agreement, and shall not be unjustly prejudicial to holders of outstanding Parity Debt not parties to such direction.

The Authority, in its discretion, may assign its rights under the Loan Agreement to the Trustee. In the event of any such assignment, all references in the Resolution and the Loan Agreement to actions to be taken by the Authority under or with respect to the Loan Agreement shall be deemed to be references to the Trustee.

Events of Default and Remedies

Events of Default
(Section 7.01)

Events of Default under the Resolution include, among others: the failure to pay the principal of or interest on any of the Bonds when the same shall become due and payable; the failure to pay the purchase price of any Bond required by its terms to be purchased from the holder thereof by the Authority on any date prior to its stated maturity; and any default in the performance of any covenants contained in any Bond or the Resolution, subject to certain grace periods.

Acceleration of Maturity; Remedies
(Sections 7.02, 7.03 and 7.06)

Upon the happening and continuance of any Event of Default under the Resolution, the Trustee may, and upon the written request of the holders of not less than 10% in aggregate principal amount of the Outstanding Bonds shall, declare the principal of all of the Outstanding Bonds to be due and payable. The Trustee also shall declare the principal of all Outstanding Bonds to be due and payable upon the written direction of the Authority following the occurrence of any Event of Default under the Loan Agreement.

Upon the giving of notice of such declaration, such principal shall become and be immediately due and payable. The Trustee may annul such declaration under certain circumstances set forth in the Resolution.

Upon the happening and continuance of any Event of Default, the Trustee may proceed, and upon the written request of the Holders of not less than 10% in aggregate principal amount of the outstanding Parity Debt, shall proceed to protect and enforce its rights and the rights of the Holders of Parity Debt under the laws of the State of Maryland and under the Resolution.

By the terms of the Resolution, the Obligated Group Members are not prohibited from taking any action, to the extent permitted by applicable law, to remedy any Event of Default.

Priority of Payments Following Default
(Sections 4.06 and 7.04)

If the Authority shall take possession of any of the Group Facilities following the occurrence of any Event of Default under the Loan Agreement, the Revenues received from the Group Facilities by the Authority during each calendar month shall be paid over by the Authority to the Trustee on or before the fifth Business Day of the immediately succeeding month for deposit to the credit of the Revenue Fund. So long as any Event of Default under the Loan Agreement shall not have been cured, amounts deposited in the Revenue Fund, and all Receipts transferred to the Trustee for deposit in the Revenue Fund pursuant to the Loan Agreement upon the occurrence of any Event of Default under the Loan Agreement shall be paid by the Trustee upon deposit thereof as follows and in the following order of priority:

FIRST: (i) if the Authority is in possession of any of the Group Facilities, to the Authority for deposit in the Operating Fund, the lesser of (A) the balance in the Revenue Fund and (B) the sum certified by the Authority as sufficient to cover Operating Expenses for the Group Facilities for the month in which payment is made by the Trustee; and (ii) if the Obligated Group Members are in possession of any portion of the Group Facilities, to the Obligated Group Members, the amount, if any, which the Authority in its discretion deems desirable in order to permit the Obligated Group Members to pay the Operating Expenses; and

SECOND: to the Interest Account, the Principal Account and any debt service reserve funds as described below.

At such time as the Trustee shall be required to make any payments described in clause SECOND above, the Trustee shall establish a Debt Service Fund including an Interest Account and a Principal Account for any Parity Debt for which no Debt Service Fund shall have theretofore been established. The Trustee shall allocate the money required to be deposited in accordance with clause SECOND as follows: (a) to each Interest Account, the interest expected to accrue on the outstanding Parity Debt for which such Interest Account is established until the first day of the immediately succeeding calendar month, proportionately, on the basis of the respective amounts of such interest (assuming any Parity Debt on which the interest rate is not fixed during such period continues to bear interest at the rate then borne by such Parity Debt), or

such lesser amount as shall be required to make the amount on deposit in such Interest Account equal the amount of such interest that will have accrued on such Parity Debt as of such date; (b) to each Principal Account an amount equal to one-twelfth (1/12) of the principal of (which shall include any mandatory sinking fund installments for) the outstanding Parity Debt for which such Principal Account is established payable on the immediately succeeding principal payment date or such lesser amount as shall be required to make the amount on deposit in such Principal Account equal the amount of such principal becoming due on such date; and (c) among any debt service reserve funds established for any Parity Debt, the amounts required to be deposited therein in such month. Amounts deposited in any Debt Service Fund created for any Parity Obligation shall be paid to the holder thereof on the due dates for such payments.

Notwithstanding the foregoing:

(1) if on any date on which amounts are required to be deposited or paid under clause SECOND above, fewer than 12 whole calendar months remain during the period from and including such date to but excluding the immediately succeeding principal payment date, then from and including the date of the first such deposit and payment to but excluding the immediately succeeding principal payment date, in lieu of the fraction set forth in clause (b) above, there shall be substituted a fraction, the numerator of which is one and the denominator of which is the number of whole calendar months in such period;

(2) if on any date on which amounts are required to be deposited or paid in accordance with clause (a) or (b) above, the amount available shall be insufficient to make all deposits and payments required to be made thereunder with respect to outstanding Parity Debt, then the Revenues shall be deposited or paid *pro rata* on the basis of the respective amounts required to be so deposited or paid with respect to such Parity Debt in such month;

(3) if on any date on which amounts are required to be deposited in accordance with clause (c) above, the amount available shall be insufficient to make all deposits required to be made thereunder, then the Revenues (and any amounts required to be transferred to any debt service reserve fund from any Construction Fund or the Redemption Fund, other than any Construction Fund or Redemption Fund established solely for particular Bonds) on such date shall be allocated *pro rata* among all debt service reserve funds established for outstanding Parity Debt on the basis of the respective aggregate principal amounts of Parity Debt outstanding secured thereby; and

(4) in the event that the due date for the payment of any Parity Debt shall have been accelerated, the amount payable under clause (b) above shall be the principal amount of such Parity Debt that is then due and payable.

Amounts deposited in the Revenue Fund as described above that remain in the Revenue Fund at the end of any month shall be retained in the Revenue Fund and applied in the next month to the payments described above.

If at any time there shall have occurred and be continuing an Event of Default under the Resolution, amounts held by the Trustee under the Resolution together with any money

thereafter becoming available for such purpose (after payment of all Administrative Expenditures, including, without limitation, any indemnity payments due to the Trustee) shall be paid to the persons entitled thereto as provided in the following paragraphs (a) and (b):

(a) Unless the principal of all Outstanding Parity Debt shall have become or shall have been declared due and payable, all such money shall be applied:

FIRST: to the payment of all installments of interest then due on all Outstanding Parity Debt, in the order in which such installments became due and payable and, if the amount available shall not be sufficient to pay in full any particular installment, then to the payment of such installment, ratably, according to the amounts due on such installment, to the persons entitled thereto;

SECOND: to the payment of the unpaid principal of any Outstanding Parity Debt that shall have become due and payable, in the order of the due dates for such payments, with interest upon the principal amount of such Parity Debt from the respective dates upon which it shall have become due and payable and, if the amount available shall not be sufficient to pay in full the principal of the Parity Debt due and payable on any particular due date, together with such interest, then to the payment first of the interest, ratably, according to the amount of interest due on such date, and then to the payment of the principal, ratably, according to the amount of principal due on such date; and

THIRD: to the payment of the interest on and the principal of the Parity Debt Outstanding as the same become due and payable.

(b) If the principal of all Outstanding Parity Debt shall have become due and payable either by its terms or by a declaration of acceleration, the money held by the Trustee under the Resolution shall be applied to the payment of the principal and interest then due and unpaid upon such Parity Debt, without preference or priority of principal over interest or of interest over principal, or of any installment of interest over any other installment of interest, ratably, according to the amounts due respectively for principal and interest, to the persons entitled thereto.

Notwithstanding the foregoing, amounts on deposit in funds and accounts maintained for particular Bonds shall be applied solely to the payment of such Bonds. Prior to making the payments described above, the Trustee shall give effect to the application of amounts on deposit in the respective funds and accounts to the payment of Parity Debt for which such funds are maintained. Notwithstanding the foregoing, prior to the application of any money that constitutes proceeds of any Tax-Exempt Bonds or the investment earnings on such proceeds to the payment of any Bond of any other Series or any Parity Obligation, the Trustee shall obtain a Favorable Opinion of Bond Counsel.

Restrictions Upon Action by Individual Holders
(Section 7.07)

No holder of any Parity Debt shall have any right to institute any suit, action or other proceeding in equity or at law on any Parity Debt for the execution of any trust under the Resolution or for any other remedy under the Resolution unless such Holder previously shall have given to the Trustee written notice of the Event of Default on account of which such proceeding is to be instituted, the holders of not less than 10% in aggregate principal amount of the outstanding Parity Debt shall have made request to the Trustee after the right to exercise such powers or right of action, as the case may be, shall have accrued, and shall have afforded the Trustee a reasonable opportunity either to proceed to exercise the powers granted by the Resolution or to institute such proceeding in its or their name, and there shall have been offered to the Trustee reasonable security and indemnity against the costs, expenses and liabilities to be incurred therein or thereby and the Trustee shall have refused or neglected to comply with such request within a reasonable time, provided that the Holders of not less than 10% in aggregate principal amount of the outstanding Parity Debt may institute any such proceeding in their own name for the benefit of all Holders of Parity Debt.

Defeasance
(Section 9.01)

If the Authority shall pay or cause to be paid the principal or Redemption Price of and interest on all Parity Debt and Subordinate Obligations at the times and in the manner stipulated therein, then the pledge of any Revenues and other property pledged by the Resolution to the Parity Debt and Subordinate Obligations and all other rights granted by the Resolution to the Parity Debt shall be discharged and satisfied.

A Bond shall be deemed to have been paid within the meaning of and with the effect expressed in the Resolution if (i) money for the payment or redemption of such Bond shall be held by the Trustee (regardless of the source of such money), whether at or prior to the maturity or the redemption date of such Bond, or (ii) if the maturity or redemption date of such Bond shall not have arrived, provision shall have been made by the Authority by deposit with the Trustee of money (or other method satisfactory to the Trustee) or Government Obligations, the principal of and the interest on which when due will provide for such payment, and the Authority shall have made provision satisfactory to the Trustee for the giving of notice to the Holder of such Bond that such money is so available for such payment, provided that if such Bond is to be redeemed prior to the maturity thereof, the Authority shall have taken all action necessary to redeem such Bond and notice of such redemption shall have been duly given or provisions satisfactory to the Trustee shall have been made for the giving of such notice.

Any money held by the Trustee in trust for the payment of any of the Parity Debt which remains unclaimed for three years after the later of the date at which such Parity Debt became due and payable and the date of deposit of such money shall be repaid by the Trustee to the Authority, or to such officer, board or body as may then be entitled by law to receive such money, as its absolute property and free from trust, and the Trustee shall thereupon be released and discharged.

Authority Protected in Acting in Good Faith
(Section 10.06)

In the exercise of the powers of the Authority and its members, officers, employees and agents under the Resolution, the Loan Agreement, including (without limitation) the application of money, the investment of funds and the pursuit of or failure to pursue any remedy in the event of default by the Obligated Group Members, the Authority and its members, officers, employees and agents shall not be accountable to any Obligated Group Member, the Trustee or any holder of any Parity Debt or Subordinate Obligations for any action taken or omitted by it or its members, officers, employees and agents in good faith and believed in good faith by it or them to be authorized or within the discretion or rights conferred by the Resolution, the Loan Agreement. The Authority and its members, officers, employees and agents shall be protected in its or their acting upon any paper or document believed in good faith by it or them to be genuine, and it or they may conclusively rely upon the advice of counsel or other experts and may require further evidence of any fact or matter before taking any action. No recourse shall be had by any Obligated Group Member, the Trustee or any holder of any Parity Debt or Subordinate Obligations for any claims based on the Resolution, the Loan Agreement or any Bond, Parity Obligation or Subordinate Obligation against any member, officer, employee or agent of the Authority alleging personal liability on the part of such person unless such claims are based upon the bad faith, fraud or deceit of such person.

Concerning the Trustee

Responsibilities of the Trustee; Indemnification *(Sections 6.02 and 6.03)*

Except as otherwise expressly provided in the Resolution, the Trustee shall have no responsibility or duty with respect to: (i) the issuance of the Parity Debt or Subordinate Obligations for value; (ii) the application of the proceeds thereof, except to the extent that such proceeds are received by it in its capacity as Trustee; (iii) the application of any money paid to the Authority or others in accordance with the Resolution except as to the application of any money paid to it in its capacity as Trustee; (iv) any calculation of arbitrage or rebate under the Code; (v) prior to any Event of Default, any determination with respect to the insurance requirements of the Obligated Group or the appointment of any Management Consultant; (vi) any information, statement or recital in any official statement, offering memorandum or any other disclosure material prepared or distributed with respect to the Bonds, except for any information provided by the Trustee; (vii) compliance with any state or federal securities laws in connection with the Bonds; or (viii) the issuance of any Bonds as obligations the interest on which is excludable from gross income for federal income tax purposes or the maintenance of the tax-exempt status of any Bonds subsequent to their issuance. The duties of the Trustee shall be determined by the express provisions of the Resolution, and the Trustee shall not be liable except for the performance of such duties as are specifically set forth in the Resolution.

The Trustee shall not be liable for any action taken or omitted by it in the performance of its duties under the Resolution except for its own negligence or willful default.

The Trustee shall be under no obligation to institute suit, to undertake any proceeding under the Resolution, or to enter any appearance or in any way defend in any suit in which it may be made defendant, or to take any steps in the execution of the trusts created thereby or in the enforcement of any rights and powers thereunder, until it shall be indemnified to its satisfaction against any and all costs and expenses, outlays and counsel fees and other reasonable disbursements, and against all liability except as a consequence of its own negligence or willful misconduct. Nevertheless, the Trustee may take such action without indemnity, and in such case the Authority shall reimburse the Trustee from the Revenues for all costs and expenses properly incurred in connection therewith. If the Authority shall fail to make such reimbursement, the Trustee may reimburse itself from any money in its possession under the provisions of the Resolution and shall be entitled to a preference therefor over any Parity Debt and Subordinate Obligations Outstanding under the Resolution.

Resignation and Removal *(Sections 6.08 and 6.09)*

The Trustee may resign and be discharged by giving not fewer than 30 days' written notice to the Authority and each holder of any outstanding Parity Debt or Subordinate Obligations. Such resignation shall take effect upon the appointment of a successor and acceptance of such appointment by such successor.

The Trustee may be removed at any time by (i) the Authority, so long as no Event of Default shall have occurred and be continuing or (ii) if any Event of Default shall have occurred and be continuing, the holders of a majority in aggregate principal amount of the outstanding Parity Debt by a written instrument executed by such holders or their attorneys-in-fact. The Trustee may also be removed for any breach of trust or for acting, or for failing to act, or proceeding in violation of any provision of the Resolution by any court upon the application of the Authority or of the holders of not less than 10% in aggregate principal amount of the Parity Debt outstanding.

Successor Trustee *(Section 6.10)*

If the Trustee shall resign, be removed, be dissolved or become incapable of acting, or shall be adjudged insolvent, or if a receiver, liquidator or conservator shall be appointed for the Trustee's property, or if any public officer shall take control of the Trustee or its property or affairs, the position of the Trustee shall thereupon become vacant and a successor Trustee shall be appointed by the Authority or, if an Event of Default under the Resolution shall have occurred and be continuing, the holders of 10% in aggregate principal amount of outstanding Parity Debt.

If no appointment of a successor Trustee is made within 45 days after the giving of written notice of resignation by any Trustee, or after the occurrence of any other event requiring or authorizing such appointment, the Trustee or any holder of Parity Debt may apply to any court for the appointment of such a successor. Any successor Trustee shall be a commercial bank or trust company or national banking association having a capital and surplus aggregating at least $50,000,000, if there be such a commercial bank or trust company or national banking association willing and able to accept the appointment on reasonable and customary terms.

SUMMARY OF CERTAIN PROVISIONS OF THE LOAN AGREEMENT

The following is a summary of certain provisions of the Loan Agreement. This is not a complete recital of the terms of the Loan Agreement and reference should be made to the Loan Agreement for a complete statement of its terms.

Admission to Obligated Group
(Section 3.02)

Other entities may be admitted to the Obligated Group, from time to time, upon the satisfaction of the following conditions, among others, on and as of the date of admission:

(a) the entity proposing to become an Obligated Group Member (the "Applicant") shall have agreed to provide to the Authority a lien on and security interest in all of its Receipts, subject only to Permitted Encumbrances;

(b) after giving effect to the admission of the Applicant, (i) the Liquidity Requirement shall be satisfied and there shall be delivered to the Authority and the Trustee a Certificate of the Obligated Group demonstrating compliance therewith, provided that the Obligated Group need not meet the Liquidity Requirement in connection with any such admission if there is delivered to the Authority and the Trustee a Certificate of the Obligated Group demonstrating that the Days' Cash on Hand of the Obligated Group immediately after giving effect to such admission will be equal to or greater than the Days' Cash on Hand of the Obligated Group immediately prior thereto; and (ii) no Event of Default or event that, with notice or lapse of time or both, would constitute an Event of Default shall have occurred and be continuing, and a Certificate to that effect shall have been delivered to the Authority and the Trustee by the Obligated Group Representative;

(c) the Authority and the Trustee shall have received a Favorable Opinion of Bond Counsel; and

(d) the Revenue Test shall have been satisfied.

Withdrawal from Obligated Group
(Section 3.03)

Obligated Group Members other than the Institution may withdraw from the Obligated Group upon the satisfaction of the following conditions, among others, on and as of the date of such withdrawal:

(a) the Authority and the Trustee shall have received a Favorable Opinion of Bond Counsel;

(b) after giving effect to such withdrawal (i) no Event of Default or event that, with notice or lapse of time or both, would constitute an Event of Default shall have occurred and be continuing, and a Certificate to that effect shall have been delivered to the Authority and the

Trustee by the Obligated Group Representative; and (ii) after giving effect to such withdrawal, the Liquidity Requirement shall be satisfied and there shall be delivered to the Authority and the Trustee a Certificate of the Obligated Group demonstrating compliance therewith;

(c) the Revenue Test shall have been satisfied after giving effect to the withdrawal of such Obligated Group Member.

Upon the withdrawal of any person from the Obligated Group, such person will have no further liability as obligor or guarantor of any obligation under the Loan Agreement. Notwithstanding the foregoing, the Institution may not withdraw from the Obligated Group.

Loan Payments
(Sections 4.02)

The Obligated Group Members shall pay when due (without limitation) (i) the total interest becoming due on all outstanding Parity Debt to the respective dates of payment thereof; (ii) the total principal amount of outstanding Parity Debt; and (iii) all redemption premiums (if any) payable on the redemption of outstanding Parity Debt prior to stated payment dates. In addition, the Obligated Group Members shall pay when due the Annual Administrative Fees and the Administrative Expenditures.

In order to provide for the payment of the amounts due under the Loan Agreement with respect to the Bonds, except as otherwise provided in the Supplemental Resolution authorizing the issuance of any Additional Bonds with respect to such Bonds, the Obligated Group Members shall pay on or before the fifth Business Day prior to each date on which any principal of, Sinking Fund Installment for or interest on any outstanding Bond becomes due, the sum of:

(a) the lesser of (i) the interest becoming due on the Outstanding Bonds on the immediately succeeding interest payment date and (ii) the amount required to make the amount on deposit in the Interest Account maintained for such Bonds available for the payment thereof equal to the interest becoming due on such date; and

(b) the lesser of (i) the principal of and Sinking Fund Installment for the outstanding Bonds becoming due on such date and (ii) the amount required to make the amount on deposit in the Principal Account maintained for such Bonds available for the payment thereof equal to the principal of and the Sinking Fund Installment for such Bonds becoming due on such date.

Operation and Maintenance of the Operating Assets; Payment of Impositions
(Sections 6.01 and 7.09)

The Obligated Group Members shall operate the Operating Assets in a sound and economical manner, shall maintain, preserve and keep the Operating Assets in good condition and repair and shall pay all necessary expenses of maintaining, repairing and replacing the

Operating Assets to the extent necessary to permit the Obligated Group Members to make the payments required by the Loan Agreement and to perform their obligations thereunder. Nothing in the Loan Agreement shall be deemed to require the Obligated Group Members to operate and maintain any Operating Assets to the extent that the Obligated Group Members determine that to do so is not in the best economic interest of the Obligated Group.

The Obligated Group Members shall pay all governmental impositions and assessments, if any, lawfully levied or assessed upon or with respect to the Operating Assets or any revenues therefrom. Nothing contained in the Loan Agreement shall be construed to prevent any Obligated Group Member from contesting in good faith any governmental imposition or assessment with respect to the Operating Assets, provided that such contest shall not materially adversely affect the ability of the Obligated Group Members to make the payments required by the Loan Agreement, the security for the Parity Debt or Subordinate Obligations or the effective use or operation of the Operating Assets.

Disposition of Assets
(Section 7.14)

Subject to the provisions set forth below, an Obligated Group Member may demolish, remove, sell, lease, loan, assign, transfer or otherwise dispose of any property in any Fiscal Year if:

(i) the aggregate Book Value or Current Value of all property disposed of by the Obligated Group Members pursuant to this clause (i) in such Fiscal Year does not exceed ten percent of the aggregate unrestricted net assets (defined as net assets without donor restriction under GAAP) of the Obligated Group Members as of the last day of the most recent Fiscal Year for which audited financial statements of the Obligated Group or the Health System (as the case may be) have been filed with the Authority; or

(ii) such Obligated Group Member shall receive, in consideration of the disposition of such property, money or other property having a fair market value at least equal to the fair market value of such property immediately prior to such disposition; or

(iii) such Obligated Group Member shall have delivered to the Authority and Trustee either (A) a Certificate to the effect that the Coverage Ratio for the most recent Fiscal Year for which audited financial statements of the Obligated Group or the Health System (as the case may be) have been prepared would not have been less than 1.50 if the disposition of such property had taken place on the first day of such Fiscal Year or (B) an opinion of a Management Consultant stating that the Coverage Ratio for each of the first two Fiscal Years after the date of the disposition of such property should be greater than the Coverage Ratio for each such Fiscal Year assuming that such property had not been disposed of; or

(iv) the disposition of property that is unused or surplus or has, or within the next succeeding 24 calendar months is reasonably expected to, become inadequate,

obsolete, worn out, unsuitable, unprofitable, undesirable or unnecessary and the disposition thereof will not impair the structural soundness, efficiency or economic value of the remaining property of the Obligated Group; or

(v) the disposition of property to any Person, provided such property is or was received by such Obligated Group Member as a gift, grant, bequest or donation and is restricted as to use for a particular purpose inconsistent with its use for payment of debt service on Indebtedness and such Person has as one of its corporate purposes the receipt of gifts, bequests and donations and the application of such property in accordance with such restrictions; or

(vi) the Revenue Test shall have been satisfied.

In addition to dispositions of property permitted by the preceding paragraph, an Obligated Group Member may sell, lease or otherwise transfer any of its property to any other Obligated Group Member. The Obligated Group Members shall be permitted to dispose of property only if after giving effect to such disposition, no Event of Default or event that, with notice or lapse of time or both, would constitute an Event of Default shall have occurred and be continuing.

Nothing contained in the Loan Agreement shall be construed to restrict the right of the Obligated Group Members to (i) purchase or sell any property in the ordinary course of business, (ii) transfer cash, securities or other investment properties in connection with ordinary investment transactions, (iii) purchase or lease any property for cash at its fair market value, (iv) apply any donor restricted assets to the purposes for which such assets were donated or (v) sell, lease, loan, assign or otherwise transfer any of their respective properties if such property has become inadequate, obsolete or worn out.

Limitations on Merger, Consolidation and Transfer of Assets
(Section 7.10)

None of the Obligated Group Members shall merge or consolidate with or transfer all or substantially all of its assets to any other person, unless (a) in the case of any merger or consolidation, any surviving, resulting or transferee entity is an Obligated Group Member or, as part of such transaction, becomes an Obligated Group Member and such entity assumes in writing all of the obligations of the Obligated Group Members under the Loan Agreement; (b) in the case of any merger, consolidation or transfer, on or before the effective date of such merger, consolidation or transfer, the Obligated Group files with the Authority and the Trustee, among other things, a Favorable Opinion of Bond Counsel, (c) the Revenue Test shall have been satisfied after giving effect to such merger, consolidation or transfer and (d) immediately following such merger, consolidation or transfer, (i) the Liquidity Requirement shall be satisfied and (ii) no Event of Default or event that, with notice or lapse of time or both, would constitute an Event of Default, shall have occurred and be continuing.

The merger or consolidation of any two or more Obligated Group Members or any transfer of any or all of the assets of any Obligated Group Member to any other Obligated Group Member shall not be deemed to constitute a merger, consolidation or transfer of substantially all of an Obligated Group Member's assets within the meaning of the Loan Agreement, provided that the requirements of clause (b) above shall be satisfied in the event that either of such Obligated Group Members is a Tax-Exempt Obligated Group Member.

Additional Indebtedness
(Section 7.11)

No Obligated Group Member shall incur or permit to exist any additional Indebtedness except:

(a) Indebtedness with respect to the Series 2015 Bonds evidenced by the Loan Agreement;

(b) Short-Term Indebtedness in an aggregate principal amount that shall not exceed 20% of the Total Revenues of the Obligated Group for the most recent Fiscal Year for which audited financial statements of the Obligated Group or the Health System (as the case may be) have been prepared, provided that the Obligated Group shall have no such Indebtedness outstanding on any day unless, during the 12 calendar month period immediately preceding such day, there has been a period of at least 15 consecutive days during which all such Indebtedness outstanding has not exceeded five percent of the Total Revenues of the Obligated Group for such 12-month period, unless there is delivered to the Authority a Certificate of the Obligated Group to the effect that such Indebtedness was incurred or continues to exist as a result of a temporary delay in the receipt by any Obligated Group Member of amounts due from third-party payors, governmental agencies or grantors and that the outstanding amount of such Indebtedness has been reduced to the minimum amount practicable under the circumstances;

(c) Long-Term Indebtedness issued for the purpose of refunding (whether in advance or otherwise) any Outstanding Indebtedness of any Obligated Group Member, if the Authority shall have received a Certificate of the Obligated Group Representative to the effect that, after giving effect to the proposed refunding, the Maximum Annual Debt Service on all Outstanding Long-Term Indebtedness will not be increased more than ten percent;

(d) Non-Recourse Indebtedness;

(e) any other Long-Term Indebtedness if the Revenue Test shall have been satisfied;

(f) any additional Long-Term Indebtedness, provided that the aggregate principal amount of such Indebtedness, together with the aggregate principal amount of all other Indebtedness described in clause (b) above and this clause (f) that is then outstanding, shall not exceed 25% of the Total Revenues of the Obligated Group for the most recent Fiscal Year for which audited financial statements have been prepared; and

(g) certain Indebtedness under any Credit Facility Agreement.

If the Obligated Group Members shall at any time deliver to the Authority the evidence described in clause (e) above with respect to any Indebtedness initially issued or incurred as described in clause (f) above, such Indebtedness shall no longer be deemed to be described in clause (f) above.

The Obligated Group Representative shall give Notice to the Authority regarding (i) the principal amount of the Indebtedness to be incurred, (ii) the date on which such Indebtedness is to be incurred and (iii) the provisions above being relied upon to permit such Indebtedness to be incurred, at least three Business Days prior to incurring any Indebtedness pursuant to clause (b), (c), (d), (e) or (f) above (or such other notice as shall be acceptable to the Authority), provided, however, that with respect to clause (b) such Notice shall only be required at the time the agreement to incur such Indebtedness is initially entered into. The Obligated Group Representative shall furnish to the Authority such Certificates of an Independent Public Accountant as the Authority may reasonably request to evidence compliance with the provisions above.

Parity Obligations
(Section 7.12)

Each Obligated Group Member has the right under the Loan Agreement to issue, or to have issued on its behalf, Parity Obligations for any lawful purpose, upon the satisfaction of the conditions described above under "Additional Indebtedness" or below under "Certain Hedging Transactions" and of certain other conditions. Parity Obligations shall be secured equally and ratably by the Receipts and the Revenues to the extent provided in the Resolution.

Certain Hedging Transactions
(Section 7.15)

(a) The Obligated Group Members may secure any agreement in connection with any Hedging Transaction as a Parity Obligation (a "Hedge Agreement") under the Loan Agreement or by providing a lien on or security interest in any property of the Obligated Group constituting a Permitted Encumbrance, provided that, prior to any date on which a Hedging Agreement is certified as a Parity Obligation or an Obligated Group Member enters into any agreement to provide such lien or security interest, there shall be delivered to the Authority (a) a copy of such Hedge Agreement, and (b) a Certificate of the Obligated Group Representative demonstrating that, if an early termination date were to occur under all Hedging Transactions to which any Obligated Group Member is then a party as of such date and the Obligated Group Members were required to pay an amount equal to the Maximum Adverse Termination Payment (hereinafter defined) on such date, then (i) the Obligated Group would be able to meet the Revenue Test and (ii) the amount of the Unrestricted Cash and Marketable Securities of the Obligated Group immediately following such payment would not be less than the Liquidity Requirement.

(b) The Maximum Adverse Termination Payment shall be determined as follows:

(i) The value of one standard deviation of fixed swap rates for Hedging Transactions of a similar duration and basis (*e.g.*, LIBOR or SIFMA) shall be calculated.

The standard deviation used in this calculation shall be the greater of the value determined using five years and the value determined using ten years of historical data. The probable range of fixed rates with a 95% confidence level shall then be estimated by adding the value of 1.96 standard deviations to the current fixed rate to establish an upper level, and deducting the value of 1.96 standard deviations from the current fixed rate to determine the lower level. The value of a Hedging Transaction shall be calculated by using the fixed rates at the upper and lower levels to determine the mark to market valuation of such Hedging Transaction.

(ii) In the case of basis swap transactions, the value of one standard deviation of basis ratios for basis swaps of similar duration and basis (*e.g.*, SIFMA versus LIBOR) shall be calculated. The standard deviation used in this calculation shall be the greater of the value determined using five years and the value determined using ten years of historical data. The probable range of ratios with a 95% confidence level shall then be estimated by adding the value of 1.96 standard deviations to the current ratio to establish an upper level, and deducting the value of 1.96 standard deviations from the current ratio to determine the lower level.

(iii) The Maximum Adverse Termination Payment shall be equal to the largest negative value determined as provided in paragraphs (i) and (ii) above; provided that if Obligated Group Members are party to more than one Hedging Transaction as of the date of calculation, the Maximum Adverse Termination Payment shall be calculated by summing the positive and negative values of all Hedging Transactions then in effect, including the Hedging Transaction to be secured as of the date of calculation.

(c) Notwithstanding the foregoing, the Obligated Group Members shall not be required to comply with the provisions of clause (a) above in connection with any amendment to or modification or novation of any existing Hedge Agreement entered into for the purpose of managing the Obligated Group's risk position under its existing Hedging Transactions, including replacing any counterparty on substantially the same terms as such existing Hedge Agreement, eliminating or reducing any security requirement under such Hedge Agreement and otherwise amending, modifying or novating such Hedge Agreement provided that the Obligated Group's exposure under such Hedge Agreement is not materially increased.

Notwithstanding the foregoing, the Maximum Adverse Termination Payment for fixed or variable rate swaps, basis swap transactions and other Hedging Transactions may be determined in accordance with such other methodology based upon current market practices as of the date of calculation thereof as shall be reasonably acceptable to the Authority.

The Maximum Adverse Termination Payment shall be evidenced by a Certificate of the counterparty under a Hedging Transaction or other person having skill and experience in the valuation of Hedging Transactions. No error or other defect in the calculation of the Maximum Adverse Termination Payment shall affect the validity of any Hedge Agreement duly authorized, executed or delivered by an Obligated Group Member.

Liens and Encumbrances
(Section 7.13)

Except as otherwise expressly permitted by the Loan Agreement, no Obligated Group Member may create any lien or encumbrance or allow any lien or encumbrance to remain against any portion of its property, including (without limitation) the Operating Assets and the Receipts, other than any Permitted Encumbrances, without the prior written consent of the Authority, which consent shall not be unreasonably withheld.

Notwithstanding the foregoing, so long as no Event of Default under the Loan Agreement shall have occurred and be continuing, the Obligated Group Members are permitted to place a lien or encumbrance on any property that could be disposed of under the provisions of the Loan Agreement described above under "Disposition of Assets" in order to secure Indebtedness incurred to finance or refinance the cost of improving such property.

Insurance
(Section 6.04)

The Obligated Group Members shall keep the Operating Assets adequately insured at all times and shall maintain with responsible insurers with respect to their facilities and operations insurance of such types, in such amounts and against such risks as are customarily maintained by persons in similar circumstances having facilities of a comparable type and size and offering comparable services as those of the Obligated Group Members and is obtainable upon commercially reasonable terms, including (without limitation) the following insurance to the extent such insurance is customarily maintained by such persons, taking into account Section 19-354 of the Health-General Article of the Annotated Code of Maryland, as amended, to the extent such statute is applicable to the Obligated Group Members: (i) full fire and extended coverage insurance on all of the insurable Operating Assets providing for not less than full recovery of the insurable value (less reasonable deductibles and exclusions) of any damaged property; (ii) public liability and property damage insurance, including (without limitation) business automobile liability insurance, and, with respect to each Obligated Group Member providing any health care services, medical and professional liability insurance in amounts estimated to indemnify fully (less reasonable deductibles and exclusions) the Obligated Group Members and the Authority against the estimated loss or damage; (iii) fidelity, comprehensive dishonesty, disappearance and destruction insurance; and (iv) "use and occupancy" insurance or "business interruption" insurance covering the loss of revenues attributable to the Operating Assets by reason of the total or partial suspension of or interruption in the operation of the Operating Assets caused by damage to or destruction of the Operating Assets in an amount not less than the amount required to meet the Debt Service Requirements of Outstanding Long-Term Indebtedness for a period of two years.

The Obligated Group Members may satisfy the requirements of the preceding paragraph by establishing and maintaining a self-insurance plan, including (without limitation) an insurance company or association controlled by an Obligated Group Member (either singly or with other Obligated Group Members or other persons) or by a risk retention group, protecting each Obligated Group Member against the risks required to be insured against.

Neither the Authority nor the Trustee shall have any responsibility with respect to any insurance required under the Loan Agreement, except that the Trustee shall receive the letters and opinions required to be delivered in accordance with the Loan Agreement and shall hold the same for inspection by any holder of outstanding Parity Debt or Subordinate Obligations. The Authority and the Trustee shall be entitled to rely upon any opinions, letters, certifications, recommendations and reports provided in accordance with the Loan Agreement and shall have no responsibility or duty to conduct any independent inquiry or investigation as to the adequacy or enforceability of any insurance procured or maintained by the Obligated Group Members or as to whether the Obligated Group Members have in fact procured and maintained the insurance required.

Application of Proceeds of Insurance and Condemnation
(Section 6.05)

If any Operating Assets shall be lost, damaged or destroyed and the amount of such loss, damage or destruction in any single Fiscal Year is in excess of ten percent of the Book Value of the Operating Assets of the Obligated Group for the most recent Fiscal Year for which audited financial statements have been prepared, the Authority and the Obligated Group Members shall pay over to the Trustee for deposit in the Insurance and Condemnation Award Fund upon receipt thereof (a) all proceeds received under any title insurance policy relative to any Operating Assets ("title insurance proceeds"), (b) the proceeds of any Operating Assets taken in the exercise of the power of eminent domain, condemnation or through the exercise of any right or any obligation on the part of any public authority to purchase the same, or as a result of any agreement between the Obligated Group Members and any such public authority ("condemnation proceeds"), and (c) any insurance proceeds payable in connection with the loss, damage or destruction of any Operating Assets ("casualty insurance proceeds" and, together with any title insurance proceeds and condemnation proceeds, the "Net Proceeds").

The proceeds paid over to the Trustee shall be applied as follows:

(i) The Obligated Group Members may elect within six months of such loss, damage, destruction or taking to apply any Net Proceeds and expend such other amount as shall be necessary to repair or replace the lost, damaged, destroyed or taken property, if: (A) with respect to property other than equipment, the Obligated Group Members deliver to the Authority a Certificate of an architect setting forth such architect's estimate of the cost of repairing or replacing the lost, damaged, destroyed or taken property to be repaired or replaced and the time required therefor; and (B) the Obligated Group Members deliver to the Authority evidence that (1) the amount of such Net Proceeds, together with any other money deposited or available for deposit in the Insurance and Condemnation Award Fund (which may include, without limitation, amounts available to be drawn under a letter of credit, guaranty or other commitments) will be sufficient to pay the costs of repairing or replacing the lost, damaged, destroyed or taken property to be repaired or replaced and (2) either satisfy the Revenue Test or deliver to the Authority a Statement of a Management Consultant to the effect that the Coverage Ratio (taking into account Net Proceeds available to the Obligated Group) for each Fiscal Year during the

period of restoration and for the first two full Fiscal Years thereafter is projected to be not less than 1.10.

(ii) The Obligated Group Members may elect within six months of such loss, damage, destruction or taking to apply such proceeds to the redemption of Long-Term Indebtedness if:

(A) the Obligated Group Members satisfy the Revenue Test after giving effect to such application of proceeds; or

(B) the Obligated Group Members shall pay to the Trustee for deposit in the Insurance and Condemnation Award Fund an amount of money that, together with the Net Proceeds and any other money held to the credit of the funds and accounts created by the Resolution and any money on deposit in the funds and accounts created for any Parity Obligations, shall be sufficient to provide for the payment or redemption of all Outstanding Parity Debt.

(iii) The Obligated Group Members may elect to repair or replace a portion of the lost, damaged, destroyed or taken property and to pay or redeem a portion of the Outstanding Long-Term Indebtedness so long as the Obligated Group Members shall satisfy the requirements of paragraph (i) above.

(iv) The Obligated Group Members shall make an election in accordance with paragraph (i), (ii) or (iii) above within six months of such loss, damage, destruction or taking. If the Obligated Group Members do not or are not entitled to make any such election, the Authority shall employ a Management Consultant at the expense of the Obligated Group Members, within six months of such loss, damage, destruction or taking, to submit a Report including recommendations as to the use of the Net Proceeds and other available amounts that should result in the maximum feasible Coverage Ratio. Such report shall include a financial projection for a period extending at least through the second full Fiscal Year after the date of completion of any repairs or replacements recommended by such Management Consultant. The Obligated Group Members shall apply the Net Proceeds and other available amounts in accordance with the reasonable recommendations of such Management Consultant.

The proceeds of any use and occupancy or business interruption insurance policy representing the coverage of the Debt Service Requirements of any Bonds shall be paid to the Trustee for deposit in the Debt Service Fund.

As used in the Loan Agreement, the terms “repair” and “replace” include (without limitation) the construction or acquisition of replacement or substitute property, structures, machinery, equipment or other improvements, which need not serve the same function as the property lost, damaged, destroyed or taken.

The provisions of the Loan Agreement described above are subject to the rights of the holders of any Permitted Encumbrances taking priority over the rights of the Authority in the property which is subject to such Permitted Encumbrances.

Events of Default and Remedies
(Sections 8.01 and 8.02)

"Events of Default" under the Loan Agreement include, among others: failure by the Obligated Group Members to pay when due amounts sufficient to pay the principal or Redemption Price of or interest on any outstanding Bonds; failure by the Obligated Group Members to pay when due any other payment required to be made under the Loan Agreement, which failure shall continue for a period of 30 days after written notice is given to the Obligated Group Representative by the Authority; failure by any Obligated Group Member to comply with any other of the terms of the Loan Agreement, which failure shall continue for a period of 30 days after written notice shall have been given to the Obligated Group Representative by the Authority, or for a longer period permitted under the Loan Agreement to cure such failure, unless such failure is due to any cause or event not reasonably within the control of any Obligated Group Member, in which case the Obligated Group Members shall not be deemed in default during the continuance of their inability to comply due to such cause or event; certain events of insolvency or bankruptcy of certain Obligated Group Members; loss of federal tax-exempt status for the interest on any Tax-Exempt Bonds as a result of any action by any Obligated Group Member; if any event shall occur or circumstance shall exist (other than any termination at the option of an Obligated Group Member) as a result of which any Obligated Group Member could be required to pay to a counterparty under any Hedging Transaction an aggregate amount the payment of which would cause the amount of the Unrestricted Cash and Marketable Securities of the Obligated Group to be less than an amount equal to 50% of the Unrestricted Cash and Marketable Securities as of the date such circumstance arises or 50 Days' Cash on Hand, which event or circumstance continues beyond any applicable grace period; default in the payment of principal of or interest on any Outstanding Indebtedness of any Obligated Group Member in an amount exceeding five (5%) of the Total Revenues of the Obligated Group for the most recent Fiscal Year for which audited financial statements of the Obligated Group or Health System (as the case may be) have been prepared, or default under any indenture, agreement or other similar instrument under which any such Indebtedness may be issued, which default permits the acceleration of the maturity of such Indebtedness; or default under any Parity Obligation or under any agreement for the repayment of such Parity Obligation, which default shall not have been cured within any applicable grace period provided in such Parity Obligation.

Upon the occurrence of an Event of Default under the Loan Agreement, the Authority may (i) accelerate the payment of the Loans and all other amounts payable under the Loan Agreement, and (ii) take any action at law or in equity to collect the payments due and thereafter to become due, or to enforce the performance and observance of any obligation, agreement or covenant of the Obligated Group Members under the Loan Agreement.

Continuing Disclosure
(Section 7.18)

The Obligated Group Members shall annually provide certain financial information and operating data in accordance with the provisions of Section (b)(5)(i) of Rule 15c2-12 (the "Rule") promulgated by the Securities and Exchange Commission (the "SEC"), as follows:

(a) financial information or operating data with respect to the Obligated Group Members of the general type provided in Appendix A to the Official Statement dated May 29, 2025 under the charts captioned "Payor Mix Trends," "Historical Utilization," "Consolidated Statement of Operations," "Consolidated Balance Sheets," "Investment Policy," "Historical and Pro Forma Liquidity, and "Historical and Pro Forma Debt Service Coverage," to the extent such information is not included in the financial statements referred to in clause (b) below; and

(b) audited financial statements with respect to the Obligated Group or, at the election of the Obligated Group Representative, consolidated and consolidating audited financial statements of the Health System, in each case in accordance with generally accepted accounting principles.

Not later than 150 days after the end of each Fiscal Year the Obligated Group Members shall provide the financial information and operating data described above with respect to the immediately preceding Fiscal Year (the "Continuing Disclosure") to the Authority, the Trustee, and the Municipal Securities Rulemaking Board (the "MSRB") through its Electronic Municipal Market Access System ("EMMA"), and shall provide to the Authority and the Trustee a Certificate of the Obligated Group Representative to the effect that the information complies with the Loan Agreement.

Any of the Continuing Disclosure may be included by specific reference to other documents previously provided to EMMA, or filed with the SEC and publicly available, *provided* that any final official statement incorporated by reference must be available on EMMA.

If on or before the date that is 150 days after the end of any Fiscal Year the Trustee does not receive a Certificate of the Obligated Group Representative to the effect that the Obligated Group has filed the Continuing Disclosure as required by the Loan Agreement, the Trustee shall provide notice thereof in a timely manner to the Authority and the MSRB. The Trustee shall have no liability to any party (including, but not limited to, the Authority, the Obligated Group or any Bondholder) for failure to provide such notice.

The Obligated Group Members shall notify the MSRB, through EMMA, in a timely manner, not in excess of ten business days after the occurrence of any of the following events with respect to any Covered Bonds (hereinafter defined) and shall provide the Authority and the Trustee with a copy of each such notice:

(i) principal and interest payment delinquencies;

(ii) non-payment related defaults, if material;

(iii) unscheduled draws on debt service reserves reflecting financial difficulties;

(iv) unscheduled draws on credit enhancements reflecting financial difficulties;

(v) substitution of credit or liquidity providers, or their failure to perform;

(vi) adverse tax opinions, the issuance by the Internal Revenue Service of proposed or final determinations of taxability, Notices of Proposed Issue (IRS Form 5701-TEB) or other material notices or determinations with respect to the tax status of such Covered Bonds, or other material events affecting the tax status of such Covered Bonds;

(vii) modifications to rights of Holders, if material;

(viii) bond calls, if material, and tender offers;

(ix) defeasances;

(x) release, substitution or sale of property securing repayment of such Covered Bonds, if material;

(xi) rating changes;

(xii) bankruptcy, insolvency, receivership or similar event of an Obligated Group Member,

(xiii) the consummation of a merger, consolidation or acquisition involving an Obligated Group Member or the sale of all or substantially all of the assets of an Obligated Group Member, other than in the ordinary course of business, the entry into a definitive agreement to undertake such an action or the termination of a definitive agreement relating to any such actions, other than pursuant to its terms, if material;

(xiv) appointment of a successor or additional trustee or the change of name of a trustee, if material;

(xv) incurrence of a Financial Obligation (hereinafter defined) of an Obligated Group Member, if material, or agreement to covenants, events of default, remedies, priority rights, or other similar terms of a Financial Obligation of an Obligated Group Member, any of which affect Holders, if material; and

(xvi) default, event of acceleration, termination event, modification of terms, or other similar events under the terms of a Financial Obligation of an Obligated Group Member, any of which reflects financial difficulties.

The term "Financial Obligation" shall mean (A) a debt obligation; (B) a derivative instrument entered into in connection with, or pledged as security or a source of payment for, an existing or planned debt obligation; or (C) a guarantee of clause (A) or (B). The term Financial Obligation shall not include municipal securities as to which a final official statement has been provided to the MSRB consistent with the Rule.

In addition, the Obligated Group Members shall provide (i) to EMMA the unaudited quarterly financial statements of Obligated Group and its subsidiaries within 45 days after the end of the first three fiscal quarters and not later than 90 days after the end of the fourth fiscal quarter of each Fiscal Year; and (ii) to any holder of outstanding Covered Bonds who shall have filed a written request therefor with the Obligated Group Representative, the Continuing Disclosure and the quarterly financial statements described in clause (i) of this paragraph at the time such items are filed with EMMA.

The covenants and obligations of the Obligated Group Members specified above with respect to any Covered Bonds will terminate on the date on which such Covered Bonds are paid in full or provision for the payment thereof is made in accordance with the Resolution.

With the consent of the Authority, the Obligated Group Members may modify the information required to be provided as described herein, *provided* that such modification complies with the Rule as it exists at the time of modification.

Any failure by the Obligated Group Members to perform their obligations described above shall not constitute an Event of Default under this Loan Agreement or the Resolution and the rights and remedies provided by this Loan Agreement and the Resolution upon the occurrence of an Event of Default shall not apply to any such failure. The sole and exclusive remedy for any such failure shall be an action brought by the Authority, the Trustee (upon the Trustee being indemnified to its reasonable satisfaction) or the holders of outstanding Covered Bonds to compel specific performance by the Obligated Group Members of such undertakings.

As used herein, the term "Covered Bonds" shall mean (i) the Existing Bonds (as defined below), (ii) the Series 2025 Bonds, and (iii) any other Additional Bonds or Parity Obligations designated as such in any Supplement authorizing the issuance thereof or any supplement to this Loan Agreement executed and delivered in connection therewith. As used herein, the term "Existing Bonds" shall mean the Series 2015 Bonds.

The Obligated Group Members may from time to time disclose certain information and data in addition to the Continuing Disclosure. Notwithstanding anything herein to the contrary, the Obligated Group Members shall not incur any obligation to continue to provide, or to update, such additional information or data.

Release of Liens and Security Interests
(Section 7.16)

The Authority and the Trustee shall execute and deliver any instrument necessary or appropriate (a) to confirm, grant or convey any property or interest therein transferred in accordance with the provisions of the Loan Agreement described above under "Withdrawal from Obligated Group" or "Disposition of Assets" or (b) to grant or confirm the priority of any lien or encumbrance described in clause (d), (e), (g), (h) or (j) of the definition of "Permitted Encumbrances" set forth above under "Definitions of Certain Terms" over the liens and security interests granted to the Authority and the Trustee as security for outstanding Parity Debt.

In addition, the Authority may, in its reasonable discretion, and the Trustee shall, at the direction of the Authority, execute and deliver any instrument necessary or appropriate to confirm or give effect to any Permitted Encumbrance.

SUMMARY OF CERTAIN PROVISIONS OF OTHER CREDIT AGREEMENTS CONSTITUTING PARITY DEBT

The Institution has entered into a separate agreement for Parity Debt with a financial institution (the "Other Parity Debt Holder") in connection with a term loan(the "Other Credit Agreement"), pursuant to which the Institution executed and delivered to the Other Parity Debt Holder a promissory note to evidence the term loan (the "Parity Note"). In general, the Other Credit Agreement requires that the Obligated Group comply with the provisions of the Loan Agreement. In addition, the Other Credit Agreement includes additional requirements, including, among others, the provisions summarized below. Any failure to comply with the provisions of the Other Credit Agreement that is not remedied during any applicable cure period or waived by the Other Parity Debt Holder (whether or not waived by the holders of a majority in aggregate principal amount of the Parity Debt, in the case of provisions included in the Loan Agreement), would constitute an Event of Default under the Loan Agreement, which could result in an acceleration of the Series 2025 Bonds and other Parity Debt.

The following is a summary of certain provisions of the Other Credit Agreement, but it is not a complete recital of such terms. Words and terms in this summary shall have the meanings set forth in the Loan Agreement, except where otherwise noted.

Rate Covenant

As of the last day of each fiscal year and as of the last day of the second quarter of each fiscal year, the Obligated Group Members must maintain a Coverage Ratio for the 12-month period then ended of not less than 1.10. While the Coverage Ratio required under the Loan Agreement is also 1.10, the Loan Agreement requires the Coverage Ratio to be met annually, and, as described above, the Other Credit Agreement requires that it be met semi-annually. In lieu of the requirement to retain a Management Consultant following any failure to meet the Rate Covenant, the Other Credit Agreement provides that a failure to meet the Rate Covenant constitutes an immediate Event of Default, with no applicable grace or cure period.

Liquidity Covenant

As of the last day of each fiscal year and as of the last day of the second quarter of each fiscal year, the Days' Cash on Hand of the Health System must be not less than 85. The Loan Agreement requires 50 Days' Cash on Hand, tested annually, based on the Days' Cash on Hand of the Obligated Group Members; as described above, the Other Credit Agreement requires 85 Days' Cash on Hand tested semi-annually based on the Days' Cash on Hand of the Health System. In lieu of the requirement to retain a Management Consultant following any failure to meet the Liquidity Covenant, the Other Credit Agreement provides that a failure to meet the

Liquidity Covenant constitutes an immediate Event of Default, with no applicable grace or cure period.

Events of Default

Events of Default under the Other Credit Agreement include substantially the same Events of Default as provided in the Loan Agreement as well as the following, among others:

(a) The Obligated Group Members fail to pay any amount other than principal of or interest on, or purchase price of, the Parity Note when due and such failure shall continue for ten Business Days after written notice to the Institution;

(b) Any representation or warranty made by any Obligated Group Member in the Other Credit Agreement or any related document or in any certificate or statement delivered pursuant to the Other Credit Agreement proves to have been incorrect or untrue in any material respect when made;

(c) The Obligated Group Members fail to submit any financial report, compliance certificate, or other statement, certificate, or information required under the Other Credit Agreement within fifteen (15) days after the due date;

(d) Any failure of the principal and interest on the Parity Note to constitute a Parity Obligation;

(e) Any default in the due performance or observance of the Coverage Ratio or the Liquidity Covenant contained in the Other Credit Agreement;

(f) If any amendment or supplement to the Resolution or the Loan Agreement is executed and delivered (other than any such amendment or supplement which does not require the consent of holders of Parity Debt) without the consent of the Other Parity Debt Holder;

(g) If any Obligated Group Member shall merge, dissolve, liquidate, consolidate with another entity other than another Obligated Group Member, or dispose of all or substantially all of its assets, without the prior written consent of the Other Parity Debt Holder, even if it is permitted under the terms of the Loan Agreement

(h) Any material provision of the Other Credit Agreement or the Loan Agreement at any time for any reason ceases to be valid and binding on the Obligated Group Members or is declared to be null and void, invalid, or unenforceable, or the validity or enforceability thereof is contested by any Obligated Group Member;

(i) Any Rating Agency downgrades its rating of any long-term unenhanced Parity Debt of the Obligated Group to "BBB-" or lower (in the case of a rating assigned by Fitch or S&P) or "Baa3" or lower (in the case of a rating assigned by Moody's), respectively, or suspends or withdraws its rating of the same for credit-related reasons and such rating is not restored to a level of BBB or higher (in the case of a rating assigned by Fitch or S&P)

or Baa2 or higher (in the case of a rating assigned by Moody's) within sixty (60) days after the date of such downgrade, suspension, or withdrawal; and

(j) An ERISA Event occurs with respect to a Pension Plan or Multiemployer Plan which has resulted or could reasonably be expected to result in liability of any Obligated Group Member or any ERISA Affiliate under ERISA in an aggregate amount equal to or greater than 0.5% of the Total Revenues of the Obligated Group for the then most recent Fiscal Year for which audited financial statements have been submitted or any Obligated Group Member or ERISA Affiliate fails to pay any installment payment with respect to its withdrawal liability under ERISA, after the expiration of any grace period, in an aggregate amount equal to or greater than 0.5% of the Total Revenues of the Obligated Group for the most recent Fiscal Year for which audited financial statements have been submitted.

APPENDIX D

FORM OF OPINION OF BOND COUNSEL

[Closing Date]

Maryland Health and Higher
Educational Facilities Authority
Baltimore, Maryland

Members of the Authority:

As Bond Counsel to Maryland Health and Higher Educational Facilities Authority (the "Authority") in connection with the issuance by the Authority of its $_____ Revenue Bonds, Meritus Health Issue, Series 2025 (the "Series 2025 Bonds"), as special obligations of the Authority, we have examined:

(i) Sections 10-301 through 10-356, inclusive, of the Economic Development Article of the Annotated Code of Maryland (2024 Replacement Volume), as amended (the "Act");

(ii) the Meritus Medical Center Bond Resolution adopted by the Authority dated as of July 1, 2015 as amended and supplemented by the First Supplemental Bond Resolution and Supplemental Master Loan Agreement dated as of March 1, 2022 (the "First Supplement") between the Authority and Meritus Medical Center, Inc. (the "Institution") and the Second Supplemental Bond Resolution and Supplemental Master Loan Agreement dated as of May 1, 2025 (the "Second Supplement") and the Third Supplemental Bond Resolution and Supplemental Master Loan Agreement dated as of June 1, 2025 (the "Third Supplement"), each between the Authority, the Institution, MSOM, Inc. and Brook Lane Health Services, Inc. (collectively, the "Obligated Group Members") (as so amended and supplemented, the "Resolution");

(iii) the Master Loan Agreement dated as of July 1, 2015, by and between the Authority and the Institution, as amended and supplemented by the First Supplement, the Second Supplement and the Third Supplement (as so amended and supplemented, the "Loan Agreement");

(iv) the form of Series 2025 Bond;

(v) relevant provisions of the Constitution and laws of the State of Maryland;

(vi) relevant provisions of the Internal Revenue Code of 1986, as amended (the "Code"); and

(vii) other proofs submitted to us relative to the issuance and sale of the Series 2025 Bonds.

The terms of the Series 2025 Bonds are contained in the Third Supplement and the Series 2025 Bonds.

In rendering this opinion, (a) we have relied on the Obligated Group's Tax and Section 148 Certificate and Agreement dated this date made on behalf of the Obligated Group Members by an officer thereof with respect to certain material facts within the knowledge of the Obligated Group Members; and (b) we have assumed the correctness of the opinion of the Chief Legal Officer and Vice President of Legal Services of the Institution, dated this date regarding, among other things, the tax-exempt status of the Obligated Group Members, in each case without investigation.

We have made no investigation of, and are rendering no opinion regarding, the title to, liens on or security interests in real or personal property.

Based upon the foregoing, it is our opinion that, under existing statutes, regulations and decisions:

(a) The Resolution and the Loan Agreement have been duly authorized, executed and delivered by the Authority and, assuming the due authorization, execution and delivery thereof by the other parties thereto, the Resolution and the Loan Agreement constitute the valid and binding obligations of the Authority.

(b) The Authority is duly authorized and entitled to issue the Series 2025 Bonds. Series 2025 Bonds executed and authenticated as provided in the Resolution have been duly and validly issued and constitute valid and binding special obligations of the Authority payable solely from Revenues (as defined in the Resolution) and other amounts pledged to such payment under the Resolution.

(c) The Resolution, the Loan Agreement and the Series 2025 Bonds are subject to bankruptcy, insolvency, moratorium, reorganization and other state and federal laws affecting the enforcement of creditors' rights and to general principles of equity, and enforceability of the indemnification provisions of the Loan Agreement may be limited by applicable public policy.

(d) By the terms of the Act and the Resolution, the Series 2025 Bonds do not constitute a debt or liability of the State of Maryland, of any political subdivision thereof or of the Authority. None of the State of Maryland, any political subdivision thereof or the Authority shall be obligated to pay the Series 2025 Bonds or the interest thereon except from the Revenues and other amounts pledged to the payment of the Series 2025 Bonds under the Resolution. Neither the faith and credit nor the taxing power of the State of Maryland, of any political subdivision thereof or of the Authority is pledged to the payment of the principal of or the interest on the Series 2025 Bonds. The issuance of the Series 2025 Bonds does not directly or indirectly or contingently obligate, morally or otherwise, the State of Maryland, any political subdivision thereof or the Authority to levy or to pledge any form of taxation whatever therefor or to make any appropriation for their payment. The Authority has no taxing power.

(e) By the terms of the Act, the interest on the Series 2025 Bonds, the transfer of the Series 2025 Bonds and any income derived from the Series 2025 Bonds, including profits made in their sale or transfer, are exempt from all Maryland state and local taxes; no opinion is expressed as to estate or inheritance taxes or any other taxes not levied or assessed directly on the Series 2025 Bonds, their transfer or the income therefrom.

(f) Assuming compliance with the covenants referred to herein, interest on the Series 2025 Bonds is excludable from gross income for federal income tax purposes. It is noted that under the provisions of the Code, there are certain restrictions that must be met subsequent to the delivery of the Series 2025 Bonds in order for interest on the Series 2025 Bonds to remain excludable from gross income for federal income tax purposes, including restrictions that must be complied with throughout the term of the Series 2025 Bonds. These include the following: (i) a requirement that certain earnings received from the investment of the proceeds of the Series 2025 Bonds be rebated to the United States of America under certain circumstances (or that certain payments in lieu of rebate be made); (ii) other requirements applicable to the investment of the proceeds of the Series 2025 Bonds; and (iii) other requirements applicable to the use of the proceeds of the Series 2025 Bonds and the facilities financed or refinanced with proceeds of the Series 2025 Bonds. Failure to comply with one or more of these requirements could result in the inclusion of the interest payable on the Series 2025 Bonds in gross income for federal income tax purposes, effective from the date of their issuance. The Authority and the Obligated Group Members have made certain covenants regarding actions required to maintain the excludability from gross income for federal income tax purposes of interest on the Series 2025 Bonds. It is our opinion that, assuming compliance with such covenants, the interest on the Series 2025 Bonds will remain excludable from gross income for federal income tax purposes under the provisions of the Code.

(g) Interest on the Series 2025 Bonds is not includable in the alternative minimum taxable income of individuals as an enumerated item of tax preference or other specific adjustment. Interest on the Series 2025 Bonds will be part of adjusted financial statement income, fifteen percent of which is included in the computation of the corporate alternative minimum tax imposed on applicable corporations. Interest income on the Series 2025 Bonds will be includable in the applicable taxable base for the purposes of determining the branch profits tax imposed by the Code on certain foreign corporations engaged in a trade or business in the United States of America.

We assume no obligation to supplement this opinion if any applicable laws or interpretations thereof change after the date hereof or if we become aware of any facts or circumstances that might change this opinion after the date hereof. This opinion is limited to the matters set forth above, and no other opinions should be inferred beyond the matters expressly stated.

Very truly yours,

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APPENDIX E

Book-Entry Only System

The information in this section has been obtained from sources that the Authority, the Obligated Group Members and the Underwriters believe to be reliable, but none of the Authority, the Obligated Group Members or the Underwriters takes any responsibility for the accuracy thereof.

The Depository Trust Company

The Depository Trust Company, New York, New York ("DTC" or, together with any successor securities depository for the Series 2025 Bonds, the "Securities Depository"), will act as securities depository for the Series 2025 Bonds. The Series 2025 Bonds will be issued as fully-registered securities registered in the name of Cede & Co., DTC's partnership nominee, or such other name as may be requested by an authorized representative of DTC. One fully-registered certificate of the Series 2025 Bonds will be issued for each maturity of the Series 2025 Bonds in principal amount equal to the aggregate principal amount of the Series 2025 Bonds of such maturity and will be deposited with DTC or its agent.

DTC, the world's largest securities depository, is a limited-purpose trust company organized under New York Banking Law, a "banking organization" within the meaning of New York Banking Law, a member of the Federal Reserve System, a "clearing corporation" within the meaning of the New York Uniform Commercial Code, and a "clearing agency" registered pursuant to the provisions of Section 17A of the Securities Exchange Act of 1934, as amended. DTC holds and provides asset servicing for over 3.5 million issues of United States and non-United States equity issues, corporate and municipal debt issues, and money market instruments from over 100 countries that DTC's participants ("Direct Participants") deposit with DTC. DTC also facilitates the post-trade settlement among Direct Participants of sales and other securities transactions in deposited securities, through electronic computerized book-entry transfers and pledges between Direct Participants' accounts. This eliminates the need for physical movement of securities certificates. Direct Participants include both United States and non-United States securities brokers and dealers, banks, trust companies, clearing corporations and certain other organizations.

DTC is a wholly-owned subsidiary of The Depository Trust & Clearing Corporation ("DTCC"). DTCC is the holding company for DTC, National Securities Clearing Corporation and Fixed Income Clearing Corporation, all of which are registered clearing agencies. DTCC is owned by the users of its regulated subsidiaries. Access to the DTC system is also available to others, such as both U.S. and non-U.S. securities brokers and dealers, banks, trust companies and clearing corporations that clear through or maintain a custodial relationship with a Direct Participant, either directly or indirectly (the "Indirect Participants"). DTC has Standard & Poor's rating of AA+. The DTC Rules applicable to its Direct and Indirect Participants are on file with the Securities and Exchange Commission. More information about DTC can be found at www.dtcc.com and www.dtc.org.

Ownership of Series 2025 Bonds

Purchases of the Series 2025 Bonds under the DTC system must be made by or through Direct Participants, which will receive a credit for the Series 2025 Bonds on DTC's records. The ownership interest of each actual purchaser of each Series 2025 Bond (the "Beneficial Owner") is in turn to be recorded on the Direct and Indirect Participants' records. Beneficial Owners will not receive written confirmation from DTC of their purchases. Beneficial Owners are, however, expected to receive written confirmations providing details of their transactions, as well as periodic statements of their holdings, from the Direct or Indirect Participants through which the Beneficial Owners entered into the transaction. Transfers of ownership interests in the Series 2025 Bonds are to be accomplished by entries made on the books of Direct and Indirect Participants acting on behalf of the Beneficial Owners. *Beneficial Owners will not receive certificates representing their ownership interests in the Series 2025 Bonds except in the event that use of the book-entry only system for the Series 2025 Bonds is discontinued under the circumstances described below under "Discontinuance of Book-Entry Only System."*

To facilitate subsequent transfers, all Series 2025 Bonds deposited by Direct and Indirect Participants with DTC are registered in the name of DTC's partnership nominee, Cede & Co., or such other name as may be requested by an authorized representative of DTC. The deposit of Series 2025 Bonds with DTC and their registration in the name of Cede & Co. or such other DTC nominee do not effect any change in beneficial ownership. DTC has no knowledge of the actual Beneficial Owners of the Series 2025 Bonds; DTC's records reflect only the identity of the Direct Participants to whose accounts such Series 2025 Bonds are credited, which may or may not be the Beneficial Owners. The Direct and Indirect Participants will remain responsible for keeping account of their holdings on behalf of their customers.

Conveyance of notices and other communications by DTC to Direct Participants, by Direct Participants to Indirect Participants and by Direct Participants and Indirect Participants to Beneficial Owners will be governed by arrangements among them, subject to any statutory or regulatory requirements as may be in effect from time to time. Beneficial Owners of Series 2025 Bonds may wish to take certain steps to augment transmission to them of notices of significant events with respect to the Series 2025 Bonds, such as redemptions, tenders, defaults and proposed amendments to the security documents. For example, Beneficial Owners of Series 2025 Bonds may wish to ascertain that the nominee holding the Series 2025 Bonds for their benefit has agreed to obtain and transmit notices to Beneficial Owners. In the alternative, Beneficial Owners may wish to provide their names and addresses to the Trustee and request that copies of the notices be provided directly to them.

So long as a nominee of DTC is the registered owner of the Series 2025 Bonds, references herein to the Bondholders or the holders or owners of the Series 2025 Bonds shall mean DTC and shall not mean the Beneficial Owners of the Series 2025 Bonds. The Authority and the Trustee will recognize DTC or its nominee as the holder of all of the Series 2025 Bonds for all purposes, including the payment of the principal or Redemption Price of and interest on, and the purchase price of, the Series 2025 Bonds, as well as the giving of notices and any consent or direction required or permitted to be given to or on behalf of the Bondholders under the Resolution. Neither the Authority nor the Trustee will have any responsibility or obligation to Direct or Indirect

Participants or Beneficial Owners with respect to payments or notices to Direct or Indirect Participants or Beneficial Owners.

Payments on and Redemption or Purchase of Series 2025 Bonds

So long as the Series 2025 Bonds are held by DTC under a book-entry system, principal and interest payments on the Series 2025 Bonds will be made to DTC. DTC's practice is to credit Direct Participants' accounts upon DTC's receipt of funds and corresponding information from the Trustee on the applicable payment date in accordance with their respective holdings shown on DTC's records. Payments by Participants to Beneficial Owners will be governed by standing instructions and customary practices, as is the case with securities held for the accounts of customers in bearer form or registered in "street name," and will be the responsibility of such Participants and not of DTC, the Trustee or the Authority, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of principal and interest to DTC is the responsibility of the Authority or the Trustee, disbursement of such payments to Direct Participants shall be the responsibility of DTC and disbursement of such payments to the Beneficial Owners shall be the responsibility of Direct and Indirect Participants.

So long as the Series 2025 Bonds are held by DTC under a book-entry only system, the Trustee will send any notice of redemption or purchase with respect to the Series 2025 Bonds only to Cede & Co. or such other nominee as may be requested by an authorized representative of DTC. Any failure of DTC to advise any Direct Participant, or of any Direct Participant to notify any Indirect Participant or of any Direct or Indirect Participant to notify any Beneficial Owner, of any such notice and its content or effect will not affect the validity of the proceedings for the redemption or purchase of the Series 2025 Bonds or of any other action premised on such notice. If fewer than all of the Series 2025 Bonds of any one maturity are selected for redemption or purchase, DTC's practice is to determine by lot the amount of the interest of each Direct Participant to be redeemed or purchased, except as otherwise directed by the Authority.

None of the Authority, the Trustee, the Underwriters or the Obligated Group Members can give any assurances that DTC or the Direct or Indirect Participants will distribute payments of the principal or Redemption Price of and interest on or the purchase price of the Series 2025 Bonds paid to DTC or its nominee, as the registered owner of the Series 2025 Bonds, or any redemption, purchase or other notices, to the Beneficial Owners or that they will do so on a timely basis or that DTC will serve and act in the manner described in this Official Statement.

Discontinuance of Book-Entry Only System

DTC may discontinue its services as a securities depository for the Series 2025 Bonds at any time by giving reasonable notice to the Authority, the Obligated Group Members and the Trustee, or the Authority may discontinue use of the system of book-entry transfers through DTC. Under such circumstances, in the event that a successor securities depository is not obtained, Series 2025 Bonds are required to be printed and delivered in fully certificated form to the Participants shown on the records of DTC provided to the Trustee or, to the extent requested by any Participant, to the Beneficial Owners of the Series 2025 Bonds shown on the records of such Participant provided to the Trustee.

The Authority may also discontinue its maintenance of the Series 2025 Bonds under the book-entry system, issue replacement Series 2025 Bonds directly to the Participants or, to the extent requested by any Participant, to the Beneficial Owners of such Series 2025 Bonds, and shall make provisions to notify Participants and the Beneficial Owners of the Series 2025 Bonds of the same. In such event, the Authority shall promptly have prepared Bonds in certificated form registered in the names of the Participants as shown on the records of DTC provided to the Trustee or, to the extent requested in writing by any Participant, in the names of the beneficial owners of such Series 2025 Bonds shown on the records of such Participant provided to the Trustee, as provided in the Resolution.

Registration and Exchange of Series 2025 Bonds

So long as the Series 2025 Bonds are maintained under a book-entry system, transfers of ownership interests in the Series 2025 Bonds will be made as described above under "Book-Entry Only System." If the book-entry only system is discontinued, any Series 2025 Bond may be exchanged for an equal aggregate principal amount of Series 2025 Bonds of the same maturity and bearing interest at the same rate of other authorized denominations, and the transfer of any Series 2025 Bond may be registered, upon presentation and surrender of such Bond at the designated office of the Trustee, together with an assignment duly executed by the registered owner or his attorney or legal representative. The Authority and the Trustee may require the person requesting any such exchange or transfer to reimburse them for any tax or other governmental charge payable in connection therewith. Neither the Authority nor the Trustee shall be required to register the transfer of any Series 2025 Bond or make any such exchange of any Series 2025 Bond during the 15 days preceding the date of mailing of any notice of redemption or purchase or after such Series 2025 Bond or any portion thereof has been selected for redemption or purchase.

ASSURED GUARANTY®

MUNICIPAL BOND INSURANCE POLICY

ISSUER: Policy No.: -N

BONDS: $ in aggregate principal amount of Effective Date:

Premium: $

ASSURED GUARANTY INC. ("AG"), for consideration received, hereby UNCONDITIONALLY AND IRREVOCABLY agrees to pay to the trustee (the "Trustee") or paying agent (the "Paying Agent") (as set forth in the documentation providing for the issuance of and securing the Bonds) for the Bonds, for the benefit of the Owners or, at the election of AG, directly to each Owner, subject only to the terms of this Policy (which includes each endorsement hereto), that portion of the principal of and interest on the Bonds that shall become Due for Payment but shall be unpaid by reason of Nonpayment by the Issuer.

On the later of the day on which such principal and interest becomes Due for Payment or the Business Day next following the Business Day on which AG shall have received Notice of Nonpayment, AG will disburse to or for the benefit of each Owner of a Bond the face amount of principal of and interest on the Bond that is then Due for Payment but is then unpaid by reason of Nonpayment by the Issuer, but only upon receipt by AG, in a form reasonably satisfactory to it, of (a) evidence of the Owner's right to receive payment of the principal or interest then Due for Payment and (b) evidence, including any appropriate instruments of assignment, that all of the Owner's rights with respect to payment of such principal or interest that is Due for Payment shall thereupon vest in AG. A Notice of Nonpayment will be deemed received on a given Business Day if it is received prior to 1:00 p.m. (New York time) on such Business Day; otherwise, it will be deemed received on the next Business Day. If any Notice of Nonpayment received by AG is incomplete, it shall be deemed not to have been received by AG for purposes of the preceding sentence and AG shall promptly so advise the Trustee, Paying Agent or Owner, as appropriate, who may submit an amended Notice of Nonpayment. Upon disbursement in respect of a Bond, AG shall become the owner of the Bond, any appurtenant coupon to the Bond or right to receipt of payment of principal of or interest on the Bond and shall be fully subrogated to the rights of the Owner, including the Owner's right to receive payments under the Bond, to the extent of any payment by AG hereunder. Payment by AG to the Trustee or Paying Agent for the benefit of the Owners shall, to the extent thereof, discharge the obligation of AG under this Policy.

Except to the extent expressly modified by an endorsement hereto, the following terms shall have the meanings specified for all purposes of this Policy. "Business Day" means any day other than (a) a Saturday or Sunday or (b) a day on which banking institutions in the State of New York or the Insurer's Fiscal Agent are authorized or required by law or executive order to remain closed. "Due for Payment" means (a) when referring to the principal of a Bond, payable on the stated maturity date thereof or the date on which the same shall have been duly called for mandatory sinking fund redemption and does not refer to any earlier date on which payment is due by reason of call for redemption (other than by mandatory sinking fund redemption), acceleration or other advancement of maturity unless AG shall elect, in its sole discretion, to pay such principal due upon such acceleration together with any accrued interest to the date of acceleration and (b) when referring to interest on a Bond, payable on the stated date for payment of interest. "Nonpayment" means, in respect of a Bond, the failure of the Issuer to have provided sufficient funds to the Trustee or, if there is no Trustee, to the Paying Agent for payment in full of all principal and interest that is Due for Payment on such Bond. "Nonpayment" shall also include, in respect of a Bond, any payment of principal or interest that is Due for Payment made to an Owner by or on behalf of the Issuer which has been recovered from such Owner pursuant to the United States Bankruptcy Code by a trustee in bankruptcy in accordance with a final, nonappealable order of a court having competent jurisdiction. "Notice" means telephonic or telecopied notice, subsequently confirmed in a signed writing, or written notice by registered or certified mail, from an Owner, the Trustee or the Paying Agent to AG which notice shall specify (a) the person or entity making the claim, (b) the Policy Number, (c) the claimed amount and (d) the date such claimed amount became Due for Payment. "Owner" means, in respect of a Bond, the person or entity who, at the time of Nonpayment, is entitled under the terms of such Bond to payment thereof, except that "Owner" shall not include the Issuer or any person or entity whose direct or indirect obligation constitutes the underlying security for the Bonds.

AG may appoint a fiscal agent (the "Insurer's Fiscal Agent") for purposes of this Policy by giving written notice to the Trustee and the Paying Agent specifying the name and notice address of the Insurer's Fiscal Agent. From and after the date of receipt of such notice by the Trustee and the Paying Agent, (a) copies of all notices required to be delivered to AG pursuant to this Policy shall be simultaneously delivered to the Insurer's Fiscal Agent and to AG and shall not be deemed received until received by both and (b) all payments required to be made by AG under this Policy may be made directly by AG or by the Insurer's Fiscal Agent on behalf of AG. The Insurer's Fiscal Agent is the agent of AG only and the Insurer's Fiscal Agent shall in no event be liable to any Owner for any act of the Insurer's Fiscal Agent or any failure of AG to deposit or cause to be deposited sufficient funds to make payments due under this Policy.

To the fullest extent permitted by applicable law, AG agrees not to assert, and hereby waives, only for the benefit of each Owner, all rights (whether by counterclaim, setoff or otherwise) and defenses (including, without limitation, the defense of fraud), whether acquired by subrogation, assignment or otherwise, to the extent that such rights and defenses may be available to AG to avoid payment of its obligations under this Policy in accordance with the express provisions of this Policy.

This Policy sets forth in full the undertaking of AG, and shall not be modified, altered or affected by any other agreement or instrument, including any modification or amendment thereto. Except to the extent expressly modified by an endorsement hereto, (a) any premium paid in respect of this Policy is nonrefundable for any reason whatsoever, including payment, or provision being made for payment, of the Bonds prior to maturity and (b) this Policy may not be canceled or revoked. THIS POLICY IS NOT COVERED BY THE PROPERTY/CASUALTY INSURANCE SECURITY FUND SPECIFIED IN ARTICLE 76 OF THE NEW YORK INSURANCE LAW.

In witness whereof, ASSURED GUARANTY INC. has caused this Policy to be executed on its behalf by its Authorized Officer.

ASSURED GUARANTY INC.

By _____
Authorized Officer

1633 Broadway, New York, N.Y. 10019 (212) 974-0100

Form 500 (8/24)

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